Obama Care and the Future of Radiology

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“The only thing constant…is change”

-- Heraclitus; 500 B.C.
Nothing is so difficult to change as a successful business!

“Firms develop valuable path-dependent routines (i.e., core competencies) that are difficult to change.” Nelson & Winter

“Adaptation, new competence creation, & learning are crucial components of strategic management.” McGrath/MacMillan
Key Observations

Radiology has been successful!
Whom the gods wish to destroy, they first give 40 years of success… P. Drucker

Success breeds persistence in what we do well at the expense of adaptability and innovation.

Success breeds **COMPLACENCY** - **BLUNTS**
**APPROPRIATE RESPONSE TO THREATS**
Sources of Complacency

- Too much happy talk from senior management
- The absence of a major and visible crisis
- Too many visible resources
- Human nature, with its capacity for denial, especially if people are already busy or stressed
- Low overall performance standards
- A kill-the-messenger-of-bad-news, low-candor, low-confrontation culture
- Organizational structures that focus employees on narrow functional goals
- A lack of sufficient performance feedback from external sources
- Internal measurement systems that focus on the wrong performance indexes
Physicians’ Views of the Relative Importance of Thirty Medical Innovations (the absence of which would have the most adverse effect on patients)

MRI and CT scanning – “the most important innovation by a considerable margin…”

![Demonstrating the value of imaging](image-url)

Rising Use of Diagnostic Medical Imaging (Group Health Coop)
Smith-Bindman, R; Miglioretti, DL. Health Affairs 27(6), 1491-1502: 2008

Increases across all age groups, including the managed care setting
Tripling from 1997 to 2006 (Gr Health): x-sect’l 260->478 /1000 enrolees, CT 14%, MRI26% per year to 181 and 72 per 1000 per year by ’06 (NM stable)
Each add’l CT unit in MD office is associated with $685,000 in add’l spending per year
Spending: 2000-5 Medicare 6.6 $Bil to 13.7 – 2x Phys fee schedule
MULTI-DETECTOR SPIRAL CT
THE BEST MEDICAL DIAGNOSTIC WEAPON FOR THE NEW MILLENIUM...??

...OR WEAPON OF MASS DESTRUCTION!??!!
The US has more and better medical equipment than any other country. But reliance on technology like MRI scanners is a big reason why costs are so much higher here.

msn.com 9.22.2009
Today, value tends to be defined by what can be easily measured given flawed organizational structures (processes), rather than what actually matters for patients (outcomes). - M. Porter

**VALUE** = **Outcome** + **Patient Experience**

**COST**

- must be defined around the CUSTOMER, not the supplier.
Nighthawks-26 wks Vacation, $550-$620k + All Benefits
Emergency Radiology Services, PA (ERS) is growing. We are seeking a total of eight new radiologists who want to be part of an expansion of our practice and the field of radiology. We are seeking four radiologists who are interested in being a part of our emergency night-time overnight practice. Candidates should have experience and training in all types of body imaging, and basic Neuro MRI. ERS, in partnership with Nighthawk Radiology Services and St Paul Radiology, provides 24/7/365 coverage of radiology practices. All of the positions include an average of 26 weeks of vacation. All positions are partnership track, with one year to partner and two years to monetary parity with senior partnership. Positions include full benefits. For further information contact Timothy V. Myers, MD, Medical Director for ERS, at (pager) 612-740-6546, e-mail tmyers@stpaulrad.com or Barry Lindo, Director of Human Resources, at 651-292-2003 and e-mail blindo@stpaulrad.com.
“Per Click” (Fee for Service) Reimbursement : Sustainable?

