

RADIOLOGY MANAGEMENT

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The Journal of AHRA: The Association for Medical Imaging Management

The Transition from Clinical Staff Member to Manager

By Brian Leicher, MS, CMD, RT(T) and
Sandra K. Collins MBA, PhD



Lean Management Systems in Radiology: Elements for Success

By Stacy R. Schultz, BA, Royce L. Ruter,
BS, CIIP, CPAS, CNMT, RT(N)(ARRT),
and Laura C. Tibor, MBA, BEng



Observation Leads to Improved Operations in Nuclear Medicine

By Deo G. Religioso, CNMT, RT(N), MBA, CRA



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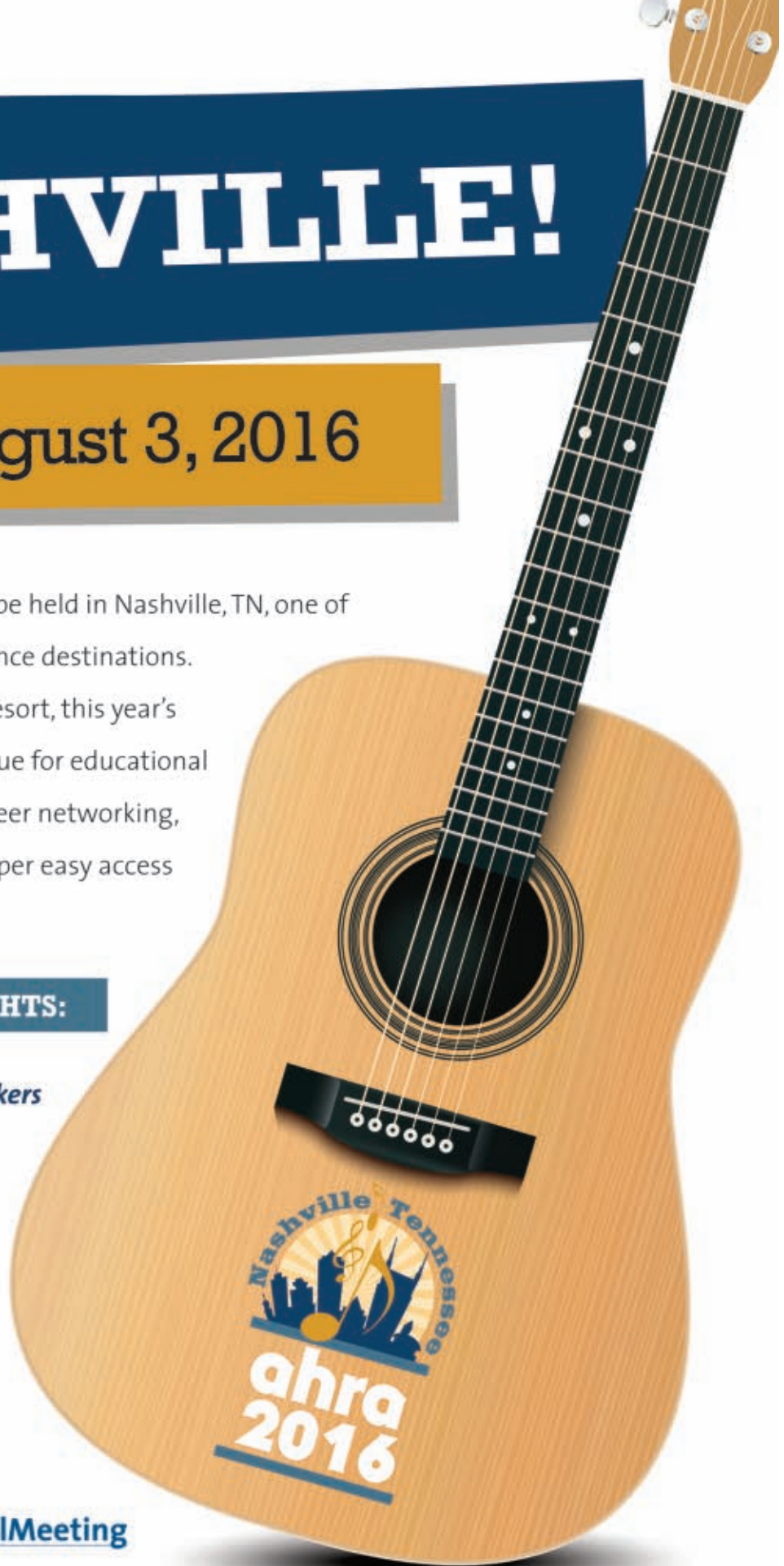
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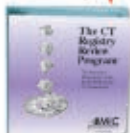
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Cover photo (top): AHRA Past-President Ed Yoder with 2014 Annual Meeting keynote speaker, Lt. Col. (ret.) Rob 'Waldo' Waldman.

Cover photo (bottom): Ed Yoder and his wife, Rita.

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Remembering Ed Yoder

By Debra L. Murphy

Ed Yoder was an interesting cat. For those of you who did not know him, Ed joined AHRA in 2000 and in no time got involved in our organization. He started writing for *Radiology Management* as a regular columnist in 2004 ("Medical Imaging Meets the Proforma"). Although his niche was finance, the metamorphosis of his writing shifted over the years, most likely, as his own career development, goals, and interests shifted. When he wrote his last column in 2015 ("Time: Just Say Yes") the change was obvious. He was more than a director managing the bottom line, he became a leader (a Studer devotee) and wished to impart just a little bit of that to our readers, his colleagues.

Ed passed away in January of this year. Cancer won. No matter how cliché it sounds, I'll go ahead and say it—for anyone who knew him, **we** won. I read an interesting quote a little while ago about travel. The basic message was that the biggest impact you will get from traveling is how it shapes you after you come home. While the experience itself is a (good/bad/fun/adventurous/etc) one-time event, it's the memories of it and how the journey affected you that that can be most meaningful. You look through your everyday lens (maybe just ever so slightly) different. This struck a nerve because the traveling I have done *has* changed me. Just as some of the people I've known have changed me, even just ever so slightly. Including Ed.

I edited his writing for nearly 10 years. While not a grammar expert (glad your first love was imaging, man) his sentiments were provoking and on target. He loved to write and loved even more when fellow AHRA members would reach out to him about a particular article. He was usually late, but always forgiven (how could I not with all of those LOL's!!! and YOU DA BOMB's!!! splashed through his emails). He even encouraged me to up my own leadership game and pursue the executive title I have now.

As a final tribute to Ed, I reprinted an article he wrote in 2011 (p. 48) on creating a culture of extraordinary care. It's the first in a six part series, and I encourage you to read all of them. It gets to the core of what he was about as a leader in medical imaging. And a good reminder of why you do what you do every day. He left a legacy in these pages his family, friends, and colleagues should be proud of.

Rock on, Ed. 🌱

Deb Murphy is the Deputy Executive Director at AHRA. She is also managing editor of Radiology Management and may be contacted at dmurphy@ahraonline.org.

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Editor-in-Chief

Paul Dubiel, RT(R), MS, FAHRA, CRA
Director of Imaging
Seton Family of Hospitals
Austin, TX

AHRA Managing Editor

Debra L. Murphy

Design

Mary McKeon

Production

Cenveo® Publisher Services

AHRA Associate Editor

Kerri Hart-Morris

Editorial Review Board

Bill Algee

Radiology Manager
Columbus Regional Hospital
Columbus, IN

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Houston Methodist Hospital
Houston, TX

Elisabeth Yacoback,

CRA, BSRT, CPHQ, CCA
Administrative Analyst
Medical College Physicians Group
Little Rock, AR

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Contact Radiology Management

Editor

Debra L. Murphy

AHRA
490-B Boston Post Road, Suite 200
Sudbury, MA 01776
Phone: (800) 334-2472, (978) 443-7591
Fax: (978) 443-8046
dmurphy@ahraonline.org

Advertising Sales

Kelly Miller

M.J. Mrvica Associates, Inc.
2 West Taunton Avenue
Berlin, NJ 08009
Phone: (856) 768-9360
Fax: (856) 753-0064
kmiller@mrsvica.com

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Hospital Wars: Fiction Imitates Reality

By Paul Dubiel, MS, RT(R), CRA, FAHRA

I'll admit it—I'm a big *Downton Abbey* fan (I also watch *Mob Wives*, but you'll never see an article comparing that to anything radiology related). Yes, for the last five and a half years my Sunday evenings are spent on the couch tuned into PBS. It was a family affair with my wife and children also joining in the fun. That is, until they killed off my daughter's favorite two characters (Sybil and Matthew) and not even bringing Tom back from Boston could bring her to the couch again on Sunday nights.

I have always been fascinated by British TV, but usually my taste leaned toward *Monty Python* and *Fawlty Towers* versus *Masterpiece Theatre*. But, for some reason, *Downton* really spoke to me and I have been hooked ever since. Maybe it's just watching the upstairs crowd argue over what is the right tux to wear to tea on Sunday afternoons in June or which fork to use with duck pate. Or what zinger Mary will lob at Edith and what pithy comeback Edith will muster. Or which brandy Lord Grantham would pick for his after dinner drink with the boys as they discuss politics. Or which summer home the family will be vacationing in this year. After all, can't go to the same summer home two years in a row (how ghastly). On the downstairs side, what will ever become of the staff as the world rolls into the 1920s. Will Thomas find a job and play nice with anyone? Will something good finally happen to Mr. Bates

and Anna? Will Mrs. Patmore find true love with the local pig farmer?

But this fantasy world I have lived in came to a crashing halt when a dose of reality crept in that hits all too close to home for a number of us in healthcare today—hospital mergers.

Yes, *Downton* has hit the big time and their local community hospital is being looked at by the big city hospital to "join" them in a win/win partnership to better serve the people of the community. The usual argument we have all heard of increased capital spending, more prestige, and better access to specialists and an overall increase in resources that makes partnering with the big city hospital the right thing to do for the staff and people of *Downton*. This argument is countered by that of the current president and chairperson of the board, the Dowager Countess, who is fighting to keep things as they always were and citing local governance and care, history, and the undying devotion to the people of *Downton* they don't need the big city people to take care of them. They can do it on their own. The intense battle between the Dowager Countess and her frenemy, Lady Isabel Crawley, while comical to watch is all too familiar with those of us who have gone through this type of merger or have watched from afar as others have. The politics and posturing going on as key members of the hospital board, community, and physicians choose sides in the battle balancing

what's best for the town and what's best for the patients or the importance of preserving the past versus moving on to the future of healthcare.

My favorite piece so far has been Dowager Countess calling in political favors by inviting Lord Chamberlin, then the minister of health, to understand the true meaning of the *Downton* hospital and win him to her side of the argument to preserve local rule. You may laugh, but how many hospitals have brought in local politicians to help keep things local? As I write this, I don't know the outcome of the battle of the hospital. My feeling is that the small local one will merge with the big city hospital and gain all the benefits and lose some of the local flavor that goes along when these things happen in the real world. The Dowager Countess will have some life changing medical event and, because of the merger, the *Downton* hospital will have access to the latest medical equipment. And, as it so happens, the eminent specialist in whatever her medical emergency will be is chief of staff at the big city hospital and happens to be in town. The Dowager, never one to admit she is wrong, will say some condescending remark to the doctor about his status in life then give a short nod and move on to find new ways to put down the rabble and her frenemy Isabel Crawley.

At the start of the season, I was already disappointed that this was the last for *Downton Abbey*. The writers are trying

to tie up all the loose ends by the end of the season, but I doubt it will tie them all up. It will be interesting to see where they all end up, both upstairs and down. Who survives the upcoming changes in the system and how will both parties face the uncertain future with World War II just around the corner. I wish there was a seventh season to continue the storyline of the hospital merger and what happens after the ink dries. How is the merger accepted by staff and what changes are made to policy and procedure? What new services are being offered and how much control is left to the local level versus dictated out of the corporate office? Will services be cut at the local level and will the dreaded hub and spoke method be used to stabilize and ship patients to the mother ship and away from local care? The future has finally hit *Downton Abbey* and, like us 80 years later, we don't always like what we see. There is merit to both sides of the argument and passion runs high on each. But, in the end, as healthcare continues to evolve and change what needs to be at the forefront of every discussion is what's best for the patient. Sometimes the answer isn't what we want it to be, but making that assessment and making the decision based on the facts and not just emotion will position us to be successful in the future and to always keep the patient at the center of our concerns. 🌱

Paul A. Dubiel, MS, RT(R), CRA, FAHRA has been the senior director, imaging at Seton Family of Hospitals in Austin, TX since 2002. An AHRA member since 1993, he is currently editor-in-chief of Radiology Management and has volunteered for numerous other task forces and committees. Paul can be contacted at pdubiel@seton.org.



Washington Still Operating As Election Season Kicks Off

By Bill Finerfrock and Nathan Baugh

With all the focus on the presidential election, we tend to forget that there are still elected representatives governing, legislating, and appropriating in Washington right now! Congress and the President came to an agreement on government funding for fiscal year 2016 (including changes in imaging reimbursement), and Congress passed a so-called Affordable Care Act Repeal bill (more on that later).

The Consolidated Appropriations Act of 2016

In December, Congress passed, and the President signed, the Consolidated Appropriations Act of 2016, also known as the Omnibus, which funds the Federal Government through fiscal year 2016. As is common with large appropriations bills, a number of so called “Riders” (or smaller pieces of legislation) were included in the law. One of the riders that made it into the final language of the Omnibus was a version of a smaller piece of legislation introduced as the Medical Imaging Modernization Act of 2015. This bill incentivized practices to use digital x-ray techniques and included a provision the American College of Radiology (ACR) had long sought to the professional component Medicare Multiple Procedure Payment Reduction (MPPR) policy.

