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KNOWLEDGE EXCHANGE

Keeping Care Local: Radiology as a Catalyst for Rural Transformation

Radiology driving access, workforce and innovation

Sponsored by: the radiology group

Introduction

Keeping Care Local: Radiology as a Catalyst for Rural Transformation

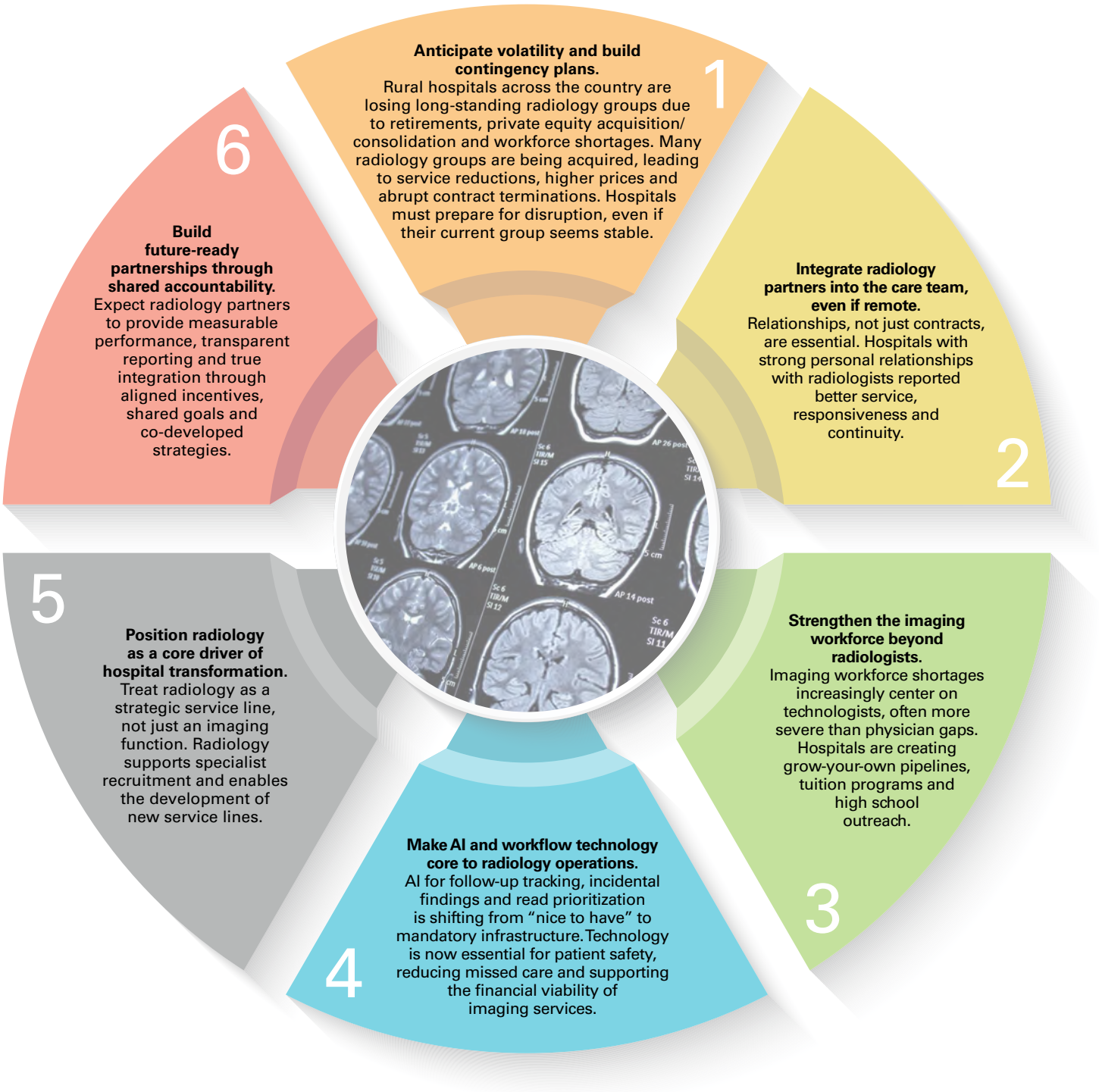
Radiology driving access, workforce and innovation