Um novo vídeo todo dia!

http://www.bacaninha.com.br
Health Care Reform ➔ Health Cost Reform?
Entitlement Based ➔ Accountability Based System

Traditional Business Model: Practice of Medicine… As We Knew It
Health: Walk-in health clinic at Wal-Mart opens
Bangor debut a prelude to Brewer, Palmyra, Presque Isle sites
By Meg Haskell

...Wal-Mart Imaging Centers being tested ...
Culture of Entitlement:

- **Patients:** Believe they are entitled to state-of-the-art care regardless of health habits, ability to pay
- **Physicians:** Believe they are entitled to a high degree of clinical autonomy, historical levels of reimbursement
- **Hospitals:** Believe they are entitled to collect highest levels of compensation rates in the world
- **Insurers:** Believe they are entitled to high margins regardless of the relative value they provide to the system
Entitlement:
Belief that one deserves certain rights, privileges, rewards based on tradition or past achievements

Accountability:
Rights, privileges, rewards are earned based on merits the measurable results of current performance. VALUE

Rights, privileges no longer automatic, leaving the entitled party feeling disappointed, angry, or mistreated
ACO model: Core components

Payer Partners
- Insurers
- CMS
- Employers
During the 18th century, the British government hired captains of large shipping vessels to transport prisoners to Australia. As many as one third of the male prisoners died before reaching Australia because of malnutrition, starvation and brutal physical treatment from the ship's crew.
Creation of second-generation clinically integrated networks capable of managing risk and targeting the 20 percent of the population that incurs 80 percent of the cost.

Rather than pilot test an ACO model on these networks should cut their teeth on the self-funded pool of hospital employees and dependents, where a reduction in admissions and costs results in savings for the organization.

Critical elements for a successful second-generation clinically integrated network include primary care–based medical homes coupled to wellness and chronic disease management programs, integrated efficient process shops for acute episodes of care, digitally connected electronic medical records with point-of-care protocols, and relationships with post-acute providers (SNFs, Acute rehab), and a group culture committed to improving the cost and quality of care for patients **rather than to maintaining individual provider income and autonomy.**
ACO shared savings

Value Driven Shared Risk Reimbursement and Cost Control Strategies:

- Creates an opportunity for stakeholders to partner in new and more collaborative ways that partner expertise, share risk, and cost management
  - Aligns incentives with outcome and efficiency, not care volume delivery
  - More diverse and provider driven approaches to cost control cost

- Move will be gradual at first but will likely reach a tipping point
  - Sharing risk with payers is a new paradigm and few have experience
  - Multiple models and approaches can be confusing to providers
Consolidation Of Healthcare Delivery: Radiology’s “Partners”

- **Regulated Federal Networks**
  - eg; CMS, Veterans, Insurance Exchanges

- **Integrated Corporate Networks**
  - eg; Kaiser, Geisinger, Partners

- **Integrated Collaborative networks**
  - eg; ACOs, Quantum/IPA distributive networks
<table>
<thead>
<tr>
<th></th>
<th>Hospitals</th>
<th>Health Plans</th>
<th>MD Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Aggregate Lives</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Patient Control</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Managed Risk</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
In 2008, America's hospitals treated 123 million people in their emergency departments, provided care for 624 million outpatients, performed 27 million surgeries, and delivered 4 million babies. Every year, hospitals provide vital health care services like these to millions of people in thousands of communities. However, the importance of hospitals to their communities extends far beyond health care. Hospital care is the largest component of the health care sector, which itself is a growing segment of the U.S. economy. In 2008, this sector represented 16.2 percent of Gross Domestic Product (GDP)—a measure of economic output—or approximately $2.3 trillion. Hospitals accounted for $718 billion of that total. The health care sector is an economic mainstay, providing stability and even growth during times of recession. In 2008, hospitals:

- Spent about $320 billion on goods and services from other businesses.

...and create over 2 trillion dollars of economic activity.

The goods and services hospitals purchase from other businesses create additional economic value for the community. With these “ripple effects” included, each hospital job supports about two more jobs and every dollar spent by a hospital supports roughly $2.30 of additional business activity. Overall, hospitals:

- Support nearly one of 9 jobs in the U.S.
- Support over $2 trillion in economic activity.
Hospital Strategy: Old Game / New Game…

- Focus & Finish
- Evolve
- Old Game
- New Game
- Inpatient/Hospital
- Continuum Of Care
- Population Health

Improve Quality
Increase Efficiency
Lower Costs
Improve Patient Experience
Strategic Growth

Physician Alignment:
Physician Leaders to Physician Leadership
Sutter is hiring radiologists to work under the umbrella of its own medical foundation.
Salary

- increasingly the preferred choice for new rads
- predictable income
- minimizes overhead, risk
- lessens input to governance, control of quality
- not dissimilar from large radiology group practice!
Radiology at the Core..

