The Imaging Leader’s Hospital-Radiologist Alignment Manual

A Review of Formal Alignment Models Found in Imaging
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**The Changing Radiologist Role**
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**The Imaging Leader’s Change Management Crosswalk**
This tool helps radiology leaders quickly locate resources to implement the five change management principles for imaging.

**Four Ways to “C” Radiologist Engagement**
This webconference offers four tactics to motivate radiologist performance in value-generating activities: communication, competition, compensation, and culture.

**Imaging Metric Selection Tool**
This tool allows members to create a customized performance dashboard with quality, efficiency, and finance metrics—each with a suggested goal or benchmark and a reference for additional information.

**Peer-to-Peer Networking**
Interested in learning more about the alignment models outlined in this publication? We can arrange for networking with leaders at the profiled institutions. Contact your Advisory Board relationship manager to get started.

Also Available from the Advisory Board

Consulting and Management

**Physician Services Consulting**
A consulting engagement to help build a sustainable model for physician alignment—financially viable, operationally efficient, and patient-centered.

Talent Development

**Physician Collaboration**
A partnership to help develop physicians who are engaged in the organization’s strategic priorities and contribute to larger initiatives.

Performance Technologies

**Crimson Continuum of Care**
A performance technology service that helps hospitals achieve the physician alignment needed to pursue quality goals and cost savings.

**Physician Alignment Solutions**
A customized Advisory Board portfolio of performance technologies, consulting services, and dedicated support—all based in best practice research—to help design and implement radiologist alignment strategy.
With Sincere Appreciation

The Imaging Performance Partnership is grateful to the individuals who shared their insights, analysis, and expertise with us. In particular, we would like to recognize the following for being especially generous with their time.

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Asheville, NC

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Mark Farmer  
Mark Jensen  
Charlotte Radiology  
Charlotte, NC

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Children’s Hospital of Philadelphia  
Philadelphia, PA

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Karen Kleinhas  
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High Point, NC

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Denver, CO

Patty Smith  
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Tom Skelton  
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Greensboro Radiology  
Greensboro, NC

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Dr. Keith White  
Intermountain Health Care  
Salt Lake City, UT

W. Kenneth Davis, Jr.  
Katten Muchin Rosenman LLP  
Chicago, IL

Dr. Dan Johnson  
Mayo Clinic  
Scottsdale, AZ

Linda Wilgus  
Northwest Radiology Network  
Indianapolis, IN

Kirk Hintz  
Radiology Alliance, P.C.  
Nashville, TN

Dr. Syed Zaidi  
Radiology Associates of Canton  
Canton, OH

Dr. Ricardo Cury  
Radiology Associates of South Florida  
Miami, FL

Tom Greeson  
Paul Pitts  
Reed Smith LLP  
Falls Church, VA  
San Francisco, CA

Dr. Sharon Byrd  
Bernard Peculis  
Rush University Medical Center  
Chicago, IL

Robert Cove  
Sunshine Radiology  
Winter Haven, FL

Dr. Jonathan Breslau  
Sutter Health  
Sacramento, CA

Brenda Izzi  
UCLA Health  
Los Angeles, CA

Dr. Murray Becker  
Tom Dunlap  
Dr. Rob Epstein  
University Radiology Group  
East Brunswick, NJ
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Essay
Aligning for Unified Sustainability
Alignment can mean different things to different people.

The nation’s health care delivery system is changing rapidly, and the implications for imaging are tremendous. To respond to these challenges and secure long-term sustainability, radiologists must align their interests with those of the people they serve. But what does alignment mean for radiology? There is no clear consensus.

When it comes to defining alignment, the good news is that no one is wrong—because alignment truly encompasses all of the terms in the word cloud above. Conversely, the bad news is that the term alignment is confusing, because there is no precise, succinct way to explain what you’re talking about.

For the purpose of clarity, this publication uses the definition of alignment developed by the Imaging Performance Partnership research team.

align·ment
noun

A measure of the strength of professional, cultural, and/or economic relationships between physicians and hospitals. In imaging, this typically refers to the degree of coordinated integration between radiologists, hospitals, and referring physicians—regardless of whether radiologists are independent, employed, or otherwise affiliated with a health system.
The transition from volumes to value means a new reality for imaging.

Before outlining some of the radiology alignment models we found in our research, it is important to emphasize the very tangible reasons that this topic is so critical. It’s certainly not headline news that our health care system is in a state of flux as our health care delivery model transitions from volume-based to value-based. And we are feeling the full force of health care reform in imaging.

Radiologists in particular have seen cut after cut through the Medicare Physician Fee Schedule (MPFS). And while their salaries are still relatively strong, the downward trend and the uncertainty of the future is understandably alarming.

Recent Cuts to Radiologist Reimbursement

<table>
<thead>
<tr>
<th>Practice Expense RVU Adjustment</th>
<th>MPPR 1 Applied to All Physicians in Same Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice expense/hour data updated; input impacts practice expense RVUs in MPFS</td>
<td>25% cut to professional component when multiple physicians in same practice perform second imaging scan in same session</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
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<tbody>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Addition of Professional Component to MPPR</th>
<th>Capital Interest Rate Cut</th>
</tr>
</thead>
<tbody>
<tr>
<td>25% cut to professional component of MPFS for second scan</td>
<td>Reduced from 11% to 5.5-8%, affecting practice expense RVUs in MPFS</td>
</tr>
</tbody>
</table>


1) Multiple Procedure Payment Reduction.

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Radiology programs have been quick to react to these changes in health care.

Perhaps nothing illustrates the uncertainty of future compensation better than the trend of rapid radiology group consolidation in recent years. To radiologists’ credit, they have been remarkably fast at reacting to the changes in health care. It seems radiology group leaders have seen the writing on the wall and have acted quickly to bolster against growing competition.

Consolidating

2010: Springfield Radiologists + Central Illinois Radiologic Associates

2012: Greensboro Radiology + High Point Radiology

2013: San Diego Imaging + North County Radiology

2011: Radiology Associates of Tarrant County + Southwest Imaging and Interventional Specialists + Grapevine Radiology Associates

2012: Houston Progressive Radiology Associates + Sweetwater Radiology Group

2009: Charlotte Radiology + Carrabusa Radiologists

2011: Radiology Alliance + Diagnostic Imaging

2014: South Jersey Radiology Associates + Booth Radiology

2012: Inland Imaging + Seattle Radiologists

70.4%
Percentage of large independent radiology groups that have considered merging or otherwise consolidating with other radiology groups in the past year

It isn’t just radiology groups who have been quick to respond to the economic threats facing imaging. Imaging programs across the board have had to innovate on strategy to compensate for volume and profitability losses, and they’ve done so in four primary ways.

Compensating

Referral Strategy
Strengthening relationships with referrers; investigating and securing new referral streams

Growth Opportunities
Identifying new applications for principled imaging growth, such as CCTA,\textsuperscript{2} tomosynthesis

Revenue Optimization
Increasing investment in pre-authorization acquisition, point-of-service collections, and billing

Service Diversification
Offering teleradiology, IT infrastructure, management services, even data analytics


1) n=27
2) Coronary CT Angiography.

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Unfortunately, we are starting to see diminishing returns on those compensation efforts. We are running out of these stopgap measures that we’ve been using to buffer ourselves against the realities of the changing health care market. It is time to take a critical look at how imaging can best align itself with our care partners to be sustainable in the long run.

First, that means competing on price. The rise of high-deductible health plans and price transparency creates a patient population significantly more price-sensitive than we’ve traditionally seen.

**Competing on Price**

To survive, programs must face **competitive pressures** head on.

Second, we have to compete on quality. Our customers are expecting more and more of us, and imaging leaders need to establish themselves as the provider of choice not only for patients but also for our referrers. Competing for referrals requires imaging leaders to recognize and respond to the unique needs of the many cohorts of referring clinicians we serve.

**Competing on Quality**

- **Primary Care Physicians**
  - Critical results reporting, clear explanation of findings, incidental findings follow-up

- **Emergency Physicians**
  - Quick turnaround time with clear recommendations for next steps

- **Physician Specialists**
  - Access to subspecialty radiologists for diagnosis and treatment discussion

- **Advanced Practitioners**
  - Consultations with radiologists to discuss appropriate ordering and follow-up care

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**Related Resource:** *The New Radiology Quality Mandate*

A study on elevating imaging’s value proposition to key stakeholders

**Related Resource:** *The New Imaging Pricing Mandate*

A webconference on developing a pricing strategy for imaging

Source: Imaging Performance Partnership interviews and analysis.
Program sustainability requires an alliance with health system leadership.

Alignment is no longer a benefit—it’s a requirement. This is the case of Novak Radiology Group, a true example of the importance of alignment.

