



## Distributed imaging unified workflow brings better outcomes

—Dave Pearson; Mary Tierney

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Any distributed workflow solution worth its salt helps radiologists work at the top of their clinical skill set, maximize their productivity and fully integrate their workflow with that of the rest of their practice—and, ultimately, with the workflow of the ordering physician, practice or provider organization.

In other words, the best distributed solution is one that helps the radiologist work smarter rather than harder in this era of outcomes-driven care.

Milwaukee-based Integrated Radiology Partners is lighting the way along this technological path, having developed with its partner, Plexus TeleRadiology, LLC its Imaging Workflow Management system for medium-size radiology practices—namely those with 15 to 50 radiologists—that want to leverage their radiologist sub-specialist pool for maximal clinical effectiveness and business acumen.

Meanwhile, the system is scalable to hospital clients of all sizes, up to and including multi-hospital integrated delivery systems, whose constituent imaging stakeholders are not connected via unified PACS.

William G. Pickart, IRP's chief executive officer, explains that the system design grew out of a common concern shared by nearly all radiology providers today: how to load balance and manage the provision of subspecialty access 24/7 to the interpretation demand that exists across their network of clients.

"In the case where a radiology practice enjoys the luxury of providing interpretations for not only a hospital system but also for various outreach clients, the need for a unified work-

list becomes even more critical," he says.

Traditionally, a hospital system doesn't extend its unified PACS—if it even has one—out to other business or support opportunities that the practices engage in to provide services to the community.

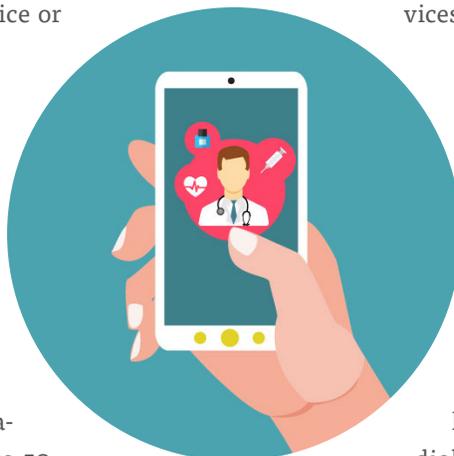
The IRP system is, in essence, a kind of network "umbrella" overlaying all those different sites. It can encourage appropriate load-balancing, resource management and the efficiencies needed to deploy radiologists' skills and expertise in a truly enterprise-wide approach.

"Typically there are high expenses and large capital costs associated with maintaining a teleradiology capability like IRPs," says Pickart. "The Plexus TeleRadiology model is set up as a software as a service (SaaS) type model, where we deliver the technologies through the cloud. As a result, we can keep expenses and capital outlays very low."

### Ordering a la carte off the menu

Unlike most competitive offerings, and part of the genius of the IRP/Plexus Imaging Workflow Management system is that it is neither tied to a specific technology nor dedicated to a specific type of vendor. The consultancy picks vendors to work with based on the vendors' ability to offer best-of-class capabilities. Mixing and matching to fit clients' unique needs, IRP builds a modular solution that facilitates not only a unified work list but also a unified business or teleradiology subsystem to the client practice.

The solution incorporates PACS and the workflow assign-



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ment logic that goes behind moving images across the enterprise, and it allows the incorporation of IRP analytics. From these can flow such worthwhile add-ons as revenue cycle management, critical results management and other technologies that lay on top of the core distributed imaging.

“For lack of a better analogy, it is configured like an a la carte menu,” says Pickart. “The client doesn’t have to buy everything we sell. So it is a comprehensive and all-enveloping type of scalable support to the practice, allowing them to provide service at a very high marginal utility with low marginal cost. And that brings significant value back to their outreach clients and to the hospital systems that they support.”

Such full bundling at a low cost is the key advantage that has turned IRP’s onetime prospects into longtime clients.

“Our efficiency improvements range between 30 percent to as much as 60 percent,” says Pickart. “And in addition to providing the Plexus technology, IRP is capable of brokering relationships between radiology groups. Because we are not a teleradiology practice—we are a technology services provider—we broker both capacity and expertise between groups. It has worked out to the great benefit of groups challenged by a lack of resources.”

## Mighty modularity

Keith Chew, IRP’s senior vice president, voices his enthusiasm for where the company’s distributed workflow solution may help take U.S. healthcare. One of the areas sure to start emerging is the technological push for follow-up compliance, he says.

“Today when a radiologist sees something and calls for follow-up, the statistics show that the actual follow-up rate can be under 10 percent” says Chew. “To add true value into that equation, radiology is going to have to become engaged in follow-up compliance. We need to see whether follow-up has been done and, if not, make certain that we take responsibility to get back with the referring physician or even possibly the patient.”

Chew points out that, as U.S. healthcare moves to emphasize value and quality, a major area of scrutiny is sure to be low-value imaging.

“Low-value imaging has as one component the fact that a radiologist may have to provide such a large differential di-

agnosis that the report doesn’t really answer the question the referring clinician has asked,” he explains.

For example, the single biggest problem with many teleradiology systems is that “all they do is transmit an image,” says Chew. “The image doesn’t really help a radiologist as much as would understanding the clinical picture of the patient.”

The capability to automatically pull in clinical histories for radiologists to consider alongside images, along with other elements of full EMR integration, “is going to bring radiology a lot more power down the road because radiologists are more able to move into that value proposition that radiology can bring. This can help get radiologists back to being the doctor’s doctor.”

Chew further stresses that the modular design of IRP’s approach allows a great deal of flexibility that may not be present in other systems or other vendor models.

“That modularity in and of itself represents, in my estimation, one of the system’s greatest strengths,” he says. “From the physician’s perspective, anything can be added on and integrated relatively easily. From the perspective of analytics and background, it may be more difficult to get the access that is necessary and to write the appropriate interface. Still, it will be relatively seamless to the physician once that is accomplished.”

## Working smarter, not harder

Pickart offers an observation made over many years in the business of radiology: When selecting the technologies they will use to support their work, most radiology practices end up assembling each of the components themselves—for better or for worse.

“They choose from a PACS vendor, a voice recognition vendor, and a work list provider and then are challenged to integrate the disparate components,” he says. “We bring all of those components together, configured so that the core components come together with additional modular add-on functionality at a very low additional marginal cost. We can plug in a critical results module. We can also activate functionality to extract data points and records from the EMR to integrate into our system.”

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With its Imaging Workflow Management system, IRP is actively looking to promote this approach, he says, because changes in reimbursement, regulation and quality control are forcing radiology practices to tap into emerging as well as established technologies.

Not by accident does the system incorporate a unified work list, enhanced dictations, advanced performance reporting, automated peer review and critical results notification.

“Interoperability and enterprise informatics are in our blood. It is our culture. It is our business purpose. We are not just selling one or more vertical components,” says Pickart. “Ours is an integrated approach to really make radiologists as efficient and as effective as they can be. And that combination of efficient and effective means grabbing the pertinent patient histories and data before they get on the system and call up the study through a unified worklist.”

The end zone is reached when “radiologists call up a study, and they have everything right there in front of them. They just continue to move through their work list at an efficient and effective pace.”

In other words, the day will be won when radiologists find themselves working smarter rather than harder in this era of outcomes-driven care.