...Radiology Provides:

- critical diagnostic information
- multi-specialty experience/expertise
- broad portfolio of technology support
- volume efficiency
- connectivity to the entire health system
- history of facilitating subspecialist needs

What better interface to the clinical enterprise for primary care extenders than Radiology?
Key Talking Points:
Role of Radiology in ACOs, Bundled Payment, Integrated Care Models

- Imaging is data, a major component of Information Technology for the Integrated Continuum of Care.
- The information derived *by the imager* from the data is critical to diagnosis, triage, decision support, outcomes, and drives efficiency of the entire enterprise.
- The interpretation of the image, the report, is only a small piece of the Radiologist’s responsibility…
- As is guiding utilization, including selection of most appropriate imaging test, providing the transaction efficiently, safely, and with rapid deliverables.
Key Talking Points:
Role of Radiology in ACOs, Bundled Payment, Integrated Care Models

• In a primary care driven model, the Imaging specialist is a key educator of the provider...
• ..And a key connector to appropriate specialist when one is needed.. The integrator in the continuum of care
• The “management” value added of those functions has, in the past, been assumed within the reimbursement for the “read”
• The temptation to treat “reads” as a commodity risks organizational loss of the value added of those key “management” functions.
• Such a loss would be of detriment to the quality and financial viability of the organization
In EDs there are a number of possible reasons for the rapid increase in CT utilization.

- In 1990 preoperative CT was done in only 1% of patients undergoing appendectomy, normal appendices were found in 23%.

- By 2007, preoperative CT was done in 97.5% of suspected appendicitis cases, and normal appendices were found in only 1.7%.

- First, sharply better outcomes
- Second, increased patient throughput
- Third, there is increased access to CT
- Finally, fear of malpractice liability

Radiology... at the Core of the Medical Enterprise: The IT/Decision Support of Clinical Medicine*

- ACOs /IHNs becoming the local health care enterprise model
- ACOs /IHNs use primary care access points
- Primary care is “down-licensing”, increasing role for NPs PAs RNs
- Such MD extenders need more decision support for triage
- Radiology is positioned to be their primary care partner…

*Integrating the access points with specialty services and triaging appropriately as needed.
Added Value/Competitive Advantage of On Site Radiologists

- Optimizing Access for, Triage of patients
- Supervision of equipment, choices, discounts, facility planning
- Oversight, education of technologists
- Selection/modification of appropriate sequences
- Consultation with referring physicians
- Personal relationships
- Promotion of services

- Quality control/peer review/JCAHO standards/credentialling
- Participation in medical staff governance
- Participation in hospital operations
- Involvement in strategic planning
- Attendance at organizational meetings
- In-house patient care
- In-house educational multidisciplinary rounds, tumor board, etc.
Co-Management Agreement

- puts radiologists at partnership table
- promotes leadership skills in organization overall
- highlights value of radiology to overall healthcare system
- requires strong organizational, political, managerial skills
- facilitates reimbursement for “added value” activities

Of all the models, this one can perhaps best address citizenship, expense control, teamwork, patient satisfaction, and outcomes
CO-MANAGEMENT MODEL EXAMPLE…

ST. NICK HOSP

OPT IMAGING CTR

IN-PATIENT
Equip
Techs
Support Staff
Offices
Overhead

NEWCO
MGMT LLC

$$ net
profit

$$ %

UM
POLICY.PROC
SAFETY
COST CONT’L
IT
EFFICIENCY
VENDOR REL’S
HOSP ADMIN
..etc..(metrics)

ELVES RADIOLOGY PC

FMV: TIME = $
Radiology at the Core..