Leaders at one of Novak’s partner hospitals abruptly canceled their contract in favor of a national radiology company. Novak radiologists were shocked. However, only three months later, referring physician complaints led the hospital to cancel the national contract and re-approach Novak. Knowing that the hospital would get what it wanted, either from them or from a competitor, Novak leaders negotiated with hospital leaders and agreed to terms that would accomplish both sides’ goals.

A Tumultuous Path to Alignment at Novak Radiology Group

Novak provides traditional services to hospital
National radiology company fails to deliver adequate value to referring physicians
Novak adjusts personnel, elevates service offerings, commits to being collaborative partner
Hospital cancels Novak’s contract in favor of national radiology company
Hospital cancels national contract after only three months; approaches Novak to renegotiate

As this case demonstrates, hospital leaders don’t see alignment as a superfluous benefit. In fact, in the Advisory Board’s 2014 Executive Perspectives Survey, hospital leaders with reporting lines to imaging ranked building and strengthening relationships as the most important skill for an effective service line leader. Over service, communication, and even financial acumen, hospital leaders want imaging directors to build strong relationships.

Most Important Skills for an Effective Service Line Leader
As Ranked on 1-7 Scale by CXOs with Reporting Line to Imaging
n=33

<table>
<thead>
<tr>
<th>Rank</th>
<th>Skill</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Building, strengthening relationships</td>
</tr>
<tr>
<td>2</td>
<td>Service orientation, customer focus</td>
</tr>
<tr>
<td>3</td>
<td>Communicating effectively</td>
</tr>
<tr>
<td>4</td>
<td>Change management</td>
</tr>
<tr>
<td>5</td>
<td>Process management</td>
</tr>
<tr>
<td>5</td>
<td>Financial acumen</td>
</tr>
</tbody>
</table>

1) Pseudonym.
2) Top five responses shown; process management and financial acumen were tied for fifth place.
Success hinges on collaboratively working toward shared goals.

At the end of the day, imaging is up against a number of threats, both internal and external. Imaging has always been so profitable that hospital and radiologists didn’t necessarily need to be closely aligned—but times have changed.

In the face of a health care system that demands better coordination, and a regulatory landscape that isn’t particularly favorable to imaging, we simply need to work together to demonstrate our value. And while it sometimes seems that hospitals and radiologists have different objectives, everyone really has the same goal in the long term—a thriving, sustainable imaging program. To achieve that end for each partner, hospitals and radiology groups must work together.

The Advisory Board’s 2014 Hospital-Radiologist Alignment Survey asked institutions why they implemented the alignment models they have in place. These are some of the responses. The key takeaway: stronger alignment seems to support our strategic goals in today’s health care environment, for both hospitals and radiology groups. Furthermore, alignment is not a short-term project; the goal is to deliver the best clinical service possible to achieve long-term success.

Hospital Perspective

“Align goals and reward achieving benchmarks”

“Strive to create engagement, provide improved value to referring physicians, improve departmental quality”

“Need for more activity, input, and support by the radiology group to achieve organizational and departmental goals”

“Wanting to retain a high-quality radiology group”

Group Perspective

“…effort to transition from volume to value”

“Attempt to increase integration into the health care system and strengthen relationship with the hospital”

“Strategic relationship; positioning for future payment models”

“Declining volumes/revenue; compensation for quality/service metrics and participation with shared savings”

“Potential to generate additional margin through hospital-based OP procedures”

Radiologists can’t demonstrate value without the key players aligned.

Our team began researching alignment with a relatively simple goal: to go out and find the innovative alignment models we were hearing about, figure out what they look like and how they’re built, and learn why these institutions chose to implement the models they did.

The Hospital-Radiologist Relationship

Radiologists

“Let’s create a joint venture. How do we get started?”

Care Partners

“You’re right. I think a shared management agreement is a better fit for us than a management services agreement.”

“We had assumed that there was a sort of menu—that imaging leaders picked out what model they wanted and executed on it based on the established precedent. In other words, we thought this was a “top-down” method.

As it turns out, alignment in imaging hasn’t followed that approach. In fact, it’s been the opposite. The way we’ve seen alignment work is that radiologists and administrators identify and examine their goals, come together to discuss potential options for integration, and establish alignment models that are unique to the relationships and leadership talents in each situation. In reality, it’s been more of a “bottom-up” approach.

Our Assumption

“Top-Down” Approach

1. Select alignment model from established list
2. Plan and execute based on precedent
3. Achieve desired model

The Reality

“Bottom-Up” Approach

1. Identify and examine goals
2. Build relationships with key players
3. Establish unique, mutually beneficial arrangement

The next section profiles how some of these bottom-up alignment models took shape. While they are unique to the institutions and leaders who implemented them, and a model that works in one community may not always work in another, we selected the following alignment models specifically for the lessons they can teach all imaging leaders.

Source: Imaging Performance Partnership interviews and analysis.
Formal Alignment Models
Options to Integrate for Mutual Benefit
Exploring Hospital-Radiologist Alignment

In the following pages, we will walk through some of the most prevalent models of alignment in radiology. To show you just how prevalent they are, we will present data from our 2014 Hospital-Radiologist Alignment Survey.

While there is no perfect way to organize formal alignment models that exist in imaging, this section loosely organizes the following models into three categories. It is also important to note that these models can overlap not only in organization but also in practice; some institutions use multiple models simultaneously as part of a comprehensive strategy for both inpatient and outpatient imaging.

We’ll review a couple traditional models before continuing on to explore novel case studies of how radiologists and hospital administrators have advanced mutual goals through formal alignment.¹

<table>
<thead>
<tr>
<th>Baseline alignment</th>
<th>Incentive-Based PSA</th>
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<tbody>
<tr>
<td>Exclusive Provider Contract</td>
<td></td>
</tr>
<tr>
<td>Outpatient Joint Venture</td>
<td></td>
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<tr>
<td>Management Services Agreement</td>
<td></td>
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<tr>
<td>Shared Management Agreement</td>
<td></td>
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</tbody>
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<table>
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<tr>
<th>Co-management</th>
<th>Co-management Organization</th>
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<tr>
<td>Clinical Integration Network</td>
<td></td>
</tr>
<tr>
<td>Health System Employment</td>
<td></td>
</tr>
</tbody>
</table>

¹ Please seek legal counsel when pursuing any contractual partnership.

Source: Imaging Performance Partnership interviews and analysis.
Incentive-Based PSA

A professional services agreement (PSA) between an independent practice and a health system that includes financial bonuses (or penalties) for radiologist performance on predefined quality and service metrics.

This first model represents a low-risk way to align hospital and radiologist goals without pursuing any sort of structural integration. When implementing incentives or penalties, however, leaders should be very careful to select metrics that have a demonstrable impact on care.

We see roughly the same trend across hospitals and radiology groups, except for the significantly higher percentage of radiology group leaders who would consider this model in the future. In fact, almost 90% of the independent groups surveyed either have implemented or would consider implementing performance incentives. In the context of declining reimbursement and a desire to serve hospital partners, that number shouldn’t be surprising, but it does represent a noticeable willingness on the part of radiologists to depart from the traditional model of complete practice autonomy.

Prevalence of Incentive-Based PSAs

<table>
<thead>
<tr>
<th></th>
<th>Hospital Respondents</th>
<th>Independent Group Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implemented 2+ Years Ago</td>
<td>23.6%</td>
<td>22.2%</td>
</tr>
<tr>
<td>Implemented Within Past 2 Years</td>
<td>7.3%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Considering in Next 2 Years</td>
<td>14.6%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Would Consider in the Future</td>
<td>23.6%</td>
<td>44.4%</td>
</tr>
</tbody>
</table>
Another way to align without formal integration is to enter into an exclusive provider contract. Our survey data tell us that the majority of hospitals contract with only one radiology group, and that some hospitals simply associate informally with a single group. The vast majority of radiology groups surveyed are the sole contracted provider of radiology services to a hospital—and usually to more than one. Overall, it appears that these formal exclusivity contracts are widely prevalent, with informal agreements present in about one out of ten providers. Providers without any exclusive provider agreement are a minority.

One health system in this minority actually prefers it that way. Contracting with two radiology groups was originally a source of conflict. But the system imaging director now views this model as advantageous, as it creates an environment of healthy competition that pushes each group to innovate on the value they deliver.

