



Closing the Loop.

What Radiology Leaders Told Us About Follow-Up Care — and a Framework for Fixing It

FINDINGS FROM A VIRTUAL FOCUS GROUP OF RADIOLOGY AND
IMAGING LEADERS · JULY 2026

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Introduction

In July 2026, ten radiology and imaging services leaders — representing academic systems, multi-state health systems, and community hospitals across eight states — participated in a 90-minute virtual focus group on radiology follow-up management. Participants ranged from directors of imaging at community hospitals to system vice presidents of radiology overseeing multi-state networks. All quotes below are presented anonymously and lightly edited for readability.

A pre-session survey foreshadowed the discussion: only one of ten organizations could reliably track its follow-up closure rate, half agreed there is no clear owner of the follow-up problem, and eight of ten cited budget as the top barrier to addressing it. The conversation that followed explained why those three findings are not separate problems — they are the same problem.

PRE-SESSION SURVEY

1 of 10

can reliably track follow-up closure rate

1 in 2

say no clear owner exists

8 of 10

cite budget as the top barrier

What We Heard

Theme 1: Nobody owns the follow-up

The most consistent thread in the discussion was the absence of clear ownership. When a radiologist flags an actionable finding, responsibility for what happens next is contested — or simply unassigned. Participants described organizations where accountability diffuses across imaging, the ordering provider, and the patient, with no systematic answer.

“There’s something abnormal — whose problem is it? Is it imaging’s problem to follow up? Is it the ordering provider’s problem? Does it go to the patient to take responsibility in their own health care? No one has a good answer or a solution. We’re all trying to invent the wheel as it’s rolling to keep it moving and keep patients safe.”

— Focus group participant

“There just doesn’t seem to be a systematic approach to how we’re answering this overall. Everybody’s sort of doing their own thing to some degree.” — Focus group participant

Notably, the organizations reporting the strongest results were those that had made an explicit governance decision — designating radiology as the owner of the process from finding to closure. Where that decision hadn’t been made, follow-up work defaulted to whoever noticed it.

Theme 2: Maturity ends at breast and lung

Nearly every participant described well-established breast and lung programs — often five or more years old, with dedicated navigators and defined pathways. But that maturity stops abruptly at the boundary of those two disease states. Hepatobiliary, renal, vascular, adrenal, and other incidental findings are managed through ad hoc processes, “collateral duty” assignments, or not at all — often with a different vendor or tool for each finding type, creating a patchwork of siloed programs.

“We still have some silos going on. I do think that trying to get to a place where we use one vendor and have one process is probably going to help us quite a bit.” — Focus group participant

“There’s a lot of loose areas in that process for everything outside of breast and lung. A lot of our process is super manual, and there’s almost next to no follow-up. It’s just — hey, we’ve recognized this is abnormal in the study, good luck. And that doesn’t really benefit the patient or imaging at all.” — Focus group participant

Participants were clear that demand for expansion exists — specialists actively ask why other finding types don’t get the same treatment. What’s missing is not clinical will but a scalable model.

Theme 3: You can't manage — or fund — what you can't measure

Only one participant reported reliable visibility into follow-up closure rates, and the discussion revealed why: most leaders don't know where the data would come from, don't trust the data they have, or are still too early in tool adoption to produce a defensible number. This is more than a reporting inconvenience. Participants connected the measurement gap directly to the funding gap — without a closure-rate baseline, there is no quantified problem, and without a quantified problem, there is no business case.

"No way to measure it. And I just didn't know where to go." — Focus group participant

"I do have those dashboards, but I don't know if I trust everything on it, because I don't know if it's being worked the way it needs to be." — Focus group participant

The one participant with a mature dashboard — showing what closed, what didn't, and where patients went — described it as a rare blessing, and even that organization acknowledged its radiologists were under-flagging actionable findings, meaning the denominator itself was incomplete.

Theme 4: Existing tools find the problem but don't finish the job

Participants with EHR-based actionable-findings tools and point-solution vendors described the same pattern: the technology performs the easy step — extracting a finding from a report onto a work list — and leaves the hard work of closure to manual human effort. The volume generated can be overwhelming enough that organizations decline to fully activate the tools they already own.