Radiologists’ Three Potential Roles:

• Line worker
  -- commoditized reads

• Manager
  -- accountable operations executive: IT integrator, consultant, educator, quality control supervisor, facilities, inventory control, HR manager

• Leader
  -- strategy, business model development, allocation of resources
Core Assets and Competencies

• Technological expertise grounded in specialized training and discipline
• Intrinsic value of information provided by our tools...as supervised and interpreted by us...trusted partners of the medical community!
• Satisfying Information thirst of our customers
• Lead in electronically based work-flow
• Rapid turnaround of large volume of patient transactions
• Management of the Imaging/Decision Support Operations and Systems...IT!
Patient Centered Radiology

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The Customer is Always Right....
“Freddie Odlum spent two terrible days waiting by the phone for her doctor to call. She had had a CT scan to investigate a suspicious mass in her lungs and Ms. Odlum, a Los Angeles breast cancer patient, was all too aware that if the cancer had spread, her prognosis would not be good. . . . But her doctor did not call [for several weeks]. . . . The scan did not show cancer, but she could not forgive her doctor. ‘This internist had been my family doctor for years,’ Ms. Odlum said. . . . ‘I never spoke to him again.’”
Statement of the Coalition for Patient-Centered Imaging to the Ways and Means Subcommittee on Health

February 10, 2005

The Coalition for Patient-Centered Imaging (CPCI) represents the undersigned healthcare organizations committed to ensuring that patients have full access to high quality, convenient, and up-to-date imaging technology. The Coalition organized in response to efforts to limit the availability of imaging services provided in physicians' offices.

As the use of imaging services has increased, some medical organizations and health plans have sought to place the "blame" for this change on physicians, such as obstetricians/gynecologists, neurologists, orthopedic surgeons, cardiologists and urologists, to name a few, who use these technologies in their office practices. Because these physician services are included under the volume considerations of the sustainable growth rate, they are clearly relevant to today's hearing on physician payments.

Office-based imaging services offer three important advantages to patients. First, office-based imaging speeds correct diagnosis and treatment of the patient's medical condition. For example, a patient who visits an orthopaedic surgeon with knee pain will almost certainly need an image of the knee for proper diagnosis. If the orthopaedist provides these services in the office, examination, diagnosis and initiation of therapy can be done in one encounter with the patient. If the physician were not able to provide the service, diagnosis and treatment would be delayed until the patient was seen by the radiologist and that physician sent the report back to the orthopaedist. Another patient visit to the orthopaedist would be needed to review the findings and determine the appropriate therapy. This
What is an ACO?

(“A Unicorn”)

An ACO is a *local, physician led* health care organization that is *accountable* for 100 percent of the expenditures and care of a *defined population* of patients. An ACO may include primary care physicians, specialists and, typically, hospitals, that work together to provide evidence-based care in a coordinated model. The three major foci of these organizations are:

1) Organization of all activities and accountability at the local level
2) **Measurement of outcomes and costs**
3) **Distribution of cost savings to ACO members**.
<table>
<thead>
<tr>
<th>Aim: improved care</th>
<th>Proposed Measures for ACO Quality-Performance Standards.</th>
</tr>
</thead>
</table>
| Patient and caregiver experience | - Getting timely care, appointments, and information  
  - How well your doctors communicate  
  - Helpful, courteous, respectful office staff  
  - Patients’ ratings of doctor  
  - Health promotion and education  
  - Shared decision making  
  - Health status or functional status |
| Care coordination — transitions | - Risk-standardized, all-condition readmission  
  - 30-Day post-discharge physician visit  
  - Medication reconciliation  
  - Care transitions measure  
  - Management of ambulatory-sensitive conditions: diabetes; chronic obstructive pulmonary disease (COPD); congestive heart failure (CHF); dehydration; bacterial pneumonia; urinary tract infections (UTIs)  
  - % of all physicians meeting HITECH meaningful use requirements  |
| Care coordination — information systems | - % of PCPs meeting HITECH meaningful use requirements  
  - % of PCPs using clinical decision support  
  - % of PCPs meeting eRx incentive program requirements  
  - Patient registry use |
| Patient safety | - Health care–acquired conditions composite (includes foreign object retained after surgery, central-line—associated bloodstream infections [CLABSI], falls and trauma, catheter associated UTI, and others)  
  - CLABSI bundle use |