**Prevalence of Exclusive Provider Contracts**

*n=77*

<table>
<thead>
<tr>
<th>Hospital Respondents</th>
<th>Independent Group Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, with Formal Contract</td>
<td>Yes, Formal Contract with Sole Partner</td>
</tr>
<tr>
<td>67%</td>
<td>15%</td>
</tr>
<tr>
<td>Yes, w/o Formal Contract</td>
<td>Yes, Formal Contract but Also Read for Others</td>
</tr>
<tr>
<td>12%</td>
<td>73%</td>
</tr>
<tr>
<td>No</td>
<td>Yes, w/o Formal Contract</td>
</tr>
<tr>
<td>6%</td>
<td>8%</td>
</tr>
<tr>
<td>N/A</td>
<td>No</td>
</tr>
<tr>
<td>16%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: Advisory Board Radiologist Hospital Alignment Survey, 2014. Imaging Performance Partnership interviews and analysis.
Outpatient Joint Venture

An outpatient imaging center developed as a separate entity with shared assets, in which all parties (usually a hospital/health system and a radiology group) contribute equity; equity need not be equal.

Joint ventures are certainly not new to the imaging industry, but they can play an especially important role in today’s financial and regulatory environments. Data from our alignment survey indicate a fair amount of joint venture activity over two years ago, especially on the radiology group side, and also plans for more joint ventures in the future. It is interesting, though, to see how few organizations seem to have built joint ventures in the past two years—not one hospital out of the dozens of respondents. That said, we have heard anecdotally about recent joint ventures, so these low numbers more likely represent a decline in recent joint venture activity rather than a complete standstill.

Prevalence of Outpatient Joint Ventures

n=82

- **Implemented 2+ Years ago**: 12.7%
- **Implemented Within Past 2 Years**: 0.0%, 3.7%
- **Considering in Next 2 Years**: 10.9%, 11.1%
- **Would Consider in the Future**: 20.0%, 18.5%

Joint ventures can be an appealing strategy in today’s health care environment.

It is important to recognize that low-cost imaging benefits everyone, in any payment environment. While payers have traditionally taken on the cost of imaging exams, patients are increasingly assuming more of the financial burden through employer cost-shifting and high-deductible health plans. Ultimately, risk-bearing providers like ACOs will be responsible for medical costs, so leaders will be incentivized to send patients to the lowest-cost sites of care, within their own networks.

Low-Cost Imaging Beneficial to All Stakeholders

<table>
<thead>
<tr>
<th>Payers</th>
<th>Patients</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payers employ RBMs¹ to manage overall costs for advanced imaging via preauthorization process</td>
<td>Increased cost-shifting onto patients has led to price shopping and a call for greater price transparency</td>
<td>Payment reform shifting risk for cost onto provider-based ACOs</td>
</tr>
</tbody>
</table>

Evolution of Risk-Bearing

Here is an example of how a joint venture can benefit both partners. Howerton Health System, a pseudonym, offers hospital-based outpatient imaging at a relatively high price point. Its partner, Dewey Radiology, also a pseudonym, currently has no outpatient imaging business in Howerton’s market. A joint venture, set up on the Medicare Physician Fee Schedule, allows Howerton to keep price-conscious patients in their network by referring them to the lower-priced center, and provides Dewey an opportunity to build a new revenue stream, assume management responsibilities, and strengthen its relationship with Howerton.

1) Radiology benefits managers.
2) Pseudonym.
3) Hospital Outpatient Department.
4) Hospital Outpatient Prospective Payment System.
5) Medicare Physician Fee Schedule.

Source: Imaging Performance Partnership interviews and analysis.
Providers must examine how a joint venture fits in with larger outpatient strategy.

These three scenarios offer insight into the challenges inherent in creating an outpatient imaging strategy with your care partners. Any combination of center ownership models and market penetration that positions your partner as your competitor is likely to be destructive to your alignment efforts.

- **A Good Idea**
  Market Collaboration

  - **Market A**
    - JV

  - **Market B**
    - Hospital IDTF
    - Physician IDTF

- **A Fine Idea**
  Market Segmentation

  - **Market A**
    - Hospital IDTF
    - Physician IDTF

  - **Market B**
    - Hospital IDTF
    - Physician IDTF

- **A Bad Idea**
  Market Competition

  - **Market A**
    - Hospital IDTF
    - JV

  - **Market B**
    - Physician IDTF

- **Market Collaboration**
  - Hospital and radiology group establish network of joint ventures
  - Joint ventured centers saturate market such that there is no competition between partners and both parties benefit from collaborative partnership

- **Market Segmentation**
  - Hospital and radiology group establish freestanding centers in separate markets
  - Because hospital and group operate in different markets, there is no competition
  - While not competing, both parties miss opportunity for collaborative partnership

- **Market Competition**
  - Hospital and radiology group establish individual and/or joint ventured outpatient centers in same market
  - IDTF footprint causes direct competition between hospital and radiology group centers, hindering collaborative partnership

The benefit of joint ventures is largely financial, as prices for imaging services are set much lower under MPFS than under HOPPS. However, it is important to note that CMS has indicated that it may equalize fee schedules in the near future. These outpatient imaging dynamics will change significantly if CMS ultimately reduces HOPPS reimbursements to match those under MPFS.

---

**Related Resources**

- Imaging Center Joint Ventures
- Acquiring Imaging Centers

**Will Medicare Equalize Fees?**

"Medicare should pay the same amount for the same service, even when it is provided in different settings"

Report to the Congress: Medicare Payment Policy; MedPAC, March 2014

For the latest on policy affecting imaging, subscribe to our blog.

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1) Independent diagnostic testing facility.
Co-management offers a nebulous definition but a clear opportunity.

You will notice that the outpatient joint venture model spans both the baseline alignment and the co-management categories established at the beginning of this section; this overlap is meant to indicate that joint ventures do not necessarily need to be collaboratively managed (though many are).

While the term "co-management" has fairly specific implications in other service lines, our research interviews revealed that imaging leaders have been using the term to describe any number of integrated management structures. Following suit, this publication uses "co-management" as a broader classification for any collaborative management model between hospital administrators and radiologists.

As you can see, there are many potential benefits with a co-management arrangement.

Howerton Health System¹

- Extra hands to help manage department and/or outpatient centers
- Opportunity for imaging staff to learn clinical and operational skills from radiologists
- In some cases, ability to aggregate physicians from different groups to streamline contracting

Dewey Radiology Group¹

- Additional revenue source for practice through management fees and incentive payouts
- New opportunity to demonstrate radiologist value and interact with hospital physicians
- Ability to retain group autonomy, governance structure while integrating with health system

Co-management

- Collaboration on improving quality, decreasing cost, and fostering better provider coordination
- Opportunity to strengthen relationships between radiologists and care partners

¹) Pseudonym.

Source: Imaging Performance Partnership interviews and analysis.
Co-management models vary but generally adhere to one of two basic paradigms.

Using “co-management” as a loose term means that it can take many forms. Ultimately, there are two basic types. The first, and more common, is a direct contract. We often see this when a hospital pays its partner radiology group for management services in the hospital imaging department and/or an outpatient center. A second option is to contract co-management through a designated organization. We see this when hospitals set up a joint ventured LLC to contract with physicians from multiple independent practices, or when a similar organization already exists.

**More Popular Now**

- **Hospital/Health System**
  - **Direct Management Agreement**
  - **Radiology Group**

**Examples:**
- Management of outpatient imaging center (either hospital owned or joint ventured)
- Technologist education program in hospital imaging department
- Shared management agreement with shared risk in achieving mutual goals

**Generating More Interest**

- **Hospital/Health System**
  - **Designated Co-management Organization**
  - **Radiology Group**

**Examples:**
- Joint ventured organization founded to include physicians from multiple practices
- LLC formed to unite employed and independent radiologists around imaging utilization initiative
- Radiology group management services organization already in place to provide IT tools

We’ll now walk through three co-management case studies—one direct management agreement, one designated co-management organization, and one hybrid—the shared management agreement.

**Management Services Agreement**

**Shared Management Agreement**

**Co-management Organization**

---

1) Limited Liability Company.

Source: Imaging Performance Partnership interviews and analysis.
Management Services Agreement

A contract between a hospital and a radiology group whereby radiologists agree to assume management responsibilities in a radiology department or outpatient center in exchange for a flat fee and/or incentive-based compensation.

The direct co-management model often takes the form of a management services agreement, where a hospital or health system hires radiologists for management services in return for compensation—usually a flat fee plus some quality-oriented performance incentives. Many organizations already have such an arrangement in place—almost a quarter of hospital respondents and over a third of radiology group respondents. There is also a fair amount of interest in management services agreements going forward.

### Prevalence of Management Services Agreements

n=82

- **Implemented 2+ Years Ago**
  - Hospital Respondents: 20.0%
  - Independent Group Respondents: 44.4%

- **Implemented Within Past 2 Years**
  - Hospital Respondents: 3.6%
  - Independent Group Respondents: 3.7%

- **Considering in Next 2 Years**
  - Hospital Respondents: 5.5%
  - Independent Group Respondents: 14.8%

- **Would Consider in the Future**
  - Hospital Respondents: 25.5%
  - Independent Group Respondents: 25.9%

Holm Hospital\(^1\) assumed center ownership but pays for radiologist services.