"It is a lot. We can't turn it on for everything because of just the amount of data that's in that report for just the two locations that are turned on. It's kind of a 'this is this person's extra job for today' type of a thing... They might go through fifty patients to get two that didn't have something scheduled already." — Focus group participant

"They're basically just helping keep your list of follow-ups and referrals efficient. That's really all they're doing for you. And it's costly." — Focus group participant

The gap participants described is the middle of the workflow: getting the finding to the right provider, securing the order, scheduling the exam, confirming completion, and documenting closure — the steps where patients are actually lost.

Theme 5: The navigator math doesn't work

Navigators were universally valued — and universally scarce. Participants described hiring difficulty, cost pressure, FTE approval denials, and the fragility of single-navigator programs ("you can't just hire one"). Smaller and community hospitals reported having no navigators at all, with follow-up absorbed as an unfunded side duty. When asked directly whether follow-up failure is a people problem or a technology problem, the group converged on an answer: both — with technology carrying the routine workload so scarce humans can focus on exceptions and patient connection.

“Trying to find good people, especially nurse navigators, is not easy. And they’re not cheap. At some point you have to look at the return on investment — you can’t keep hiring navigator after navigator and expect that to pay off.” — Focus group participant

“We just don’t get approval for all of those navigators. The more we can put on technology, and just have a human follow up when needed, is best.” — Focus group participant

Theme 6: The business case requires champions, risk, and revenue — and must survive IT

Participants who had successfully launched programs described a repeatable justification formula: a physician champion who carries the request to administration, a risk and liability narrative (often catalyzed by a real missed-finding event), and downstream revenue evidence from completed follow-up imaging and treatment. Even with that formula, two structural barriers persist — capital competition and IT/integration bottlenecks.

“I can go to administration all day and ask for people. But when the doctors go to administration and ask for people, you’re much more likely to get those.” — Focus group participant

“IT priority is killing everybody, because IT is involved in everything now... Nobody’s getting everything they want these days, so you have to have a really stellar ROI and story to get whatever you need.” — Focus group participant

Theme 7: The patient now reads the report first — and no one is managing that experience

Seven of ten participants identified “the patient reads the results before the call” as a point of breakdown. The discussion connected this to a broader cultural shift: with information-blocking rules under the 21st Century Cures Act delivering results to patient portals immediately, radiology has moved from consultant to front line — fielding patient questions that once went through ordering providers, while the structured conversation that used to contextualize results has disappeared. At the same time, participants acknowledged that patient engagement itself is a weak point: patients don’t follow up despite outreach, portal-based communication misses less tech-savvy and older populations, and no one described a deliberate strategy for the patient’s emotional experience of reading an uninterpreted report.

“With MyChart and all of these at-your-fingertips results, radiology is becoming more frontline than anything, and we’re not relying on those providers to be that in-between. Everyone’s getting pulled in a lot of different directions.” — Focus group participant

“We have a very elderly population here. How do we keep them in the loop? Because for some of them, technology just isn’t happening... MyChart has been amazing keeping them engaged, but what’s the second piece to that?” — Focus group participant

A Framework for a Comprehensive Approach

The seven themes above are not seven problems. They are one problem — a fragmented response to a systemic care gap — observed from seven angles. Point solutions, disease-specific programs, and incremental FTE requests have produced islands of excellence in breast and lung while leaving the majority of actionable findings unmanaged, unmeasured, and unfunded. Breaking that cycle requires radiology and quality leadership to advance a shared vision:

every actionable finding, in every disease state, tracked from identification to closure — with technology doing the routine work and humans handling the exceptions and the patients.

The framework below gives leadership a sequenced path to justify and build that vision. Each stage answers the objection that stalls most programs at the stage before it.



Stage 1: Establish visibility — baseline the closure rate

The focus group made the causal chain explicit: no measurement → no quantified problem → no business case → no budget. So measurement comes first, before any workflow change and before any FTE request.