Radiologists have long argued that the fact that multiple imaging procedures were performed on the same patient, on the same day, had no bearing on the amount of work it takes for the radiologist to read the corresponding images. As such, they argued, the current Medicare MPPR policy unfairly penalized their reimbursement for the work they did on those subsequent images. For more than four years, the ACR lobbied Congress to change this policy.

The Medical Imaging Modernization Act of 2015 completely eliminated the reduction in payment for the professional component of imaging services for radiologists who interpret multiple images from the same patient during a single session on the same day. On its own, the bill did not get much momentum and it never made it out of committee. However, the concept was popular enough among lawmakers that it was incorporated into the Omnibus package with one key change: the sponsors had to settle for simply lowering the reduction in payment from 25% to 5% instead of eliminating it altogether. Still a significant victory for the ACR, the reduced discount begins in 2017.

To be clear: the technical component policy of MPPR remains the same.

As mentioned earlier, the Omnibus also included language that prods the industry towards digital x-ray imaging.

In order to push practices and hospitals towards digital x-ray the Omnibus codified the following changes for both the Physician Fee Schedule as well as the Hospital Outpatient Prospective Payment System (HOPPS):

1. For imaging services with x-rays taken using film instead of digital, payment is reduced by 20% beginning in 2017.
2. For x-rays furnished using computed radiography imaging services, payment will be reduced by 7% from 2018-2022, and by 10% from 2023 and onwards. (Computed radiography technology means cassette-based imaging which utilizes an imaging plate to create the image involved.)

The Congressional Budget Office (CBO) estimates that these changes will save \$352 million (in reduced Medicare outlays) over the next ten years.

Restoring Americans’ Healthcare Freedom Reconciliation Act of 2015

The Restoring Americans’ Healthcare Freedom Reconciliation Act of 2015 was recently passed by Congress, but vetoed by the President on January 8, 2016. The veto is sure to be upheld as opponents do not have enough votes to override. Unlike other bills that repealed the

entire Affordable Care Act (ACA) and fell short in the Senate, this bill repealed only portions of the ACA, passed the Senate, and made it all the way to the President's desk. A politically significant achievement for Republicans and signal to the American public of what could be achieved with a Republican in the White House. This legislation is more colloquially referred to as the "reconciliation" bill because of the legislative procedure used to pass it.

While many have labeled this legislation as a "repeal" of the ACA, the legislation did not fully repeal the law. Rather, it ended certain key aspects of the ACA related strictly to the budget. While it would significantly undermine the ability for the ACA to work as intended, it does not change policies in the ACA such as the prohibition against insurance companies to deny people with pre-existing conditions or the ability of young people to stay on their parent's insurance plan through age 26.

Instead, because the bill focuses on items only related to the budget, the reconciliation bill was allowed to be passed via the "Budget Reconciliation" process which is important because it is not subject to the Senate's filibuster rules, and thus may pass with a simple majority of Senators. A significant point, because the Democrats' ability to filibuster traditional legislative efforts has prevented any sort of "repeal" bill from reaching the President's desk despite numerous successful votes in the House of Representatives to do so. However, this bill demonstrates that sticking solely to budgetary items can achieve almost the same effect as repealing the ACA outright. This Reconciliation Bill significantly affected the following aspects of the ACA:

Immediately Eliminates Funding for the Prevention and Public Health Fund

This was a fund used by Health and Human Services (HHS) to set up various public health programs aimed at preventing disease. Republicans question the cost effectiveness of these Federal Programs and argue that the funds

could be better spent elsewhere or not spent at all.

Eliminates the Risk Corridor Program

The Risk Corridor Program was established as a way to assure health insurance companies offering plans on the health exchange would not have to accept much risk. The concept involved taxing those health plans that were profitable and then paying out those health plans which had lost a significant amount of money. This program was created to entice health insurance companies to offer affordable premiums. The first year of the risk corridor revealed a severe shortfall between the amount of taxes yielded on profitable plans and the amount of risk adjustment owed out to the struggling plans. Republicans argue that eliminating this program would force insurance companies to properly calculate their premium offerings, which may lead to higher premiums.

Repeals the Premium Tax Credit Individuals Can Qualify for in the Healthcare Exchange

This is a centerpiece of the ACA. These premium tax credits were made available for those earning between 100% and 400% of the Federal Poverty Line buying insurance in the individual market created by the ACA. Access to these tax credits was the biggest incentive offered in the ACA to buy insurance.

Repeals the Small Business Tax Credit

This tax credit was offered to certain small businesses with average annual wages less than \$50,000 if they paid for a uniform percentage of all employees premiums.

Repeals the Individual Mandate by Completely Eliminating the Penalty for Not Having Insurance

The metaphorical "stick" to the "carrot" of the premium tax credit. The penalty for not having insurance (sometimes called the "individual mandate") would be reduced to zero in this bill. Penalties

for not having health insurance have steadily increased from \$95 in 2014, to \$325 in 2015, and now to \$695 in 2016.

Repeals the Employer Mandate by Also Eliminating the Penalty for Not Providing Insurance to Employees

The "employer mandate" imposes heavy fees on employers who did not provide insurance to a specified percentage of their workers beginning in 2016. There are separate sets of rules for companies with 50-99 employees, and companies with over 100 employees. Aspects of this provision were delayed several times, but began in 2015 and were expanded in 2016.

Repeals Medicaid Expansion by Eliminating the Extra Federal Funds for States that Have Expanded Their Medicaid Program

Medicaid expansion was initially mandatory for all 50 states, but a Supreme Court ruling determined that states should have the right to opt-out if they want. The expansion would expand Medicaid to families with incomes up to 138% of the poverty line as well as single adults who were not previously eligible. Since Medicaid is administered by state governments, the federal government offered to assume all of the costs of adding these new beneficiaries initially. However, beginning in 2017, the federal government would only pay for 95% of the costs, and only 90% of the costs beyond 2020. Many states have opted not to expand Medicaid due to the added cost concerns it would place on state budgets.

Repeals Cadillac Tax

The Cadillac Tax was designed to reduce unnecessary medical utilization by those with the most comprehensive, expensive plans. Wary of any new taxes that could increase the cost of healthcare for consumers or employers, Republicans and some Democrats have long worked to get rid of this tax. The recently passed Omnibus deal of 2015 delayed implementation of this tax to 2018.

Repeals Medical Device Excise Tax

The Medical Device Excise tax is a 2.3% tax on manufacturers of medical devices. The tax was justified as a way to pay for other aspects of the ACA by taxing an industry that was supposed to benefit from the law (due to more people having insurance). The tax took effect in 2013, but has proven to be unpopular and was suspended for 2016 and 2017 as a part of the Omnibus package approved in December 2015.

While some of these changes were to take effect immediately, the elimination of the tax credits to individuals and small businesses, as well as the Medicaid expansion repeal, would not occur until 2018. The reconciliation bill was designed this way to give Republicans two years to pass an alternative to ACA that would supplant the tax credits or “subsidies” as they are sometimes called.

As a whole, this reconciliation bill would significantly undermine the ACA’s ability to function as intended, which is of course the purpose of the bill. If the 2016 elections result in Republican majorities in the House and Senate, and a Republican president, then a bill very similar to this would almost certainly be passed and signed into law. However, only time (and an election) will reveal how this all plays out. 🍀

Bill Finerfrock is the president and owner of Capitol Associates, a government relations/consulting firm based in Washington, DC, who has partnered with AHRA on their regulatory affairs issues. Nathan Baugh is an associate with CAI. They can be contacted at bf@capitolassociates.com and baughn@capitolassociates.com.

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The Transition from Clinical Staff Member to Manager

By Brian Leicher, MS, CMD, RT(T) and Sandra K. Collins MBA, PhD

The credit earned from the Quick Credit™ test accompanying this article may be applied to the CRA human resources management (HR) domain.

EXECUTIVE SUMMARY

- Internally promoting clinical staff members into management positions is often a wise organizational strategy. Although there are advantages in doing such, there are also a number of challenges.
- Newly appointed managers may need introductory management level training given technical expertise does not always equate to management expertise. Devoting time to teaching even the most basic management skills will assure a more seamless role transition for the promoted employee.
- Upper administration also needs to be aware that possessing clinical expertise does not always serve as a precursor to promotion. Not every clinical employee, regardless of how proficient they are in their technical roles, seeks to be a manager.

In the clinical setting, the opportunity may arise to promote staff members into management positions. This has several advantages. Internal promotions may motivate other employees to improve their clinical and technical skills and pursue advancement as well. Furthermore, promoting individuals who have been successful in their current roles is advantageous for the organization. This is in contrast to enduring a protracted orientation period with outside hires who may not be familiar with the organization's normal operations. Even the best and brightest outside candidates typically require a period of time to become acclimated to a new work environment.

Although there are advantages to internal promotion, problems may arise when new managers are given responsibilities without adequate preparation. They may struggle with their new administrative roles even if they excelled in the clinical setting. The work ethic and clinical skill sets responsible for promotion do not necessarily translate into effective management abilities. Senior management must recognize that formally training new managers is as important as training newly hired clinical staff members. Assuring newly appointed managers are knowledgeable of basic management issues is vital to their success. Administrators must realize that not

all clinical staff members aspire to be in management positions.

Moving Up

As with any industry, several factors may be considered when deciding to fill a management position in the healthcare environment. It must be determined if it is best to promote a current employee or hire from outside the organization. Hiring from within has advantages given the organization is already familiar with the individual. The internal candidate is typically well known to superiors, is respected by peers, and has a significant amount of technical knowledge.¹ Hiring from within also has patient-care linkages. Recent studies indicate that hospitals promoting those with strong clinical backgrounds into management roles experience lower morbidity and mortality rates among their patients. The benefits associated with hiring from within have caused many institutions to focus on filling management positions with former clinical employees rather than pure administrators.²

Traits that may make an individual seem prepared to make the transition from clinical expert to manager include: technical and clinical skill sets, knowledge base, work ethic, and the ability to interact successfully with others. The person may also display leadership traits,

■ **TABLE 1.** Leadership versus Management Competencies

Leadership Competencies	Management Competencies
Setting Direction or Mission	Staffing Personnel
Motivating Stakeholders	Controlling Resources
Being an Effective Spokesperson	Supervising Service Provided
Determining Strategies for Future	Overseeing Adherence to Regulations
Transforming Organization	Counseling Employees

but leadership traits and management abilities are not mutually inclusive. As shown in Table 1, there are clear distinctions between leadership and management competencies.³

In the healthcare industry, many are promoted to management because they excel at something else.⁴ The assumption that clinical abilities instinctively prepare a new manager for the trials and challenges of administration can result in mistakes and oversights. Unfortunately, it is a common practice to promote clinical employees into management without adequate orientation. Therefore, organizations need to create a plan for orientating newly promoted employees. If this step is ignored, key positions could erroneously be filled by unprepared managers and this may strain department resources.⁵ The failure to develop newly appointed managers is compounded by the tendency to promote highly skilled technical staff who may have no management skill or aspiration.⁶ Continuing with this inadequate process may eventually lead to a compromise in the quality of care. Additionally, there may be an erosion of faith on the part of the general public.

The transition into leadership may be particularly intimidating if the individual's new position includes both clinical and managerial duties. Being pulled in different directions without proper preparation may be overwhelming. Learning to appropriately allocate time to meet the demands of the new managerial position

can be a task in itself. As opposed to 100% of the former clinical staff member's time being spent on technical issues, 40% of their time as a new administrator will be spent overseeing subordinate staff members. For a working supervisor, another 40% may be spent performing clinical work, 15% goes toward training and counseling, and the remaining 5% is devoted to miscellaneous tasks. It is incumbent upon the senior management team to adequately train and then provide follow up support for new managers who have been promoted from the within the clinical environment.⁷

When a previous clinical staff member begins a new role as a manager, the most basic management functions should be addressed. The new manager must realize what defines a supervisor. The Taft-Hartley Act of 1947, also known as the Labor-Management Relations Act of 1947, Section 101, Subsection 2(11), identifies a supervisor as "any individual having the authority to hire, transfer, suspend, recall, or discipline other employees; or responsibility to direct them, or to adjust their grievances."⁷ Many healthcare facilities may offer some forms of training or leadership classes to help support newly appointed administrators because successfully transitioning from the clinic

into management means that the new manager must learn an entire new set of skills including planning, organizing, leading, and staffing.⁸ Coupled with insufficient or nonexistent management training, the newly promoted manager may soon find that the clinical skills that served them so well in the technical arena may not translate into successful management skills. As previously stated, even natural leadership ability will not necessarily equate to successful management ability. The newly promoted staff member may be faced with an entirely new set of rules and regulations. There may be a significant amount of stress associated with new policies and procedures.

Another potential hurdle for the new manager is that remaining staff members must now report to an individual who previously was their peer. This can cause envy and resentment. Some former coworkers may attempt to use the previous relationship to further their own personal agendas. Others may challenge the new manager so as to reveal weaknesses and ultimately sabotage their previous colleague's chances of success in their new managerial role.⁹ Ignoring or incorrectly addressing these issues can undermine the manager's authority and/or lower department morale. The newly promoted manager should avoid maintaining social bonds with subordinate staff in situations where their judgment and effectiveness may be compromised. Siding with former coworkers rather than with upper management may give the perception of weak or ineffective management.¹ Some studies indicate a mentor may be helpful to help alleviate some of these issues. Although mentorship may be somewhat helpful, studies also indicate there is little support suggesting a mentorship program increases the leadership effectiveness of the mentee.¹⁰

The assumption that clinical abilities instinctively prepare a new manager for the trials and challenges of administration can result in mistakes and oversights.