In this case, while the radiology group had planned to fully own a new outpatient imaging center, they worked with their hospital partner to establish a more collaborative model.

**Impetus for a Management Services Agreement at Holm**

- **Planning an IDTF**
  - Partners initiate plan to establish joint venture with radiology group as majority owner

- **Snag in Payer Contracting**
  - Partners learn hospital’s favorable commercial payer global billing contracts would not apply to new center

- **Saving the Center**
  - To avoid leaving money on the table, partners agree to establish facility as hospital outpatient center

- **Maintaining Management Roles**
  - To preserve close hospital-radiologist alignment, partners agree to management services agreement, where hospital pays radiologists for department support and quality improvement initiatives

In addition to a base management services fee, the hospital vice president offers the radiology group incentive payment on three to five annual initiatives that align with the hospital’s strategic goals. These initiatives can relate directly to the imaging department and/or to the outpatient centers. This year, there are four initiatives:

### 2014 Incentive Initiatives

- **Use of Head/Neck Node Classification System** ($10K)
  - 75% if 75-89% reports compliant
  - 100% if 90%+ reports compliant

- **Use of Structured Reporting System** ($10K)
  - 75% if 75-89% reports compliant
  - 100% if 90%+ reports compliant

- **IVC Filter Follow-Up** ($10K)
  - 100% if appropriate follow-up completed at least 95% of the time

- **Utilization Management** ($20K)
  - Completion of five individual tasks as assigned

= $50,000/year in incentive opportunity

\(^1\) Pseudonym.
Leaders of both parties set clear expectations to generate benefit without conflict.

Holm Hospital already acted as the radiology group’s billing agent, but the management services agreements added two additional components to the radiology group’s revenue.

\[
\text{radiology group revenue} = \text{professional fees} + \text{management services fee} + \text{management services incentives}
\]

Management services fee: $320,000/year
- Set about 10 years ago at $250K; increases annually with inflation (according to CPI\(^1\))
- To qualify, all radiologists must meet task expectations as outlined in detailed contract; radiologists record hours quarterly (contract requires minimum 65-80 hours per month, though radiologists often exceed this amount)
- Hospital continues to act as billing agent for radiology group professional services
- One “MSA/PSA” contract set up for both professional and management services fees; fees paid monthly, contract automatically renews annually unless 180 days notice of termination given by either party

Additional incentive opportunity: $50,000/year
- All radiologists in radiology group participate in management services initiatives
- Like base fee, incentives paid to group; group leaders have freedom to spend or distribute
- Hospital VP assigns three to five initiatives each year according to hospital strategic goals
- Some initiatives extend into multiple years if previously incomplete or particularly intensive

This agreement has been very successful at both improving quality and strengthening alignment. It is worth noting that management services agreements can legally be contracted for many more years than a typical professional services agreement, which can give all parties some peace of mind. Many institutions have actually created management services agreements to overcome competitive outpatient dynamics as well.

“It is absolutely critical to be as precise as possible from the outset about the goal of these initiatives and how progress will be measured. We always attach a detailed description of these expectations to the contract itself to avoid any misinterpretation disputes down the line.”

Vice President, Holm Hospital

Case in Brief: Holm Hospital and Holm Radiology Associates\(^2\)
- Radiology group forfeits joint venture majority ownership to hospital; partners establish management services agreement to preserve close alignment
- Hospital continues to bill professional fees for radiologists, adds base management services fee plus incentive bonus opportunity for 3-5 strategic initiatives

---

1) Consumer Price Index.
2) Pseudonym.

Source: Imaging Performance Partnership interviews and analysis.
Shared Management Agreement

A collaborative agreement in which a hospital/health system and radiology group create a shared risk pool, whereby capital is rewarded to both parties after mutually set performance targets are achieved.

This next model appears similar to the management services agreement, but the difference is that there is some shared risk involved. An imaging department and a radiology group, often in conjunction with hospital leadership, construct a shared pool of resources. They then allocate those resources only upon meeting certain mutually established performance targets. Very few organizations have adopted this model so far, but there is clearly significant interest.

Prevalence of Shared Management Agreements

n=82

<table>
<thead>
<tr>
<th>Implemented 2+ Years Ago</th>
<th>Implemented Within Past 2 Years</th>
<th>Considering in Next 2 Years</th>
<th>Would Consider in the Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Respondents</td>
<td>Independent Group Respondents</td>
<td>Hospital Respondents</td>
<td>Independent Group Respondents</td>
</tr>
<tr>
<td>5.5%</td>
<td>5.5%</td>
<td>9.1%</td>
<td>22.2%</td>
</tr>
<tr>
<td>11.1%</td>
<td>3.7%</td>
<td>23.6%</td>
<td>40.7%</td>
</tr>
</tbody>
</table>

Source: Advisory Board Radiologist-Hospital Alignment Survey, 2014, Imaging Performance Partnership interviews and analysis.
Poorly aligned partners seek to share not only goals but financial incentives.

Radiology Associates of Canton, in Ohio, and their partners at Aultman Hospital had been poorly aligned in recent years.

“Each side basically wanted more responsiveness. The hospital wanted faster turnaround time on imaging studies and reports, while my group wanted to eliminate certain inefficiencies built into the radiology department. Both of us were stuck in a status quo of mutual dissatisfaction.”

Dr. Syed Zaidi
CEO, Radiology Associates of Canton

The radiology group CEO set out to change that sour dynamic. He approached Aultman’s CEO about starting a new collaborative arrangement. The CEO was on board, and soon they had created a committee to identify mutual goals and negotiate the terms of a new agreement.

Monthly Operations Meeting

Key Hospital Players
- CEO
- COO
- Imaging director
- Radiology chair
- Chief Information Officer
- (any interested administrators)

Key Radiology Group Players
- CEO (medical director of co-management)
- All other medical directors:
  - Quality assurance
  - Residency program
  - Patient services
  - Physician outreach
- (any interested radiologists)

“There was no transparency and little trust between the radiologists and the administration…These meetings allow for much more communication, transparency, and trust between the radiologists and the hospital…expectations are met on both sides.”

Christine Donato
Executive Director of Imaging, Aultman Hospital

The agreement offers many benefits—above all, a positive working relationship.

Immediately, the radiologist-hospital relationship began to improve. The open forum allowed the imaging director to articulate her expectations for radiologists and for the radiology group leaders to articulate their value. Ultimately, the team decided to set up a management agreement with a shared pool of resources. Both parties would establish mutually beneficial quality improvement projects and award themselves only if they hit predetermined metrics.

Immediately, the radiologist-hospital relationship began to improve. The open forum allowed the imaging director to articulate her expectations for radiologists and for the radiology group leaders to articulate their value. Ultimately, the team decided to set up a management agreement with a shared pool of resources. Both parties would establish mutually beneficial quality improvement projects and award themselves only if they hit predetermined metrics.

Hospital Wins

- Willing partner in quality and service improvement initiatives
- Experience, expertise, and good data relating to appropriate imaging utilization
- Clinical perspective in equipment and supply purchasing decisions
- Physician allies to liaise with referrers, hospital leadership, payers
- Additional imaging experts to identify department inefficiencies

Radiology Group Wins

- Opportunity to show dedication to service
- Attention from administrators who best understand group’s value; ally to defend group in front of cost-conscious hospital/system/ACO leadership
- Hospital clout to negotiate with payers on reimbursement, utilization management
- Stronger connection to technologists to ensure consistently high image quality

It took two years of negotiation to create this shared management agreement. Every year, both parties come together to review and revise performance targets and their corresponding financial payouts. They are now in the second year of this agreement and are already looking forward to more radiologist participation in department management.

“It’s giving us more control, more participation, and more cohesiveness with the hospital. We turned our relationship toward the positive.”

Dr. Syed Zaidi
CEO, Radiology Associates of Canton

Case in Brief: Radiology Associates of Canton and Aultman Hospital

- 22-radiologist independent group serving nine sites; 800-bed hospital located in Canton, Ohio
- Founded committee to bring hospital, radiology group leaders together; initiated incentive program whereby team shares in predetermined monetary rewards if mutual goals are achieved
- Parties feel that program has benefitted both sides, will continue to foster strong relationship with aligned objectives

Co-management Organization

An organization either created or used to compensate a collective body of radiologists for management duties in a hospital imaging department and/or outpatient center.

Now let’s turn to the second general form of co-management—the designated co-management organization. There has been a remarkable degree of interest in this method, though very few have adopted it. Because there aren’t many established precedents for designated co-management organizations in radiology, we use this term in reference to any intermediary organization through which radiologists assume accountability for management.

