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Value-Based Radiology: View from the United States

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As the United States moves to value-based healthcare, how should radiology concentrate on delivering better value, both at the individual and organisational level?

Radiology across the world is facing the same challenges. There was a time, before digitised films, picture archive and communication systems (PACS) and computers to view the images, when the images were printed out as hard copies. If clinicians wanted to look at the films, they had to come down to the radiology department and talk to the radiologist. That was extremely helpful to radiology and to clinical services, because we had that contact between primary care, the physician, the surgeon and the radiologist. Some senior radiologists say that at that time we were considered the doctor's doctor, because the surgeon wasn't going to operate without going over the films with the radiologist; the primary care doctor wasn't necessarily going to treat the patient without going through the film with the radiologist and so on. That has all changed. Physicians look at their films remotely. It is a rarity for a clinician to come down and go over cases with us. They still do, but not as much as before. I think this has made radiology and radiologists much more of a commodity, because we are not presumed to be part of a value-based team.

We recognise that this is an issue that we have to focus on. There are initiatives underway to address this. The American College of Radiology (ACR) has been instrumental, along with the Radiology Society of North America (RSNA), and the European and world radiology community is active as well. For example, the ACR's Imaging 3.0 initiative is asking us to be less concerned about the volume but to focus more on value. I think it is a big challenge still. There are a lot of films that need to be read. We want to get to value, but we've got to get the work done. What makes it easier is that there's legislation in this country. The Medicare Access and CHIP Reauthorization Act (MACRA), is asking us to demonstrate and provide value. This will make it easier for radiologists to focus on doing those things that are examples of how we can provide value. The most important thing is to collaborate with the referring physicians. This may be as easy as stepping away from the reading station, where we're very marginalised, and joining our colleagues on intensive care rounds, for example. In intensive care rounds, you have the gastroenterologist, cardiologist, pulmonary physician—there is no reason that the radiologist can't be there as well. There are computer monitors there, or we can bring along a tablet and go over the images. We are part of the team and we want to help the patient.

Patient-centered medicine is also a huge focus. It is bringing the patient to the centre of care. Producing a value-based report means reviewing the patient's chart, to tie the description of the findings into what is going on, giving an informed interpretation as any specialist would do. The ACR has established a Commission on Patient and Family Centered Care to address this important issue, and I serve on the Commission's Outreach committee.

We have to focus on outcomes: are we doing appropriate imaging? Are we reducing incidental findings? How do we address incidental findings? We don't want patients to get more imaging, if they don't have to: it's unnecessary radiation exposure, and it costs the patients. The Image Wisely® and Image Gently® initiatives have helped to address radiation safety concerns and to decrease the exposure to the patient as well as to eliminate unnecessary procedures.

Radiology has to be integral to hospitals: we can't just sit in our reading room and read films. We need to serve on hospital committees. We need to be part of our culture. For the hospital community as a whole, there is no reason that we shouldn't be going to local organisations outside of medicine, outside of the hospital and helping. We have a lot to contribute. We can certainly contribute in mammography. We can educate the public. These are all things that we can do so that radiology isn't perceived as someone sitting in their dark room not contributing to patient care and overall healthcare.

What should the priority be for radiologists moving towards value-based care?

As I tell my residents, we've got to be available for referring physicians, to collaborate and be there. It has got to be a team approach. The other aspect, which is extremely important, is the patient. We have to put the patient at the centre of care. The patient is what counts. We have to step aside, put the patient where they belong and collaborate with the patient as well. If we can do this in a team-based approach with the referring doctor, the radiologist, the patient and the administration, this is the way we are going to improve healthcare and continue to provide value.

Are younger radiologists prepared for this change to value-based healthcare?

My perception, based on working with young radiologists, is that it's a different generation. The millennial generation really wants to be more involved. They are much more team-oriented, and they don't remember how radiology was previously. For many older radiologists, if they are not generating the same income, they feel like they are failing. Younger radiologists have never experienced that way of working, so for them it is about working as a team and solving problems. I also think a lot of them value life in the work-life balance as well. There are many people from my generation, who are very dedicated physicians, but who do not have time to spend with their families. But the younger generation, they want to spend time with their family.

How can radiologists work with referring physicians to ensure only the best value and appropriate imaging is performed?

The most important aspect is collaboration. Fortunately, there are initiatives underway to make it easier for radiologists to do this, including Radiology Support Communication and Alignment Network (R-SCAN)™ (rscan.org), and the Imaging 3.0 case studies, both provided by the ACR. For example, in one organisation, by collaborating closely with the emergency room physicians, radiologists were able to decrease unnecessary imaging by 50%. This is an active process, which is funded through the Transforming Clinical Practice Initiative of the Centers for Medicare & Medicaid Services (CMS). By using resources from the ACR, such as R-SCAN™, research from the Harvey L. Neiman Health Policy Institute, and also drawing on Image Wisely® and Image Gently®, we are going to make sure that we're doing appropriate imaging and that patients are getting the best care they need with the least amount of radiation.

In your own organisation, the Veterans Health Administration, how is the transition to value-based healthcare being managed?

The Veterans Health Administration (VHA) is a federal organisation; it's the largest healthcare system in the United States. I have worked both in private practice and now for the VHA. When I was in private practice, I wanted to help patients and provide value. However, I felt pressure, as did a lot of my colleagues, to generate a high volume. At the VHA they don't ask for the same metrics or the same volume as the private sector. They want us to focus on providing value, to not do unnecessary imaging and to stop excess radiation to the patient. We face less pressure from that point of view. We also have a very robust integrated healthcare system. If a patient is seen in a different state to mine, I have access to the charts. I can pull together the information and make sure I give them a value-based interpretation.

In 2014, the VHA published their Blueprint for excellence (Veterans Health Administration 2014). This recognised that, like other healthcare organisations, the VHA has to improve performance, promote a positive culture of service, advance healthcare innovation and increase operational effectiveness and accountability. The VA has established a Center for Innovation (www.innovation. va.gov) that encourages employee participation, including 'spark' grants to support proof-of-concepts through to 'seed' and 'spread' grants. Designing for veterans: a toolkit for human-centered design (Veterans Administration 2015) supports the move to patient-centred medicine, putting the patient at the centre of care.

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