

Strategic Market Guide



Volume 1:
Understanding
Radiology Administrators



What keeps me up at night is to see myself no longer in control

If there's one insight Verbatim interviews uncovered that captures the current mood of radiology administrators, this is it.

Verbatim Customer Insights™ provides a nuanced, personal perspective on the most pressing issues surrounding healthcare delivery – a new model for uncovering candid, unbiased customer insights in an unfiltered format.

With the recent discussion around healthcare reform in the United States so volatile, we asked Verbatim participants for their thoughts in one-on-one phone interviews.

We also wanted to learn their opinions on other topics including what steps they're taking to create a better patient experience; how they're attracting and retaining more referrals; how they're approaching the threats and opportunities surrounding turf battles; what they expect from vendors to help them improve quality management; and what vendors can say and do to help them manage their departments more effectively.

What follows is a summary of what they told us – in their own words*.

**Note: Participant comments are separated by an orange box.*

Issues

1. Defining success.

What are the three factors most critical to the success of your radiology department?

2. Impactful trends.

Which trends will have the largest impact on your ability to deliver quality services in the next few years?

3. Biggest challenges.

What are your most pressing problems? What keeps you up at night?

4. Satisfying patients.

How important is customer satisfaction and what are you doing to create better patient experiences?

5. Satisfying referring physicians.

What is most important to your referring physicians and what are you doing to attract and retain them?

6. Turf battles.

Where are the departmental threats and opportunities in the blurring of clinical boundaries?

7. Healthcare reform.

What impact has healthcare reform had on your practice so far and what will it mean for you in the future?

8. Improving quality.

What do you expect from vendors in the area of quality management?

9. New investment.

How will the current healthcare environment impact your investment in new systems and services in the next few years?

10. Vendor messages.

What should vendors do and say to help you manage your department more effectively?

The panelists

This report presents the views of 10 Verbatim panelists, representing various types of hospitals and health systems throughout the United States. They were purposely chosen because of their diversity and range of experience. Here are their profiles:

- Radiology manager, community hospital; East Coast
- Chief operating officer; non-profit healthcare system with multiple hospitals and levels of care; East Coast
- Radiology administrative director, academic healthcare system with hospitals at various sites; Middle Atlantic Coast
- Radiology administrative director, research oncology hospital; Southeast Coast
- Vice president, ambulatory services, including radiology, non-profit health system with multiple hospitals; Southeast Coast
- Radiology director, non-profit healthcare system; East Coast
- Director, radiation and cellular oncology and radiology services, academic healthcare system; Midwest
- Division director, radiology services, acute care hospital; Midwest
- Administrative director, radiology, academic hospital; East Coast
- Service line director, radiology service line, group medical practice; West Coast

A word of thanks

Verbatim gratefully acknowledges the contributions of our participants, without whom this sharing of knowledge would not be possible. In each and every case, they have graciously carved time out of their busy schedules to talk with us and share their views.

1 DEFINING SUCCESS

“Success for our radiology department is reducing the cost-per-workload unit. My goal in 2009 was to reduce it at least 1 percent, which accounts for a \$700,000 to \$1,000,000 reduction in expenses”

Let's start at the top. How do you define success in your department and what do you see as the two to three most critical factors for improving on that success in the coming year?

I think we all measure by volume and repeat business. So, everybody looks at their revenue stream and volume, and patient and physician's satisfaction.

Depending on the physician and the type of office, they're looking for instantaneous responses so they can treat their patients. The challenge for us is to be able to meet those demands because usually when they call up at three o'clock in the afternoon and say, "I need a specific study," they don't want to hear, "Well, we can do it the following Tuesday." They want to hear, "Send them right in."

Depending on capacity and volume, that's not always the case. So, of course, that gives you the black eye for the day, but that's one of the measures that we look at that says, "Is the practice successful and how do we move it forward?"

Then, of course, you ask, do we have the technology that some of the physicians are looking for? Some of them are very specific about the technology that they want for their patients. ■

As reimbursements shrink, that tends to go to our bottom line. Then our productivity standards become higher. And so now you're doing even more with fewer people.

So you're always working and trying to find other ways to drive costs out of your operations. The more we can routinize and standardize our work, the more we will be able to improve our efficiencies and effectiveness. But more importantly, when there's something that goes against a routine, we'll be able to recognize it and respond a lot quicker. ■

Success for our radiology department is reducing the cost-per-workload unit. My goal in 2009 was to reduce it at least 1 percent, which accounts for a \$700,000-1,000,000 reduction in expenses.

Success also is looking at how our customers rate us in patient satisfaction, and right now we're at an 85 percent rate of customer satisfaction. So we do pretty well.

Access also has been very important. We have greater access than practices in the fee-for-service world. We're trying to reduce that access to less than 14 days, if not the same week. ■

Success is directly related to patient satisfaction and how employees interact with them, because that also comes through to patients if there's any kind of behavioral stuff going on in the background. Because if patients are not happy with you, they won't come back. Their perception is everything.

I believe they expect to get a good exam. They don't really know much about that end of it, but the people part is critical. Sometimes it's just about giving somebody a warm blanket.

My employees will take time to take a patient somewhere themselves if transportation within the facility is slow. All those things, I think, are very important.

I myself had a procedure at one of our facilities recently and one person was nicer than the other. So, it's true. You have to relate it to yourself. I went in. I felt calm. They knew what they were doing. Everybody came in one by one and explained their part. They were happy. There was no tension. Those things come across. ■

Patient safety is key. In general, patients are much savvier about their care, which is good. I don't think we've ever tried to hide when we've made mistakes, but we've really continued to move toward a more transparent organization.

We're now are looking across all three campuses and doing a lot of education. Instead of operating in silence, we are advocating, saying instead, "This occurred at this campus. Go back and check your processes so it doesn't occur somewhere else." ■

Defining success, continued

Success for me revolves around developing outpatient access points. Our health system is looking at what we need to do to move volume to keep from losing it. Because, let's face it, whether hospitals know it or not, there's an erosion not only of volume but reimbursement.

So I'm looking at access points and ways to fund this outside of the routine capital process. We're looking at venture capital funding and some other unique ways to get funding without having to get it through the routine capital process. ■

Success is having a productive department, meeting our volume budget and having a good group of radiologists that are on the same wavelength.

I don't care how good they are at reading, if they don't develop different levels of relationship with the referring physicians, you're going to have one time-kind of referrals and they're going to start looking at our competitors. So we really bank on our radiologists to help with that. ■

With all the issues that exist today around utilization, success for us means doing the right procedure at the right time for the right patient. Making all the systems and processes come together while providing good patient interaction. We want to serve them technically, but also inter-personally.

The main thing is providing good service. Convenience. An outstanding experience. Healthcare isn't always a pleasant experience. So you try to make a personal connection with the patients and make it as good as you can. ■

To be successful on the outpatient side, obviously we need to do more business. And that means keeping pace with changing technology, making our workflow processes as efficient as possible, minimizing our costs, and improving our service levels. Making it very easy for our referring physicians to do business with us. That's the way to do it. ■



**Sometimes it's just
about giving somebody
a warm blanket**



2

IMPACTFUL TRENDS

I don't have all the answers but the staff does.
Don't sit down with them and ask what they think
needs to be changed. Have a staff meeting and say,

What's dumb around here?

In your view, what trends will have the largest impact on delivering quality services – both clinically and economically – in the next few years?

Quality of service is number one. That means employee conduct, behavior, and interaction with the patient, providing services. We've started to pre-cert for some of the physicians because it's a hassle for them.

There's a lot of work to that. So we've hired personnel, beefed up our coding in radiology, and are providing that service. As we get more people on board and get a handle on it, we'll expand it and open it up to all the physicians. That's a quality service. They're also our customer. ■

I think basically we're just trying to really watch our financial page and at the same time, provide the same quality. I mean, we're not going around cutting anything drastically. We're careful about what comes in and what can be replaced, but I can't say we're operating differently in the sense that we're being even more diligent about overtime and those things. Most facilities, there is no overtime, period. ■

An ongoing trend relates to reimbursement. Pre-authorizations for our tests often cause delays and as a result, patients often have to go to other facilities. The economy is challenging in that capital funding is a lot more restrictive than it used to be, which conflicts with our goal of always wanting to be cutting-edge, on the front end of technology. ■

What we're seeing is that there are more people becoming uninsured. We try to get them charity care, but then you try to turn them over to Medicaid. That's a direct result of the economy. ■

Philanthropy is down. We could count on that in the past. Our access to capital is restricted too. Like everyone else, the hospitals have money invested in various funds and if those funds' value goes down, so do your assets. So, it's going to be harder to get capital. ■

Actually, a big part of the utilization problem isn't radiology itself, it has to do with the fact that anybody with an M.D. after their name can go out and buy whatever equipment they want to buy and do whatever procedures they want to do.

There have been a lot of clinics and non-radiology practices buying imaging equipment, just like they buy laboratory equipment to do tests, and this is a form of diversifying their income streams and maintaining their revenue. But in the course of doing that, it drives up utilization. Whether you need it or not is another question, but it's definitely been the cause of a huge, ten-fold increase in imaging. ■

On the positive side, at least in the short term, hospital-based radiology providers have a reimbursement advantage over for-profit standalone imaging centers.

What we'll probably be doing in the future is partnering with our radiology group who own four or five imaging centers and an imaging center on our main campus. They're going to partner with us because they really don't have any capital and need to upgrade their imaging infrastructure in their offices. So, they'll become partners with us and the imaging center in our medical office building, but we're going to become partners with them in all their offices in the community. ■

Payors are moving reimbursement away from a hospital's outpatient radiology services to free-standing imaging centers. In fact, in our market – I'm sure it's no different than others – they actually are sending letters to referring physicians and saying, if you get this done at this imaging center, which is not affiliated with a particular hospital, you don't have to get a pre-certification to perform the study.

The charge structure is much less at a free-standing center than at a hospital outpatient center because you don't have all the overhead from the hospital, which is probably one-third to one-half higher. ■

On a positive note, some of our research and related technology is changing immensely. We're getting more into molecular imaging and that's really going to change the face of imaging over the next five to 10 years. It's exciting that we're involved in that and we're looking for newer modalities coming down the line that are going to improve patient care, so that's pretty exciting stuff. ■

Impactful trends, continued

Radiation dose is a big problem. We have been reading more stories about excessive radiation dose, specifically some CT studies that were generating excessive radiation due to the lack of calibration of the equipment.