Prevalence of Co-management Organizations

n=82

- Implemented 2+ Years Ago: 1.8%
- Implemented Within Past 2 Years: 3.7%
- Considering in Next 2 Years: 18.5%
- Would Consider in the Future: 51.9%

Source: Advisory Board Radiologist-Hospital Alignment Survey, 2014, Imaging Performance Partnership interviews and analysis.
One system included radiologists in a **multispecialty LLC** to reduce turf conflicts.

As noted on page 23, one reason to found a co-management organization is to include physicians from multiple specialty practices. Baptist Health South Florida founded an LLC with 50% of shares owned by the health system and the remaining 50% owned by the physicians. There are three classes within those physician shares, each with a different number of shares and benefits.

**Universal Performance Indicators**
- Meeting participation
- Turnaround time
- Patient satisfaction
- On-time dictations
- On-time transcriptions
- On-time report sign-off

**Subspecialty Indicators**
- Cardiac surgery
- Vascular surgery
- Interventional services
- Medical cardiology

**Three Ways to Alter Metrics**

1. **Adjustment of Goal**
   - Ex: Vent time for aortic valves adjusted from 22 hours to 8 hours between first and second contract

2. **Recalibration of Payout**
   - Ex: Amount allocated to CABG vent time metric decreased; amount allocated to blood utilization increased

3. **Elimination of Metric**
   - Ex: Vent time for aortic valves eventually eliminated from list of metrics; currently stands at five hours

Baptist wanted to include the specialties shown above to foster strong working relationships between cardiovascular physicians and their frequent care partners. Physician contracts, revised every two years, hardwire metrics for collaboration into its incentive structure. There are categories of metrics for all physicians and for specific specialties—all aimed at driving collaborative performance improvement.
Co-management is not a simple endeavor, but our expert consultants can help.

Co-management Checklist

- **Legally viable, fair-market appraised structure**
  Agreement structure been reviewed and approved by experienced legal counsel; incentive structure is supported by a third-party valuation group

- **Defined governance/management responsibilities**
  Physician roles and responsibilities are clearly delineated in the agreement, communicated to participating physicians

- **Targeted performance management metrics**
  Narrowly tailored, highly specific metrics have been established to accurately assess physicians’ success against predetermined objectives

- **Meaningful physician incentives**
  Incentive structure is transparent and legitimized by accurate performance data; incentive model carefully crafted to reward desired physician behavior

- **Performance management infrastructure**
  Infrastructure is in place to accurately track physician performance against stated objectives to measure success

Case in Brief: Baptist Health South Florida

- Seven-hospital health system based in Miami, Florida
- Created LLC as part of co-management agreement with cardiovascular physicians; radiologists included as partners with the goal of defusing common turf conflicts that occur with interventional cardiologists

The Advisory Board Company’s Physician Alignment Solutions

A customized Advisory Board portfolio of performance technologies, consulting services, and dedicated support—all based in best practice research—to help design and implement radiologist alignment strategy.

Source: Baptist Health South Florida, Miami, FL; Radiology Associates of South Florida, Miami, FL; Imaging Performance Partnership interviews and analysis.
Clinical Integration Network (CIN)

A legal arrangement allowing physicians and hospital leaders to collaborate on improving quality and controlling costs while remaining separate entities; these networks often invest in IT infrastructure, create committees for various aspects of performance improvement, and negotiate with payers to receive shared savings or other performance-based incentives.

A number of imaging leaders participating in our survey, especially those from independent physician practices, reported that they participate in clinical integration networks, or CINs. These complex entities provide a ripe opportunity for imaging to demonstrate value on quality and cost indicators. While it is not uncommon to have radiologist representation in CIN leadership, it is worth noting that the radiology program rarely initiates its formation. Therefore, imaging leaders should generally consider clinical integration to be an alignment model to take advantage of, rather than one to develop independently.

Prevalence of Clinical Integration Networks

n=82

- Implemented 2+ Years Ago (Hospital: 7.3%, Independent: 12.7%)
- Implemented Within Past 2 Years (Hospital: 18.5%, Independent: 18.5%)
- Considering in Next 2 Years (Hospital: 14.6%, Independent: 37.0%)
- Would Consider in the Future (Hospital: 21.8%, Independent: 18.5%)

CINs offer favorable reimbursement for performance improvement efforts.

In a typical clinical integration (or clinically integrated) network, hospital-physician partnerships use data to develop coordinated, evidence-based care guidelines. CINs generally select specific metrics to track performance improvement and then work with payers or other risk-bearers to establish more favorable base rates, shared savings, or other pay-for-performance incentive structures.

Clinical Integration Network

Core Contract Components

- **Selective physician partnerships**: Network of physicians opting to collaborate with hospitals in delivering evidence-based care and improving quality, efficiency, and coordination of care.

- **Comprehensive improvement initiatives**: Clear, evolving metrics and targets designed to meaningfully impact clinical practice of all physicians in network to improve value across full continuum of care.

- **Performance improvement architecture**: Data-driven mechanisms and processes to monitor and manage utilization of health care services, designed to control costs and ensure quality of care.

Clinical Integration is especially appealing because it can provide benefits in both fee-for-service and accountable care payment environments. Improving quality, reducing cost, and strengthening alignment are all prime ways to demonstrate imaging’s value, even without regard to reimbursement.

Returns from CI During Evolution to Risk-Based Payment

Realizing Returns Today
- Stabilize physician economics
- Improve performance on key quality and cost initiatives
- Increase market share

Preparing for Tomorrow
- Create infrastructure for care coordination, management
- Build physician comfort with performance focus, cost awareness

Time

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advisory.com
Including imaging leaders in CIN management ensures radiologist input.

The CEO of Baptist Health South Florida’s radiology group is one of only 12 physicians on the 17-member board of its CIN, Baptist Health Quality Network (BHQN). Members of the radiology group also sit on all three CIN subcommittees to brainstorm how radiology can contribute to the established CIN goals.

Radiology's presence is especially noteworthy in the quality subcommittee, where the radiology group has launched initiatives aligned with two CIN metric categories.

### Sample Metric

<table>
<thead>
<tr>
<th>Clinical Programs</th>
<th>RASF² Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developed and implemented in 2014: description of program, adoption of practice</td>
<td>Working with primary care physicians and specialists to develop clinical</td>
</tr>
<tr>
<td>guidelines or protocols, and completion of a distribution and monitored education</td>
<td>pathways for specific clinical scenarios</td>
</tr>
<tr>
<td>plan for physicians/staff</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Network CME</th>
<th>Developing educational programs tailored to patient and referrer engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational sessions and activities organized and hosted for BHQN participants and</td>
<td>/education for imaging utilization, appropriateness criteria for ordering exams,</td>
</tr>
<tr>
<td>patients</td>
<td>value of screening exams</td>
</tr>
</tbody>
</table>

### Sample Project: Imaging Magazine

- 15-20 pages with articles written by section chiefs; discussed in CIN but solely produced by radiology group
- Material includes information on low back pain, screening appropriateness, patient claustrophobia, inflammatory bowel disease imaging
- Distributed to network referring physicians and patients
- Offers opportunity for radiologists to differentiate from competition by meeting, explaining magazine to 3-5 patients per day; early data suggests positive effect on likelihood of patients to refer friends to center

---

1) Non-voting members.
2) Radiology Associates of South Florida.

Baptist Health Quality Network already negotiates shared savings with payers.

Baptist Health Quality Network has already secured shared savings contracts with three payers, including Duplass Health Plan.¹ To reduce costs, the CIN tracks about 15 specific metrics spread across various categories.

**Clinical Integration Contract**

- Contract covers 6,000 lives
- Shared savings relies on CIN’s ability to reduce cost on approximately 15 specific metrics
- Metric categories include preventive care, inpatient quality and cost, physician engagement, etc.
- Many imaging-specific metrics focus on screening exam accuracy/efficiency to support high-risk patient management and lower-risk patient prevention
- Duplass one of three payers contracting with BHQN; other contracts involve similar shared savings models

“*The Baptist Health Quality Network is a physician-led network of healthcare providers working together to improve the health of our patients and the quality of healthcare overall, while reducing cost and responding collectively, and more effectively, to healthcare reform.*”

BaptistHealthQualityNetwork.com

**Case in Brief: Baptist Health Quality Network**

- Clinical integration network of Baptist Health South Florida, a seven-hospital health system based in Miami, Florida
- Active radiology group involvement safeguards input on major decisions, demonstrates value of radiologists in achieving cost and quality outcomes

¹ Pseudonym.

Source: Radiology Associates of South Florida, Miami, FL; Baptist Health Quality Network; www.baptisthealthqualitynetwork.com; Imaging Performance Partnership interviews and analysis.
Health System Employment

Hospital/health system employment of radiologists, either directly through an affiliated medical group or indirectly through a designated foundation.

Hospital employment of radiologists is without a doubt a topic that’s received a lot of buzz recently as leaders seek to improve radiologist alignment. Opinions and perspectives run across the spectrum, but let’s look at the data.