Radiology is central to accurate diagnosis, treatment monitoring and minimally invasive procedures. Yet rural communities face a growing crisis in access, driven by service reductions, workforce attrition and limited availability of advanced imaging. A persistent challenge is the shortfall in screening services for diseases such as breast and lung cancers — conditions where early detection dramatically improves outcomes. Opportunities exist to strengthen rural care by closing imaging gaps, reducing travel burdens and expanding service offerings through advanced diagnostics.

This Knowledge Exchange e-book explores how rural health care leaders optimize existing equipment, build workforce pipelines, strengthen partnerships with radiology groups and harness innovation to expand access, reinforce local systems and improve patient outcomes.

Action Items

6 ways hospital leaders can strengthen rural radiology through partnership and innovation



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MODERATOR SUZANNA HOPPSZALLERN *(American Hospital Association):* **How is your hospital responding to the increasing demand for imaging services and the rural radiologist shortage? What strategies are you using to recruit, retain and supplement radiology professionals to ensure quality, patient safety and overall hospital viability?**

SHAWN TESTER *(Northeastern Vermont Regional Hospital)*: We're a very rural hospital in Vermont, and for nearly 50 years, we relied on a small radiology group that consistently met our needs. Recently, the principal told me they're retiring and shutting down at the end of this year, which leaves us without a radiology solution on January 1, 2027. This is a real crisis in Vermont and the region. The group has already withdrawn from another hospital. A major regional system can't meet its radiology service needs. Another critical access hospital lost its radiologist last summer and has been working with a large national contractor, but its providers are dissatisfied with the level of service and haven't been able to find an alternative.

LANDON DYBDAL *(Lake Health District):* We partner with a radiology group based about three hours away, and they've been a strong partner for decades, providing excellent reads and sending an interventional radiologist (IR) every other week. The group has grown significantly over the past decade and now serves much of Eastern Oregon. They've been a reliable regional provider for us, though we're uncertain what will happen when our long-term IR retires.

JOE THEINE *(Southwest Health System):* We're geographically isolated — you have to cross one or more mountain passes just to reach the interstate. For decades, we've had a strong relationship with a radiology group about an hour away. We're fortunate to have an on-site radiologist Monday through Friday, which allows us to perform a good range of procedures, with teleradiology support when they're not here. The group has several pending retirements. Replacing an on-site radiologist would be extremely difficult.

We're also concerned about the future of our technical workforce. You can't deliver care, on-site or remote, without radiology technologists, and recruiting and retaining them is becoming just as challenging as securing radiologists.

DAWN HODGES *(Campbell County Health):* We're in the far northeast corner of the state — about an hour from South Dakota and two hours from Montana. It's a small community of roughly 36,000 people, heavily centered around coal and natural gas, with a very young population. We went through a similar transition: Our long-time partner radiology group retired, and we eventually found a new group that's been excellent.

Recruiting support staff here is incredibly challenging; it took us nearly three years to hire an echo technician. We also have three independent imaging centers in town competing for the same talent. We invest in training and onboarding, only to have staff poached by other centers.

To help stabilize our pipeline, we launched the Journey Program. We go into local high schools to recruit students interested in radiology and nursing, and we pay their college tuition in exchange for a three-year commitment after graduation. It's one of the few strategies that helps us build a more reliable workforce.

SHELLY GOMPF *(Astera Health):* Our radiology partnership began about six years ago with a regional group, about 30 radiologists covering 11 sites 24/7 across Minnesota. Earlier this year, our lead partner

DAWN HODGES | CAMPBELL COUNTY HEALTH

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announced her retirement; thankfully, she had a solid succession plan in place.