And then on the other end of the spectrum, in radiation oncology, there were some really negative reports coming out of New York with respect to radiation therapy treatments not being delivered with the appropriate quality and precision. So you have two ends, the diagnostic related issues and then you have the therapy side, both of which can cause harm to patients. ■

The bigger trend is how you're dealing with the demands of service lines, such as oncology or urology. It gets back to the technology they want, but sometimes they also want access to equipment and they want to do certain procedures inside your rooms, with your staff. How do you do that properly, while billing properly for the technology and professional services?

Of course, they would rather rent the room from you and the staff, but that's difficult. Sometimes all of this is very difficult to keep track of, while making sure that you're in compliance with all of the rules and regulations. ■

There's been a lot of talk about improving productivity. I've done a lot of work in my career on process redesign. It's a mistake to keep cranking down on productivity numbers. That's not the right way to do it. When redesigning processes, you're actually taking non-value-added work out of the system instead of just addressing the existing people in those positions.

From my perspective, there needs to be a lot more focus on process redesign and taking out the non-value-added work. There's a lot of talk about lean production and Six Sigma techniques. That is really a lot of hoo-ha, from my perspective.

In trying to come up with answers about improving productivity, I told the radiology director, "Look, I don't have all the answers but the staff does." I said, "Don't sit down with them and ask what they think needs to be changed. Have a staff meeting and say, 'What's dumb around here?'" She did and got the staff engaged and thinking about ways they can do things differently and it's like a completely different environment. ■

3 BIGGEST CHALLENGES

“What keeps me up at night is to see myself
no longer in control”

Can you give us a sense of your most pressing problems? What keeps you up at night?

What keeps me up at night is to see myself no longer in control. That we're going to have to make changes based on what's coming from either Congress or anybody else that doesn't have a whole lot vested in the quality of the service, or what satisfies patients and what it really takes to run good imaging services.

I know that the Centers for Medicare and Medicaid Services has instituted this quality matrix and the reimbursement base and quality standards. To me, I find it's very difficult to meet work quality standards while reimbursement shrinks. How do we meet quality standards when you're doing things with the people you have, while at the same time we are seeing an increase in volumes? That, to me, is a very tough order and nearly an impossible task.

In order for us to meet our new increased volume, they probably would have to give me another FTE (full-time equivalent), but then I would have to cut somewhere else. They always want to make it organizationally neutral when it comes to an FTE. That's the first question that my CFO asked me. "Fine, you can add another CT tech, but can you take out another FTE somewhere else?"

Our hospital used to have a whole quality department with four individuals. Today, that department consists of one individual, who does quality improvement and quality measures, and studies for everybody. He's incredible. If I wanted to take on a quality project or improve my workflow in radiology today, I would probably have to outsource that service because there's no way we can get anything done internally. ■

Competition is another important area. There's another hospital in the area that's our biggest competitor, so it always seems if we start up a new service then they're starting it up. Of if they buy a building then we're buying a building.

So, I think our competitors know that consumers are shopping around and they're trying to get their brand out there with advertising. People certainly do shop around trying to get the best price. We do have patients that call here wanting to know what their pricing is going to be. People who are self pay or have no insurance spend time shopping around. ■

You look at all we have to do for reimbursement. You have the insurance companies, saying "Wait a minute. You have to do this, this, and this and we're going to come in and inspect you as well."

Some are saying, "When was your last upgrade? What technology do you have?" So, they're basing where they send their patients on technology. Those are some of the things that keep us up at night because if you get rejected by the insurance company due to not having the right technology, it's almost impossible to get back in. ■

What keeps me up at night is, are we fast enough at getting our work done? Our healthcare industry is close to 22 years behind in information services, as compared to the banking/finance industry. And yet healthcare is one-sixth of the Gross National Product. How will we get there in three years? How fast can we catch up? ■

4

SATISFYING PATIENTS

“ I mean, the satisfaction of a patient is paramount
for us to compete, period ”

We are all aware of patients becoming more involved in their care. How important is customer satisfaction to you, and what are you currently doing to create better experiences for your patients?

Obviously, customer loyalty and patient satisfaction are the pillars of what's going to keep you here in the long run. If you want to survive in a competitive environment like the one that we live in, you have got to hit them right at customer service. The satisfaction of a patient is paramount for us to compete, period.

We are entertaining the idea of offering patient self-scheduling, meaning they can get online and schedule their own appointment at the time they want, things like that.

I think the Centers for Medicare and Medicaid Services will very soon be getting into the business of measuring patient satisfaction with everything that we do.

Last year, we noticed that when one of the commercial insurer companies sends the bill to the patient, it says: "You had pneumonia. Here's a report on the hospital that you went to. This is how well they do on this disease. They have seen this many patients with pneumonia. One of those 25 dies."

Sharing that kind of information is new – and rather shocking. This isn't coming from the Centers for Medicare and Medicaid Services, but from our commercial insurer. ■

We're always asking ourselves how we're handling the patient experience and what our people do, not only at the appointment desk but also all the way through the process of delivering care.

This is a sort of back to the future initiative. We're breaking down the key elements of what the patient experience is when someone comes here. What works well. Where the pitfalls are.

Part of the challenge we and a lot of other healthcare facilities face is that we're operating in a dual environment. On the in-patient side, we have an electronic medical record and order entry system.

On the out-patient side it's a much bigger challenge. And the problem is that out-patient is a big piece of what we do. The systems there are subject to breaking and can be easily interrupted. Things don't always go as planned. ■

It's very important. What we're trying to do is provide services on a timely basis so our customers get the services they want when they want them.

A lot of it has to do with same week access. Before I started, the first available appointment for ultrasound was 30 days out. I did research in the area and found a lot of people that are providing fee for service have next day access.



Before I started, the first available appointment for ultrasound was 30 days out





This example sounds very inefficient, and it was. Yet, we do 300,000 exams a year. Now if that isn't a factory, I don't know what is



We're also doing reminder calls for screening and diagnosing mammo patients. We have a database that shows all the patients that are due for annual screening. The patients like it, and it's also helped our national benchmark compliance measures.

We were at 69 percent compliance for eight quarters in a row and just by doing reminder calls we jumped up two percentage points. ■

We're looking at breakdowns in the hand-off process. For instance, I've been looking at a problem we had with a patient who came to the urology clinic. I believe he had a cancer diagnosis and so he needed to get a workup and consequently they called radiology from the clinic and scheduled an MR and a nuclear medicine scan.

Now those are two very complex scans and that becomes a long day for the patient to do both in one day. In total, it takes at least five hours in the department. Maybe the patient prefers to get it all done in one day and not have to come back, but nonetheless, it makes for a long day.

And so the patient shows up and sure enough, he wasn't on the schedule. And then we had to scramble. In the course of scrambling, we made him wait a couple of hours for a number of reasons.

One being that there's a nationwide isotope shortage, so if you need a bone scan done, you have to really plan because you have a very finite amount of isotopes available and you have to plan ahead.

And so the patient shows up. We had to take a dose that was intended for another patient and give it to this one because it was a VIP type of situation. So we ended up rescheduling this patient for another time, and that's not good.

So we're going to work on a further understanding of what went wrong. Was it a process failure? Was it an employee failure? This is something we look at and try to learn from.

This example sounds very inefficient, and it was. Yet, we do 300,000 exams a year. Now if that isn't a factory, I don't know what is.

And so on any given day, we might be doing 1,000 exams. Even if you say that you're willing to put up with a 1 percent error rate, you know, that's 3,000 errors you're going to make.

Satisfying patients, continued

The numbers become daunting. You want to have a zero-defect culture, which we do, but things still go sideways in part because we've got more than one kind of system that people have to manipulate. And there's a lot of data and prep work that goes into it, so things can go wrong just by the complexity of what we need to be doing. So we're focusing on that.

We are a problem-oriented group. We do a root cause analysis on every major type of inefficiency and try to not repeat those kinds of events.

Whether automation can solve all those kinds of issues, I don't know, because automation brings in its own set of issues. So you solve one group of problems and then you're creating other sorts of scenarios that have to be managed. So it's an ongoing challenge, no matter what kind of system environment you're in. That's really a key thing for us.

In terms of patient satisfaction, measurement's a key thing for us. To know how we're doing and then also to just sort of drill down into particular failures and see why they happen and how not to repeat them. And that's how we move forward. ■

Customer satisfaction is, of course, patient satisfaction, which is critical. And patient satisfaction means they're going to go back to their physician and tell them, "You sent me to XYZ outpatient radiology and I had an 11:00 a.m. appointment and they didn't take me until 1:00 p.m." Or, "I was treated rudely." Or, "The place was dirty."

Your referring physicians get enough of that, and they're not going to want to send patients there anymore. There's so much competition.

The other thing is the customer service to the physicians. You have to get their pre-certifications. You have to make it easy for them to get results and reports.

The radiologists have to be available to interact with the referring physicians. The availability of the radiologist is critical. And you need to make it easy for them to do business, especially physicians that not only refer outpatients to you, but also practice at your hospital. That's really important.



**If an internal medicine
guy has a question
and he can get that
radiologist right away,
then you're golden**



Satisfying patients, continued

We're ingraining and hardwiring service excellence into our entire staff. And we're doing some technology things for centralized scheduling. Deploying PACS technology and the availability of radiologists is something that you always struggle with.

But, we've got cell phones for our radiologists, so in case they're not at the reading station we can forward calls to them for follow up. If you can do these sorts of things, you're going to differentiate yourself. If an internal medicine guy has a question and he can get that radiologist right away, then you're golden. ■

We rely on clerical and ancillary staff to help get the patients through the system so that the technologists can just focus on their imaging protocols. The techs are not getting the patient, starting IVs and taking them to the bathroom.

I need my technologists performing imaging studies, so we're trying to really focus on our processes so that we can compress our timeframes down. We try to get as many patients into the system as we can and do things as thoroughly as possible.

Our report turnaround time now is under two hours for almost the whole department. So from the time the study is completed, within two hours, virtually all of our studies are dictated, finalized and available for referring physicians. So that's been a marvelous change. Our doctors in the hospital love that level of service. ■

Patient satisfaction is basically their perception of who we are. This has to do with making sure our employees are presenting the face of our hospital. We're very much involved in transitioning the culture here. I think we've come a long way to being more patient-oriented.

We're also a Planetree Hospital. Again, everyone has to be in that customer service mode and that means putting your own stuff aside because people can sense it.

I have no problems getting out from behind my desk and walking someone to an elevator, showing them where to go. My staff does the same thing.

It's the simple things. Helping someone with a form if they can't see well. A nice warm blanket when they're sitting in the waiting area, and taking the time to explain procedures.

