Is Commoditization Inevitable for Radiology?
While commoditization pressures are visible every day to radiologists, there are practical steps that can be taken to push in the other direction. ACR and others are working hard to show the way. However, like most things worthwhile, it isn’t easy. We describe important ways to start the journey.

More than most other specialties, radiology seems to be “schizophrenic” these days. On the one hand are the well-known pressures that radiologists feel every day:
- Productivity (more cases!)
- More quality measures, with more complexity
- More regulations
- Expanding hospital expectations
- Threats from national radiology companies
- New forms of payment: bundled payments (e.g. hip and knee replacements), ACO’s, etc.

As many have observed, these forces and others are pushing radiology toward commoditization.

On the other hand, ACR Imaging 3.0 and many others are advocating for a different model of radiology; one where the radiologist is clearly seen as adding value. Ways to do so include:
- Being visible and available to patients: “empower patients”
- Interacting much more with referring physicians
- Assuring appropriateness of ordered imaging tests
- Actionable reporting with evidence-based follow-up recommendations
- Playing a larger and more visible role within the hospital
- Being proactive with new payment models

Achieving the positive mindset required to operate in these “new” ways isn’t always easy, particularly since “Imaging 2.0” has often made radiologists “invisible” to its key stakeholders: patients, hospitals and referring physicians. Some observers worry that younger radiologists are more concerned about their lifestyle and are therefore less likely to take the “extra” steps required by Imaging 3.0. Others worry that the “old guard” isn’t receptive to the culture shift required. Regardless of the impediments, it is clear that, without culture change, radiology will continue on the path to commoditization.

So how can these value-adding steps work? And are radiologists doing enough to offset the pressures toward commoditization?
PATIENTS

Studies have shown what most of us know: most patients don’t know that there is a physician radiologist reading their exam. And even if they do know, they don’t have any idea what the radiologist does.

“Actual patients are often unaware who reads their imaging studies, let alone their qualifications,” said Teri Yates, founder and principal consultant for Accountable Radiology Advisors in Columbus, Ohio, since the radiologist isn’t typically visible to them. That’s often a function of the workflow. “I think that’s the more challenging area, establishing a reputation for yourself with patients and the public,” she said. “Breast imagers have done this very nicely. They have an opportunity to be more interactive with the patient. I think patients do choose a breast imager based on the radiologist and their reputation. One of the reasons is that they have contact, and the other is that they specialize.”

For those in different imaging fields, Yates recommends raising their profile with patients by highlighting their expertise. The group can increase the level of specialization within how cases are read. “Play to the strength of individuals and their expertise,” she said.

There are other ways to connect with patients, said Geraldine McGinty, MD assistant professor of radiology, assistant director at Weill Cornell Medical College, and chair of the American College of Radiology’s (ACR) Commission on Economics.1 Introduce yourself during the imaging exam. Make reports, images and consultations available to patients, optimize your patient portal.2

REFERRING PHYSICIANS

A key goal of Imaging 3.0 is for radiologists to collaborate with other physicians to improve imaging care. Of course, radiologists have always worked with referring physicians but, in many cases, the relationship has evolved to limited interaction such as monthly meetings with clinical interaction limited to emergency cases.

Achieving the “value-add” goals of “assuring appropriateness of ordered imaging tests” and “actionable reporting with evidence-based follow-up recommendations” requires radiologists to have a more active day-to-day role with referring physicians. Of course, part of this equation will now be driven by the legally-mandated requirement for CDS use, beginning January of 2017.

Appropriateness criteria in the CDS should help referring providers identify the appropriate study. However, for the minority of cases where a referrer has questions, the radiologist needs to be available to take their call, according to Bibb Allen, Jr, MD, FACR.3

More broadly, referring physicians look to radiologists for their expertise, not just in reading studies, but in advising about the patient’s treatment. Emory University School of Medicine surveyed referring

---

physicians to find out what these doctors wanted from their radiology colleagues. The results? They want greater interactions with the radiologists, including recommendations for next steps for treatment in their reports. Half of respondents indicated that the limited contact between the radiologists and referring physicians hindered best patient care.4

HOSPITALS

In a recent RBMA discussion, speakers advocated that radiologists be (more) pro-hospital. In a best case scenario, radiology should be perceived as a clear leader in the hospital. They need to be friends with the ER docs even though it may be hard. They need to be active on committees.

Additionally, it is often important to have radiologists tell the hospital HOW radiology is working with them ALREADY; otherwise they may not know. This means an active promotion strategy needs to be in place. For a contracted group, if a hospital asks for things in contract negotiations that radiology is already providing [it has happened!], this is a sure sign of poor communications.

Hospitals now have quality measures from payors. Obviously radiology has a role to play in achieving these measures. Many existing and most new hospital contracts and employment agreements have quality measures: typically 5 to 10. And there may be “stretch” measures. For example, call backs on mammos [which can affect the hospital’s patient satisfaction scores].

At the same time, of course, radiology has PQRS and VBM quality measures [to be replaced by the consolidated MIPS program in 2019 for physicians not participating in Alternative Payment Models]. But many radiologists continue to view PQRS, etc. as an unwelcome intrusion on their “real work.” This mindset isn’t helpful today and won’t work with the rapidly emerging world where payment will be ever more tightly linked to quality.

NEW PAYMENT MODELS

Leading hospitals and medical groups are responding to the industry’s shift to value by beginning to develop population health management and care coordination capabilities. While these new approaches are largely about eliminating waste and providing the appropriate care at the right time, they may reduce a group’s payment under a fee-for-service contract. Any reductions in utilization or costs may help the patient, and certainly the payer’s bottom line, but do little to compensate the medical group and/or hospital that has invested in the care model redesign, IT, and staffing necessary to implement population health management.

Radiology groups and hospitals should take a more aggressive and proactive approach to payer contracting. Rather than waiting for health plans to offer new payment models while they invest in care redesign,

---

groups should identify opportunities to negotiate care management payments or shared savings arrangements that allow the group to share in the cost reductions it generates. As the group gains experience, it can consider more advanced models, including risk-based models.\(^5\)

**SUMMARY**

The pressures toward commoditization of radiology haven’t stopped. But there are ways that radiologists can overcome these pressures. They start with a positive mindset to embrace the environment as it is, not the one that used to exist or the one we wish existed. The ACR Imaging 3.0 provides part of the roadmap. The rest needs to come from each individual, group and department involved in radiology.

Some of the steps highlight why, in addition to clinical skills, it is becoming critical to develop nonclinical skills, such as leadership, negotiation, human resources and finance. As healthcare continues to change, radiology will need more of these skills, not less.

As a final example, consider the move to ICD-10. “ICD-10 complements the call in Imaging 3.0\(^{TM}\) for radiologists to help shape the future of health care. The practice of radiology centers on diagnoses of diseases, so radiologists should be leaders in the ICD-10 effort among our fellow physicians, billing staff members, and hospital administrators. The transition will make our reports more focused on clinical questions and more relevant and meaningful to our referring physicians. Furthermore, with improved diagnosis coding, we can better track the impact of our reports on patient outcomes and better participate in registries, such as the new lung cancer screening registry and the ACR’s Qualified Clinical Data Registry. Above all, ICD-10 gives us the opportunity to be better doctors.”\(^6\)

---