In the graph below, we can see that almost a quarter of respondents already employed radiologists as of two years ago, and a few have recently transitioned to an employment model. Looking ahead, a number of institutions, including a surprising number of independent group respondents, would consider such a model in the future. Note that this graph excludes academic medical centers, simply because the vast majority operate on an employment model of some sort.

Prevalence of Health System Employment  
(excluding academic medical centers)  
n=68

<table>
<thead>
<tr>
<th>Implemented 2+ Years Ago</th>
<th>Implemented Within Past 2 Years</th>
<th>Considering in Next 2 Years</th>
<th>Would Consider in the Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.5%</td>
<td>7.3%</td>
<td>0.0%</td>
<td>29.3%</td>
</tr>
<tr>
<td>25.9%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>25.9%</td>
</tr>
</tbody>
</table>

Hospital Respondents ■ Independent Group Respondents

Source: Advisory Board Radiologist-Hospital Alignment Survey, 2014; Imaging Performance Partnership interviews and analysis.
Despite concerns, hospitals don’t seem to be employing radiologists en masse.

Whether for or against, opinions about employment are generally strong. Remarkably, despite the buzz, the percentage of hospitals and radiology groups indicating that they are considering employing radiologists in the next two years is zero.

Many independent physician practice leaders expressed concern regarding hospitals wanting to employ radiologists, and also a fair amount of confusion in wondering what a hospital’s motivations would be for doing so. Below are some key pros and cons when it comes to hospital employment. There are arguments on all sides, which suggests that employing radiologists is something organizations should consider very carefully and with a high level of radiologist input.

<table>
<thead>
<tr>
<th>Pro</th>
<th>Con</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For Radiologists</strong></td>
<td><strong>For Hospitals</strong></td>
</tr>
<tr>
<td>More predictable compensation</td>
<td>More institutional control of radiologist activities</td>
</tr>
<tr>
<td>Compensation structures that better foster academic work</td>
<td>Increased coordination, collaboration between radiologists and imaging administrators, referrers</td>
</tr>
<tr>
<td>Natural integration with peer physicians, with built-in referral stream</td>
<td>Better care coordination due to integrated IT</td>
</tr>
<tr>
<td>Access to hospital infrastructure</td>
<td>Possible elimination of outpatient competition</td>
</tr>
<tr>
<td>Potentially more favorable payer contracts</td>
<td>Radiology not a referral-generating specialty</td>
</tr>
<tr>
<td>Fewer business management responsibilities</td>
<td>High average salaries, at least for now</td>
</tr>
<tr>
<td>Job security</td>
<td>High expectations for benefit packages</td>
</tr>
<tr>
<td></td>
<td>Risk of decreased productivity on salary model</td>
</tr>
<tr>
<td></td>
<td>Potential cultural conflict</td>
</tr>
<tr>
<td></td>
<td>Less autonomy</td>
</tr>
<tr>
<td></td>
<td>No stake in business ownership</td>
</tr>
<tr>
<td></td>
<td>Less control over daily operations</td>
</tr>
<tr>
<td></td>
<td>Potential isolation from hospital governance</td>
</tr>
<tr>
<td></td>
<td>Less nimble organization; more politics/bureaucracy to navigate</td>
</tr>
<tr>
<td></td>
<td>Limited opportunity for growth</td>
</tr>
<tr>
<td></td>
<td>Risk inherent in aligning with one revenue source</td>
</tr>
<tr>
<td></td>
<td>Less bargaining power in employment contracts</td>
</tr>
</tbody>
</table>

Health system employment can be a safe haven from radiologist competition.

One of the main employment pros stemming from our research was the potential for better job security in the hospital setting. Not surprisingly, those perceptions held true in our survey data. Respondents employed by health systems were more likely to disagree that their peer radiologists fear being replaced by competitors.

<table>
<thead>
<tr>
<th>Radiologists at My Organization Fear Being Replaced by Competitors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>n=61</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Independent Physician Practices</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Hospitals/Health Systems</strong></td>
<td>29.5%</td>
<td>70.5%</td>
</tr>
</tbody>
</table>

Employing radiologists can work, but only if everyone is on board.

Many hospital and health system leaders seem to view employment as the only way to achieve true alignment. Other hospitals and health systems simply have a tradition of employing radiologists. One such institution, Beaumont Health System, recognized that integrating cultures after an acquisition can take time.

**Beaumont Supports Transition from Private Practice to Health System Employment**

**Not forcing employment:** Beaumont acquired Bon Secours Hospital but allowed its radiologists to continue working as an independent group despite Beaumont’s employment model.

**Fostering open communication:** System and group leaders discussed pluses and minuses of employment; discussions focused on impact on income and benefits, provision of services, and ability to maintain relative autonomy.

**Giving the group time:** Beaumont leadership understood that transition would require time to adjust to new culture; initiated discussions related to employment with private radiology group after one year.

**Reaching their own conclusion:** As contract ended, group agreed that employment would ultimately be beneficial; currently in year two of employment with both parties very satisfied with the arrangement.

**Why Employment Worked at Beaumont Health System**

- **Time:** Gave the private group time to adjust to acquisition
- **Autonomy:** Offers its radiologists substantial autonomy
- **Culture:** Prioritizes engagement, welcoming culture

“"It was their show to run. Our strategy was based on not forcing anyone to become employed, but rather having an open discussion and welcoming them into our culture should they choose to join.”

*System Director of Radiology*

**Case in Brief: Beaumont Health**

- Eight-hospital health system based in Royal Oak, Michigan
- System acquired new hospital but allowed its radiology group to continue practicing independently, rather than forcing it to join system’s employed group with other radiologists
- After negotiations, group ultimately decided employed model provided numerous benefits, became part of system group

Source: Beaumont Health System, Royal Oak, MI; Imaging Performance Partnership interviews and analysis.
Beyond Alignment Models
Executing on Care Partner Priorities
True alignment goes beyond the alignment model selected.

Alignment doesn’t end once you’ve implemented a formal model. In fact, that’s when the real work begins. Close alignment is not contingent on having a formal model; the alignment models presented in this study simply create an infrastructure to foster productive collaboration. The case studies in this section illustrate how radiologists have successfully responded to the needs of their care partners and, in doing so, positioned themselves as a valued partner in health care delivery.

“We have to realize we have multiple customers…and it’s not just a matter of saying, ‘What do you want?’ It’s a matter of being able to surmise what they want before they tell you.”

Dr. Edward Rittweger
President, Navesink Radiology

In a new health care delivery system, we have new responsibilities in radiology.

Traditionally, radiologists have been responsible for reading and reporting exams. That used to be it. Then, as a field, radiologists recognized the importance of serving their stakeholders by improving clinical service. Now, it isn’t just about clinical excellence and referring physician satisfaction. Radiologists need to go one step further and position themselves as trusted partners who are simply too valuable to lose.

A Rapid Evolution of Radiologist Responsibilities

Demonstrate Value

Goal: Integrated Partner
- Become a willing partner with aligned goals
- Predict and prepare to meet customers’ needs

Improve Service

Goal: Efficiency, Service
- Low turnaround times
- 24/7 subspecialist reads
- High patient satisfaction
- High referrer satisfaction

Goal: Clinical Accuracy
- Robust peer review
- Protocol standardization
- Care committees
- Dose optimization

Goal: Read and Report
- Low turnaround times
- 24/7 subspecialist reads
- High patient satisfaction
- High referrer satisfaction

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Alignment means **strategy that anticipates** your partners’ next moves.

Aligning isn’t just about serving radiologists’ own goals anymore. In this health care economy, leaders need to structure alignment such that radiologists can anticipate their health systems’ needs and proactively serve their care partners. Radiologists should commit to adopting health system goals, identifying specific strategic initiatives, and figuring out how radiology can contribute. It certainly isn’t feasible to do everything, but radiologists can prioritize by evaluating the potential impact of their contributions.

What will health care look like in five years?  
What will hospital CEOs need to compete?  
How can radiologists deliver on those goals?

<table>
<thead>
<tr>
<th>Health System Strategic Priorities</th>
<th>Opportunity for Radiology to Contribute</th>
<th>Relative Impact</th>
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<tr>
<td>Cost control</td>
<td>Reduce inappropriate utilization</td>
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<tr>
<td>Volume growth</td>
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<tr>
<td>Primary care expansion</td>
<td>Educate new referrers on ordering</td>
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<td>Physician marketing</td>
<td>Collaborate on physician outreach</td>
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<tr>
<td>Identify new growth areas</td>
<td>Develop diagnostic screening programs</td>
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<tr>
<td>Population health management</td>
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<tr>
<td>Patient care coordination</td>
<td>Take over patient care management from PCPs</td>
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<tr>
<td>Patient leakage prevention</td>
<td>Navigate patients to in-network downstream care</td>
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<tr>
<td>Patient risk stratification</td>
<td>Analyze radiology billing data</td>
<td>↑↑</td>
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<tr>
<td>Emphasis on prevention</td>
<td>Develop diagnostic screening programs</td>
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Distance may not make the heart grow fonder.