Communication

Direct and open communication can help to combat complaints and resentment. A new manager must become proficient in receiving orders from superiors, delivering orders to subordinates, coaching, counseling, taking disciplinary action when needed, interviewing prospective job candidates, and interacting with other managers. Without proper training in communication techniques, the new manager may fall back on inappropriate methods based on previous work experience rather than formal techniques developed through proper management training.¹ Formal communication training should emphasize gathering and delivering feedback through listening. Ideally, communication consists of 40% listening, 35% talking, 16% reading, and 9% writing. Unfortunately, most people commit only 25% of the total communication process to listening.¹¹ Without learning how to actively listen, there is a risk that important information will be missed and problems not resolved.¹² Subordinates who are agitated must be handled particularly carefully. Providing negative or inappropriate feedback to a subordinate in the form of anger or a dismissive attitude may cause subordinates to avoid communicating with the manager in the future. The new manager must also realize that feedback does not end when a conversation is finished. The technical staff must understand the manager's feedback and be able to apply it successfully to their work.¹³

A new manager must also learn to employ these same listening and communication skills when dealing with superiors and other managers. When interacting with members of one's own department, it may be common to communicate using terms or phrases unique to that specific environment. However, a new manager must learn to limit the use

of insider language when dealing with those from other departments.¹ Sitting in a general meeting and using abbreviations and acronyms to a group of uninformed listeners will only cause confusion. Care must be taken to avoid using terms and expressions that are unknown to the overall group.¹⁴

The simple act of communicating properly can potentially take on an entirely different meaning as the previous technical employee transitions from clinic to management. There are several methods of communication that the new manager will deal with on a daily basis. One of the most common may be simple face-to-face communication. This is potentially the most powerful because it combines not only verbal messages with tone and volume, but also very strong non-verbal signals with body language.¹ The ability to recognize both verbal and non-verbal signals will certainly help when dealing with irate or noncompliant subordinates. The new manager must interpret non-verbal communication from staff members often times in high stress situations. Non-verbal cues can be exceedingly powerful and overshadow verbal messages.

In addition to being able to send and interpret verbal and non-verbal cues, new managers must also keep in mind their own physical presence. Much like real estate, location is everything. There are in fact four components of communication distance. They are applicable to both verbal and non-verbal situations. These four components include¹⁵:

1. Intimate (16 to 18 inches)
2. Personal (1 1/2 to 4 feet)
3. Social (4 to 12 feet)
4. Public (12 feet and beyond)

Distance may be particularly critical for new managers to understand especially where culture and gender are considered. For example, the intimate zone

for someone from one country may only be nine to ten inches, but the same distance may be considered much too close, and perhaps even threatening, for someone from another country. Physical contact with any employee in the workplace by the new manager, even with persons who were formally friends and coworkers, are strongly discouraged as these actions may be easily be misinterpreted by other staff members.

Since communication does not occur by words alone, a multicultural workforce requires new managers to be cautious when using hand signals or gestures as well. To some individuals, hand signals such as "OK" or "thumbs-up" are generally thought to convey acceptance or approval. However, these same hand gestures may take on an extremely negative connotation to other individuals.¹⁵

Delegation

Another critical management skill is that of delegation, and not delegating enough is thought to be the number one mistake of new managers.¹⁶ It may be one of the most uncomfortable tasks for newly promoted technical staff, and this can be compounded by the fact that the subordinate may not be able to perform a particular function as well as the new manager. Coming from a background where the former staff member excelled, it may be difficult for the new manager to relinquish control of a task or process that had been such a large part of their own scope of practice. In addition to countering this mindset, the manager must still realize that, regardless of who completes a given task, the ultimate responsibility lies with the manager.¹⁷

The hesitancy to delegate may also be tied into the issue of recognition. Top performing clinical employees typically take great pride in their accomplishments. Delegating work removes the new manager from the spotlight and the satisfaction and recognition that used to follow their accomplishments. The new manager must learn to compensate for this by dealing with the satisfaction of

*Delegation may be one of the most uncomfortable tasks
for newly promoted technical staff.*

overseeing a successful group or department. The new goal of the manager must be to learn how to transition from worker to teacher or mentor. Patience must be exercised as staff members will surely make mistakes as it takes time for their skill levels to increase. If the new manager is taught how to develop individual training plans and provide support, these mistakes and missteps can be kept to a minimum. The task of delegation must be handled carefully. Delegating too much can lead to low morale among subordinates and a sense that the new manager is either no longer clinically competent or is out of touch with current technical practices. Delegating too little can impair a manager's ability to function adequately as an administrator. If the new manager is unable to delegate effectively then he or she will have to assume the technical responsibilities that should rightly be delegated to other staff members. If this is the case, the administrative tasks facing the manager will still need to be addressed and the resulting workload associated with being pulled in multiple directions can stress an individual to the point of being unable to function in the workplace as either a technical expert or administrator. This scenario is also certain to attract the negative attention of senior management.¹⁸

Holding Effective Meetings

Frequent regular meetings with fellow supervisors and subordinate staff can help to maintain control of a high clinical and administrative workload. Meeting with other managers can avoid situations where authority might inadvertently be undermined. Meeting with senior administration can serve to reinforce the new manager's skill and confidence as well as preventing the practice of delegating up to higher level administrators. Meeting with subordinates lets them know who is responsible for each area or task in the department. It must be stated, however, that the new manager must not fall into the trap of having meetings

just for the sake of having meetings. Too many meetings, especially if they are vacuous, will rob the manager of the ability to implement those issues that are discussed. Furthermore, employees can be negatively affected by bad meetings. They could very well perceive them as a waste of time. Regular staff meetings should be treated as an essential work activity. Once again, the new manager must be trained in how to organize and conduct meetings.¹⁹

Utilizing Time Effectively

Time management is another critical skill that needs to be addressed. New managers may not only have trouble managing their own time in their new role, but managing the time of others can also be challenging. In reality, a manager cannot really manage time. Instead, they must be taught to manage events. Vacations, personal days, seminars, and mandatory in-services all come into play when trying to maintain an adequate workforce in the clinic. Unfortunately, even the best plans can be unraveled by unexpected events. Sudden illness, the request for emergency personal time, bereavement time, and sudden unexpected staff attrition can adversely affect how to schedule staff and normal business procedures. New managers should develop a time management system that is flexible enough to account for changes in staffing and workload. There may be instances where requests for time off, including vacation, may be denied in order to ensure that there is clinical coverage in the event of an emergency. This can cause discontent among clinical staff, as they may only be focused on current workload and available clinical coverage rather than the

global outlook. The clinical staff may also resent the new manager's refusal to allow time off given that they were previously a coworker. Since the responsibility for providing an adequate workforce, regardless of unforeseen events, lies on the shoulders of the manager, the new manager must be cautious when dealing with these situations. It can become too easy to fall into old habits and resort to working in the clinic as a technical staff member as opposed to managing a workforce.²⁰

Maintaining Dual Roles

In addition to maintaining clinical and technical expertise, the new manager must often assume the dual role of specialist and generalist. As previously stated, it is common practice to be selected for promotion due to the skill sets and knowledge base necessary for clinical success. The newly promoted technologist was a specialist in his or her field prior to promotion. This technical expertise can be the result of formal training, experience, working with and watching others, or any combination of these factors. A critical error on the part of senior management is the assumption that a simple change of title imbues the new manager with all of the skills necessary to cope with the demands of the new position. In assuming the unfamiliar role of generalist, the new manager must now learn to acquire knowledge in every facet of departmental operations. Given that they must have a much broader understanding of the entire work area, the new manager has to learn to segue into the position of knowing a little bit of everything. This may be a difficult challenge coming from a clinical background where their expertise was evident.¹

A critical error on the part of senior management is the assumption that a simple change of title imbues the new manager with all of the skills necessary to cope with the demands of the new position.

Not Everyone Can Be a Manager

One aspect that is often overlooked when dealing with the issue of promoting top performing staff members is that these individuals may not desire a promotion into management or administration. Senior management may feel that everyone wants to be rewarded by moving up the organizational ladder. While this may often times be true, administration should also keep an open mind. Furthermore, while many employees aspire to reach the level of management, not all of them are suited for this transition. This may be the case even if there is a formal management training program in place.²¹ Some organizations are known for providing career advancement programs which are thought to motivate and prepare clinical staff for the transition to management. This is a good strategy, but some healthcare organizations may merely promote who they see fit and expect new managers to learn their new skills through trial and error. Unfortunately, this can be an ineffective training initiative.

Even with a formal management training program in place, care should be taken when selecting a person or group of potential candidates for promotion. Staff members may initially desire an upward transition into management, but may find that they are not well suited to this aspect of their work environment. In fact, there is the story of one company that wanted to reduce the possibility of moving the wrong people into management. Every candidate for promotion into management was invited to an all-day seminar on what management actually involves. This training session included typical management problems and scenarios. Of the approximately 500 people who attended the seminar, roughly 100 of them (or about 20%) realized that they did not want to be managers.⁹ Just think of it, a potential failure rate of 20% for individuals who originally thought that they wanted to be promoted into management. One can only wonder what the failure rate is for

staff members who receive an unwanted promotion. Before asking the obvious question of why accept a management position if it is not what you want, a very important issue needs to be considered. Many individuals may accept a promotion simply because of the possibility there will be negative repercussions if the promotion is rejected.

A novel approach to taking care of valued employees may be to think outside of the box when looking to reward valuable employees who perform above average in the clinic. Healthcare institutions should strive to avoid blanket approaches to employee recognition and motivation. Instead, rewards and recognition should be matched to the individual as well as the achievements.²² Rewards can be as simple as an extra day off with pay or moving a workspace to a more pleasant environment. Often times, rewards can be meted out at no cost to the institution. By personalizing a reward system, valuable employees can be retained and continue to improve the quality of the healthcare environment. Promoting someone to management who does not want to be in this role may cause an outstanding employee to quit and leave. Perhaps even worse, they may decide to quit and stay.

Conclusion

With the increasing complexity of the healthcare industry, greater challenges are being presented to clinical employees if they are promoted into a management role. Although promoting those with clinical skills has organizational advantages, there is often a need to teach the new manager some basic management skills to assure the transition from clinical to management is as successful as possible. Interpreting budgets, marketing, recruitment and retention, and fulfilling legal requirements are but a few managerial duties the new managers will need to address that may offer some challenges to those former clinical staff members who find themselves headed toward an administrative role. However, some of the basic management skills may be the most

challenging and should be addressed as they are trained and prepared for the new role. Holding a dual clinical/management position can be daunting as new managers must find new ways to manage their time and communicate with others. However, upper administration must be cognizant that technical ability does not always translate into management ability especially without additional training and development. 🌱

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Brian Leicher, MS, CMD, RT(T) is a medical dosimetrist at Allegheny General Hospital in Pittsburgh, PA. He can be contacted at bleicher@wpahs.org.

Sandra K. Collins MBA, PhD is associate professor and program director of the Health Care Management Program in the School of Allied Health at Southern Illinois University Carbondale in Carbondale, Illinois. She can be contacted at skcollin@siu.edu



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QUESTIONS

Instructions: Choose the answer that is most correct. Note: Per a recent ARRT policy change, the number of post-test questions has been reduced from 20 to 8.

1. Every clinical staff member desires to be a manager.
 - a. True
 - b. False
2. The role of Supervisor as identified by the Taft-Hartley Act of 1947 is:
 - a. Someone who delegates all tasks
 - b. An individual who schedules multiple meetings
 - c. Any individual having the authority to hire, transfer, suspend, or discipline employees
 - d. All of the above
3. When communicating, most people commit only ____% of the process to listening.
 - a. 40%
 - b. 16%
 - c. 35%
 - d. 25%
4. There are four components to communication distance. What distance is considered personal?
 - a. 16 to 18 inches
 - b. 1.5 to 4 feet
 - c. 4 to 12 feet
 - d. 12 feet and beyond
5. Frequent meetings with fellow supervisors and subordinate staff can help to maintain:
 - a. Social media contacts
 - b. Personal well-being by complaining to other managers
 - c. Control of a high clinical and administrative workload
 - d. Authority over subordinates
6. Approximately 500 individuals were invited to attend a pre-promotion management seminar. At the end of the day-long event, what percentage of employees realized that they did not want to become managers?
 - a. 10%
 - b. 20%
 - c. 30%
 - d. 50%
7. One of the benefits of internally promoting a clinical staff member to management is:
 - a. The internal candidate may be well known to superiors and respected by peers
 - b. The internal candidate may be good friends with members of administration
 - c. The internal candidate may know who to butter up in order to achieve goals
 - d. The internal candidate will bring fresh ideas and a new perspective to existing problems
8. Some potential downsides of internally promoting staff members to management are:
 - a. Possible resentment on the part of staff members having to report to a former peer
 - b. Some former coworkers may try to use the new manager to further their own agendas
 - c. Former peers may challenge the new manager or put them to the test
 - d. All of the above



How Does Your Department Feel?

By Mark Lerner

Many of us attend meetings where we're instructed on how to become better managers. One of the primary reasons I try not to miss the AHRA Annual Meeting is to take advantage of lectures of this type. We've heard about the concept of emotional intelligence, which embodies such things as empathy and social competence in interpersonal relationships, but one subject I haven't heard discussed is the ability of leaders to be able to feel the pulse of the departments for which they are responsible.

I've had instances in the past where I have been able to sense whether things are going well or not for the people I work with, without needing to discuss the matter in words. Perhaps I have this trait because my wife and I raised two daughters. I can remember when they were teenagers and I'd come in the front door after a long day at work (together with an hour and a half difficult commute by car), and I could read the tension between Amy or Sarah and their mother before anyone uttered a sentence. You could have nearly cut the anxiety in the air with a knife.

Or I might have been able to do this because I was raised in New York early in my life. Frequent trips to Manhattan taught me that I needed to be completely aware of my surroundings. Finding yourself caught off guard could lead to bad situations that may threaten your physical well being. Both of our kids ended up going to college in New York City, and I credit our frequent trips for

preparing them for their eventual highly successful four years of education after high school. Because spending time in this town instructs people to raise their self-awareness, I highly recommend the experience.