So much is expressed through body language and people pick up on that. I just think that's the most important thing. Because I think about it myself when I've been a patient. I see employees who come in and may be abrupt.

They might not mean anything by it, but again, your perception is, "Whoa." They don't take that time and that's what people are looking for.

You talk about competition. Customer satisfaction is something that's very important because I think patients expect us to all be doing our jobs clinically. They don't really understand what we do clinically. So they expect, if you break your arm, you're going to get it fixed. It's all going to be done right.

But it's all those other things before that, up until that point. Do the doctors come and speak to you? Do the nurses speak to you? Do the technologists tell you what they're going to do? Do you feel like you were rolled on to the table without any concern that maybe you're uncomfortable or in pain, and just had surgery? It's the littlest things. It's the small stuff.

Because patients today have to pay for more of their insurance, it's resulting in a much savvier customer. They don't accept people being rude, mean or not paying attention to their job. ■

Satisfying patients, continued

Customer satisfaction relates more to the physicians and radiologists talking to one another, making sure that we meet their demands and that goes back to communication between them.

Sometimes it takes that phone call that says, “Well, what exactly are you looking for so we make sure that we do the right exam?” Because unfortunately, the doctors don’t necessarily know what they’re ordering and that goes back to communication.

After that, we focus on patients themselves. How do we make them happy? How do we keep everybody apprised of what’s going on? More communications in the waiting room that says, “We’re getting right with you.”

Sometimes that’s not good enough because on busy days with a lot of walk-ins, the patients with appointments feel that there are too many people coming in. They want to move in and out.

So, it’s a very big balancing act because you can’t just go purely by schedule. You often have walk-ins so it’s very difficult to manage, especially as one of my managers says, “It’s when the bus unloads.”

Patients ask, “Can I have it now? Can I have it now?” And the answer is, “No. This is a CT with contrast. You’ve got to drink and have to be prepped.” But that goes back to how you get the doctors and the patients on the same page.

Doctors say, “You need a CT,” but they forget to say, “You have to be prepped and cannot eat,” or whatever the steps may be. So there’s a lot of communication. That’s what we’re all working on: how to make sure the patients are kept abreast of everything that’s going on and know what they’re getting. ■

I really don’t think there’s any loyalty to a radiology department in a hospital. There’s no connection that the patient has with that department. They’re there because their physician has referred them there. ■



Because patients today have to pay for more of their insurance, it’s resulting in a much savvier customer. They don’t accept people being rude or mean or not paying attention to their job



SATISFYING REFERRING PHYSICIANS

5

But it's not even the referring physician who controls where they send patients; it's their office staff. So you can send marketing people over there all you want. If you

“ don't deliver on that service piece, you're done ”

What about your other customer stakeholders? What is most important to referring physicians today and what are you doing to attract and retain them?

What referring doctors want is to have their patient come right from their office to ours. And, what we do here is say yes to every patient immediately and if we're not ready, we'll just bring them over here and keep them in our waiting room. We have an individual in our front office who pretty much takes care of those individuals.

If you come for an extremity X-ray and have to wait, we'll say, "Here's an unlimited ticket to the cafeteria for one day. Go ahead and eat something while you wait." We do a lot of different things like that. So, I think that has paid off for us a little bit. ■

Getting patients in is critical and we have what we call a same-day line. If you need a patient done immediately that day, we have a special number you call in and we know that means it needs to be done today, hopefully.

So, instead of going through scheduling, you'd call this number and they would say, "We need a CT or MR. What's it look like today?" And we never deny patients. What we try to do is look at the schedule and see what's realistic.

We say, "Right now, between 9:00 a.m. and 11:00 a.m., we're really tight, but if the patient can come in at 11:15 a.m. or 11:30 a.m., they won't have to wait." Or if they have to drink, maybe we'd tell them, "Definitely come in now because you have a two-hour wait." This promotes patient and referring physician satisfaction.

We also provide a lot of educational material that explains why there might be a delay. Whenever we have time delays for procedures or, say, there's a trauma coming in, I tell the techs, "Go out and talk to the patients personally. It's important to keep people informed, treat them with respect, and acknowledge their needs." ■

There are two things, really. Access and reputation. How quickly are you getting the patient in? Whether it's 8:00 a.m., 7:00 a.m. or 7:00 p.m., you have to say, "Yes, we'll do it."

The other piece is having a good stable group of radiologists. If Dr. Smith is a Harvard graduate and he's done a fellowship, etc., they'll trust him. They just take that report to the bank.

Three years ago we changed radiology groups and it was very painful because their reputations weren't stellar. We had a lot of surgeons who were questioning every report. We learned the hard way. ■

When you look at physician offices, they are just cranking patients through in order to try to keep up with what they used to make financially. It costs a lot more money to do that stuff today and there's so much more paperwork.

But it's not even the referring physician who controls where they send patients; it's their office staff. So you can send marketing people over there all you want. If you don't deliver on that service piece, you're done.

You might get one or two chances because maybe somebody in that group has a relationship with that referring physician, but at the end of the day, they are not controlling where those patients go. Office staff members are. Referring physicians control the process by saying, "Fine. Send them to hospital Y because I don't want to have to listen to your complaints." ■

Satisfying referring physicians, continued

I think the biggest problem that we face every now and then is pre-authorizations. Pre-authorizations for certain exams go back to the referring physician because technically, when you ask the insurance companies, I, as a provider, cannot get the pre-authorization for a CT with and without contrast.

The real question is, what did the referring doctor want to order? This seems to be the biggest bone of contention. We're starting to see companies that work in-between radiology and the referring doctor's office, which go out and get the pre-authorization. The key is to make referring physician offices understand medical necessity.

For example, when you have an order for an MR, the question is, do you want that with or without contrast? The referring physicians go, "Whatever the radiologist wants."

That's not good enough because now, as we know, with the pre-authorizations, if you called up and said that to the insurance company, they're going to give it to you without contrast, the lowest base pay that they can give you. So, this often requires a call back and a new pre-cert. If you don't do that, you don't get paid.

When you call to clarify this, sometimes the referring physician will ask, "Why are you bothering me?" We then go back to the physicians and say, "Well, doc, you have to tell me why you really want this," and the physician will say, "I don't know. That's why you're doing it, so you can tell me what's wrong with the patient." Then we ask, "Well, what are your indications? Give me something to go by."

But then you have to be careful because some of the rules at the Centers for Medicare and Medicaid Services are that you can't lead the witness. ■

At our hospital, we've started to do pre-certifications for a lot of the referring physicians because that's a hassle for a lot of them. They actually order the exam, yet they feel maybe we get the credit because they don't really get payment for it. They're referring them to us. There's a lot of work in that.

So, we've actually hired personnel, beefed up our coding area in radiology and are providing that service. We're trialing that now and as we get more people on board and get a handle on it, then we will expand it and open it up to all the physicians. Right now, we're just doing it with certain groups to get our feet wet, but that's something that's a quality service for them. They're our customer.

In other words, a referring physician sends me a patient and gives me the insurance information. Then our staff will call the insurance company. I will get all of that taken care of. And this way, when the patient comes in, there are no glitches. We know it's approved.

If there's a problem when a patient is on the table, the techs know that they need to call coding right away if they need to change something so that that patient isn't inconvenienced with a lot of the hassles of payment and that kind of thing. ■



In the case of referring docs, they want the information, and they don't want to get any negative blow-back from the patients they refer



The first priority is to have the turnaround of reports and interpretations as quickly as we can make them. We measure this pretty extensively. We've got a pretty sophisticated dashboard of different metrics, through which we can measure by modality.

So the first thing is to get those diagnostic interpretations back to the people who've requested them. And of course, if we treat patients well, they will be satisfied and will give positive feedback to the physicians who referred the patient to us.

I think serving our referring docs means being able not only to give them the information quickly and correctly, but also being able to provide full service capabilities, regardless of what kind of modality exam they want, and do that in a convenient way. It's customer service 101.

In the case of referring docs, they want the information, and they don't want to get any negative blow-back from the patients they refer. They want it to work just as well as we do, and so that's really what we're focusing ourselves on. ■

Number one, faster report turnaround time, has been a huge improvement. Number two, we don't just do imaging, we also do a wide variety of invasive procedures and the clinicians really rely on our radiologists to get those scheduled as quickly as possible so that they can get the results back from pathology.

We're seeing a very high service demand for our invasive procedures and that's another big satisfier to the referring physicians, and a big dissatisfier when we can't get them in on time.

The other piece would be the interaction with the radiologists. At the cancer center, physicians meet in multidisciplinary groups to discuss cases and the radiologist is a vital part of that.

Radiologists are definitely viewed as a major contributor to the patient's treatment plan. We're not just reading a chest x-ray; we're also recommending procedures and treatments that we can provide in our area to help the patient as well. ■

Satisfying referring physicians, continued

It is very important to have quick access and quick reports. Referring physicians want to be able to send their patient in as fast as they can, then they want immediate results. Our goal is to have all reports read within 24 hours after a patient shows.

They also want quick access to the images and want to see previous films. So we're working to connect them to our PACS system so that they can actually log on and see the images, whether or not they are stored at the hospital. ■

I also think physician-to-physician rapport is extremely important because if it's poor, relationships ain't gonna go anywhere. We can do our job, but it comes down to people and what the relationship is between physicians.

They want to know that you're doing quality work. If you don't have quality work, I think that can be a problem. Taking the time to meet with referring physicians and finding out what they want. You have to conform a little bit to their needs and consider how to satisfy those needs. ■

The other thing referring physicians want is communication from the radiologist. While it's great to get that report back to them pretty quick, something has to go on in terms of the relationship between the referring physician and radiologist.

I think that's what we have lost in radiology, because PACS have made it possible for people to see images anywhere. Along the way, that colleague interaction has been lost. Sometimes I think that the radiologist needs to pick up the phone and call the other person and have that conversation. ■

Referring physicians do drive the business. Even inside the hospital, they drive technology because if they want certain technology, and they're willing to say that inside a hospital, our referring physicians a lot of times will tilt the scale.

It's not just that radiology wants a new toy, because that's how administration always thinks about radiology. They're expensive and their technology is expensive. But if the referring physician says, "No, I have to have that," it's a different story because then not only is it that we need the technology, but the doctors also are clamoring for it and then they'll send volume here.

I think the third thing would be subspecialty interpretation. Meaning that I have a subspecialist interpreting my CT lumbar spine who is a neuroradiologist. He or she has seen 200 of these a week as opposed to 20 a week, and should be able to see the nuances. ■



With physicians, quality is assumed unless they get something terrible



That's another thing that was an "ah-ha" moment for me actually. Physicians don't care that they've got a single slice CT down at this imaging center. They don't care that the recons aren't exactly very pretty, but it's good service so they assume quality.