Part of the reason it is important to proactively reach out and ask how to help is that radiologists have historically done the opposite. The diagnostic nature of the specialty, as well as advances in remote reading technology, have allowed radiologists to step out of the forefront of health care and perform what is often viewed as a support role—often from a remote location. When it comes to serving our partners, radiologists have built themselves an uphill battle.

“We are in a service field…we are incredibly important but we’ve let ourselves become invisible.”

*Dr. C. Daniel Johnson*  
*Chair, Department of Radiology, Mayo Clinic*
Case #1: Mayo Clinic

A mobile image viewer can meet referrer needs without burdening radiologists.

Mayo Clinic set out to close that distance between radiologists and their care partners. Like many organizations, Mayo conducts satisfaction surveys of referring physicians. Radiology leaders noticed that many referring physicians listed off-hours access to subspecialty radiologists as an improvement they’d like to see. To foster this coordination in a setting without ample subspecialists for call coverage, Mayo launched a study to investigate the efficacy and feasibility of a mobile image viewer program—ResolutionMD.

The study revealed significant reductions in image access time when using the tablet-based software when compared to both Mayo’s in-house viewing system and a commercial desktop PACS viewer. Beyond access time, the referring physicians were generally thrilled about the features of the software—some even used it to share results with patients.

In this case, Mayo Clinic fully acknowledged that technology contributed to the distancing of radiologists and referring physicians. So, they identified a piece of technology that would compensate, and actually strengthen that relationship—just as their care partners requested. The initiative even benefited radiologists too, as they could provide subspecialist coverage without having to be on-site.

Technology in Brief: ResolutionMD

- Allows radiologist and referrer to securely view and annotate images, discuss findings and follow-up care in real time from any location
- FDA-cleared program can be installed on smartphone or tablet for mobile viewing and discussing; software can be integrated with EMR and PACS

Study in Brief: Medicine on the Go

- 17 clinicians provided data on 552 image-viewing events across three products
- Concluded that ResolutionMD provides high clinician satisfaction, significantly faster image access, comparable diagnostic confidence and ease of use compared with standard of care viewers

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85%

Percentage of participants expressing a moderate to high desire for permanent implementation of ResolutionMD

Radiology should aim to serve diverse stakeholders with diverse needs.

Believing that radiologists have value as clinicians, leaders at one radiology group, Radiology & Imaging, Inc. (R&I), started a care management program for breast cancer patients. Called the Priority Breast Care Program, it enrolls primary care physicians and breast surgeons, and assumes responsibility for patients during the diagnostic process.

Thus, the program supports the goals of those care providers—it takes a burden off primary care physicians while ensuring great patient care, and it acts as a referral generator to the health system’s breast surgeons. In fact, the program has worked so well that they are now including oncologists and hematologists and expanding to include lung cancer screening patients. The group’s chief mammographer acts as the program director and receives compensation for administrative time from the health system.

The program strategically serves the health system as well, as it encourages patients to seek care within the system. Patients benefit from knowing that R&I radiologists are experts in diagnostic imaging who can answer their questions at any time. Radiologists here truly demonstrate value to their peer physicians, their patients, and their health system partner.

“Taking on the role of care coordinator helps us build stronger relationships with referrers, specialists, and our health system partner.”

Dr. Lawrence Goodman
President, Radiology & Imaging

Case in Brief: Radiology & Imaging, Inc.

• 30-physician independent radiology group based in Springfield, Massachusetts
• Developed breast cancer patient program whereby radiologists assume responsibility for care management
• Program supports PCPs and drives in-network referrals
**Patient navigators** can be well worth the investment to demonstrate value.

Rogen Radiology Partners also recognized that they could add value by keeping patients in-network. Rogen runs a joint ventured imaging center with one of its health system partners, and noticed that only half of patients who received positive diagnostic screening results for breast cancer went to their system partner for downstream care.

"As we move into the population health space, we’re trying to help our system partners in any way we can. Coordinating care can keep patients in the right network, make sure they’re getting great care, and show our hospitals that we’re serious about being their partner. It really does help achieve both of our goals.”

Chief Financial Officer, Rogen Radiology

Recognizing that reducing patient leakage would benefit both partners, Rogen instated a trial nurse navigator program. At the end of the trial period, Rogen leaders recalculated patient leakage and found that 89% of their breast cancer patients sought care in their network. This result clearly benefits all stakeholders involved.

**Case in Brief: Rogen Radiology Partners**

- Large radiology group hired breast cancer nurse navigators to coordinate care from JV to health system partner
- Initiative successfully reduced patient leakage, improved patient care, secured sufficient revenue for both parties to garner positive return on investment, and strengthened hospital-radiologist alignment
Case #4: Hader Radiology Associates and Weeks Radiology (pseudonyms)

Can radiologists become the new utilization managers?

One idea for radiologists to demonstrate value is for them to manage appropriate utilization; one imaging leader even called this concept “the holy grail.” A typical scenario for advanced outpatient imaging currently involves a necessary pre-authorization step with a radiology benefits manager (RBM) to ensure appropriate utilization.

The Current Model for Advanced Exams

- Referrer
- Referring office staff
- RBM (hired by payer)
- Technologist
- Radiologist

An alternative would be for payers (including self-insured employers and ACOs) to authorize radiologists to manage utilization. After all, they are the experts when it comes to appropriate imaging, and they could be more efficient and effective when it comes to understanding nuances in various ordering situations.

A New Model for Advanced Exams

- Referrer
- Radiologist (approved by payer)
- Technologist

Some radiology groups are already assuming risk and negotiating with payers.

Here are two examples of radiology groups making progress on performing the tasks traditionally outsourced to RBMs.

**Example #1: Hader Radiology Associates**
- Actively negotiating with large regional health plan to manage utilization
- Plan has no RBM, does not want to risk existing relationship with physicians by hiring external RBM
- Radiologists would provide clinically nuanced consultations for potentially incorrect orders, track outcomes data
- Initiative has support from all parties; hospital eager to reduce cost, referring physicians more amenable to having peer physicians as ordering gatekeeper

**Example #2: Weeks Radiology**
- Radiologists review CT, MRI, and mammography orders for all outpatient exams; call referrers to discuss potentially inappropriate orders
- Group accepts shared financial risk with local accountable care consortium of referring physicians
- Local payer branch very interested in group as RBM; ultimately overruled by headquarters due to existing national RBM contract
- Currently tracking data to identify group’s impact on ordering and quantify value as utilization managers

One important factor to consider is the 2014 Protecting Access to Medicare Act, which mandated the consultation of an appropriate use criteria program for providers ordering advanced imaging exams. Beginning in 2017, reimbursement for these exams will become contingent on providers’ compliance. Because of this law, we are likely to see clinical decision support supplant preauthorization as the primary means of controlling imaging utilization—particularly in the ACO setting.

However, beginning in 2020, physicians identified as noncompliant “outliers” will have to obtain preauthorization for any advanced imaging exam. This stipulation suggests that, even though the onus for appropriateness may be shifting to the referrer, preauthorization won’t disappear in the near future—indicating a clear opportunity for radiologists to add value.
Case #5: Greensboro Radiology and Cornerstone Health Care

Greensboro Radiology won an ACO contract for their willingness to partner.

Regardless of whether or not radiologists become official utilization gatekeepers, they will always have a role to play in promoting appropriate ordering. This final case study profiles Cornerstone Health Care, a physician-owned ACO, whose leaders recently put out an RFP with specific services they were seeking in a radiology partner. Four groups responded to the RFP—including their current group and a national group—but Greensboro Radiology stood out for their interest in becoming a true partner, rather than just a vendor. In less than a year of partnership, Cornerstone and Greensboro had collaborated on utilization management protocols and reduced unnecessary advanced imaging utilization by 9%.

Cornerstone Health Care RFP Process

1. Releasing an RFP
   - Expiration of contract led Cornerstone to seek group best aligned with its goals
   - Wanted partner willing to help develop clinical protocols, decrease duplicative imaging, provide seamless access to subspecialists, contribute IT

2. Identifying a Partner
   - RFP process and value stream identification took place over several months
   - Greensboro stood out as a willing partner, not just vendor

3. Making a Difference
   - Cornerstone shares data, payer contracts with Greensboro for clinical protocol development
   - Radiologists evaluated on service, participation metrics
   - Currently working on risk-based contract, decision support tool

Greensboro Radiology

9% Reduction in unnecessary advanced imaging utilization

Reduced utilization does mean reduced revenue in fee-for-service, but the fact that Greensboro was willing to work as a partner accounted for that other 91% in growth. Furthermore, these partners are currently negotiating a shared savings contract. They are also working to implement a clinical decision support platform for imaging at Cornerstone.