<table>
<thead>
<tr>
<th>Aim: improved health</th>
<th>Preventive health</th>
</tr>
</thead>
</table>
| At-risk population — diabetes | - Influenza immunization  
  - Pneumococcal vaccination  
  - Mammography screening  
  - Colorectal cancer screening  
  - Cholesterol management for patients with cardiovascular conditions  
  - Adult weight screening and follow-up  
  - Blood-pressure measurement  
  - Tobacco-use assessment and intervention  
  - Depression screening |
| At-risk population — heart failure | - Composite and individual measures (glycated hemoglobin, LDL cholesterol <100 mg/dl, blood pressure <140/90 mm Hg, tobacco nonuse, aspirin use)  
  - Poor glycemic control (glycated hemoglobin >9%)  
  - Blood pressure control in diabetes  
  - Screening rates for microalbuminuria  
  - Dilated eye exam; foot exam |
| At-risk population — coronary artery disease | - Venricular function assessment  
  - Venricular function testing  
  - Weight measurement  
  - Patient education  
  - Heart failure prescription rates for left venricular systolic dysfunction (LVSD)  
  - Angiotensin-converting-enzyme inhibitor or angiotensin-receptor blocker (ACE/ARB) rates for LVSD  
  - Warfarin therapy for patients with atrial fibrillation |
| At-risk population — hypertension | - Coronary artery disease (CAD) composite and individual measures (oral antplatelet therapy for patients with CAD; drug therapy for lowering LDL cholesterol; beta-blocker for patients with CAD with prior myocardial infarction; LDL cholesterol <100 mg/dl; ACE/ARB therapy for patients with CAD and diabetes, LVSD, or all of the above)  
  - Blood-pressure control rates (<140/90 mm Hg)  
  - Hypertension plan of care |
| At-risk population — COPD | - Spirometry evaluation  
  - Smoking-cessation counseling  
  - Bronchodilator therapy based on FEV1 |
| At-risk population — frail elderly | - Screening for fall risk  
  - Osteoporosis management in women who had a prior fracture  
  - Monthly INR for beneficiaries on warfarin |

* Most measures and standards would be based on rates within the total eligible population. HITECH denotes the Health Information Technology for Economic and Clinical Health Act, LDL low-density lipoprotein, FEV1 forced expiratory volume in 1 second, INR international normalized ratio, and PCPs primary care physicians.
• Continuously monitor the patient experience of care. Is he or she greeted by friendly staff who introduce themselves?

• Use technology to empower patients and to provide nontraditional modes for accessing care, such as video consults, telemedicine, patient portals for accessing personal health records.

• Instructions and educational materials must be created at the appropriate literacy level to meet the needs of customers with health literacy issues. For example, it will no longer be sufficient to provide a woman with an order for a screening mammogram. Instead, the ACO needs mechanisms in place to help schedule the appointment, ensure prior to the procedure that she is prepared properly and has transportation, ensure the procedure is completed, check results, and ensure the patient receives the results and appropriate follow-up care.
WHAT DO PATIENTS WANT?...

LESSONS FROM MAMMOGRAPHY, ULTRASOUND, IR:

Easy access
Information content of study
“Face Time” with MD
Rapid feedback
Reassurance or rapid triage
Cost flexibility
Transparent pricing/billing
Self reliance

...greater degree of control!
**Commoditizing the “read”....**

**Teleradiology Solutions CT, MRI, US, X-RAY**

- We provide coverage 24/7/365 including holidays and weekends. We will meet your requirements and schedule.

- Subspecialized, service oriented, prompt radiology coverage for your orthopedic office or Radiology Department at times of need.

- Board certified, US based, fellowship-trained radiologists.

- Turnaround time typically in 30 minutes or less for preliminary STAT reports.

- HIPAA and ACR Compliant.

- We service hospitals, urgent care facilities, imaging centers, groups and physician offices.

- Our state-of-the-art web-based Radiology information system (RIS) and PACS allows us to interface with most system. We also offer your facility access to our RIS so that you may control order entry and check status of your reports.

- Please fill in and fax/email back to us teleradiology questionnaire, that we could determine service availability and match your teleradiology needs. Questionnaire located on the next page.