With physicians, quality is assumed unless they get something terrible. Primary care docs, where most of the requests come from, don't look at the images. They read the report. Surgeons and specialists look at the images. That was a huge "ah-ha" for me.

Imaging centers don't even buy new equipment. They buy refurbished equipment to get the costs down. It's all about cost and they want to keep as much of the money in their pocket as they can.

That was first time in my life I've ever heard that and I was surprised. ■

6 TURF BATTLES

When physicians come together – radiologists, cardiologists, and interventionalists – and try to work as a team, it’s all about volume and money.

That is the blurring factor because

everybody is trying to hold on

How is your practice being affected by advancements that cross clinical boundaries? Do you see a blurring between what is considered typical radiology practice versus other clinical specialties? Do you consider these opportunities or threats?

Vascular surgeons have taken quite a bit of business from our practice. We struggle to maintain a good vascular surgeon on staff and we'll continue to recruit for that.

When they initially come for an interview, they ask, "What equipment do you have?" When we say it's all done in radiology, the vascular surgeons say, "That's fine, but let me use the radiology equipment to do my patients." And then you have the radiologist who says, "Over my dead body."

I don't think radiologists can win this battle alone because the problem that I see is there are a high number of patients who need these services, and cardiologists or vascular surgeons own those patients. They're the ones that refer the patients.

So if the radiologist is not accepting the ground rules, the cardiologist is not ordering from radiologists. The cardiovascular surgeon is not ordering as many exams. Radiology has to come to the table and say, "Let's play. Let's find a way to make this work." ■

We have seen a lot of the high-end neuro establishments with a surgical suite with an MR right next to it. You can actually bring the entire patient bed and pitch it right into the MR without really going to elevators or anything like that.

There was a children's hospital in Fort Worth, Texas, that had installed the first intra-operative MR and I know there's another vendor working very heavily in this area. It is an MR within a surgical suite and they have two different entrances. You can still use that MR for your regular patients, but it has a big door in the back that leads right to the surgical suite. ■

Surgeons are encroaching as well in the operating room. There's MR-guided surgery now, which requires radiologic equipment. We're going to be installing an MR in one of the OR suites in our new hospital and it's still not clear how that's going to work. We're going to have to staff it with our people, but yet the surgeons are the ones that are going to be using the equipment. We are going to have to work out a collaborative team approach.

I think it's an opportunity actually, but the difficulty is about reimbursement being under pressure. We may need to spend a few million dollars on an MR unit to put in the OR and yet we may not get federally reimbursed for that. It may get bundled with the surgical fee or constrained in the amount of revenue that could be billed for an MR-guided surgery.

So there are lots of questions as to whether the economics of this will work to everybody's benefit or whether we're looking at a bundled fee. Probably by the time we get going with it, which will be in a couple years, it's going to be a bundled fee and then you wonder how we divvy that up.

MR-guided surgery is an opportunity primarily because we could point to the fact that we're doing state-of-the-art surgery that's using image guidance, and accuracy comes with that. There's a benefit to the patient and it would improve the quality of various surgical procedures.

So in that respect, it would draw people to our institution. But at the same time, it may create internal issues as to how to divvy up the revenue. We want to be sure we are recovering everything for the investment we would make. ■

There's a group of urologists in the area that have banded together to open a radiation therapy practice to treat prostate cancer. Prior to this model forming, a urologist would either recommend that the patient get seeds, where he'd make maybe \$1,500-2,000, or he would have a prostatectomy, where the urologist would make maybe \$4,000-5,000.

Now, he's recommending that the patient have Intensity-Modulated Radiation Therapy (IMRT), where he's going to make \$35,000 or \$40,000. So, this practice of medicine has changed, based on economic factors. I think you'll see that blow up in the future, eventually. ■



And then you have the radiologist who says, 'Over my dead body'



In the early to late 90s, anesthesiologists started to do a lot of pain management and then they got into neural blocks and other treatment options. That was definitely a threat at the time that actually impacted our imaging quite a bit.

Right now interventional radiology and cardiology have a turf battle. They've found a way to work together by sharing the professional fees. ■

There's a huge battle between interventional radiologists, vascular surgeons and interventional cardiologists on peripheral interventions. That is something that's been going on for a long, long time.

Actually, what I see happening in the future is that you would eventually want to get those three specialties together, maybe in one private corporation or private practice. And yet none of these specialists actually owns the patients. The people who own the patients are the internal medicine people and the clinical cardiologists.

The turf wars are unfortunate and sometimes it means the hospital has to spend more money to do things. If they were working together in one private practice or corporation, they could share the revenue and make the whole process more efficient. ■

When physicians come together – radiologists, cardiologists and interventionists – and try to work as a team, it's all about volume and money. That is the blurring factor because everybody is trying to hold on to procedures or revenue that they were making before.

Medicare just voted another 21 percent payment reduction for physicians. Doctors are asking how they can keep making the money they made before. Well, then you need more volume. That's the way our system is set up. The only thing they can do this is go out there and look to see what else they can do. That's a system problem.

But it could actually be beneficial to the patient because then you would have more than one expert in different areas that overlap looking at a patient instead of two separate ones, and sometimes two or three separate procedures. ■

Turf battles, continued

Our interventional procedures over the past year have exploded. We brought in more interventional radiologists for that. I'm actually looking to expand my IR department this coming year with another piece of equipment. It's definitely our growth area.

Now is that specific to me being a cancer center? It's possible. But I do know that minimally invasive procedures definitely are much more attractive to the patients, to the ordering clinicians, and to the insurance companies that are paying for all this stuff, so I definitely think that's going to be our future growth. Vascular surgeons are trying to get more and more into the IR field, basically. ■

Now there are neurosurgeons that are doing neuro-interventional cases. You have vascular doctors doing a lot of the vascular work that radiology used to do. So, if you have the equipment, expertise and training, then you can do it, but sometimes it causes extra equipment, more radiation to patients and duplication of services. ■

Interventional radiologists are doing uterine artery embolizations, and are competing with gynecologists. This is basically the shoemaker theory. If you take a pair of shoes to a shoemaker and say, "Should I fix them or get new shoes?" He's going to say, "Fix them."

So, if a woman with fibroids goes for a physician evaluation, her gynecologist is supposed to tell the patient about uterine artery embolization. But many gynecologists will say, "Have a hysterectomy." So, there are battles there and the problem is that the gynecologists usually own the patient.

Radiology has always had turf wars that have gone on with ultrasound and obstetrics and gynecology. Every OB/GYN office now has an ultrasound machine. However, at four or five o'clock when the office closes, it all comes back to the main campuses when they say, "This is an emergency. I need it done." ■

In the area of cardiac imaging, there seems to be a big issue with the overlap between vascular procedures, cardiac CT and MR. I consider that an opportunity if the two service lines work together. It's a threat if they don't trust each other. I think radiology is further ahead than cardiology.

From my aspect, cardiology likes to team with radiology when they can, but they're also looking at the business, and growing their business as well. So nuclear cardiology, CT, cardiac work, and CT/MR are all up for grabs. I can see it being a turf battle.

We really had to work slowly to make sure all parties were represented and had their say. It took a long time. We invited one of the cardiologists and had to adopt him as part of the radiology department. It took a long time to make sure that all voices were heard. It took a lot of communication and hand-holding. ■

I've talked to a lot of different radiology practices over time. I always used to tease them and say, "If you're afraid you're going to be taken on by a cardiologist in cardiac CT, why not think about adding an interventional imaging cardiologist to your practice group? Is there a way to handle the threat from a pro side?"

The other part is, the more that the radiologists interact with their referring physicians, the more they're seen as adding value. So a lot of that is relationship building.

The doctor doesn't want to talk to me. I'm called a 'bean counter' by the best of them. The only time the doctor wants to talk to me is when they've got a complaint. They want to talk to the radiologist. They want to talk to one of their peers. ■

“

I'm called a 'bean counter' by the best of them. The only time the doctor wants to talk to me is when they've got a complaint

”

Nerve blocks haven't been done by radiology in awhile. Why? I would say it wasn't worth it for radiologists to do them. It wasn't worth it in terms of time and I guess what they got back.

Here's my perspective: Radiologists waited too long to build a bridge with referring physicians. And the bottom line is specialists admit patients to hospitals; radiologists don't. So when a hospital administrator is faced with a specialist saying, "Well, you won't let me do this and I'm leaving and taking all of my admissions with me," or letting them do interventional procedures or whatever procedure, the administrator is not going to side with the radiologist.

Radiologists have been in a dark room for so long they painted themselves into a corner. Then their only recourse was war.

I used to say to the radiologists at my former hospital, "You need to figure out what you can agree on and get with the cardiologists and work on a collaborative approach rather than a pissing contest, because you're going to lose the pissing contest."

I preached that to them for years. They ended up with a pissing contest. I think it would be better to work on a collaborative sharing model where they accept them and work out a way in their practice to get a piece of the pie instead of them taking all of it. That's their choice but they haven't bellied up to the bar with that. ■

It's really territorial in-fighting. Cardiology wants to do more imaging and feels that it's got a skill set for that. They may or may not, depending on their training. So we're getting into turf battles with cardiology and have been in it for a long time.

And that's probably a big one given what interventional cardiology is like. Some of those specialists have their own equipment and facilities and their own identity separate from radiology. It's not clear that that is ever going to go away, because anybody with an M.D. after their name can go out and buy equipment and then set up shop.

Part of the challenge radiologists have is to educate referring docs on what we do and what our capabilities are, and why you would prefer to have a board-certified radiologist involved in various activities versus others. ■

“

Well, I'm already here, so why can't I look at that? I'm certified to this level. Can I just slip in that catheter?

”

Radiology is doing more PICC (peripherally inserted central catheter) lines and more spine punctures than the rest because we can do them under image guidance. But then there are other sections in the hospital or in the market that will also do that business because other physicians can own equipment and do the procedures.

So, some of it is staying in the hospitals and you see some of it is leaving and I think it depends on the area of who is doing what.

So many different people have access or have credentials to do things. Those turf wars have been going on for a long time. Will the pendulum swing back the other way? A lot depends on how they handle credentialing and how somebody really decides who is qualified to do these studies.

Was a two-day seminar in Hawaii effective for somebody to become certified? I think we're seeing more certification for certain types of studies, but then you have to watch because there's always what I'll call creep, where a person says, "Well, I'm already here, so why can't I look at that? I'm certified to this level. Can I just slip in that catheter?"