But the cause of possessing this particular skill is not really as crucial as the ability to develop it in oneself. The reason that managers need to be able to feel the collective pulse of their departments (a subject that can be considered within the scope of developing one's emotional intelligence) is that this can lead to making decisions that dramatically improve the work environment. Allow me to provide you with an example.

I once worked for a hospital that was losing market share in patient volume to other centers over many years. This resulted in numerous layoffs at my facility and I had to complete several cycles of employee reductions. We had reached a point where staffing was exceptionally low and on a particular morning perhaps an x-ray technologist had called in sick. I could see on the face of one of the other radiographers how sad and disappointed she was that she was going to have to complete her day with the anticipated pressure for her to perform several studies simultaneously. This is the type of stress that can cause a person to quit a job. Because of my read of her mood I approached this individual with an expression of sympathy and a willingness to help in any way that I could. I also informed her of my plan to provide

assistance to her in the future. This employee then stayed in her position for many years after our conversation.

Even if you are not absolutely on target in deciphering an employee's state of mind by osmosis, simply checking in on them demonstrates that you are interested in their well being. I've often inquired of someone if he or she was alright only to be told that everything was perfectly fine with the addition of "Thank you so much for asking!" I'm sure readers will recall that the question "Does my supervisor, or someone at work, seem to care about me as a person?" is one of the 12 that the Gallup organization utilizes to measure levels of employee satisfaction. Showing that you are concerned about how they are doing is a sure fire way to raise staff engagement.

We spend our careers assisting people so it only makes sense that our compassion should extend to our coworkers as well as our patients. We can express benevolence through words but in some circumstances this will be long after consternation has begun in someone's thoughts. Being able to feel whether an issue has arisen with an employee can relieve hours or days or more of concern and significantly strengthen the culture of your radiology department. 🌱

Mark Lerner is the director of diagnostic imaging at the George Washington University Hospital. He can be reached at Mark.Lerner@gwu-hospital.com.

Are Old Surgical Sites Coming Back to Haunt You in 3D Mammography?

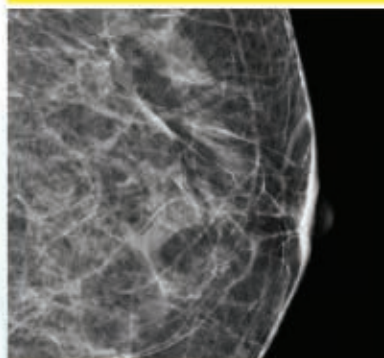
Chances are you are seeing a lot more architectural distortion since you went to DBT.

How far back in the patient's records do you go to compare images to determine if it's something new?

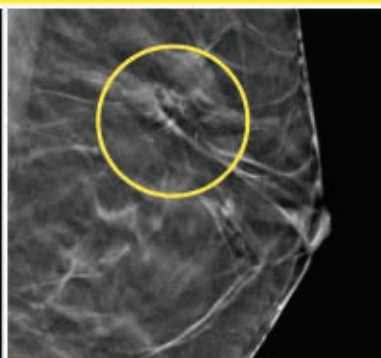
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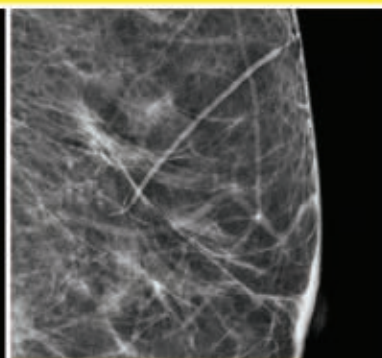
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2015 screening mammogram in DBT, Left MLO, 2D view.
No abnormalities noted.



2015 screening mammogram in DBT, Left MLO, 3D view.
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Lean Management Systems in Radiology: Elements for Success

By Stacy R. Schultz, BA, Royce L. Ruter, BS, CIIP, CPAS, CNMT, RT(N)(ARRT),
and Laura C. Tibor, MBA, BEng

*The credit earned from the Quick Credit™ test
accompanying this article may be applied to the
CRA operations management (OM) domain.*

EXECUTIVE SUMMARY

- This article is a review of the literature on Lean and Lean Management Systems and how they have been implemented in healthcare organizations and particularly in radiology departments.
- The review focuses on the elements required for a successful implementation of Lean by applying the principles of a Lean Management System instead of a Lean tools-only approach. This review shares the successes and failures from healthcare organizations' efforts to improve the quality and safety of the services they provide.
- There are a limited number of healthcare organizations in the literature who have shared their experiences and additional research is necessary to determine whether a Lean Management System is a viable alternative to the current management structure in healthcare.

Whether you call it Lean, as Krafcik first coined in 1988, Lean thinking, Lean manufacturing, Lean production, or Lean Management System; many organizations across the world, including healthcare, have been applying the principles of Taiichi Ohno's Toyota Production System with limited success.^{1,2} The reason for this gap is that many organizations focus heavily on the tools introduced by the system without understanding Lean as an entire system that permeates an organization's culture.² Critiques of the tools-only focus note that even brilliant use of tools without changes in culture rarely produces lasting change, or even lasting improvement.³ Implementing Lean tools is a more manageable undertaking than the effort required to change an organization's culture or style of management. However, in order to make the kind of change required in healthcare, to address the safety concerns raised by the Institute of Medicine with their landmark report *To Err is Human*, and to also address the cost concerns raised by the public, a dramatic change is called for.⁴

Lean Management System

Value is in the eye of the customer, not the producer of a product or service, and in healthcare, value is defined by the patient. Womack and Jones were the first to summarize a process to address this change in philosophy with their five principles of Lean thinking: first specify *value* by specific product, identify the *value stream* for each product, make value *flow* without interruptions, let the customer *pull* value from the producer, and pursue *perfection*.⁵ Ohno stated it more clearly when he said, "All we are doing is looking at the timeline from the moment the customer gives us an order to the point when we collect the cash. And we are reducing that time line by removing the non-value-added wastes."² Ohno classified the wastes into seven categories: overproduction, waiting, unnecessary transport or conveyance, overprocessing or incorrect processing, excessive inventory, unnecessary movement, and defects. Womack and Jones added the classification of an additional waste: underutilization of skills. See also Box 1 for a glossary of terms.

■ Box 1. Glossary

Flow: The progressive achievement of tasks along with value stream so that a product proceeds from design to launch, orders to delivery, and raw materials into the hands of the customer without stoppages, scrap, or backflows.

Kaizen: Continuous, incremental improvement of an activity to create more value with less waste.

Non-value added waste: Waste in a process. Customers would be willing to buy a product or service that did not have these costs if it meant a lower price.

Pull: A system of cascading production and delivery instructions from downstream to upstream activities in which nothing is produced by the upstream supplier until the downstream customer signals a need.

Sensei: A personal teacher with a mastery of a body of knowledge.

Standard work: A price description of each work activity specifying cycle time, takt time, the work sequence of specific tasks, and the minimum inventory of parts on hand needed to conduct activity.

Takt time: The available production time divided by the rate of customer demand.

Throughput time: The time required for a product to proceed from concept to launch, order to delivery, or raw materials into the hands of the customer. This includes both processing and queue time.

Value added waste: Any process step or activity that transforms the form, fit, or function of the product or service for which the customer is willing to pay.

Value stream: The specific activities required to design, order, and produce a specific product, from concept to launch, order to delivery, and raw materials into the hands of the customer.

Value stream map: Identification of all the specific activities occurring along a value stream for a product or product family.

Visual control: The placement in plain view of all tools, parts, production activities, and indicators of production system performance, so the status of the system can be understood at a glance by everyone involved. Used synonymously with transparency.

Source: Womack J, Jones D. "Lean Thinking: Banish Waste and Create Wealth in Your Corporation." New York: Simon Shuster. 1996.

Can implementing a Lean Management System (LMS) provide healthcare organizations, or more specifically a radiology department, with the structure required to address safety, cost, and waste? A system for sustainable implementation and continuous improvement of LMS requires the cooperation of employees and leaders striving for perfection, including the customer focus of all processes and the long term development of employees and leaders.⁶ Virginia Mason Medical Center in Seattle, Washington, believed the Toyota Production System would make "an excellent fit in healthcare" when they began their Lean journey in 2001, as

did ThedaCare in Appleton, Wisconsin, when they began their Lean journey in 2002.⁷⁻⁹ Although Lean principles were first developed in the manufacturing industry, they are suited for application in a service industry such as radiology, which relies on customer flow and equipment function.¹⁰ Implementing an LMS and huddle structure is dependent on the size of the radiology department and the organization it serves.¹¹ There are only a limited number of healthcare organizations who have published their efforts with Lean in the literature and even fewer in the area of radiology. That being said, an LMS may be just what the doctor ordered.

Commitment

For Lean to perform as promised by the literature, awareness that a cultural change is required and a strong commitment by senior leadership is essential. Motivating employees to change their way of thinking will require stern direction as employees are directed to try things which seem completely outside their normal way of doing things.⁵ Individuals typically look for quick fixes to address issues, the path of least resistance, and this may be the reason why implementing just the Lean tools has been the way many healthcare organizations have implemented Lean.

A proven method in changing a culture is the full commitment to an LMS; however, this requires an enormous effort by everyone in the organization, specifically leaders. Implementing Lean tools represents approximately 20% of the effort in Lean transformations while the other 80% of the effort is spent on changing leaders' practices and behaviors.³ Leaders want to know how much time it will take to implement an LMS. Although a three-year commitment is needed, a five-year time frame is more realistic. A first step is to ask staff if they are willing to work hard, be willing to accept the one step backward that comes with the two steps forward, and if they can stick to the task for five full years.⁵

To change one's culture requires a strong commitment by everyone in the organization, will not happen overnight, and will take years in order to experience a shift. To create a culture conducive to improvement and implementation, leaders should not focus their efforts on changing the culture but on the management system.¹¹ LMS is designed so that issues can be quickly identified, frontline staff are empowered to fix the problems, and the problems that front-line staff cannot fix are escalated and countermeasures are created quickly.¹¹ The change in culture will occur on its own if an organization follows the structure of an LMS. A commitment of five years is the beginning of an organization's continuous journey towards the pursuit of perfection. ThedaCare started their Lean journey in 2002; however, it wasn't until 2009, seven years later, before they noticed their organization was "on the cusp of a necessary cultural shift."¹²

People

Senior Leaders

Lean is a fairly new concept in healthcare with the first organizations applying the principles at the beginning of this century. A few healthcare organizations have hired a Lean sensei, or consultant, to lead them through the critical first

few years of implementation and then as a resource going forward. Virginia Mason hired a consultant and had access to multiple sensei.⁸ Similarly, ThedaCare hired a sensei from a consulting firm who helped train 30 of their employees as facilitators and teachers. These 30 individuals worked full time for a period of one-to-two years conducting value stream analyses, kaizen events, and projects before returning to operations.¹³ The Lean transition requires new skills whereby both leaders and workers need the guidance from someone who has gone before them, to teach and mentor.⁶ Unfortunately, this key element to successful implementation of Lean is either overlooked or disregarded as cost prohibitive.

To help managers/supervisors and frontline staff know which direction to steer their improvement efforts, senior leaders must set goals for managers and employees to strive towards. People are motivated by challenging, yet attainable goals, while measuring the progress towards those goals.²

Setting goals and supporting employees as they strive to reach established goals is a key element of LMS. In radiology, Akron Children's Hospital's executive suite believed in empowering employees to create an environment whereby the employees make it better and more efficient for themselves.¹⁴ Also in radiology, at Nemour's Children's, the metrics correspond to institutional priorities and are categorized into five categories (quality and safety, patient/family experience, delivery, cost, and engaged associates) and for each category, several goals are chosen. Metrics established in an area are reviewed, and any relevant questions and issues are elicited.¹¹ In order to gauge whether improvement efforts are successful, they must be measured.

*To change one's culture requires a strong commitment
by everyone in the organization.*

Once senior leaders set the goals and the current state is defined, managers can use the LMS to guide employees to meet or exceed those goals.

Successful implementation of LMS rests solely on the shoulders of senior leaders. The reason most LMS initiatives do not succeed is due to a failure by leaders to change their own practices. Effective Lean leadership comes from the top as well as from the frontline staff. Post-mortem reviews of unsuccessful Lean implementations often blame the collapse on a failure to adhere to the Lean design at lower levels when in fact the failure is often caused by changed, weak, or absent support of senior leaders.³

Virginia Mason leaders took this philosophy seriously. In a conversation between CEO Gary Kaplan and Edgar Schein, the former MIT faculty member and organizational culture guru, Schein stated that "leaders of organizations—by their behaviors—shape the culture." Afterwards, Kaplan declared Virginia Mason leaders would, "have to engage with the method, learn it, practice it, and teach it."⁷ Toussaint described the LMS as clear and deliberate which ties the work of frontline employees to senior management decision making and vice versa.¹⁵ Gomez and colleagues in the NeuroInterventional Radiology Department at Massachusetts General Hospital pointed out that their success was directly related to the strong support of their chair and executive director.¹⁶ This is the type of action by senior leaders that is required for successful implementation of Lean.

Managers/Supervisors

Lean describes a method of displaying the behaviors one wants to see in others. Leader standard work is one of the key elements that allow frontline employees

to see the effects of standard work and how it works in a Lean environment. Managers and supervisors see their roles as most effective on the front lines and LMS is keeping the process healthy, flowing, and supporting the workers as they go about their day.⁸ Leader standard work relies heavily on checklists and standard processes and becomes more standardized the closer the leader is to the frontline; however, standardization before one knows what they are doing is probably not a good thing.¹¹ This would suggest that before managers or supervisors ask their frontline employees to begin the process of developing standard work, they themselves need to take a closer look at their processes and develop their own leader standard work.