Our biggest challenge now is turnaround time — reads can be two-three weeks out for routine exams. We've been working hard to educate our providers on what truly requires a STAT read, where scope-of-practice lines are, and when to call the radiologist directly. They're on-site two days per week to perform procedures, with the rest covered via teleradiology.

They're testing out AI-supported technology to identify exams with pathology to improve turnaround time on exams that would require further workup, but the bigger hurdle is getting our long-tenured providers to trust it. Many have been practicing for 30 years. There's understandable skepticism around new technology, so we're spending time helping them understand the benefits and get comfortable with the change. I often remind them, "When you started your practice, did you ever imagine we'd be where we are today?" It's all about helping them adapt to what's coming.

MARC AUGSBURGER *(Edgerton Hospital and Health Services):* Our long-standing radiology group was acquired by a national, private-equity–backed radiology management company, and since then, we've faced major delays and quality concerns due to their retention issues with radiologists. We went from weekly on-site coverage to sometimes having no radiologist for weeks at a time. Our patients weren't happy, we weren't happy, and we pushed hard for improvements. Turnaround times are better now, but still not where they need to be.

CARRIE LUTZ *(Holton Community Hospital):* We've invested deeply in our relationship with our radiology and nuclear medicine group, supporting them through remodels, retirements and technology upgrades. Because of that partnership, they still come on-site weekly, participate in medical staff meetings and stay closely involved in quality issues. We know this isn't the case everywhere. They've stopped traveling to two other nearby critical access hospitals.

On the credentialing side, we've seen a significant increase in night-shift reads from newly recruited radiologists to the group. Due to this we have enhanced our credentialing process to closely monitor all initial and reappointed applications.

Staffing has also been a challenge, but we've worked hard to bring students into our facility. Even as a small critical access hospital, we've grown our imaging services, and once we demonstrated that students would get strong, diverse experience, not just volume, they approved the radiology department rotation. Now we have a steady flow of students coming through.

ANAND LALAJI *(The Radiology Group, LLC):* The traditional radiology model is collapsing. Private-equity consolidation, shrinking radiologist supply and rising imaging volume are leaving rural hospitals without coverage. We've stayed independent because we believe quality and community care suffer when decisions are driven by ROI instead of patients.

Imaging volume is rising exponentially while radiologist staffing continues to decline. Training more residents is difficult because academic centers don't have enough radiologists to teach them. AI will eventually help fill the gap, but it's still decades away from replacing radiologists.

SHELLY GOMPF | ASTERA HEALTH

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Teleradiology has become the default, but radiology used to be a catalyst for hospital growth — bringing in specialists, technology and new services. That value has been lost in many places.

THEINE: We're seeing behaviors that suggest some radiology groups may be positioning themselves for a private-equity acquisition — structuring assets and contracts to make a sale easier. Even groups that remain independent seem to be preparing for that path.

Radiology is essential to our hospital; there are admissions we couldn't keep without on-site radiologists available to perform some procedures. Looking ahead, if radiologists are increasingly remote, who will handle those basic procedures that keep patients local?

LALAJI: We've been guiding hospitals to reduce reliance on on-site interventional radiologists by shifting minor procedures to mid-levels where state regulations allow — like GI studies, CT colonography, arthrograms, and even paracentesis or thoracentesis with appropriate supervision. For procedures that still require a radiologist, like breast biopsies, they can come in periodically and complete a block of cases.

There are many hybrid models, and state rules often allow more flexibility than people realize. But without a forward-thinking radiology service, even the most expensive imaging equipment goes underutilized — it's like having a great stereo system with bad speakers.

MODERATOR: When you're structuring this partnership and thinking long-term, what do you need from your radiology partner? What kind of accountability, performance measures or skin in the game would you expect that support a stronger, more integrated relationship?

TESTER: We need to feel like the radiology group is truly integrated into our system. Our clinicians want to know that the radiologists are part of the team, not a distant, faceless group you can't talk to. With today's technology, it's possible to build virtual models that feel connected and seamless.