When they're in a room and they're all by themselves – hopefully with a tech – then it's hard to say where they can stop. So, we've seen a lot of those lines blur. Sometimes, you're seeing the radiologist do the biopsies. Other times, you're seeing the specialist do the biopsy. It depends on where and how aggressive some of the other doctors are. ■

Here's what's interesting to me. I've negotiated the radiologist contracts at all of our campuses since I've been here. Each one of them has different things carved out of that contract because of which specialists are doing what on the particular campus. It's not the same, believe it or not. It just depends on who they recruit and the certain specialty of each physician. ■

I have concerns because if we can't keep the radiologist gainfully employed as a result of these subspecialty procedures being parsed away from them, I think it will erode the quality in the field. I'm not sure how you prevent that from happening.

Do the subspecialists do this because they can't get the service they need, because they have no other choice? Or are subspecialists doing this because their reimbursement is just getting eroded, and they need to find new revenues for the stream? ■

7 HEALTHCARE REFORM

There are huge pressures in play right now. The income to the clinical modality is going to decline, which puts more pressure on doing more with less, seeing more patients and getting paid less, etc. Reform is just going to

keep that momentum going

Obviously, healthcare reform is on everyone's mind right now. What impact has this issue had on your practice up to this point?

Hospitals aren't much different than the general population. Listen, I need to renovate my kitchen at home and it's probably going to cost me \$30,000 by the time I'm all done. I haven't done it. You know why? I'm worried. You never know what's going to happen. Maybe I'll lose my job.

Same thing goes for hospitals. Instead of replacing that 10-year-old MR, we'll say, "Well, you know, it's still working." All right, so it's not the most state-of-the-art technology, but I'm going to keep it. ■

We're not doing anything until we know more. We have seen a tremendous increase in a freeze on capital. We still have a freeze right now. The only thing we are getting through and approving is whatever is not in compliance with a particular requirement or law, or something that has become a risk to patient care. You have to meet those criteria in order to get something approved right now. ■

A capital freeze is still in effect and I think we're very lucky that we opened a new hospital. We spent a lot of money last year, but all of our equipment was purchased in 2009. We can pretty much say that we're not going to see a lot of equipment purchased this year. And when I talk to some of our vendors, we're being told that the capital purchases have decreased nationwide by about 45 percent. ■

There are huge pressures in play right now. The income to the clinical modality is going to decline, which puts more pressure on doing more with less, seeing more patients and getting paid less, etc. Reform is just going to keep that momentum going.

There could be more regulation to deal with radiation dose concerns. They may want to initiate legislation to improve reporting, and likely the regulatory burden will grow.

There are also regulations that came out of Medicare that require accreditation of imaging services starting in 2011. And so CT and MR are going to be modalities that will need to be accredited, which means that you've got to comply with various criteria, and document that you're complying and so on. This is occurring outside of healthcare reform. So there is a regulatory burden that is growing, not diminishing. ■

I would say right now the biggest issue is the number of uninsured patients we're seeing. So any possible changes that could possibly get more people insured will definitely help our bottom line. We've seen a dramatic increase of charity care over the past year. These are patients who did have coverage and then they either lost their jobs or coverage was eliminated.

We still get cancers and we still get other kinds of illnesses so definitely getting more payment schemes into the situation would be helpful, from our point of view.

The other big threat, I think, is how the reimbursement from Medicare continually is going down as technology continues to go up and demand goes up. And so at some point it pretty much becomes almost a no-win situation that you're providing all this very expensive care and the reimbursements seem to continue to go down even though everything else in the economy seems to be going up.

We're definitely doing a lot more educating of the ordering clinicians to avoid inappropriate tests and conflicts with the payers. So this means a lot of pre-emptive work up of the case before the patient actually comes into the department. We are trying to ensure that we're doing everything we can to get the reimbursement we should. ■

Healthcare reform, continued

From my aspect, I have not seen any change of direction. We're still growing Medicare Advantage. We've seen positive and negative impacts on the organization, but we have not changed any of our processes.

We're a contained group. The health plan and the delivery system are all under one umbrella. All of the physicians are employed by the health plan, so there are incentives for the physicians to follow. Not everything is approved, so some specialty tests like PET and cardiac MR have to be approved by a review committee before they can be completed. ■

The main thing in this kind of economy and with this healthcare thing hanging over our head, you need to really be watching your financials very closely to make sure there's no waste.

So we're watching FTEs, our employees' overtime, bringing in per-diems to work as much as possible so there is no overtime. We've taken stock and make sure employees are aware of waste in the areas of electricity, paper, ink and pens. We looked at everything, all the way down to paper and printing in color. ■

If reimbursements get cut, it means even less coming in, so we have to be more creative as to what we can offer. You don't want to go to inferior product. That's not a way to go at all. It's a matter of how do we still provide quality care and keep our heads above water. I think that we have to be innovative.

You start to look at what will we have to cut back on to live within our revenue and continue to show a positive variance. You don't want to start running in the red. ■

No, we have not gone out and changed anything yet. We have not gone ahead with certain projects. A lot of our capital projects have stopped while this all gets sorted out. That's one thing.

Then we'll reassess quarterly and say, "Well, how have we been affected? How have we not been affected? Is this working? Is that working?" and then make a decision. Based on what we know, should we go forward with some of these projects? ■



**But we're not
gatekeepers. We're
a cost department.
We do whatever comes.**



Healthcare reform, continued

You would think more people with health insurance would be a good thing. Medicare reimbursement represents close to 50 percent of your patient population, so any reduction in that is a huge hit, and it's a hit in everything else because all of the other payers are based on a percentage of Medicare: 180 percent or 200 percent.

So if that enumerator goes down, then it's not just Medicare. It's everything on the outpatient side. Inpatient it doesn't matter. It's a DRG bundling pay.

Radiologists don't want to tell referring physicians that something isn't appropriate because they're afraid the referring physicians will write in their little chart that so-and-so refused to do it. But the bottom line is by being a gatekeeper – if you could show a model where you save the hospital blah-blah money because you denied this kind of procedure in the last year, you would show a value.

But we're not gatekeepers. We're a cost department. We do whatever comes. We don't say no and that's just a piece of the DRG. It just eats out more of the profit out of the DRG.

We provide millions of dollars worth of care to poor and underserved patients on our for-profit and not-for-profit side. So it's hard. And we have community clinics where we have sliding scales for the poor and the underserved. If we didn't fund those clinics with foundation grant money, we would never break even.

It's the same with our critical access hospital. Though that's a cost-reimbursement model, the nursing home isn't. Critical access is, but the nursing home isn't, so again we're in a very poor community providing health care services where we don't get paid or reimbursed for that. So it's real hard.

Now, we've done our modeling for next year's budget that starts July 1. Our state Medicaid program is projecting a ridiculous 17 percent cut. Due to that, we have got to find \$17-19 million somewhere else. ■

So with less reimbursement, everyone's always looking to figure out a way to provide care with fewer people. You can't do it with fewer people unless you're doing fewer exams. So will there be a rationing of services? I've got concerns that once we start rationing services and having long waits, we won't be able to add in technology.

On the same side, I've also seen many jack-in-the-box centers that do not offer the same level of quality service as hospitals because we're so heavily regulated, yet our reimbursements are the same. So I'd like to see some tiered reimbursement, which could potentially be a good thing for us. It might drive some players out of the market that maybe don't belong there. ■

If more patients have health insurance, I haven't quite bought into that as a solution. I just still believe there's only X number of dollars in this pot. So we will just be given fewer dollars to do the same thing we're doing today. ■

I agree that it's time we aren't paid if we make a mistake. That's been long overdue. What I'm afraid of, though, is if they make a mistake, and then that person doesn't have access to care, will this individual slip through the cracks? ■

I think there's a focus on not duplicating services. For radiology, it's a little tougher to do. Our organization is starting to ask the question, do we need to do inpatient oncology at every one of our campuses? Do I need to do inpatient orthopedics at every one of our campuses, or schedule the highly specialized neurosurgeon at every campus?

I think in preparation, we're starting to say, let's not be redundant. Let's quit competing against ourselves. Let's start to really look at which facilities offer specialty services, and then drive some of the bread-and-butter work back to the community hospitals so we don't lose them to our competitors.

We are looking at this very, very closely. The impact on imaging will depend on what services go where and then how we gear up for it.

We'd like to follow up with you on our recent question on healthcare reform. Now that legislation has passed, what is your opinion? What will it mean for you?

(Note: The previous insights were obtained prior to passage of reform legislation. The following insights were obtained afterward.)



It's going to be chaos. I would have preferred solving the issues more incrementally, rather than all or nothing



More people with insurance coverage will be coming through the system. My concern is, will we be paid the same? I'll be spending net revenue across greater numbers of patients. Will we have to ratchet back services? ■

We already are seeing our services tightening up. Yet we will have more testing done. Services may be harder to get as a result. The Centers for Medicare and Medicaid Services is tracking imaging efficiencies. What does it mean when we will have to benchmark across the national average? ■

We will have to see what the reimbursements will end up being and Medicare coverage. That is the biggest issue that hospitals are concerned about. ■

I think we need to understand it more. My concern is that we will have 32 million more people in the system with health insurance. I wonder how we'll handle them. And who is paying for all of this? I don't look upon this as reform because we are still a volume-based system. ■

Coming from a large Catholic non-profit health system whose main mission is to provide care, including to the poor and indigent, covering 32 million people is a good thing, once the abortion issue was stripped out. ■

It's going to be chaos. I would have preferred solving the issues more incrementally, rather than all or nothing. My fear is that we will end up hurting our economy with all of this. I don't know if the 32 million uninsured people are immediately covered or not. It's very complicated and I have to read up on it. ■

Something needed to be done, especially since there are so many uninsured people. People complain about the government being between them and their doctor. But the insurance companies are already between patients and their doctors. Doctors should be making the decisions about patients' clinical needs, not insurance companies.

I work at a cancer center where I have to argue every day with insurance companies about what patients need. It shouldn't be that way. ■

8 IMPROVING QUALITY

Quality to me is what the patient's experience really is about. How do they feel? What's the rate of infection? Whichever vendor comes out with that kind of solution for imaging is going to have

tremendous success with us

With or without reforms, the issue of quality is a key topic among people we speak with. What do you expect from vendors in this area?

Different vendors provide reports and benchmark data, but nobody has developed something specifically useful for radiology. How can you improve workflow in MR? How can you put your workflow in sync with the radiologist's time? It's things like that that are valuable.

The bottom line is, we are cutting staff that typically perform this analysis. In my opinion, that's where we're going to have a lot more partnership with vendors. We're going to be able to budget that a lot easier than requesting a full-time individual for that function.