As health care providers look for radiology partners who will contribute the most value, more and more health care providers are putting out RFPs for radiology services. Furthermore, the transition to risk-based payment means that radiology’s ability and willingness to ally with an ACO will likely play a significant role in institutional sustainability. Below are only a few of many examples of how radiology groups are aligning with ACO priorities.

Superior Quality, Service
- Demonstrate low turnaround times
- Strengthen clinician review processes
- Enhance report clarity, standardization
- Provide seamless access to subspecialists
- Expand referrer and patient access

Driving Down Costs
- Invest in appropriate use protocols
- Offer appropriateness education
- Adopt ownership stake in MPFS outpatient centers
- Enhance IT capabilities, PACS network access
- Tighten preauthorization, secure patient collections

Willingness to Partner
- Understand the ACO’s strategy, objectives
- Demonstrate ability to collaborate
- Participate on planning committees
- Report on care quality and service metrics
- Refrain from working with direct competitors

Source: Cornerstone Health Care, High Point, NC; Greensboro Radiology, Greensboro, NC; Imaging Performance Partnership interviews and analysis.
Additional Resources
Tools to Evaluate and Implement Alignment Strategy

- Radiology Alignment Cheat Sheets
- Change Management Crosswalk
**Radiology Alignment Cheat Sheet**

Use this cheat sheet to quickly evaluate the formal alignment models profiled in this publication. The information below can also be used to educate colleagues and to guide conversations between health system and radiology group leaders.

### Incentive-Based PSAs

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<tr>
<th>Description</th>
<th>Strategic Advantages</th>
<th>Strategic Limitations</th>
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| A professional services agreement (PSA) between an independent practice and a health system that includes financial bonuses (or penalties) for radiologist performance on predefined quality and service metrics | • Radiologists maintain high degree of autonomy  
• May lead to increase in volume for both practice and system (given increased service)  
• Hardwires execution on quality and service metrics important for success under health care reform  
• Allows for diverse, customizable range of collaboration across multiple ACO entities  
• Can build off of existing PSA contracts | • Many performance-based PSAs fail to include clinical quality or appropriateness metrics  
• Difficult to earn compensation for non-measurable initiatives designed to help department increase quality and cut costs, such as leadership on LEAN or Six Sigma projects  
• Generally limited to hospital-based specialists or services performed in hospital-owned facilities |

**Prevalence:** Moderate

### Exclusive Provider Contracts

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<th>Strategic Limitations</th>
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| An agreement that prohibits a health system and/or a radiology group from formally contracting with a different radiology partner | • Secures commitment of radiology partner  
• Demonstrates willingness to work toward common goals  
• For radiologists, ensures constant stream of volumes | • Depending on contract, can limit opportunities for volume growth from new sources  
• Historic relationship may make partners averse to changing status quo  
• May limit hospital choice in selecting best radiology providers |

**Prevalence:** High

### Joint Ventures

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<th>Strategic Limitations</th>
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| An outpatient imaging center developed as a separate entity with shared assets, in which all parties (usually a hospital/health system and a radiology group) contribute equity; equity need not be equal | • Provides radiologists additional volumes and revenue, opportunity to manage operations, chance to strengthen alignment with health system  
• Offers health systems lower-priced sites of care to capture price sensitive patient population  
• Means of bringing outpatient facilities into referral networks of multiple ACO entities | • Significant investment; partners may earn less revenue than if center were wholly-owned  
• Risk of entering saturated market  
• Depending on ownership and management structures, may create inefficiencies through joint decision making  
• Poor performance could lead to tension  
• Future price equalization would reduce urgency for hospitals to open lower-cost site of care |

**Prevalence:** Moderate

### Management Services Agreements

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<th>Description</th>
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| A contract between a hospital and a radiology group whereby radiologists agree to assume management responsibilities in a radiology department or outpatient center in exchange for a flat fee and/or incentive-based compensation | • Aligns radiologists with health system’s strategic priorities  
• Incorporates radiologists’ clinical expertise in imaging operations  
• Diversifies radiologist revenue in era of declining professional reimbursement | • Selection of projects and metrics can create conflict between partners  
• Requires radiologist buy-in and hospital leadership willingness to cede full operational control |

**Prevalence:** Moderate

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*Source: Imaging Performance Partnership interviews and analysis.*
### Shared Management Agreements

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<th>Description</th>
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<th>Strategic Limitations</th>
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| A collaborative agreement in which a hospital/health system and radiology group create a shared risk pool, whereby capital is rewarded to both parties after mutually set performance targets are achieved | • Economic integration strengthens alignment  
• Opportunity for incentives motivates partners to collaboratively work toward goals and hold each other accountable | • Risk of not meeting goals and losing valuable resources  
• Requires constant communication to assess progress  
• Relies on positive working relationship to collaborate and avoid blame for missed targets |

**Prevalence:** Low

### Co-management Organizations

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<th>Description</th>
<th>Strategic Advantages</th>
<th>Strategic Limitations</th>
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| An organization either created or used to compensate a collective body of radiologists for management duties in a hospital imaging department and/or outpatient center | • Allows radiologists to leverage management skills gained from running outpatient centers  
• Provides alternate source of radiologist revenue  
• Can alleviate turf conflicts among specialists  
• Demonstrates practice dedication to health system and improves relationship stability  
• Facilitates, incent formal collaboration around clinical and operational processes | • Significant time, resource investment  
• Cultures of health system and radiology group may conflict in intermediary organization  
• Must simultaneously manage operations and execute on at-risk quality metrics  
• Health system may be wary to partner with a radiology practice that also competes with them or serves other health systems |

**Prevalence:** Low

### Clinical Integration Networks

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<th>Description</th>
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<th>Strategic Limitations</th>
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| A legal arrangement allowing physicians and hospital leaders to collaborate on improving quality and controlling costs while remaining separate entities; these networks often invest in IT infrastructure, create committees for various aspects of performance improvement, and negotiate with payers to receive shared savings or other performance-based incentives | • Commercial payer contracts compensate radiologists for performance improvement  
• More closely aligns radiology practice goals with goals of health systems in preparation for reform  
• Opportunity for radiologists to demonstrate value in risk-based payment environment | • Potentially high investment to build infrastructure for data collection, tracking  
• Requires ongoing radiologist time investment in committees to plan initiatives and negotiate with payers  
• Possible annual requirement for participating practices to pay dues to CI network |

**Prevalence:** Moderate

### Health System Employment

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<th>Description</th>
<th>Strategic Advantages</th>
<th>Strategic Limitations</th>
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| Hospital/health system employment of radiologists, either directly through an affiliated medical group or indirectly through a designated foundation | • Job (and compensation) security for radiologists  
• Organic integration with other specialties leads to better care  
• Better coordination with department leaders  
• Integrated IT interface offers better collaboration, data analytics  
• May eliminate outpatient competition with radiology partner | • Loss of group autonomy may hinder efficiency and innovation  
• Potential for cultural conflict  
• Radiologists would not increase referrals to health system  
• Radiologist salary and benefits often prohibitively expensive  
• Risk of decreased productivity on flat salary |

**Prevalence:** Moderate

Source: Imaging Performance Partnership interviews and analysis.
Five Steps to Change Management in Radiology

One common theme across this publication is the necessity of effective change management. Implementing any formal alignment model is a significant undertaking and requires persistent but respectful leadership. Change management skills can empower imaging leaders to achieve success in these efforts. Our research team adapted John Kotter’s established principles of change management specifically for radiology professionals, and identified resources we’ve published to support each one.

### The Imaging Leader’s Change Management Crosswalk

<table>
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<th>Change Management Principles</th>
<th>Imaging Performance Partnership Resources</th>
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<tr>
<td>Establish a sense of urgency to secure buy-in</td>
<td>- Presentation: An Imaging Leader’s Call to Action</td>
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</table>
| Form a change team and equip leaders with necessary skills | - Case Study: Leading through Alignment  
- Tactic: Supporting Leadership and Management Skill Development |
| Develop and communicate your change vision | - Tool: Dynamic Resource Crosswalk  
- Tool: Imaging Strategic Plan Template |
| Remove obstacles and generate active support | - Tactic: Identifying Radiologist Motivators  
- Tactic: Compensating Radiologists for Comprehensive Service |
| Ingrain change into organizational culture | - Tactic: Hiring and Onboarding for Leadership and Cultural Fit  
- Tactic: Fostering Accountability for Radiologist Engagement |

### Access the Crosswalk

www.advisory.com/ipp

Source: Imaging Performance Partnership interviews and analysis.