GOMPF: For us, it comes down to accountability. We track the radiologist's turnaround time on reports. When a metric triggers outside the established goal, there has to be a discussion and a plan. Radiology started reporting to me about three months ago, and in one of my first committee meetings, their report showed nine consecutive quarters in the red while everything else was green. I asked, "What's the action plan for this?"

The issue was lagging reads. I understand the realities of the workforce, but our providers still expect a plan. When you're backed up, what are the solutions? What are the low- and high-effort options to keep things moving? Doing nothing isn't an option.

The committee discussed the issues at hand with the increase in radiology exams being ordered and not enough radiologists available to keep up with the demand. The radiologist group has prioritized stat exams and higher-level imaging to be read before general X-ray. They are researching different AI technologies to assist in making sure exams with pathology are moved to the top of their reading lists. Accountability and transparency are important aspects of building a strong working relationship.

THEINE: We have a medical director from the radiology group. We mutually agree on which radiologist from the group will serve in this role. This helps ensure that both parties identify a physician who works well within the group and with the hospital.

CARRIE LUTZ | HOLTON COMMUNITY HOSPITAL

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We needed a relationship where we knew exactly who our point of contact is. We are investing in the medical director relationship.

LALAJI: The external pressure is real. If hospitals want a stable, forward-leaning radiology service, they can't rely on the old teleradiology model. Radiologists, whether remote or on-site, need to be part of the clinical care team again and have real buy-in into the hospital's success.

Across the country, we're seeing groups disengaged from what's happening on the ground. But when radiologists have skin in the game, they help solve tech shortages, rethink workflows and reinvest radiology revenue into technology that strengthens the entire hospital. Radiology can drive growth, not just read exams.

MODERATOR: What technologies and strategies are you using to improve follow-up, analyze denials and enhance the overall value and accessibility of imaging services?

THEINE: Patient access is a real challenge. The nearest hospital is about 45 minutes away, and patients will travel to the first available provider for imaging or other shoppable services. That means we can end up with a backlog for follow-up care. Even when we know patients need to be seen, the issue becomes finding where to fit them in, whether at our facility or elsewhere.

Over the past year and a half, our radiology department has focused heavily on maximizing capacity. We used to schedule MRIs in fixed slots — an MRI was an MRI — but we've moved away from that, and now we can schedule several more each day. X-ray has shifted to a 24-hour walk-in model; as long as you have an order, you can come in anytime and usually be in and out within 30 minutes. These changes have significantly improved access, and we've seen the growth .

ANGELA ADAMS *(Inflo Health):* The quality impact is significant — some health systems miss 30–50% of follow-ups because they can't keep up with volume. Our AI engine reviews each report, flags direct and incidental findings and generates follow-up recommendations within a unified workflow. As follow-up volume increases, it strengthens the radiology department by supporting additional staff, expanding rooms and recapturing the follow-ups currently lost. It becomes a self-sustaining cycle, building the financial strength needed to expand capacity and deliver greater value to the community.

LALAJI: This is the kind of follow-up technology hospitals should expect their radiology partners to bring — because it's the future. We use an AI tool that analyzes hand and foot X-rays to help flag potential cortical fractures — one of the more commonly missed findings in musculoskeletal imaging. AI that detects fractures or flags findings is valuable for clinical quality, but the real question is how radiology helps the hospital expand capacity and manage bandwidth across modalities. Innovation has to come from the radiology service line, and that includes technology that drives follow-ups, closes gaps and supports growth.

AUGSBURGER: We're seeing how much demand there is for timely access. We're an 18-bed critical access hospital surrounded by major university systems, yet patients are waiting four to six months for an MRI or stress test. We're adding services, and patients are now driving 45 minutes to us because they can get in. We've added PET-CT, which very few small hospitals in our area offer. We've expanded MRI availability and are bringing additional cardiology imaging on board. The key, of course, is getting reads done quickly. And the other major issue is that Medicare Advantage plans are denying everything.

SHAWN TESTER | NORTHEASTERN VERMONT REGIONAL HOSPITAL

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LALAJI: We work with hospitals to improve imaging-related denials. Our team rereads denied studies, identifies incidental findings and assists with resubmissions so that important value isn't lost.