I see a lot of outsourced projects that have to do with quality. I think there's going to be a revolution in the next three to five years in quality and we're not prepared for it. I don't know whether it's only in radiology, but I can tell you we struggle quite a bit with quality.

We think that by passing the Joint Commission accreditation without any bad remarks that we're doing great. But quality is a heck of a lot more than those things.

Quality to me is what the patient's experience really is about. How do they feel? What's the rate of infection? Whichever vendor comes out with that kind of solution for imaging is going to have tremendous success with us. ■

Some of this is going to be technology driven, absolutely. There are technologies you can apply to maximize patient safety and maximize image quality. And there are other technologies that make diagnoses more precise, like CAD.

I think information technology is extremely important for reducing errors. Make the information completely available. The idea of an electronic medical record is such a good thing because so many times tests are repeated.

Information on how our machines are being used would make our lives easier, too. In other words, what's your time on and off tables? With the CT scanners now, the rate-limiting step is how quickly can you get a patient on and off the table. What can we do to facilitate things like that? ■



It stuns me that with all the technology that these machines represent, we haven't done a good job of what I would call human factors engineering.



What has happened over the years is that the technology has really evolved in wonderful ways. But I was shocked when I listened to the most recent Congressional hearings and learned that there is no uniform way that manufacturers monitor or record dose that is delivered.

I wonder, how many decades have we had CT scanners and we still don't have a uniform way of reporting and recording how much dose a patient gets? Or even any way for the machine to tell you, hey, you're operating outside the parameters of what it should be? There should be red lights blinking or whatever.

It stuns me that with all the technology that these machines represent, we haven't done a good job of what I would call human factors engineering. In other words, the people operating the equipment at the console don't have goof-proof controls.

And the manufacturers have not given the sort of system monitoring data that's needed. It would be nice to be able to say how much dose patients get, let alone if the machine mis-calibrated in some way. That's a real failing. There's a lot to be done in that area if the manufacturers said this is something they can do.

At the last RSNA meeting, a number of vendors said they've come up with a new way to maintain image quality but yet cut dose by at least 50 percent. You want to get the best image with the least dose, but that's never been a priority in the past.

So it's reassuring to me to think that the manufacturers can actually help with all of that. I think over the next year, everyone's going to be focusing on that and cleaning up their act, so to speak, with the way the equipment is operated.

There's a lot of potential for operator error – there are no fail-safe capabilities – and this is true with the linear accelerator. It's really scary in that area because the dose that you're delivering is much higher than a diagnostic type of scan.

There's work to do there and people are working on patient safety and managing medical errors. These issues are controllable. I think the industry is really focusing on these issues for good reason, and I think they'll be some good things coming out of that. ■

Improving quality, continued

It definitely would be helpful to get data out of the equipment. By that I mean process data. We obviously get the images out of a CT scanner but there's a lot of other data that the machine captures.

For example, when did this study start, how long did this study take, and what was the radiation output? I could use that information to help me operate my center a little bit better. There's a big focus especially on radiation safety right now. If the equipment could easily generate that information for me in a report format, that would be very helpful. ■

Vendors could help in preparation practices. For example, do we need to wait an hour for contrast or can we start procedures immediately? I'm looking at what vendors see as evidenced-based practices and how they can provide me with information to implement.

I'm also looking at how I can provide safer care to the patient such as in dose reduction. All of the major vendors have really done a good job on software enhancement to reduce radiation exposure in CT exams.

I'm looking for evidenced-based protocols. Those are tougher to implement when you're dealing with physicians, who sometimes are uncomfortable following these practices because it's like cookbook medicine and more standardized. But I think that's very important. I'm all about being outcomes-based and if another organization has great clinical outcomes, then I think we should try that here. ■

I don't know how vendors would do quality. I think basically, they're all peddling their wares and everybody wants a little piece of the pie. Vendors might come in when we get new equipment and we have protocols to set. Our radiologists are the ones who decide what kind of protocol they want.

A vendor might come in and have a new product to show something, but ultimately the physicians are the ones who set the protocols and may attend a seminar and bring back new ideas. I don't know if the vendor is the one who is in charge of quality.

I think you really need to do your research because they're all selling. Their main goal is to sell and cheaper isn't always better. More expensive doesn't mean it's always better either. ■

We do trials ourselves. We bring things in and we trial them to see how the physician likes it. When we compare, sometimes the doctors say, "You know what? For what it is, what we have is fine. We don't need to spend another \$200." ■

I don't think vendors paid any attention to the regulations, even when it came to the CPT codes that could be built into a radiology system for radiology or even the American Medical Association CPT codebook could be built in and manually updated so that it was more of a flow.

It would be helpful to receive a notice that says, "Here's all the public information that comes out every October." Vendors have to start to think about their product not just as a single entity, but how will it fit into the bigger context of radiology departments and hospital systems.

There is the larger issue of keeping track of people's health history in electronic health records. Because if you're injured or unconscious, you can't answer caregivers' questions. They may have no way of knowing whether the patient has had surgery before. That's where these health records are going to come together.

Improving quality, continued

That's also what's going on with radiation right now. I think that some of the vendors are going to have to change the way the systems are hooked up so that we know the radiation history and how we're going to pass that information along so it can be monitored over the long-term. Europe has been doing this for a while, and we have to find a better way of doing that in the United States.

I think there is a role for protocols, but they need to be easily adapted. Over the years, protocols were not received well by physicians because they felt that somebody was trying to force them to practice in a certain way.

For example, protocols would say, "According to the algorithm, this is what should happen on a three-day hospital stay and a five-day hospital stay." Sometimes it worked and sometimes it didn't. I don't think it was presented correctly. Rather than discussing protocols as, "Here's what some people are doing and the reasoning behind their actions," they were presented as the only way to work.

Many of the new, younger doctors don't understand all of the studies. If they had a type of decision tree where they understand if you have these types of conditions, they have a trail or path to follow, it probably would help them and everybody else understand where they were going.

The Joint Commission Provision of Care guidelines examine this from the day that the patient enters the hospital. Based on this, the physician determines the classification and then decides, for example, that the patient should be going home in four days.

You have to ask, when do the caregivers start telling the family that the patient should be going home in four days? You can't wait until day four at noon to say, "OK, you can go home now," because the patient and family have to plan for it, especially older patients. Who's picking them up? Can they drive? Where is the discharge summary?

I think the vendors can play a role in helping doctors and health systems understand the benefits of these kinds of provisions. It's probably not wise to state bluntly, "Based on your expected DRG, your length of stay is 10 days and you now only have six days left. According to the algorithm, you haven't done these steps."

But if the caregivers agree to the algorithm, then they might be prompted by such items as "Do you have these orders? Would you like to make the orders now? Now, don't forget this step. Don't forget about that step." Those kinds of prompts would probably do a lot to help hospitals and staff members keep to the expected length of stay and DRG expectations. ■

We don't really expect vendors to help us with quality. We are working on putting quality measures on our web site for greater transparency so patients can compare certain diseases and their outcomes at our institution. There's so much fallacy in the data that states usually put out.

So our institution is really at the forefront of quality, which is in everything that we do. We had three-hour quality training sessions more than a year ago that every single physician had to go through in order to get their credentials renewed. We had all the physicians and every single associate go through the training: more than 7,000 people in total.

At any part of the care process, any level of staff can call a stop to what's going on in patient care. That's getting to the next phase of zero preventable errors. For example, you might have an EKG tech go to the nurse to say, "Did you see this patient didn't have an EKG?"

So it's about changing the culture. To me, safety is really at that base level. Our organization has received a lot of awards on quality and safety. ■

Improving quality, continued

I think that the standardization of clinical protocols would really be very helpful. I would like to know best practices. I would like to know this is where I am, and this is where other hospitals are, and here's the best practice. I would value the vendor giving me a gap analysis and some clear direction about how to achieve best practice level.

I was talking with one of our chief medical officers the other day, and we were saying how we are suffering from CFS – consultant fatigue syndrome – because there have been so many consultants around here.

But at the end of the day, I'm still the one left trying to figure out the implementation plan. How am I going to get there? I already know that I've got this problem. You didn't have to come in and charge me to tell me I got the problem. Tell me what steps I need to take to help fix it. So that's where I think that vendors could be really important.

How can they help me see the value of their product in that whole value analysis stream that a lot of organizations are moving to? Not that it's just a new product out there or that it might be less expensive, but what's the true cost benefit of it? ■



How can they help me see the value of their product in that whole value analysis stream that a lot of organizations are moving to? Not that it's just a new product out there or that it might be less expensive, but what's the true cost benefit of it?



NEW INVESTMENT

“ It was technology at its best, not only making the RT more efficient, but also providing better quality ”

How do you anticipate the current healthcare environment will impact your investment in new diagnostic and therapy systems in the next few years?

We're still going to be very, very careful in how we replace equipment, period. Are we going to invest more capital dollars on equipment or are we going to continue to reinvest money in maintaining the quality of our service, satisfying referring doctors and patients, and competing for more patients?

I think we're going to continue to do that, but we are going to continue to be very careful about supporting new capital investment. ■

We've got several different issues. On one hand, some of the technology we have is really state-of-the-art, particularly with MR and CT. We've made huge investments to be state-of-the-art, given our reputation. And we've downplayed or minimized dollars that we've put into more conventional radiographic equipment.

That's not good, but we had to make choices as to where we spend money. We don't have open-ended budgets. And so we've let some of our technologies age beyond a level that we would normally want them to be.

Just this fall, we updated our mammography screening equipment, which was well over 10 years old. We went to new technology that's digital and the throughput we achieved was nothing short of remarkable.

We could not believe how much that helped improve our throughput and the productivity of the radiology techs, who didn't have to schlep around with cassettes. It was technology at its best, not only making the RT more efficient, but also providing better quality studies for patients.

Those investments are always challenging because they're huge. With reimbursement for mammography screening, that's a challenge to make it pay for itself.

So you need to make this investment and reimbursements are falling, so it's more of a challenge. At the same time, you're more pressured to put volume through to get the numbers where they work. It's not going to get better. I just see this continuing to be a challenge. ■



**Now, more than ever,
it's so important to
understand the business
side of radiology –
because you can
go broke**



You have to be a good manager. You have to really understand your expense and cost structure, while thinking about throughput and productivity. These things all have to come together as a business management process, even totally unrelated to clinical quality or any of that.

The question is, can you get the numbers to work for you, with respect to what you have to invest and what you can yield through use of the equipment? So that's a challenge and people spend a lot of time thinking about it.