- **Link to the next page**

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**PRICING STRUCTURE**

<table>
<thead>
<tr>
<th></th>
<th>Study Normal</th>
<th>Study STAT</th>
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</thead>
<tbody>
<tr>
<td>X Ray</td>
<td>$10.00</td>
<td>$17.00</td>
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<tr>
<td>CT</td>
<td>$33.00</td>
<td>$50.00</td>
</tr>
<tr>
<td>MRI</td>
<td>$44.00</td>
<td>$60.00</td>
</tr>
<tr>
<td>US</td>
<td>$20.00</td>
<td>$32.00</td>
</tr>
</tbody>
</table>

1$/exam and $150 Fee for each additional online access (for referring physician or site)
Perception Is Reality...
Perception Is Reality...

Waiting Room

“LOUNGE”
Reception

*Greeter During Peak Volumes*

*Manage Patient Arrivals*

*Improve Waiting Room Environment*
The Components...Patient Centered Imaging Transaction

Patient Centered Experience

Safe, appropriate exam
Patient Access

- Outpatients are Likely to Seek Alternate Provider if Backlog is > 2 Days
- Backlogs Can Drive No-Shows
- No-Show Rates – May be Higher Than You Think
- Revenue Opportunity is Significant with Backlogs
Scheduling & Registration

❖ Align Front End Processes with the Patient in Mind

❖ One Call Concept—Enterprise Wide Scheduling Solution

❖ One Voice, One Contact – Ideal from the Patient Perspective

❖ Dedicated Line for Scheduling (1-800-IMAGING)
Average Speed of Answer

Monthly Averages - Patient & Physician Lines

Target = 15 seconds
Abandoned Calls…

When Did They Hang Up? Why Did They Hang Up?

Call Abandonment Rates

Percentage

Month

Patient
MD

0.00%
2.00%
4.00%
6.00%
8.00%
10.00%
12.00%
14.00%

Jan Feb Mar Apr May Jun Jul Aug Sep Oct

Patient
MD

Percentage

Month

Call Abandonment Rates

Patient
MD

0.00%
2.00%
4.00%
6.00%
8.00%
10.00%
12.00%
14.00%

Jan Feb Mar Apr May Jun Jul Aug Sep Oct

Patient
MD

0.00%
2.00%
4.00%
6.00%
8.00%
10.00%
12.00%
14.00%

Jan Feb Mar Apr May Jun Jul Aug Sep Oct

Patient
MD
Understand Your Customers Expectations

Inform the Patient when they should expect their Exam Results

Decision to Call...
Call to Schedule
Schedule to Exam
Exam to Dictate
Dictate to Transcribe
Transcribe to Signed
Results Available !!

Their Perception

Our Measure
Report Turnaround Time

Data Source: Hoag Hospital CPOG report Jan – Dec 2005

Hoag Report Turnaround Time = 99% < 8 hours
Best in Class Benchmark < 4 Hours
How About: Report turnaround by the time patient leaves your facility!

VOICE RECOGNITION / SELF EDIT REPORTING

Hate it.. Slows me down! …But,
With structured templated reports, may not be true…

AND

Keep the end in mind!
Accurate, standardized, understandable report provided in the fastest time possible. Whose responsibility? You own your final product!
Failure to Notify Reportable Test Results: Significance in Medical Malpractice

Table 3. Contributing factors in malpractice cases associated with communications failure

<table>
<thead>
<tr>
<th>Contributing Factor</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient did not receive results: no report or wrong report</td>
<td>143</td>
</tr>
<tr>
<td>Clinician did not receive results</td>
<td>110</td>
</tr>
<tr>
<td>Failure or delay in reporting findings or revised findings</td>
<td>83</td>
</tr>
<tr>
<td>Turnaround time for results too long</td>
<td>34</td>
</tr>
<tr>
<td>Clinician did not receive results: results filed before clinician review</td>
<td>21</td>
</tr>
<tr>
<td>Clinician did not receive results: report went to wrong clinician</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>394</td>
</tr>
</tbody>
</table>

Top Ten Patient Apologies

Delay In Care
Upset about Bill
Miscommunication about Appointment Time
Lack of Communication among Caregivers about Exam
Lost or Misplaced Belongings
Misinformed of Exam Preparation
Rude Physician
Rude Care Giver
Wrong Exam Performed
Contrast Administration Issues
Service Recovery