MODERATOR: Looking ahead, what opportunities do you see for radiology innovations to transform rural health care delivery and expand local service lines?

THEINE: Clinically integrated networks (CIN) are gaining momentum, and rural health transformation funds could help strengthen or reinvest in them. In Colorado, the Western Health Alliance has operated a CIN and an Accountable Care Organization (ACO) for years, even partnering with self-insured employers in the Aspen and Glenwood areas. They recently announced a joint venture with the Eastern Plains Health Consortium to expand this into a statewide, rural-focused CIN.

As we look at improving quality, the question becomes whether partners are willing to take on risk alongside a CIN. For example, if quality measures involve breast cancer screening, detection or other imaging-based metrics, are radiologists prepared to share financial risk with the hospitals involved? Because the future of health care requires delivering more value for the same dollar.

LALAJI: Using quality measures with financial consequences is something we've done and something many groups have used historically. If turnaround times slip or quality metrics aren't met, there's a financial impact. The challenge today is the radiologist shortage — there simply aren't enough radiologists — so groups can repeatedly miss those targets and then leave for higher-paying opportunities. That's the risk in this environment.

Still, it's an important conversation to have with any radiology group. It can't just be "we read the exams." There should be shared incentives, so both sides succeed.

THEINE: In our current, primarily fee-for-service environment for radiology services, the group handles its own professional billing. Our internal capabilities for radiology billing are limited. We prefer to have some quality-based incentives tied to factors radiologists can control. Whether through a CIN or in a current fee-for-service model, there are areas where a radiology group can be accountable for helping other members of the medical staff and hospital deliver high-quality, efficient care.

ANAND LALAJI | THE RADIOLOGY GROUP, LLC

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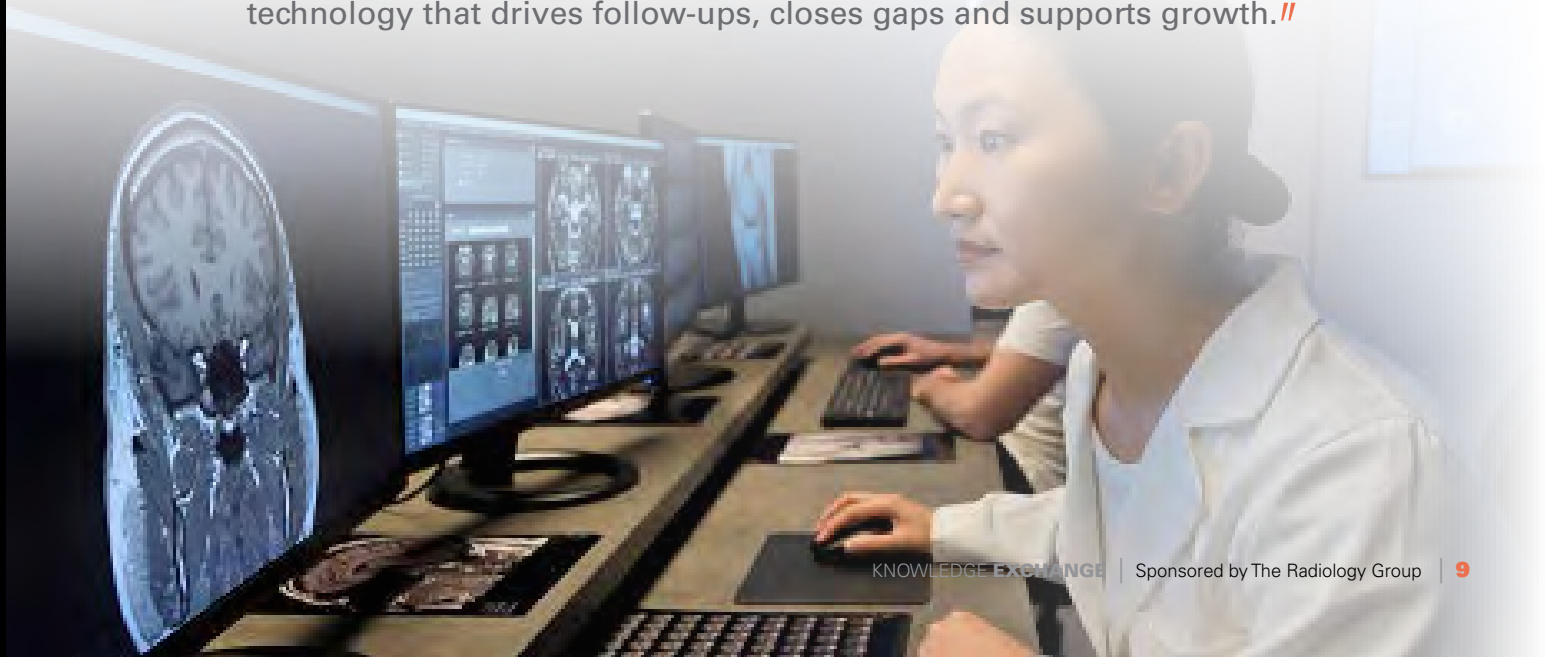