Radiology is a very factory-oriented environment that involves a lot of throughput and volume. You need people with management skills and business education to understand that. People may go in to the radiology field, either as a tech, physician or physicist, thinking they don't need to know anything about the economics of the business.

Now more than ever, it's so important to understand the business side of radiology – because you can go broke. For instance, we were the first in our major metropolitan area to get a PET/CT scanner 10 years ago. Now it's obsolete. We know we've got to upgrade, which becomes a \$2.5 million challenge.

Do we have the capital and the room prep, which always adds significant dollars to this kind of purchase? It's a big bucks scenario; you've really got to know what you're doing. We've put off making the decision but we've got to stop. Oncology is one of our strategic market initiatives. We're going to try to make a decision starting July 1. You need to make the numbers work. ■

New investment, continued

We're certainly evaluating our purchases. Every system is going to be evaluated carefully. Can I open up the system on Saturdays or Sundays? Can I get a higher throughput? Is there an upgrade I can do? Can I replace this and perhaps buy a used model that will give me an upgrade?

People now are not buying new cars; they're keeping their cars longer. That's what I see happening in radiology. The other effect of the electronic health record is that it's soaking up a lot of healthcare dollars, even though you're going to get paid for it if you reach benchmarks. You have to do it before you get paid. So, there's a cash flow issue.

So, if I'm going to put in an electronic health record at my institution it's probably going to cost, conservatively, about \$25 million. We'll probably get most of that back. But, we're not going to get it back from day one. With that \$25 million, I could have been buying MRs and CTs. In the short term, that is affecting the capital spent. ■



What does the new equipment have to do in order to be approved? You have to show a billable charge



New investment, continued

This environment definitely is making it harder to invest. We're going to have to make equipment last longer, and we may not be able to get the cutting-edge equipment as quickly as we would like. Being a research institute, just this past year we applied for some research imaging equipment that didn't get funding because the grant fell through. So without the grant, no equipment, no research.

As far as general imaging equipment, it's getting much harder to get replacement equipment. There has to be a lot of justification, planning and proformas to justify any new pieces of equipment. Until this economy changes and turns around a bit more, it's going to be harder to expand equipment-wise.

What does the new equipment have to do in order to be approved? You have to show a billable charge. We can't take on anything that is still deemed research or experimental; it has to be something we can recoup charges on.

It has to enhance clinical benefit to the patient. We're not just going to bring in a new toy because it's the latest and greatest. It has to provide more clinical information, be faster than a normal unit in that modality and provide more productivity.

We also have to look at our referral base. If we bring in another piece of equipment, do we think that the ordering patterns are there to utilize the piece of equipment?

If it's a new imaging modality, we have to query the ordering clinicians and ask, are you going to order some of these tests if we put this in? How many do you think you could send us?

And if we're bringing it in, hopefully it's for clinical reasons. We would have to explain it to them and say we think this is going to enhance your patient's care.

I think our institution will probably find ways to do advanced research, despite the economy. We've got dedicated clinicians in our research department and we have a big research institute. We probably will be able to find a way to partner with pharmaceutical companies and manufacturers to get the equipment we need. I don't know if a smaller facility would have that ability. ■

We are limiting the amount of capital initially. Our organization wanted to spend only \$3 million in capital purchases in 2010. We're already seeing that that's not going to be enough. The only thing that we were able to replace in 2010 was anything "to keep the lights on and doors open," as they say it here. We didn't have any approved funding for operational improvements or to get business in.

This organization doesn't like to lease anything. They only want to purchase. So I think the economic downturn will really refocus that and return to the question: should we be leasing equipment instead of just waiting to have the capital to buy it?

I think it's going to be a slow recovery and a slow process to get capital funding at our organization. If I can provide services at a lower cost, then it means more money is available to purchase new capital equipment. Any efficiencies and cost savings I can achieve helps me put more money toward the bottom line so we can reinvest in more equipment.

If we really needed a new system, I would get emergency capital to do that. This would mean if there were any regulatory violations, for example, or if an important modality like CT is completely dead and could not be repaired. They would always want to try to repair it first. But it would have to be pretty emergent capital. ■

We're looking at building a new hospital. When the economy fell last year, we had to delay some of our plans due to lower levels of philanthropy. People pulled back in terms of donations. But we keep moving forward. We just keep coming up with ideas for how to make it happen. We're getting another 64-slice CT.

Yesterday, at our radiologist meeting, we discussed the new emergency department. When it is built, will we get a certificate of need? We believe we will be able to get a CON for a third 64-slice scanner there by this time. So, you might not have all the monies now; you might have to hold off because donors withhold some dollars. But we're still going forward. We're just slowing down the process. The question is, to what degree? ■



You want to call the insurance company and say, 'Well, if you can guarantee the outcome by physicians in your network and get me an appointment within the next three months, then maybe I would consider it'



I think there's a level of caution as we move forward. We will do upgrades and replacement of old and tired equipment. I wonder, what is the standard of care going to be and how do you maintain standards of care? The standard of care may not be cutting edge, but what is currently accessible.

I think we're going to have to look at that now because all of our systems are computer-based. In the analog world where not everything was computer-based, things didn't change as quickly. But now things are changing very rapidly.

While the new software helps us make some of the changes, we can't respond as quickly. Some of these changes are not cheap and many require faster processing and components. Because the software is FDA-referred, you also need the vendor's help.

What is actually stressing the system right now is, how do we do all of this? I look at some of the prices today and they are through the roof. Although the prices are double or triple what they used to be in some cases, it's clear that there are indications for the new technology. But how do you find the money to pay for it?

Unfortunately, reimbursements are not based on your technology level either. So, even though you have an old MR scanner, maybe it is getting reimbursed the same as a 3T system. You have situations where the technology is superior, but is it worth the expense to revenue? That may affect quality. Would you be willing to pay for better quality given the expense? Scary.

We may be developing a mentality of mediocrity. Is that okay? For some, as long as care is decent, it's good enough. That's really not good enough for others because they're looking for upper level care.

This goes back to a kind of class system that says those who can afford to have the best healthcare go to the best facilities they can find. If it costs them money, it costs them money. Then there's the rest of the population, which is barely getting by with taxes and the rest that basically will allow mediocre service. They may not always like it, but it's affordable and fits within their guidelines.

New investment, continued

We get letters from the insurer that says, “If you would have used an in-network surgeon, some of your costs could have been decreased.” You want to call the insurance company and say, “Well, if you can guarantee the outcome by physicians in your network and get me an appointment within the next three months, then maybe I would consider it.”

We are prioritizing which projects are critical to the success of the institution. Which ones have to be done because of end-of-life issues and which ones affect marketing? So, you put them all together and ask, if the service isn't making money, is it something you have to provide? If the answer to that question is yes, then we have to go through with it. But do we have to buy the best? Do you have to buy that cutting-edge system or can we get away with state-of-the-art?

A lot of times, it goes back to your return on investment. What is the margin on these cases and is it worth it? Is a 1.5T MR good enough? If a 1.5 is good enough, and it's half the cost of a 3T system, then maybe we should stay with a 1.5.

Maybe there's a solid reason to go with the 3T system if you're in a neuro center that requires high-level brain function assessment. Then, you invest in the 3T and say, okay, we're not going to do this other project because it's probably not as important.

So, everybody's looking at, what do you have to do to attract patients and referring physicians? Will we invest in a new patient-bed tower? Will this do more for us than investing in technology, because everybody would like a private room with their own bathroom? What is that expectation? ■

If people get smart, they need to right-size their existing departments. I have to argue all the time that our radiology department doesn't need four CTs, only two. The department had four in its heyday and now the volume isn't what it was. The department director doesn't think that way.

Instead I hear, “We don't give up anything here.” But this would significantly reduce both the operational and capital costs in the long term because you don't have to replace four systems, only two, going forward.

I don't see hospitals changing. We don't buy refurbished systems here. We didn't buy refurbished where I was before. Part of the challenge with the refurbished market is it doesn't keep up with the new market so what I can buy as a refurbished four-slice CT today, I could buy a new 16-slice.

When you're keeping a system for seven to 10 years, it doesn't make sense to buy something that's already three to four years old, coming off its lease. So I think it's just going to get tougher. At our health system, the model for capital is based on a percentage of your bottom line, if you hit your targets as allocated for capital.

As the bottom line gets more challenged, I think capital will get harder to find. It's been hard to do major projects. We're opening a brand new hospital in October worth \$300 million. I think you will see fewer of these huge projects. ■

The capital market will get even more challenging, depending on what happens. We'll have to invest in replacement. But I don't see us investing in rarely used systems. Some of it might be a nice bell or whistle to have, but I'm never going to use it.

So I think we're really going to be challenged by our senior administration to say, “Do you really need this? Is it a nice-to-have, or do you really need it? And if you really need it, how are you going to use it? How often are you going to use it?”

I just had a discussion at one of our other urban campuses about new MR software. In talking with the director of operations, the radiology chairman and I almost said at the same time, “Turn the software on, but we want to know how often they're using it over the next 30 days.” Before, if we used the software 10 times a year, that was okay. Now it's going to be used 300 times a year. ■

10 VENDOR MESSAGES

I have some vendors that are really, really good,
but overall, I don't know. I think

**some of them are just trying
to peddle their stuff**

Finally, what do you think the vendors need to be most cognizant of to help you manage all these changes? Have you heard any messages from any of the vendors in the last year or so that really resonate with you and if not, what should they be saying to you right now?

I think the vendors are becoming more flexible. I think there are a lot of times when we were considering investing on a capital piece of equipment, not even thinking about leasing or working on a joint venture with a vendor.

I am seeing a lot more vendors now saying, “What can we do to help you? Would a lease option help you? Can we do a venture with you?” Even at that level, we’re still not seeing a lot of transactions being done, even with the flexibility that some vendors are offering.

I think a lot of vendors are continuing to be very aggressive and visiting. They haven’t stopped visiting and keeping things going. They feel that at any point the freeze is going to be lifted and here we come. The purchase orders are going to start flowing again. I think they are going to be very few and far between, not like it was many years ago.

But, at some point we’ve got to be standing up, to some degree, to accommodate all the new patients coming to use our services. So, it’s going to be something. I think vendors have to think in different ways to help us out, to think in different ways to bring equipment, lease options or joint ventures. ■

The vendors are in the business of optimizing their revenue and they’ve done a good job of that. Things are changing though. I think they’re going to continue to be under pressure because no matter what they say the value of any technology is, if the market can’t afford it and pay for it, you know, what’s the point?

