Top 3
Radiology Trends for 2015
Early in a new year is always a good time to step back and assess the landscape. In this article, we highlight 3 trends that are gaining momentum in 2015. None of these are new, but we believe they are all becoming more important in 2015:

- Adding Value
- Flexibility
- Cost and Productivity Focus

ADDING VALUE

Much has been written about the need for radiologists to add value. In fact, the entire ACR Imaging 3.0 initiative can be seen in that context. Of course, accurate interpretation of images is the basis for everything done by a radiologist. But some argue that just focusing on this dimension leads to increasing commodization of radiology.

Increasingly, radiologists are adding value to patient care by focusing on the ordering process so that the right study is ordered, with the proper protocol, while minimizing radiation risk. Bibb Allen, Jr, MD, FACR, diagnostic radiologist in the Birmingham Radiological Group in Alabama and a leading proponent of Imaging 3.0, says “Look at it this way. A lot of imaging care occurs before the patients ever get to the hospital or imaging center. If you think about it, an imaging study begins when an ordering physician has a patient encounter and is considering imaging to help in the diagnosis or treatment.”

A key component of Imaging 3.0 that is sure to get more attention in 2015 is the Appropriateness Criteria. These are evidence-based guidelines for referring providers to help them choose the most appropriate study or treatment to order, based on the patient’s specific clinical situation.

The Protecting Access to Medicare Act of 2014 (the “SGR patch” passed by Congress in late March) requires all physicians referring a Medicare patient for advanced imaging, starting January 1, 2017, to use physician-developed appropriateness criteria. Most observers expect the ACR criteria to be included, if not the core of the required criteria.

The criteria 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 Dr. Allen.

Other dimensions of value include providing patients with information (see The Patient Engagement Wave) and interacting with patients: e.g. as often happens today in Breast Centers.

Of course, an explicit measure of value is the “Holy Grail.” While that is a difficult challenge, integrating radiology information with other patient data is a critical first step. Given radiology’s leading role in informatics in the past, there is a clear opportunity here. This is particularly true where a radiology department or practice is part of an ACO (or similar) initiative. In fact, it can be argued that proactively gaining a seat at the table of these efforts in your area is essential.

---

2 Ibid.
FLEXIBILITY

Certain trends are very clear:
- The need to add more value, as just described
- The move away from Fee for Service reimbursement, toward some form of value-based reimbursement. As an example, there are now more than 600 active ACO’s, not counting many trials and experiments.
- The ongoing need to reduce overall healthcare costs while improving patient outcomes
- Increasing “consumerism” in healthcare driven by higher patient deductibles and co-pays and by expectations for instantaneous communications.

In the face of these trends (some might say pressures), radiology departments and practices have chosen a variety of approaches. In some cases, radiologists who were formerly independent are now employed by a hospital or health system. In other cases, radiology groups have merged to create a larger scale. In still others, radiology has become part of a multi-specialty group.

There are pro and con arguments to be made for each model but it appears that only time will tell if one is superior. Plus, of course, local circumstances may favor one approach vs. another. But regardless of current model, in the meantime, each group or department must continue to manage for success.

Many have argued that this calls for flexibility and experimentation. “It makes no sense to plan beyond a couple years out,” according to Alan Kaye, MD, President of Advanced Radiology Consultants in Shelton, Connecticut. “There’s too much uncertainty. Continue to maintain quality of service in whatever venue you are in, maintain your current hospital relationships and be the provider of choice for all of the alternatives. Get buy-in from staff and practice members so that you can cover all of your bases and tolerance for uncertainty. In other words, stay flexible.”

As an example of experimentation, William Bradley, MD, PhD, chief of radiology at UC San Diego talks about “pods of expertise” in which “head and neck radiologists will hang out with the head and neck surgeons. There won’t be one big reading room like we’ve always had; radiologists will work closer to where the clinical activity is. Then these pods will coalesce to form new ACOs.”

Another example of experimentation comes from Lahey Health. Lahey is considering assigning a daily-rotational radiologist liaison whose responsibilities for the day are to consult with clinicians about their patients’ cases and to recommend the best diagnostic imaging procedures for clinical diagnoses.

In the face of the many forces at work, it seems clear that successful groups and departments will remain flexible so that they can respond as circumstances evolve and trends become clearer. Part of this flexibility means trying new ideas and approaches to determine which fit the local environment.

---

4 Ibid.
5 Ibid.
Top 3 Radiology Trends for 2015

COST AND PRODUCTIVITY FOCUS

With the waves of radiology reimbursement cuts over the past ten years, it may seem un-necessary to highlight cost and productivity pressures. However, it seems clearer than ever that what must happen for radiology to be successful in the future requires a fundamental, structural improvement in cost structure.

With the trend to value-based reimbursement and the need to add value beyond reading images, traditional RVU or similar approaches will be insufficient (even though they will be around for a long time and may be part of the ultimate solution).

Traditional and ongoing cost management efforts need to continue such as personnel management, equipment, and supplies. Standardizing processes [e.g. report format, turnaround times, review procedures, etc.] can reduce costs and improve quality.

Some hospitals and practices have adopted Lean or other TQM (Total Quality Management) approaches which provide a structured way to reduce waste (i.e. reduce costs) and improve quality. The lessons from these efforts are clear:
- Substantial cost savings and quality improvements are feasible, but
- Practice leadership must be committed and active, while
- Each radiologist and staff member must be or become involved, and
- Results take time: months or more.

One cautionary note is that groups who have tried the TQM approach as a one-time project may achieve some short term benefit but inevitably miss the much larger opportunities.

For more information on applying Lean to radiology, see Diagnostic Radiology, February 4, 2014, "Lean Transformation for Radiology: Should Imaging Go Lean?"

2015 appears to be the optimum time for proactive radiology groups that have not used these approaches to get started. Focusing on cost and quality improvement as an organized, ongoing commitment will pay dividends in 2015 and for many years beyond. Those dividends extend beyond the bottom line and include greater radiologist and staff involvement with a culture where improving costs and quality becomes expected and second nature.