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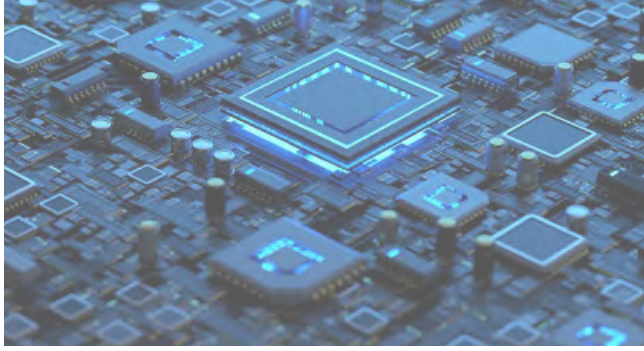
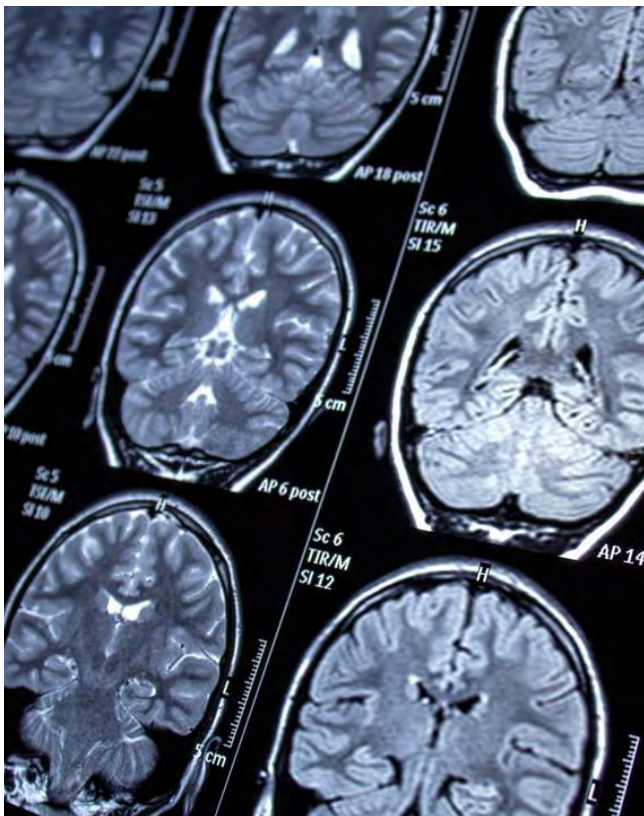


the radiology group

the radiology group difference

Expert radiology
that keeps care rural.

Access to expert radiology shouldn't depend on location. That's why we partner with rural hospitals and clinics to deliver technology-driven imaging and fast, accurate reads. Our TeleHealth platform connects patients to premium care close to home, while TRG-assist® gives radiologists the support they need to work efficiently and confidently.



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