Leaders in a LMS have two primary responsibilities: 1) to make sure the system runs as designed; and 2) to ensure continuous improvement of the system.¹¹ Simply, LMS requires a change in the way managers and supervisors lead. Managers and supervisors will be required to get out of conference rooms and offices and spend time where the work takes place—go to *gemba*.

It is likely that everyone, especially leaders, when beginning their Lean journey will fail and will fail often. An improvement culture centers around a different understanding of failure and accepting it as a means to explore improvement and learning along with finding the root cause of the failure before establishing controls so that failure will not occur again.⁶ The key is to coach employees on the behaviors and tools to help them with these failures.

As much as managers may or may not enjoy “putting out fires,” Lean leadership centers around the concept of coaching employees. Lean leaders do not solve problems, but instead ask employees questions to encourage them to be critical thinkers and solve problems themselves.¹⁷ Lean leaders require a strong commitment to self-development and it is important to first develop themselves before taking on the responsibility for teaching others.¹⁷ Lean leadership is

very contradictory to how many managers were trained and requires an entirely new set of skills. Lean leadership, in essence, is about respect for people—respect for patients, respect for employees, and respect for oneself. In a Lean organization, the management hierarchy is a chain of support whereby the role of supervisors and managers is to support the growth of all employees by helping them identify the root causes of the problems and allowing them to devise solutions to those problems.¹⁰ The LMS provides the structure to support managers and supervisors with this concept.

Frontline Employees

In the current healthcare climate, frontline employees are typically affixed to their work areas addressing the needs of patients; however, in order for LMS to take hold, employees must be granted time away to be educated on the fundamentals of Lean for improvement to occur. LMS is an operating system composed of six principles that constitute essential dynamic Lean Management and to miss any one of these principles is to neglect Lean’s full potential to benefit the organization.¹⁸ In NeuroInterventional Radiology at Massachusetts General Hospital, training cross-functional staff included physicians, nurse practitioners, staff nurses, technologists, and administrators. All roles participated in a six-hour educational session on the concepts and principles of the LMS and only emergent elective procedures were scheduled on the day of training.¹⁶ The goal in radiology at Akron Children’s Hospital was for the manager, supervisor, lead technologists, and physicians in each modality to be adept at applying the basic Lean tools and principles to their daily management system and are taught these concepts in an eight-session program.¹⁴ Frontline employees are typically

bound to their work area and do not have time allocated for improvement work so the organizational structure must provide time to accommodate these efforts. When implementing a LMS, it is vital that each initiative or project involves members of the frontline staff. Including them from the introduction of Lean, participation on every project team, and throughout the management system changes is critical to success.

The literature referenced the concern and fear raised by healthcare employees about how Lean, or more specifically standard work, takes away their freedom and creativity and how patients are neither widgets nor car parts. Virginia Mason leaders noted that their teams, through perseverance, showed that standard work not only improved quality, but reduced safety hazards and freed up time for staff to take better care of their patients.⁸ ThedaCare addressed employees concerns regarding standard work and how it does not replace critical thinking in their monthly newsletters.¹²

One misconception about standard work is that finding the scientifically one best way to do a task or best practice and then freezing it is what standard work is all about; however, it is impossible to improve a process until it is standardized.² More importantly, The Toyota Way is about enabling those doing the work to design and build in quality by writing the standardized procedures for themselves, and any quality procedures have to be simple and practical to be used every day by the people doing the work.² Employees are the ones who, on a daily basis, witness the deviations from the standard and will know best the common defects and disturbances.⁶ Healthcare is a complex environment and enabling employees to design their standard work provides them with a sense of pride and ownership, and also gives them a tool in which to train new

Lean leadership centers around the concept of coaching employees.

employees during periods of high turnover. What may feel like an arduous endeavor in the beginning saves time down the road.

Lean Management System Tools

Huddles

A key element of the LMS is the huddle. Huddles have been referred to as the getting and giving of information, an increased two-way communication method that focuses on establishing information flow from the bottom-up to top-down.¹⁷ A well-run huddle can appear casual but it is anything but. A huddle is most effective when it is standardized, follows a precise and well known formula, and is organized around improvement projects.¹² At Nemours Children's Hospital, the daily management system is structured as a tiered huddle system. All front-line clinical areas, as well as clinical and nonclinical ancillary areas, have morning huddles. Some areas huddle on a daily basis while others huddle weekly. These huddles are conducted in a standard fashion across the enterprise, are brief (usually ≤ 15 minutes), and are attended by all available front-line associates and local leaders. For huddles in the clinical setting, physicians are an important component as their perspectives and insights are crucial to optimal operations. Nemours' huddles are typically overseen by the local leaders but are run by frontline employees for which they have designed scripts to help with running the huddles. Importantly, Nemours' huddles are conducted in or near the work unit, allowing more participation by frontline employees and easy access.¹¹ Huddles, whether tiered or not, provide employees with the structure necessary to keep the lines of communication open and aid in the

improvement efforts put forth to achieve the goals of an organization.

Visual Control System

One option for a visual control system is the use of visual boards, such as a whiteboard or bulletin board, where metrics and opportunities for improvement are tracked for everyone to see. Visual control has been described as any communication device used in the work area that tells its employees, at a glance, how work should be done and whether it is deviating from the standard.² Visual control systems promote transparency of data and status of the current state. One study researched five organizations who regarded themselves to be successful Lean organizations, and all five organizations used whiteboards to support their daily improvement work.¹⁷ Each of the boards typically include two parts: 1) a means to submit ideas (a place for Post-it notes, reflection book, improvement idea form); and 2) visualization of current improvement initiatives. Like others, huddles were held around whiteboards to review the progress or status of the improvement work and to also plan future initiatives.¹⁷ Having employees huddle around the visual control system and reviewing its content allows everyone to see where opportunities for improvement exist. One of the struggles with visual boards in healthcare is the logistical location for the visual boards. For example, a large radiology department with multiple modalities (eg, CT, MRI, and ultrasound) and employees spread out over several locations may find it difficult to decide where best to place visual boards. In the current environment, a potential electronic solution such as web-based dashboards or Skype™ for Business may address these concerns. There are myriad possibilities and each organization and work unit

must decide what will work best for their employees and practice.

A3 Thinking

A critical LMS problem solving tool is an A3. An A3 is a powerful tool that establishes a concrete structure to implement PDSA (Plan-Do-Study-Act) management, drawing the report's author to a deeper understanding of the problem or opportunity for improvement.¹⁹ According to many authors, an A3 is an indispensable tool in their LMS toolbox.^{10,13-16,18,20} An A3 allows anyone in the organization to view the status of the improvement work and is typically placed on the visual control system such as a whiteboard (Figure 1).

PDSA

Whether it's called PDCA (Plan—Do—Check—Act) or PDSA (Plan—Do—Study—Act), the systematic process of testing change to gain learning is an additional essential tool in the LMS toolbox. One gains this learning by running multiple PDSA cycles (Figure 2). Through Mayo Clinic Rochester's initial Lean efforts, and as a result of 9 PDSA cycles in their radiology's Breast Imaging Division, patient surveys indicate remarkable satisfaction from a baseline of 61% to 95% with the new workflow. They were able to eliminate two communication hand offs, reduce batching, minimize paperwork and stacking errors, and decrease patient wait times by over 33%. Three months into implementation, average total screening mammogram throughput time decreased from 39 to 26 minutes.

Conclusion

The LMS may seem like a daunting undertaking; however, if structured appropriately by implementing the key elements of culture, people, and tools, and then adapting them to meet an organization's specific needs, success can be achieved. The literature cited here is limited to only a few organizations in radiology and more research is needed. 🌱

Having employees huddle around the visual control system and reviewing its content allows everyone to see where opportunities for improvement exist.


Problem-Solving Report

Title: _____

To: _____

By: _____

Date: _____

Theme
<ul style="list-style-type: none"> What are we trying to do? Concise statement of what this A-3 report is about.
Background
<ul style="list-style-type: none"> Note any contextual or background information necessary to fully understand the issue. Importance of the problem Indicate how this problem affects the company's goals or is related to its values.
Current Condition
<ul style="list-style-type: none"> Insert a diagram that illustrates how the current process works. Label the diagram so that anyone knowledgeable about the process can understand. Note the major problems (we like to put them in starbursts to set them apart) Include quantified measures of the extent of the problem – graphical representations are best! 
Root Cause Analysis
<ul style="list-style-type: none"> Ask appropriate "why?" questions until you reach the root cause. A rule-of-thumb: you haven't reached the root cause until you've asked "why?" at least 5 times! <p>Problem</p> <pre> graph TD Problem --> Why1[why] Why1 --> Why2[why] Why2 --> Why3[why] Why3 --> Why4[why] Why4 --> Why5[why] </pre>


Target Condition																		
<ul style="list-style-type: none"> Insert a diagram that illustrates how the proposed process will work, with labels. Note or list the countermeasure(s) that will address the root cause(s) identified (fluffy clouds). Predict the expected improvement in the measure of interest (specifically and quantitatively) 																		
Implementation Plan																		
<ul style="list-style-type: none"> List the actions which must be done in order to realize the Target Condition, along with the individual responsible for the action and a due date. Add other items, such as cost, that are relevant to the implementation. <table border="1"> <thead> <tr> <th>What? <i>Actions to be taken</i></th> <th>Who? <i>Responsible person</i></th> <th>When? <i>Deadline</i></th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>COST: _____</p>	What? <i>Actions to be taken</i>	Who? <i>Responsible person</i>	When? <i>Deadline</i>															
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Figure 1 • A3 Problem Solving Report



MODEL FOR IMPROVEMENT

PROJECT TITLE NAME HERE

DATE: *(date you started filling in this form)*

PDSA1.0 - TITLE OF THIS CYCLE HERE

PLAN:

Objective for this PDSA Cycle:	
Is this cycle used to develop, test, or implement a change?	
What question(s) do you want to answer with this PDSA cycle?	
Where will this PDSA cycle take place:	
What are you testing in this cycle:	
Who is involved in this cycle:	
When is this cycle going to be tested:	
Communication Plan	Enter who will be communicating, what will be communicated, when will it be communicated
Predictions for this cycle (with name of person predicting):	

DO: *Carry out the change or test; Collect data and begin analysis.*

STUDY: *Complete analysis of data; Compare the data to your predictions and summarize the learning*

ACT: *Are we ready to make a change?*

Figure 2 • PDSA Worksheet

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Stacy Schultz has been a quality improvement/ education specialist in the Department of Radiology at Mayo Clinic Rochester for nine years. She is an Institute for Healthcare Improvement trained improvement advisor. Ms. Schultz is a faculty member of the Mayo Clinic Quality Academy and an instructor in radiology at the Mayo Clinic Medical School. She can be contacted at schultz.stacy@mayo.edu.

Royce L. Ruter has worked in the Department of Radiology at Mayo Clinic Rochester for over 15 years. Many of his duties have focused on changes and improvements related to equipment, processes and people. Currently, he is actively helping to lead the implementation of a Lean Management System in the Division of Breast Imaging and Intervention. Mr. Ruter is an Associate in Radiology and holds academic appointment as an Instructor in Radiology, Mayo Clinic College of Medicine.

Laura Tibor has worked in quality/process improvement for eight years. Laura is currently the supervisor for the Department of Radiology's Value Creation Unit at Mayo Clinic. She has a bachelor's degree in industrial engineering and management and a master's degree in business administration. She is a Mayo Clinic Quality Academy faculty member and an instructor in health care systems engineering in Mayo Clinic's College of Medicine. Laura can be contacted at Tibor.Laura@mayo.edu.

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Lean Management Systems in Radiology: Elements for Success

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Carefully read the following multiple choice questions and take the post-test at AHRA's Online Institute (www.ahraonline.org/onlineinstitute)

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QUESTIONS

Instructions: Choose the answer that is most correct. Note: Per a recent ARRT policy change, the number of post-test questions has been reduced from 20 to 8.

1. In healthcare, the patient defines:
 - a. Waste
 - b. Value
 - c. Perfection
 - d. Commitment
2. Lean tools typically represent about ____% of the effort in a LMS implementation.
 - a. 50
 - b. 10
 - c. 20
 - d. 35
3. For senior leaders, supporting _____ is a key element of the LMS.
 - a. Patients
 - b. The C-suite
 - c. Projects
 - d. Employees
4. Many LMS implementations do not succeed because leaders fail to change their:
 - a. Behaviors
 - b. Tools
 - c. Attitudes
 - d. Minds
5. The Lean Management System emphasizes respect for:
 - a. Processes
 - b. Rules
 - c. Change
 - d. People
6. Standard work is important as it is often impossible to _____ a process until it is standardized.
 - a. Create
 - b. Change
 - c. Improve
 - d. Blame
7. Huddles are a LMS tool promoting open and timely:
 - a. Appointments
 - b. Communication
 - c. Disciplinary action
 - d. Tracking
8. _____ control systems might include whiteboards, charts, and metrics used to promote transparency and current state statuses.
 - a. Lean
 - b. Huddle
 - c. Programmable
 - d. Visual



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It Depends on Your View

By Melody W. Mulaik, MSHS, CRA, FAHRA, RCC, CPC, CPC-H

Over the last several years the procedure code definitions for plain film exams have migrated from specifically listed designated views (eg, AP and lateral) to only listing the number of views (eg, 2 views). This change is designed to simplify the coding process and to accommodate the variety of clinical protocols that address an array of clinical conditions. Most of the code changes have created little to no discussion or challenges, but this year the creation of the new combined hip and pelvis codes have caused a bump in the road for many organizations.

Before we discuss the hip and pelvis codes let's first look at the definition of views. Granted, the majority of you know this information like the back of your hand, but humor me as I spell this out to tie it together with proper code assignment.

The term view, also called a projection, describes the orientation of the imaging device in relation to the body part that is being studied. The ordering physician and/or radiologist will determine what views will be performed based on the patient's condition and the specific structures that need to be visualized. Typically, this is defined through the facility's protocols.