- Listen to the issue
- Acknowledge the issue and apologize
- Ask the customer what you can do to help resolve their concerns
- Explain to the customer how you intend to address the issue
- Fix-It-Fund
WHAT PATIENTS CAN LEARN FROM TALKING WITH RADIOLOGIST

RADIOLOGIST AS IMAGING EXPERT
KNOWLEDGEABLE PHYSICIAN
PATIENT ADVOCATE
TREATING PHYSICIAN
“GATEKEEPER”
REFERRING MD

PATIENT COMMUNICATION can take the Radiologist from the back room of doctor to doctor consultation, to the nexus of IT, decision support for the primary care provider - specialist interface
Overall, a majority of respondents (79%) were either very satisfied or somewhat satisfied (mean, 3.93 on scale ranging from 1 to 5) with radiology reporting.

Ninety-five percent of respondents thought that the most appropriate way for a patient to learn the results of an imaging examination was from the ordering provider.
Concerns: Focus Group methodology. Radiologists, Referrers.

Johnson et al; JACR 2010; 7:281-289

On-Line access

1. Patients ability to understand written reports (and your point is…?)
2. Anxiety if no access to physicians
3. Increased Number of phone calls for clarification
4. Radiologists not in position to know personal aspects of patients’ care or life contexts
5. Referrers lose control

Face to face:

Too time consuming
Insufficient knowledge of patients’ co-morbidities
Patients Want Results From Radiologist
Doctors Agree If Results Are Benign…

Survey of 261 patients:

92% wanted to be told of normal results
87% wanted to be told of abnormal results
94% felt entitled to an explanation from the radiologist
Schreiber et al; AJR 1995 165(2): 467-469

Doctors’ Survey – Radiologists, referring MDs
radiologist should provide result… agree?

If normal, 89% of radiologists and 76% of referrers
If mildly abnormal, 81% and 57%
If severely abnormal, 33% and 28%
Levitsky et al; AJR 1993, 161(2) 433-436
Patient Communication:
Challenges for Radiologists…

Have a seat Kermit. What I'm about to tell you might come as big shock...
Trepidation of Disclosure Unfounded

Majority of test results are normal, or do not indicate life threatening conditions

96% of 287 patients: test normal, or non-malignant condition

Vallely et al; BMJ 1990:300(6720): 305-306
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96% of 287 patients: test normal, or non-malignant condition

Vallely et al; BMJ 1990:300(6720): 305-306
In 2003, 1,275,300 newly diagnosed cases of cancer, and 23,345 Radiologists

Even if every case diagnosed by a radiologist, that’s one abnormal result per week per Radiologist.

American Cancer Society http://www.cancer.org
Pasko et al; Physician characteristics and distribution in the U.S. JAMA 2005: 1
.....Four Approaches to Informing Patients

• Refrain, even if asked
• Inform, but only if asked
• Ask all if they want to know
• Inform all
Dear Patient:

Thank you for choosing Newport Harbor Radiology Associates. We are the physicians who perform and interpret the procedure you had today. You can be assured that a board certified radiologist, one of our group’s expert subspecialist physicians, supervised and interpreted your procedure today.

The results of your procedure are being forwarded to the physician who referred you for this procedure. If you have any questions, consultation with your physician will be of value. Should you need further clarification, feel free to contact us.

Our radiologists are acknowledged experts in their field, some of our doctors having pioneered many of the radiology procedures being performed today. We aim to provide the highest possible level of care in a sensitive and patient oriented environment. We provide consultation not just to your doctor, but to other radiologists and physicians from outside this region, and help educate such physicians in the latest and most appropriate techniques tailored to a given diagnostic and therapeutic need. We staff Newport Imaging Center, and all of Hoag Hospital’s Radiology facilities.

If you require a copy of the results for your files, or a copy of the images themselves on CD, please let us know. You can make this request at the front desk or by calling (949) xxx-xxxx and our staff will make these arrangements for you.

Newport Harbor Radiology Associates offers the most advanced, comprehensive imaging services, radiological studies, and image guided treatments in all of California. To learn more, visit our web site at fill in

To schedule your next appointment, call fill in We look forward to providing imaging services for you again.

Sincerely,

The Physicians of Newport Harbor Radiology Associates
Consumerism Meets “Value” Based Care Integration... and Role of MRI