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Radiology in the Care Continuum

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Where do you see radiology's place in the care continuum?

I see radiologists as fundamental and integral to the care continuum. Traditionally, rounds ended in the radiology department. There was a sense that you had not completed the task of evaluating the patient without bringing the radiologist into the conversation. We need to return to that. Recently I was on a call with the Centers for Medicare & Medicaid Services (CMS) , and one staffer remarked that he was excited to see radiology at the nexus of clinical care and how radiologists are becoming more visible again and embedding themselves in the care delivery process. Without wishing to be too partisan about being a radiologist, I think that we are really central to the care continuum, because so often decisions require imaging and the expertise of the radiologist for the patient to move on to the next step.

Are there specific ways that radiologists can add value and position themselves at the heart of the care continuum?

It starts with being visible and being there. With the advent of Picture Archiving and Communications Systems (PACS), radiologists could interpret images remotely from where they were obtained. We became less obvious and less available to our clinical colleagues. Radiologists are taking a number of measures to become more visible, including setting up shop in the clinic, setting up consultation clinics and being much more proactive about being at case conferences and tumour boards. In my own institution our residents present at ICU rounds. They bring an iPad with all the images, and can review them with the team at the bedside.

Will greater visibility help to attract more medical students into radiology?

If you love what you do and see the hugely exciting possibilities in being a radiologist it is disappointing to think that we are not communicating that effectively to medical students. We realise that we have to attract medical students earlier in their career, because often they do not complete their radiology rotation until later in their medical school experience, by which time they have already settled on a training path. In my institution we have been having some events with medical students in their first few weeks of training. Every career has some days that are not so exciting and are routine. However, most of us in radiology are hooked! Our days are enhanced by moments when we really feel like we are making a difference, when we have really struggled through a difficult case and have come to the answer or we have done a procedure that has really changed the outcome for a patient. We have to effectively communicate those moments to medical students so they understand the possibilities.

At Massachusetts General Hospital in Boston, for example, they have a day where they set up a tent on the hospital grounds and have medical students spend a day with their faculty, who show the students the vascular procedures and biopsies we perform. The American College of Radiology (ACR) is working on a pilot programme on improving diversity in radiology, as we are not doing as well as some other specialties. by bringing in medical students early, having them meet practitioners and understand the possibilities earlier we are trying to make sure that the best and brightest medical students and those who really can contribute are choosing radiology.

In your own institution how do you demonstrate radiology's place in population health management and in the care continuum?

In terms of population health management we have a very active mammography programme, and in the past year we launched a lung cancer screening programme. In terms of being visible in the care continuum, it is a philosophy of our department and our entire institution that collaboration allows us to deliver better care – it's in our DNA. Our radiologists share the ethos of being very tightly embedded with their other

colleagues.

Could radiologists be more involved in developing and using care pathways?

Radiologists have been involved in this, but it is becoming more formalised in the U.S. as we plan for the implementation of the legislation around clinical decision support. Care pathways are a facet of that. In some instances there is a decision pathway for the referring physician, who has a patient with a particular clinical picture and who needs to know what is the appropriate imaging. Other clinical areas have a more longitudinal decision pathway. We are looking at areas such as stroke, and we are working with oncologists on follow-up imaging for cancer patients. We use evidence where possible, and, where the evidence is not there, we work on developing that evidence. We are bringing together the different stakeholders around the clinical issue to try and develop the care pathway that is going to give us the best outcomes for the patient.

Are 'turf wars' an issue for radiology in the United States?

I hope that the recent emphasis on value-based care will focus us on the best outcome for the patient and the best value for the healthcare delivery system. Whoever can do the procedure most effectively and contribute to the most effective outcome will perform it. In my personal experience as a breast radiologist, the best physicians want to focus on the thing that they uniquely can do to the benefit of the patient. This focus on value will hopefully drive us to put the patient in the centre and really make the patient our focus — not our own turf.

What advice would you give radiologists on finding time to become more visible?

For our department the patient experience is paramount. It starts when you come to the front desk. There is a picture of the radiologists on duty that day and an invitation to speak to them. We should welcome it when our patients have questions, because we know that more engaged patients are more likely to be compliant with recommendations. We are part of that engagement, helping patients to understand what we see. When I'm recommending a biopsy and trying to reassure my patient that it's probably going to be benign, showing her the tiny little calcium deposit on the mammogram so that she knows that even in the worst case scenario we are dealing with something small brings such a look of relief on her face. We have such a critical role to play in contributing to that sense of patient engagement and patient satisfaction. In terms of how radiologists can find the time for these activities I understand the concern, and I talk to radiologist groups around the country about how you find this time. What I hear back, and this has been my personal experience, is that that sense of satisfaction that you can get from delivering care directly to that patient is really motivating. Actually interacting with that patient is fuel, it keeps you going, gives you a sense of why you are doing what you do.

The American College of Radiology has launched the Radiology Support, Communication and Alignment (R-SCAN) network, which has as one of its aims to forge a collaborative cross-departmental approach. What is the idea behind this?

R-SCAN is a way to help physicians understand how to order imaging more appropriately, using clinical decision support (CDS). As physicians we are required to conduct quality improvement projects for our maintenance of certification. In addition, we want to help physicians understand what CDS means. This programme achieves both of those goals. In a nutshell you work with a number of your referring physicians to understand where they are now with the appropriateness of ordering, and see how they can improve after learning more about appropriate imaging and the clinical decision support process. The ACR was awarded a grant from a CMS programme (innovation.cms.gov/initiatives/ transforming-Clinical-Practices), Transforming Clinical Practices Initiative, with the aim of getting physicians to practise differently. This is a way to help physicians understand how to order imaging more appropriately. The goal is to recruit 1000 radiologists every year, each of whom will recruit five of their referring physicians.

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