The number of views is not necessarily the same as the number of digital images. Depending on the patient's size and other factors, more than one x-ray

image may be needed to complete a single view. CPT® codes are assigned based upon the number of views, not images or films. Though not a complete list, following are the typical views encountered:

- **AP:** anteroposterior—front to back
- **DEC:** decubitus—patient lying on their side
- **OBL:** oblique—angled view
- **LAO:** left anterior oblique—left front angled view
- **LPO:** left posterior oblique—left rear angled view
- **LAT:** lateral—side view obtained either mediolateral (ML) or lateromedial (LM)
- **PA:** posteroanterior—back to front
- **RAO:** right anterior oblique—right front angled view
- **RPO:** right posterior oblique—right rear angled view
- **Apical:** chest including apex of the lung to minimize the rib image overlapping a lung lesion
- **Bucky:** a grid formed from metal strips is placed in front of the detector in order to reduce secondary radiation
- **Frog leg:** a view of the hip joint with the patient usually positioned supine on the x-ray table with the affected limb flexed at the knee approximately 30° to 40° and the hip abducted 45°
- **Odontoid:** open-mouth cervical spine view to identify joint space C1
- **Outlet (Taylor):** a specific AP axial view where the central ray is typically angled 45°
- **Stereo:** two views of a structure, one at 90° to the detector or film and second with tube angled 12–15° toward the head
- **Supine:** AP view taken while the patient is lying down
- **Swimmers:** thoracic x-ray with one or both arms over head

Hip X-Rays

Procedure codes 73500-73540 for hip x-rays were deleted for 2016 and six new codes were added, three for unilateral and three for bilateral. All these codes include pelvic views when performed. See Table 1 for the new codes effective January 1, 2016.

Hip x-rays are now reported with codes 73501-73503 (unilateral) or 73521-73523 (bilateral). All of these codes include views of the pelvis, when performed. The code selection is based strictly on the number of views. (See *CPT® Assistant*, October 2015, and the *ACR Radiology Coding Source™*, September/October 2015.) *Clinical Examples in Radiology* (Fall 2015) states that “the total number of views is calculated by adding the number of hip views plus the number of pelvis views.” Note that a single AP view of the pelvis, which

■ **TABLE 1.** New Hip X-Ray Codes

CPT® Code	Definition
73501	<i>Radiologic examination, hip, unilateral, with pelvis when performed; 1 view</i>
73502	<i>... 2-3 views</i>
73503	<i>... minimum of 4 views</i>
73521	<i>Radiologic examination, hips, bilateral, with pelvis when performed; 2 views</i>
73522	<i>... 3-4 views</i>
73523	<i>... minimum of 5 views</i>

also includes images of both hips, constitutes one view.

Code 73501 represents a single view of the hip, which would previously have been reported with code 73500 (deleted in 2016). Even though the definition of 73501 states “with pelvis when performed,” this code represents only a single hip view. The words “with pelvis when performed” were included in the definition of 73501 so that the definitions of the entire code family would be consistent.

Code 73502 includes two to three views of the hip with or without specific images of the pelvis. For example, this code should be assigned for an exam consisting of a single view of the hip and a single view of the pelvis.

Code 73520 (deleted in 2016) was formerly used to report a bilateral hip exam consisting of one view of the pelvis and one frog-leg lateral view of each hip. This makes a total of three views, so this study is now reported with code 73522 (bilateral, 3-4 views).

Prior to 2016 there was a specific code for hip x-ray during operative procedure (73530). This service should now be reported with hip x-ray codes 73501-73503 when unilateral intraoperative views are taken. Remember that two x-rays in the same projection (eg, two lateral views of the right hip), taken at different points during the surgery,

constitute a single-view exam when they are interpreted together following surgery because only one projection was evaluated.

Prior to 2016 there was also a specific code for x-ray exam of the pelvis and hips in an infant or child (73540). This code has been deleted, and the regular hip x-ray codes should now be used regardless of patient age.

One of the biggest challenges the new codes have created is in the ordering process. The implementation of these codes has required that many organizations re-evaluate their order entry options so that referring physicians can select the appropriate exam(s). It is important to separate the clinical concerns from the coding concerns. Sometimes these concerns are one and the same but that is not always the case. The implementation of these new codes should not mean that you have to totally change how you do hip and pelvic imaging, but rather how you code for the images that you take. Whether the implementation of these new codes must trickle down to the referring physicians and change their ordering practices is more dictated by your systems and processes than it is the code definitions themselves. If the ordering physicians want images of the pelvis, they need to state that. The fact that a pelvic view now is included in the hip x-ray

codes is really not the referring physicians’ concern—it is a billing issue. That said, you may find that your systems require that you make the referring physician order in accordance with CPT® coding definitions and that is where the challenges begin. How do they easily communicate in the ordering process that a pelvic view is required in addition to the hip views?

As with all process and operational issues that arise because of coding changes it is important that you take a step back and ask yourself why things are done the way they are within your organization. For those of you that participate in Lean initiatives does that sound familiar? In the world of coding I would argue that change is neither good nor bad. It just is, and we have to adapt. When new codes come along we must take the time to not only understand the code definitions but also the operational changes that may be required as a result of their implementation—and, equally important, the education that must accompany these changes for our staff and our referring physicians. 🌱

Melody W. Mulaik is president and co-founder of Coding Strategies, Inc. She is a nationally recognized speaker and has delivered numerous presentations at AHRA annual meetings and conferences. Melody is a member of AHRA, has published extensively, and may be contacted at melody.mulaik@codingstrategies.com.

ICD-10: Traumatic Brain Injury

By Melody W. Mulaik, MSHS, CRA, FAHRA, RCC, CPC, CPC-H

Traumatic brain injury (TBI) is damage to the brain caused by an external force, such as a motor vehicle accident or a fall from a ladder. TBI is classified to ICD-10-CM category S06 (*Intracranial injury*). There are subcategories to identify the specific type of injury, such as concussion, cerebral contusion, subdural hemorrhage, etc. The codes are indexed under “Injury, intracranial,” and like other trauma codes, they require a 7th character to indicate whether the encounter is initial, subsequent, or for a sequela (late effect). The injury should be coded as initial encounter if the patient is receiving active treatment, which includes the initial imaging studies for diagnosis of the injury as well as repeat studies during active treatment.

For coding purposes, head injury is not synonymous with traumatic brain injury. “Head injury” is a very nonspecific term that is classified to S09.90- (*Unspecified injury of head*). Codes from this subcategory should not be assigned if there is documentation of a brain injury or of a more superficial head injury such as a head contusion or scalp laceration, for which there are specific codes.

The Index entry for “Injury, head, with loss of consciousness” refers the reader to TBI code S06.9- (*Unspecified intracranial injury*), so if there is documentation of loss of consciousness (LOC), the diagnosis will be coded as a TBI rather than an unspecified head injury. For example, a head CT is ordered with clinical indication of “Head injury,” and the exam is

unremarkable. The diagnosis code for this study is S09.90XA (*Unspecified injury of head, initial encounter*). However, if the clinical indication is “Head injury with LOC,” the diagnosis code will be S06.9X9A (*Unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter*).

Loss of Consciousness

The 6th character of the TBI codes indicates the duration of LOC. There are ten choices, summarized in the table that accompanies this column. If the record states there was no LOC, the 6th character of the TBI code will be 0 (*without loss of consciousness*). If the record does not mention whether the patient lost consciousness, or if it states that the patient lost consciousness but does not indicate the duration of LOC, the 6th character will be 9 (*with loss of consciousness of unspecified duration*). Or if the duration of LOC is documented, one of the other 6th characters can be selected.

The LOC classification was designed for inpatient coding, where codes are assigned at the time of discharge, and therefore some of the 6th characters require knowledge of the outcome of the LOC. For example, if a patient is unconscious for more than 24 hours, but is fully conscious by the time of discharge, the 6th character of the TBI code will be 5 (*with loss of consciousness greater than 24 hours with return to pre-existing conscious level*). See Table 1.

Skull Fracture

TBI can occur without skull fracture, and skull fracture can occur without traumatic brain injury. When the two conditions occur together, both should be coded. The TBI is reported with a code from category S06 (*Intracranial injury*), and the skull fracture is reported with a code from category S02 (*Fracture of skull and facial bones*).

There is a note under category S02 to “Code also any associated intracranial injury (S06.-).” A “code also” note means that both conditions should be coded and either one can be sequenced first, depending on the circumstances. For trauma imaging, either the TBI or the skull fracture can be the primary diagnosis, depending on the severity of each injury and the reason for the study.

Coma Scale

Come scales are sets of criteria used to identify the patient’s level of consciousness. Chapter 18 of ICD-10-CM contains codes to indicate the patient’s Glasgow coma scale score.

Subcategories R40.21-R40.23 indicate the patient’s level of eye opening, verbal response, and motor response. These codes are indexed under main term “Coma.” They require a 7th character to indicate whether the evaluation was performed in the field before transport to the hospital, on arrival in the emergency department, at admission, or subsequently.

■ **TABLE 1.** 6th Characters for TBI Codes

6th Character	Duration of LOC	Outcome
0	None	
1	30 minutes or less	
2	31-59 minutes	
3	1 hour to 5 hours 59 minutes	
4	6 hours to 24 hours	
5	Greater than 24 hours	Patient returns to pre-existing level of consciousness
6	Greater than 24 hours	Patient survives but does not return to pre-existing level of consciousness
7	Any duration	Patient dies due to brain injury prior to regaining consciousness
8	Any duration	Patient dies due to other causes prior to regaining consciousness
9	Unspecified	

There is a second series of coma scale codes that represents the patient's total Glasgow coma score. These codes are found in subcategory R40.24 and are indexed under main term "Glasgow coma scale." They are to be used only if the individual components of the total score (eye opening, verbal response, and motor response) are not documented.

For example, head CT is performed on an emergency department patient due to a closed head injury with 10-minute LOC and Glasgow coma score of 12. The exam reveals a traumatic subarachnoid hemorrhage. The brain injury is reported with code S06.6X1A (*Traumatic subarachnoid hemorrhage with loss of consciousness of 30 minutes or less, initial encounter*). The coma score is reported with code R40.242 (*Glasgow coma scale score 9-12*). ☛

Melody W. Mulaik is president and co-founder of Coding Strategies, Inc. She is a nationally recognized speaker and has delivered numerous presentations at AHRA annual meetings and conferences. Melody is a member of AHRA, has published extensively, and may be contacted at melody.mulaik@codingstrategies.com.



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Observation Leads to Improved Operations in Nuclear Medicine

By Deo G. Religioso, CNMT, RT(N), MBA, CRA

EXECUTIVE SUMMARY

- The concept of observation—going out and seeing what is happening in daily operations—would seem like a normal management activity, but the reality in practice of the philosophy and technique is often underutilized.
- Once an observation has been determined, the next steps are to test and validate any discoveries on paper. For process change to be implemented, numerical data is needed to back-up observations in order to be heard and taken seriously by the executive team
- Boca Raton Regional Hospital saw an opportunity to improve the process for radiopharmaceutical standing orders within its nuclear imaging department. As a result of this observation, the facility realized improved savings and an increase in employee motivation.

When tasked with bringing about improved operational outcomes, how to begin and where to begin are often the greatest concerns for managers. Leaders are often pre-occupied and absorbed with addressing everyday incidents and completing daily responsibilities that they can sometimes forget to be more observant and inquisitive. To bring about positive operational outcomes, simply begin with the power of direct observation combined with a sense of curiosity.

Boca Raton Regional Hospital is a not-for-profit, advanced tertiary medical center with 400 beds, over 2,100 employees and more than 800 primary and specialty physicians on staff. The hospital is a recognized leader in cardiovascular care, oncology, women's health, orthopedics, emergency medicine and the neurosciences, all of which offer state-of-the-art diagnostic and imaging capabilities. Boca Raton Regional Hospital is accredited by The Joint Commission and is one of only four hospitals in Palm Beach County to be designated by the Florida Agency for Healthcare Administration (AHCA) as a Comprehensive Stroke Center. In 2011, when doing daily rounding and inspection of the nuclear medicine service an observation was made in the hot lab. It was early in the morning and the nuclear medicine technologist was preparing unused doses for return to the originating vendor. Being relatively new to the department, I was immediately intrigued and curious by the number of

unused doses returned to the originating vendor. (See Table 1) I continued to observe for a few more days, weeks, and months and the nuclear medicine technologist indicated that this was a normal occurrence. What was discovered over time was the blind generation of waste and a need for the current order of standard doses to be examined and, in all likelihood, modified.

A standing order is “a purchase order covering repeated deliveries of goods or services, in specified quantities, at specified prices, and according to a specified schedule.” Standing orders of radiopharmaceutical doses continue to be a viable routine operationally for large, busy nuclear medicine departments. From the viewpoint of the staff, it provides convenience and comfort knowing that doses will be delivered at specified times and therefore readily available.