A lot of the pressure and budgetary challenges that come out of the reimbursement arena are going to continue flowing right to the vendor’s bottom line and so the negotiating and bargaining process is just going to be more and more stressful.

Some, but not all, of them are dealing on price and trying to keep their volumes high but it’s not going to get any different for them. They’re going have to figure out how to make this technology cheaper.

I mean, that’s a challenge for them, but, you know, we’re all in the same boat. Maybe we’re in different parts of the continuum, but they’re in the same basket we’re in and if we can’t pay what they want they’re going to have to go back and figure out how to make it more affordable. Because they’re all making healthy margins.

Of course, this year, all the companies, regardless of what business they’re in, are having trouble like everyone else, but I don’t think it’s going to go back to the good times. It’s just going to be a continuing pressure that goes up and down the line.

I don’t know what else they can tell us. It’s more of how well they understand the environment they’re competing in. It’s not just the economy. It’s the general reimbursement decline in healthcare. As pressure to hold costs down mount, the manufacturers are going to be suffering along with the rest of us.

On the good side, they design wonderful products. Every year they come out with new technology that’s more wonderful than the year before. But at the same time, because I’ve been in the business a long time, I tend to see a lot of the manufacturers over-promising things.

Vendor messages, continued

You have to be skeptical of the marketing messages. You have to sort through reality versus marketing hype. There are some legitimate advances that are really worthwhile where other things are more hype just to kind of get the buzz going. To get people interested in buying something.

The cost structures are really challenging and need to be worked on, on the vendor side as well as on our side. We all need to figure out how to make things less costly.

I mean, the manufacturers want to optimize their revenue and we in turn want to get maximum value for the dollar. On the provider side, we're all in the same boat when it comes to what's happening in the external environment with payment cuts and so on and so forth.

Part of the problem is, I shouldn't say the problem, but manufacturers sell to whoever's got the money to buy, okay?

So if you look at the problem with over-utilization in our healthcare economy, there are willing buyers and willing sellers. Maybe if there was a little bit more regulation on saying that nobody can buy imaging equipment unless they're a certified radiologist, you might have less of that problem happening.

They're as guilty of this proliferating medical arms race as anybody. It's a willing buyer and a willing seller. But I think it got us to where we are today with the way healthcare has just gone crazy with utilization, which then crowds out your ability to handle uninsured patients.

I think everybody self-optimizes. Everyone tries to get the biggest buck they can out of a situation. So you have urology practices out there in the community seeing their income eroding. What do they do? Their solution is to go buy linear accelerators and do radiation therapy.

It's like, "Hello!" That's the last place I would go to have my prostate taken care of — some urology group that's got a LINAC. I don't think so.

Here in our city we've got two huge groups, one on the north and one on the south that have done exactly that. And it's like, "What's wrong with this picture?" I mean, that is definitely crazy. It's allowed under the law but, I mean, is this the way to deliver care?

And the average public doesn't think about it. If you're a guy and you have something going on with your prostate, you go to a urologist and he says, "I think you need radiation therapy and by the way, I want you to go here and oh, by the way, I own that place."

That's the dark side of healthcare in this country, that anybody and anybody can do that kind of thing. So that's my soap box. ■

You don't see medical miracles in technology coming out of the former Soviet Union. You don't see it because it doesn't exist

Vendor messages, continued

I used to have really good relationships with the major imaging vendors but a lot of those relationships have changed. The business has become a little colder, a little harder and it's just different. It's not the way it used to be.

They clearly understand. I mean, they're downsizing their services. They don't have the added-value things anymore and I don't know if it's a good or it's a bad thing. That remains to be seen.

But one of the things I do want to comment on is just that much of the inundation in healthcare, especially in imaging, is because of the prolific market for that stuff in the United States. If that market dries up, you will see a decline in innovation, a precipitous one. Okay? You won't be able to drive it anymore.

When I started in this business 30 years ago, if you had something wrong with your belly, they would take you to the OR and do exploratory surgery. Today you get wheeled in for a CT scan and we usually find out what's wrong with you and take care of you.

That's where we were and we shouldn't go back. Innovation will grind to a halt. You don't see medical miracles in technology coming out of the former Soviet Union. You don't see it because it doesn't exist. And you really don't see tremendous medical innovations coming out of France because it really doesn't exist there, either. Stuff like that concerns me. ■

They're all trying to obviously keep up with the latest and greatest. Some of the equipment they're coming out with, like these mega-slice CT scanners, they're just huge, like 256-slice machines. And I'm having a hard time understanding the clinical need for that, to justify the expense of that piece of equipment.

I definitely need ease of connectivity between information systems. I need the scanner to talk effortlessly to my hospital information system. To talk effortlessly to the PACS system. This is where the images all end up. I need that seamless connectivity between all this equipment.

Everything that the vendors sell is always an added feature. I need a little bit more of a here's-everything-you-need kind of system without finding out six months after I put it in that, "Oh, you didn't buy that lung package that your doctor is now interested in."

I need a clear picture of everything the machine can do, clearly stated. You tend to get the marketing spiel from the vendors about, "Oh, ours is faster, ours is a 256 compared to their 64," and then when you read the technical specs you find out no, not really.

It's a 64 with some computer gyrations to make it a 256. It's a marketing scheme, you know? So I definitely want the technical specs to match what they're trying to sell me.

All the equipment these days are basically huge computers. And with any computer, it's capturing data every step of the way and capturing the point where that happens.

With our CT systems, we've had to jump through a ton of hoops to get that data. I've actually had to go through our vendor's service department to get special permission to load special software. Get special sign-ins to get access to that information.

I shouldn't have to jump through that many hoops. If I want to find out how long on average my patients are lying on that machine, I should be able to get that data out of the machine without having to go through 13 different service modules to figure that out.

I know they have to keep some of their information proprietary but it would make it easier for me to understand what's going on with my equipment if I could see some numbers out of it, some information. ■



A lot of vendors make it very difficult to share information easily and then every time you ask for something, it's a \$20,000 or \$30,000 hit. We can't keep doing that



Well, all the vendors, they'll come in and they'll pitch their product. What it is, why it's good and is better than this or that.

As soon as they come in, I'll tell them, "If it costs a lot more, it's got to be an exceptional product. Some of them just drop in and start going off on their thing and it's a bit much.

The vendors that I find helpful are the ones that call, they make an appointment. When they get here, they're concise about what they have and what it can and can't do and when I need something, they're there to provide it, but they don't get in your way.

I find a lot of them – they're just trying to sell. I mean, they're trying to make a living. They're trying to do their thing. You get bombarded with them.

Most of the time, these people are just doing cold calls or a doctor recommends something because they've made a pitch to him in his office. There's a lot of that.

I usually say, "Well, maybe we can do a trial." I told someone the other day, "We can do a trial," and while I was on leave, they ended up coming in and did about five procedures.

I'm like, "Whoa. I said a trial." They were insisting we pay for it. \$13,000. I'm like, "Well, we're going to have to talk about that."

I know it's tough out there, but still. After a while it can be agitating. It's maybe not the right attitude, but I guess it's just my experience.

I mean, I have some vendors that are really, really good, but overall, I don't know. I think some of them are just trying to peddle their stuff. ■

Vendor messages, continued

Everybody is starting to realize that healthcare has some extreme needs and it's bigger than most of us ever understood. If we're not buying because we're waiting and watching, then where will the money come from to develop new products? It's a vicious circle.

I think the vendors need to try to understand our needs better. It's not just selling us a device. A lot of vendors make it very difficult to share information easily and then every time you ask for something, it's a \$20,000 or a \$30,000 hit. We can't keep doing that.

When you do an RFP or an RFQ, they really have to sit down and think about it and say, "How does this all come together and what is my true role? What is it that I have to do to make sure that I don't just gain this business but future business and also maintain the business that I have?" I'm not so sure that's the part they understand right now.

A lot of the sales people are just, "I have to make a sale because that's what my quota says. So, here's your sale," and then you don't see them again. It's like the company is not invested in you and the facility long-term. I think that's something that they need to understand. "We understand the changes in healthcare and we understand the pressures," and not that it's just another sale.

I'll give you an example. You put in a new device and they say, "This will do everything that it possibly can. It will interface with your PACS, your ADP systems, your reporting systems. It'll send back information." Then you buy the product.

Then as the product is getting installed, all of a sudden, it's like, "Oh, well that isn't what that means." It's like, "Yeah. Well, when we had this conversation, remember this question?"

So, it's one of those things, buyer beware, but it's also seller beware and they've got to make sure that they really do meet the terms of what they say they're going to do. This is integrated healthcare. ■

I think they should be looking at consulting on staffing and doing process redesign stuff. Again, I think that's a value-add that they can bring to a relationship. Most directors don't have those skills.

I think the vendor should look at it more as a partnership instead of selling a piece of equipment. I really think they need to be incented more on the relationship.

It infuriates me to have to negotiate the service contract and the sales guy said this and the service guy says, "Oh, no," or, "No, we can't — oh, that's a different division." I don't give a rat's patooty about it being a different division. It's got your name on it so you need to have one person talking to me. So I really think they need to look at the relationship and not as transaction-based relationship. ■

If your product is supposed to do this, then tell me how it's going to do it. I'm very tired of being sold: that salesman-type mentality. I know you've got to make a living, and you know, I have something to protect.

Maybe I'm just getting older and crotchety, and I don't know, less tolerant of "I didn't quite mean that," after the papers are signed, you know?

We just went through this with a vendor recently. Three of us on our side of the table really thought, understood it one way, and he came back later and said, "No, no, no, no, no. We didn't mean it that way."

That's really a problem for us. And I think it's because the economy is down, and they're trying to get sales just like we're trying to conserve our dollars.

I hear a lot about partnering. I'm not always sure how that partnership works, because it still feels like the facilities are taking most of the risks.

I'd like them to truthfully tell me what their product can or cannot do. If I tell you that I hear something from one vendor, you know, try to talk to me in apples versus apples.

Compare the same things. And if you are more expensive, then tell me what the real value — not the perceived value — is in why you're more expensive. Or, maybe you're more expensive for me to buy initially, but my ongoing maintenance costs won't be as much. So my cost of ownership will be less.

Somewhere along the line, I want the field to be truthful in what they're doing. Because at the end of the day, we know that there's a price to doing business. If I'm burned, I'm going to be skeptical with your company moving forward. ■

StawickiAssociates

HEALTHCARE MARKETING PARTNERS

1313 North Franklin Place, Suite 1105
Milwaukee, Wisconsin 53202
(414) 277-7700

©2016 Stawicki, Inc. All rights reserved.
Do not publish without written permission.