Go, Look, and See

Observation is the action or progress of observing something or someone in order to gain information and insight. The concept of going out and seeing what is happening in daily operations would seem like a normal management activity, but the reality in practice of the philosophy and technique is often underutilized. The philosophy of go, look, and see is deeply rooted in the Japanese principle of Genchi Genbutsu. Genchi Genbutsu, in Japanese, literally means “go and see.” The nature of Genchi Genbutsu

■ **TABLE 1.** Unused and/or Expired Units Returned to Originating Vendor for February 2011

Date	MIBI 10 mCi	MIBI 30 mCi	MDP 20 mCi	Choletec 8 mCi	MAA 6 mCi	TcO4 25 mCi	MAG3 5 mCi	SC 2 mCi	TI-201 5 mCi
2/1/2011	0	0	1	1	1	3	0	0	0
2/2/2011	0	0	2	1	1	2	0	0	0
2/3/2011	2	2	1	2	1	2	0	0	0
2/4/2011	2	0	0	2	1	4	0	0	0
2/5/2011									
2/6/2011									
2/7/2011	1	2	3	2	3	2	0	0	0
2/8/2011	4	0	0	0	0	3	0	0	0
2/9/2011	0	2	1	2	1	4	0	0	0
2/10/2011	1	1	0	0	1	3	0	0	0
2/11/2011	0	2	0	2	0	2	0	0	0
2/12/2011									
2/13/2011									
2/14/2011	2	2	0	0	0	6	0	0	0
2/15/2011	1	1	0	1	1	4	0	0	0
2/16/2011	1	1	0	0	2	2	0	0	0
2/17/2011	0	2	0	0	3	2	0	0	0
2/18/2011	0	1	0	0	0	2	0	0	0
2/19/2011									
2/20/2011									
2/21/2011	0	1	0	0	0	3	0	0	0
2/22/2011	0	1	0	0	0	4	0	0	0
2/23/2011	0	0	0	0	1	1	0	0	0
2/24/2011	2	2	0	0	2	3	0	0	0
2/25/2011	0	0	0	0	0	3	0	0	0
2/26/2011									
2/27/2011									
2/28/2011	0	3	0	0	1	3	0	0	0
Total Units	16	23	8	13	19	58	0	0	0
Price/Unit	\$54.00	\$54.00	\$21.00	\$39.00	\$15.00	\$25.00	\$200.00	\$42.00	\$65.00
Total Costs	\$864.00	\$1242.00	\$168.00	\$507.00	\$285.00	\$1450.00	0	0	0
Final Sum	\$4516.00								

*Prices were altered to maintain confidentiality with Vendor.

is to “know.” Understanding and learning the work or process is what makes the management concept different and powerful. The purpose is not look or be seen, but to learn and to know.

Gemba (genba) is another Japanese term, which means “the real place.” Gemba is our workplace where valued is added. The elements of a Gemba Walk are going to where the work is performed, going to see the actual process; observing and engaging with those who do the work or process; and understanding and learning the work or process. Masaaki Imai, a world renowned organizational theorist and management consultant, once wrote “The worst thing a manager can do is live in a world isolated from gemba.”

Take the time to look around, explore, and study surroundings. It’s not a race, by any means. Open your eyes and ears for valuable information and understanding. Watch the people around you perform and interact with one another. Are attitudes among the employees in alignment with expectations and the hospital’s mission and vision? Be open

minded and willing to see the truth, for better or worse.

Thinking on Paper

Once an observation has been determined, the next steps are to test and validate any discoveries on paper. In a data-driven world, observing a discovery over a period of time to establish truth, frequency, and pattern will not be good enough to convince others of the finding. Collecting data is of utmost importance in order to be heard and taken seriously. Gathering qualitative data and speaking in qualitative terms is easy. The real challenge is translating that data into quantitative terms. Good managers speak in both qualitative and quantitative terms. Some may even argue that great managers only speak in quantitative terms. Regardless of the persuasion, numerical data is needed to back-up observations if you want to be heard and taken seriously by the executive team.

Determine what information or data needs to be gathered. Ask: What is

it that I want to ascertain? What will I measure to bring about clarity? In reference to the nuclear medicine example, it was observed that a number of doses were unused at the end of the work day and returned the next morning to the originating vendor. Given the context of that observation, a baseline of radiopharmaceuticals was first established to control and compare to, which was the standing order already in place with the vendor. To quantify the data, a daily count of returned radiopharmaceutical doses, Monday thru Friday, was taken for a month to establish frequency and pattern. To further quantify the data, the cost of each radiopharmaceutical dose was incorporated into the matrix. The total count and total cost for each radiopharmaceutical dose for a monthly period was then calculated. And, finally, the total final sum was calculated to determine total costs for the monthly period. The numerical data was collected in organized tables for quick and easy comparison, tracking, and analysis. See Tables 2-4.

■ TABLE 2. Standing Order of Radiopharmaceuticals Doses*

Delivery Time	MIBI 10 mCi	MIBI 30 mCi	MDP 20 mCi	Choletec 6 mCi	MAA 6 mCi	TcO4 25 mCi	MAG3 5 mCi	SC 2 mCi	TI-201 4 mCi
6:00AM	4	3	2	1	2	4	0	0	0
9:30AM	0	0	0	1	2	2	0	0	0

*Note: The original standing order of radiopharmaceutical doses before the modification.

■ TABLE 3. Standing Order of Radiopharmaceuticals Doses*

Delivery Time	MIBI 10 mCi	MIBI 30 mCi	MDP 20 mCi	Choletec 6 mCi	MAA 6 mCi	TcO4 25 mCi	MAG3 5 mCi	SC 2 mCi	TI-201 4 mCi
6:10PM	1	2	1	1	1	2	0	0	0
8:45PM	0	0	1	1	1	1	0	0	0
1:44PM	0	0	0	0	1	1	0	0	0

*Note: Early modified standing order of radiopharmaceutical doses.

■ **TABLE 4.** Standing Order of Radiopharmaceuticals Doses*

Delivery Time	MIBI 10 mCi	MIBI 30 mCi	MDP 20 mCi	Choletec 6 mCi	MAA 6 mCi	TcO4 25 mCi	MAG3 5 mCi	SC 2 mCi	TI-201 4 mCi
6:15AM	2	2	0	0	0	1	0	0	0
8:45AM	0	0	0	1	1	1	0	0	0
12:00 PM	0	0	0	0	0	0	0	0	0
2:40 PM	0	0	0	1	1	1	0	0	0

*Note: Current standing order of radiopharmaceutical doses.

Discussion

The results from the first month of collected data were compelling and quite convincing. The dollar amount of returned unused doses was a shocking amount of waste. What presented was the opportunity to intensely question current practice. The interpretation of the collected numerical data was straight forward and supported the qualitative observation. It was clearly evident that the standing order with the originating vendor needed to be re-examined and modified for improved savings.

Unfortunately, standing orders are often seen as stagnant contracts and unchangeable. On the contrary, it is very much a dynamic arrangement. It ought to be monitored and altered over time as the needs of the practice change. Seasonality and market trends in healthcare imaging may influence overall demand for exams. Staff will commonly order additional doses without any reservations and, yet, staff will ignore or not adjust dose levels downward to meet actual demand. The advent of web ordering has made ordering doses much more accessible and controllable.

All stakeholders must be engaged in the conversation. After questioning the staff, it was ascertained that there was an obvious disconnect and lack of understanding of the impact on operations financially. For the staff, it was natural to have radiopharmaceutical doses available at any given time on any given day. And, therefore, it was natural to have unused doses the next morning for return to the

■ Box 1. Questions to Consider Answering

1. What are the attitudes associated with radiopharmaceutical doses?
2. When was the standing order created and implemented? Does it meet our current needs?
3. When was the standing order last reviewed and modified?
4. What immediate changes can you make to address the attitudes and concerns of the staff?
5. Is your vendor open and flexible to changes? Are they truly a partner?
6. What other costs may be associated with radiopharmaceutical deliveries?

originating vendor. For the staff, it was normal and accepted practice. Their primary fear and concern was not having a radiopharmaceutical dose on hand especially for a STAT exam. Their secondary fear and concern was the lack of scheduled delivery times and delivery time delays by the radiopharmacy vendor.

The radiopharmacy vendor was open and willing to discuss, consider, and implement agreed upon changes to meet our needs and wants. It became apparent that there were other issues and related costs to consider, as well. For example, Boca Raton Regional Hospital had only two free shipping delivery times, both scheduled early in the morning. All other deliveries throughout that day were considered “STAT” delivery and thus incurred “STAT” delivery charges. Another related cost was “after hours” delivery charges. How would these delivery charges impact the bottom line going forward and how often they

would occur were two additional concerns to consider and confront. See Box 1.

Continuous Improvement

Gradual modifications were made to the standing order over several months. Internal partners (staff) had a voice in the decision-making, but expectations were clear and simple: change the standing order with improved savings. What was ordered and what was typically returned was scrutinized, as well as dose calibration times and delivery times. Furthermore, exam demands throughout the day, week, weekend, and month were scrutinized. We needed to have a better conception of our needs in the context of demand and supply. A better awareness of our actual needs and how those needs altered over the course of the year was an essential part of the exercise as we had to consider seasonality demands as well.

■ **TABLE 5.** Summary of Monthly Data Showing Gradual Modification

M – F February	MIBI 10 mCi	MIBI 30 mCi	MDP 20 mCi	Choletec 8 mCi	MAA 6 mCi	TcO4 25 mCi	MAG3 5 mCi	SC 2 mCi	TI-201 5 mCi
Total Units	16	23	8	13	19	58	1	0	0
Price/Unit	\$54.00	\$54.00	\$21.00	\$39.00	\$15.00	\$25.00	\$200.00	\$42.00	\$65.00
Total Costs	\$864.00	\$1242.00	\$168.00	\$507.00	\$285.00	\$1450.00	0	0	0
Final Sum	\$4516.00								
M – F March	MIBI 10 mCi	MIBI 30 mCi	MDP 20 mCi	Choletec 8 mCi	MAA 6 mCi	TcO4 25 mCi	MAG3 5 mCi	SC 2 mCi	TI-201 5 mCi
Total Units	18	13	17	10	8	42	0	0	1
Price/Unit	\$54.00	\$54.00	\$21.00	\$39.00	\$15.00	\$25.00	\$200.00	\$42.00	\$65.00
Total Costs	\$972.00	\$702.00	\$357.00	\$390.00	\$120.00	\$1050.00	0	0	\$65.00
Final Sum	\$3591.00								
M – F April	MIBI 10 mCi	MIBI 30 mCi	MDP 20 mCi	Choletec 8 mCi	MAA 6 mCi	TcO4 25 mCi	MAG3 5 mCi	SC 2 mCi	TI-201 5 mCi
Total Units	11	16	13	13	12	31	0	3	0
Price/Unit	\$54.00	\$54.00	\$21.00	\$39.00	\$15.00	\$25.00	\$200.00	\$42.00	\$65.00
Total Costs	\$594.00	\$864.00	\$273.00	\$507.00	\$180.00	\$775.00	0	\$126.00	0
Final Sum	\$3319.00								
M – F May	MIBI 10 mCi	MIBI 30 mCi	MDP 20 mCi	Choletec 8 mCi	MAA 6 mCi	TcO4 25 mCi	MAG3 5 mCi	SC 2 mCi	TI-201 5 mCi
Total Units	16	9	11	4	12	29	0	2	0
Price/Unit	\$54.00	\$54.00	\$21.00	\$39.00	\$15.00	\$25.00	\$200.00	\$42.00	\$65.00
Total Costs	\$864.00	\$486.00	\$231.00	\$156.00	\$180.00	\$725.00	0	\$84.00	0
Final Sum	\$2726.00								

*Prices were altered to maintain confidentiality with Vendor.

Continuous improvement, or “Kaizen” (another Japanese word), was the method and philosophy I chose to adopt. See Box 2. The fundamental goal of Lean Kaizen or Gemba Kaizen is to eliminate waste in all processes. It is a strategy where every single employee is challenged to work together proactively to achieve regular, incremental improvements to the process. Every single employee was required to assume personal responsibility. Every single employee was required to be a fixer and not a finger-pointer.

Making gradual modifications made more sense. A goal of “change and improved savings” was set. Background information was shared and a plan of action for improvement was implemented. Data was collected and reviewed for results. The PDCA (Plan, Do, Check, Act) cycle was repeated monthly to determine progress and outcome.

The goal was for internal partners and the external partner (radiopharmacy vendor) to acclimate to the changes with as little stress as possible. With intention,

these partners were deliberately shown that it was safe to practice in this manner. And having fewer inventories would not be detrimental to daily operations. Additional free shipping delivery times throughout the work day were negotiated so as to have some control over “STAT” delivery charges. Improved savings were seen month after month over a 4 month period as seen in Table 5. The employees were motivated by the results. A 40% savings was achieved on recovered waste after 4 months of gradual modifications.

■ Box 2. Lean Kaizen in Action

1. Set goals and expectations. Share information and background.
2. Develop a plan for improvement and implement.
3. Review and report results to partners.
4. Fix what doesn't work.

Deo G. Religioso, CNMT, RT(N), MBA, CRA is the lead technologist for nuclear medicine services at Boca Raton Regional Hospital. He obtained his MBA degree from Manhattan College in 1995. An AHRA member since 2004, he achieved his CRA credential in 2007. Deo can be contacted at dreligioso@brrh.com.

■ Box 3. Favorite Quotes to Ponder

"If you wait for people to come to you, you'll only get small problems. You must go and find them. The big problems are where people don't realize they have one in the first place."

— W. Edward Deming

"The most important thing in communication is hearing what isn't said."

— Peter Drucker

"Quality improvement is a continuous process and it can always be taken one step further."

— Kaoru Ishikawa

Conclusion

Engage with those who do the work— inquire, but don't interrogate. As my Uncle Barry Lee would say, "begin climate setting." Clear the clouds. Bring the sun with you. Smile. Adjust your tone of voice. Create a conversation around your purpose and/or observation. Make it feel safe. Listen and filter. Auguste Rodin once said, "Nothing is a waste of time if you use the experience wisely." A first-hand experience (ie, observation), which I like to refer to as thinking on your feet, is certainly a wise use of time. See also Box 3.

Employing the power of observation is a choice. It requires reasonable intelligence, curiosity, and courage. Any discoveries will hopefully lead to improved operational outcomes. Be a change agent.

Be active. Be transparent and educate partners. Continuously collect data and fine tune along the way. Our ecosystems are forever changing, as they should be. Manage for a dynamic world and improved outcomes! ☸

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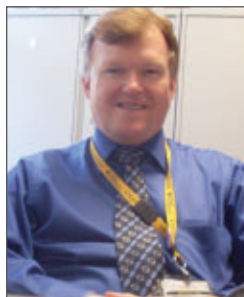
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What Exceptional Leadership Looks Like

By Dr. Steve Richardson, DHA, CRA, RT(R)

We've all seen, or worked with, others that when asked if that person is a good leader, or even an exceptional leader, we have to stop and think: what *is* a good leader? There is no clear definition of leadership, therefore making this a difficult question to answer. In research conducted, Malik and Afridi explained scholars do not have a clear definition of leadership.¹ Although, they cited one definition of leadership as inducing a subordinate to act in a desired manner.¹ Defining leadership has been a dilemma. One resource described leadership as "the creative force of morale."² In contrast, another described leadership as the process for creating influential relationships, and another provided the definition of leadership as directing or coordinating the work of group members. Nahavandi described leading as providing a direction for a given course and leadership as someone with command.³ Each example indicates that leadership involves getting people to follow direction. In contrast, Vroom and Jago had a different interpretation of leadership, which is the "influence of more than one follower."⁴ According to Vroom and Jago, the definition is short and simple: Leadership is the ability, both potential and capacity, to influence others. Leadership therefore

consists of having influence over others. They listed five elements used to characterize leadership:

1. Leadership is a process, not a personal characteristic.
2. The process involves influence commonly referred to as motivation.
3. Incentives, whether intrinsic or extrinsic, are not a part of leadership.
4. Influence by leadership is establishing collaboration with the follower to pursue a common goal.
5. Leaders need to understand when a leader has an excellent idea, it does not guarantee desirability of all parties, and may not be accepted.

Graen and Schiemann identified specific leadership characteristics that affect performance. Factors that enhance leadership include incentives, recognition, modeling behaviors for staff, developing staff, providing feedback, good communication, delegation, rewards, support, commitment, trust, and respect.⁵ A leader's values include flexibility, innovation, and adaptability, as well as concern for economic outcomes.⁶ Other leadership traits include confidence and optimism, skills and expertise, behavior, integrity, influence tactics, and attributions about followers. Leaders encourage maximum

performance from employees through training and opportunities for gaining experience.⁵

Two primary forms of leadership are transformational leadership and transactional leadership. Leadership styles are distinct from forms of leadership. Styles of leadership include categories such as democratic, autocratic, and laissez faire.⁷ The democratic style of leadership allows for group decision making and creates a relaxed and cohesive environment. An autocratic style is more rigid, with the leader making the decisions and subordinates being more submissive. Laissez-faire leaders provide no direction and have a passive-avoidant attitude toward subordinates that creates frustration and generally poor performance.⁷ There are five elements that form the bases of leadership power, which include the following⁸:

1. Reference power based on followers' identification with the leader.
2. Expert power from the leader's competence level.
3. Legitimate power or the formal status of the leader.
4. Reward power based on what the leader can award the follower.
5. Coercive power regarding punishments a leader can inflict on others.

The common denominator regarding leadership is influencing others, and the basis of the leadership has to do with the motivation behind how leaders influence followers.

So what creates exceptional leadership? The American College of Healthcare Executives (ACHE) provides 16 critical competencies for healthcare executives for creating exceptional leadership. The list includes⁹:

1. Living by personal conviction
2. Possessing emotional intelligence
3. Being visionary
4. Communicating vision
5. Earning loyalty and trust
6. Listening like you mean it
7. Giving feedback
8. Mentoring others
9. Developing teams
10. Energizing staff
11. Generating informal power
12. Building consensus
13. Making decisions
14. Driving results
15. Stimulating creativity
16. Cultivating adaptability

Each of these steps is designed to take you to the level of exceptional leadership. However, a more meager approach which was presented as early as the sixth century by a Chinese sage, or wise man, named Lao-tzu, captures the essence of servant leadership and may also provide a reasonable approach to exceptional leadership.¹⁰ The first concept is selflessness. By being selfless, the leader enhances self. The second concept is that the wise leader is like water. Like water, the leader is yielding. Because the leader does not push the group, the group does not resent or resist the leader. The third concept is unbiased leadership. This means learning to meditate regarding emotional issues and not pick sides of favorites. This can be done when remaining unbiased, clear, and down-to-earth. Lastly, is the concept of being a midwife, which means not intervening unnecessarily. In other words, the leader's presence is felt, but the group

runs itself. As with the case of a mother when using a midwife, when all is done, the mother will rightly say, "we did it ourselves!"¹² A few other concepts from this approach:

Learn to lead in a nourishing manner.
Learn to lead without being possessive.
Learn to be helpful without taking credit.
Learn to lead without coercion.

Leadership is not a new concept, although it continues to be perplexing, and general principles from as early as the sixth century apply to modern day leadership theory. As healthcare managers, our leaders and employees need and expect us to provide support, empathy towards their challenges, a fair place to work, and the tools to do their jobs. Having the knowledge and strength to watch like we are looking at ripples in water, without complaint or interference, and to shed light when needed to keep order and harmony, success should be inevitable. 🌱

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Dr. Steve Richardson DHA, CRA, RT(R) has been in radiology since 1978 when entering the Medical Center-St. Francis School of Radiologic Technology in Columbus, GA. He has served as a staff technologist and radiology manager in both the civilian and military communities. He served for 21 years in the United States Navy, and while in the military was the Director of the Naval X-ray Program in San Diego, CA. Since retiring from the U.S. Navy in 2002, he has managed outpatient imaging centers in Virginia and Maryland, as well as serving as a Director of Radiology in California. Dr. Richardson holds a doctorate in health administration and masters in organizational management from the University of Phoenix, a bachelor's degree in health care management from Southern Illinois University, and an associate's degree from the University of Maryland. He can be contacted at stevekat94@frontiernet.net.



A Culture of Extraordinary Care: Redux

By Ed Yoder, MBA, MHA, RT(R), CRA, FAHRA

Editor's note: This article originally ran as "A Culture of Extraordinary Care: Part One" in the Mar/Apr 2011 issue. For the entire series, please visit www.ahraonline.org/radiologymanagement

Recently, a colleague asked me what my top accomplishment was in the past eight years I've been at our organization. I did not have to think about it long! I knew the answer and almost could not wait to spit it out. That crowning moment was accomplished a few years ago, when I sat back and realized I had a great well rounded team providing extraordinary care in a passion fueled environment. My answer was culture change. Sure, we still have bumps here and there and every once in a while we hire someone that we thought would fit our culture but they really did not. However, we have a strong team and everyone does their part to improve our scores and our quality. Today, our patient satisfaction scores are in the 90th percentile, well above the 70th which is where we were eight years ago.

Later that night when I went home I reflected back over the conversation I had with my colleagues explaining how we accomplished this. I looked back at just what the culture change really did for us. It not only allowed us to develop a fantastic team, it also allowed us to significantly move our scores. (Remember, happy team members result in happy customers.) It also focused us on qual-

ity because quality care and meeting or exceeding benchmarks allowed us to feel good about the worthwhile work we were supplying and the compassionate care we were giving our patients. So here is the first installment of a series of articles detailing this journey so that perhaps other leaders faced with the same challenge will have a road map to follow.

When I arrived in sunny Florida eight years ago this March, I was challenged with two things. One, get the department where it needs to be from a technology standpoint. Two, move the customer service scores. To accomplish the second I knew the first thing I needed to do was get a feel for the culture. What was there, how did it operate, and was it working? As I sat down with some of my new team it did not take long to see what the current culture was and that it needed to be changed.

The previous culture was very authoritarian from the top of the department down. Promotions were handled by seniority. Team members were made to feel bad about calling off of work sick and as a result would come in ill. Team members were not empowered and there were no functioning employee teams present.

There was interdepartmental squabbling and resentment and many people did not seem willing to work in a team environment. Most departments functioned in silos and the players within those silos functioned separately. There were some teams that were very tight knit and functioned great as a unit but their teamwork skills were lacking or distrustful.

I knew I would need help on this journey towards excellence. I received approval to hire an operations manager who would be challenged with rolling out many programs of change. I found someone who understood the Studer Group techniques and had applied them before in the past with success. Armed with what we needed, we set out to create the blueprint for our culture change. We knew it would not be easy and it would take a long time. With culture change you have to be patient and move slowly. In a change environment, staff tend to be resistant of any change that moves fast and hard—you have to give them time to buy into it and own it, and you and managerial support staff must believe in it and model it in order to succeed.

With culture change you have to be patient and move slowly. In a change environment, staff tend to be resistant of any change that moves fast and hard.

The first thing we needed to do was create a passion for purpose. Everyone, from the top down, has to rediscover their own purpose. We all have it, some have just lost it. They may have lost it because of barriers specific to the healthcare environment—equipment held together with bubble gum and tape, processes that do not work, minor equipment that needs to be replaced or acquired. If it appears the organization does not care, then slowly, neither will the employees. They become frustrated, disgruntled, and remain that way, spewing that temperament onto your customers. Or some employees move on, out of your organization. This is where your retention rates go out the window, along with your best employees. Your best employees, who believe in passion, who got into healthcare to make a difference, will not work in this type of environment. All that you are left with are the discontents when what you need is passion!

I challenge you to look at your current department. Do you have consistent passion? Does your team love what they do and the environment they perform it in? You have to have relentless focus on passion. Your team and the new team members you bring in must be engaged and committed. This has to be your mission. You must focus on retaining the best people because they will provide the best service which, in turn, will drive your customer service goals. One important thing to remember is that passion is heartfelt—it overcomes barriers and can help in obtaining insurmountable goals. The world is filled with stories of extraordinary accomplishments by people and teams filled with passion. Challenge yourself to create an environment where passion can live and breathe. If you are unsure how, in the next article, I will tell you how. 🌱

Ed Yoder, MBA, MHA, RT(R), CRA, FAHRA was the director of imaging services at Lexington Medical Center in West Columbia, SC. He held a master's degree in business administration, as well as a master's degree in healthcare administration from the University of St. Francis. Ed served as the president of the AHRA Board of Directors from 2013–2014 and wrote for Radiology Management from 2004–2015.

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AHRA Still Rocks!

By Gordon Ah Tye, FAHRA

I've recently been involved with some AHRA volunteer activities that have launched me back through the past 25 years or so of my history with this organization. It's made me think about evolution and culture—about who we are as an association and how we have transcended through time. Survival of the fittest is a real thing, and from what I see, AHRA is strong and has evolved into a solid, viable organization.

I serve as a member of our Nominations Committee (whose responsibility is to provide a slate of qualified nominees for the elected offices of President-elect and the Directors). Immediate past-president David Fox was kind enough to invite me, and he was very gracious in explaining why it was valuable for me to participate. My first reaction was that I have been “out of the loop” and was not very connected to who the newest movers and shakers were in AHRA. But he explained that my experience in evaluating people and providing my perspective would be valuable. He explained that much of the diligence would be provided by our AHRA staff, and that they would provide enough information to assess who our best and most qualified candidates would be. He was absolutely right.

There has been a focus lately on re-involving our AHRA elder statesmen and women to contribute. Typically, our past leadership (after having dedicated their allotted time) “go out to pasture” and go back to focusing on their “real jobs.” But I love this re-involvement, which is the same kind of thinking and volunteerism from all of YOU that has made our beloved organization so successful.

As volunteers in the earlier AHRA years, we were required to invest many hours with the variety of offices we held as board or committee members. Some of us did not have the luxury of an administrative assistant to help us with details and organizational chores that were inherent. I can tell you that during the time I served as AHRA President, it was like a half-time job that greatly impacted my work-life balance because it was so time consumptive. Although, we all managed to get our real work and our AHRA work done with decent outcomes.

But in my re-involvement on the Nominations Committee, I have had a “Back to the Future” experience. Whereas, I had been riding an AHRA horse and carriage, I suddenly went “POOF” and was now in a smooth and sleek luxury car. Much of this has to do with the staff we have at AHRA. Sarah Murray is our organizer for the nominations process. The detailed information she provides and the electronic tools she is using have shown me how much we have grown and how much more efficient things can be done. More importantly, Sarah's presentation and how she conducts herself with us as a committee through her responsiveness, respect, and professionalism indicates to me how highly evolved our AHRA staff is in their performance. I also have the pleasure to experience similar efficiency with Debra Murphy, our *Radiology Management* managing editor for many years.

My retrospective should include how AHRA got here from those Golden Years. Difficult decisions a couple of decades ago helped to forge our current existence.

AHRA leaders like Michael Favereau, Gail Nielsen, Howard Schwartz, Brenda Holden, Roland Rhynus, and Dewey Hollingsworth, Esq., helped influence me and monumental shifts for AHRA. Two key changes were necessary in order to retool for our future: 1) eliminating the five independent regions (cost reduction); and 2) the creation of our Executive Director position (consistent organizational leadership). We needed a good leader with a background in professional organization management. Ed Cronin, our current CEO, has done an outstanding job. It is wonderful to see us consistently generate more successful events under the thoughtful guidance of our main office. But, most importantly, our success is through creative, consistent project management, and organized leadership.

Finally, what I have observed is that the core culture of AHRA has stayed intact. We still remain an organization with a big heart. There is still a very “people focused” approach to what we offer our members; the willingness for volunteers in our organization to make a difference; and the warmth and respect we have toward one another that gives us all a positive energy about the importance of what we do and who we are. AHRA has continued to strengthen, has matured, and become even richer over time. AHRA, you still ROCK! 🌟

Gordon Ah Tye, FAHRA is director of imaging and radiation oncology services for Kaweah Delta Health Care District in Visalia, CA. He holds a bachelor's degree in biological sciences from California State University in Fresno. Gordon is a past president of AHRA, received the AHRA Gold Award in 2001, and received the 2006 Minnie for Most Effective Radiology Administrator of the year. He may be contacted at gahtyes@aol.com.

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