- **Run a retrospective analysis.** Analyze 12–24 months of historical radiology reports to identify every follow-up recommendation and determine whether it was completed. This produces the single number executive teams cannot ignore: the organization’s true follow-up closure rate — and its inverse, the volume of patients currently lost.
- **Translate the gap into institutional language.** Missed follow-ups convert directly into (1) patient-safety exposure and delayed diagnoses, (2) malpractice liability — participants noted that a single missed-finding case reshaped organizational urgency, (3) forfeited downstream revenue from imaging, procedures, and treatment, and (4) leakage to competing systems.
- **Benchmark against peers.** A closure rate presented against national norms transforms the conversation from “should we invest?” to “how far behind are we?”

This stage requires no operational disruption — organizations can pursue analytics before committing to any workflow change — which also neutralizes the IT-priority objection at the point of entry.

Stage 2: Assign ownership — one accountable home, with champions

The focus group's most successful programs shared a governance decision, not a technology: radiology owns the process from finding to closure. Leadership should formalize this in a charter that names radiology as the operational owner, quality as the measurement partner, and identifies physician champions — pulmonology, breast surgery, vascular, hepatobiliary — who carry the case to administration. As participants observed, radiologists themselves are natural advocates: they carry the liability of unfollowed findings and generate the evidence of downstream value.

Ownership converts the “whose problem is it?” impasse into an answerable question — and gives the closure-rate metric from Stage 1 an accountable home.

Stage 3: Unify the platform — one process for every finding type

The siloed model — one vendor for lung, another for cardiology, a spreadsheet for everything else — multiplies integration costs, fragments data, and guarantees that new finding types launch slowly or never. The consolidation criteria that emerged from participants' own experience:

- **Universal by design.** Any follow-up recommendation extractable from any radiology report — breast and lung today, hepatobiliary, renal, adrenal, vascular, and coronary calcification as programs stair-step forward — flows into one workflow, one work list, one measurement model.
- **Embedded in the EHR, not beside it.** Providers act within their existing in-basket and ordering workflows; the platform closes the loop rather than adding another destination.
- **Automation until failure.** The system autonomously tracks whether the finding was seen, ordered, scheduled, and completed — auto-documenting closure — and escalates to a human only when automation fails. This is the operating model that resolves the group's “people vs. technology” question and the navigator math: existing navigators stop working lists start-to-finish and start managing exceptions, which is how a small, already-approved team scales across all finding types. The program becomes staff-neutral — expandable without new FTE requests.

A single platform also consolidates the IT ask into one integration effort instead of a recurring queue of point-solution projects — directly addressing the barrier participants said “is killing everybody.”

Stage 4: Engage the patient — close the loop the Cures Act opened

Immediate results access is now a permanent condition of practice. Patients will read their reports first; the only choice is whether the organization manages that moment or abandons patients to it. A comprehensive program treats patient engagement as a closure mechanism, not a courtesy:

- **Interpret, don't just release.** Pair every result with a plain-language explanation the patient can actually understand — reducing the anxiety of confronting clinical terminology alone and preempting the call volume now landing on radiology's front line.
- **Guide the next step.** Engagement should carry the patient directly into action: scheduling the follow-up appointment, connecting to telehealth when no primary care relationship exists, and confirming completion.
- **Reach beyond the portal.** Portal-dependent outreach systematically misses older and less tech-savvy populations — the patients participants worried about most. Multi-channel outreach designed for a 75-year-old, not a 25-year-old, is a design requirement, not an enhancement.

The clinical logic is straightforward: an informed, guided patient completes follow-up at meaningfully higher rates. Patient engagement is where closure rates — the metric Stage 1 made visible — actually move.

Making the case: the shared vision

Assembled in sequence, the framework gives leadership a narrative that survives executive scrutiny:

Here is our measured closure rate, and here is what the gap costs us in safety, liability, and revenue. **(Stage 1)**

Here is who owns fixing it, with the physician champions who back it. **(Stage 2)**

Here is how one platform closes the gap across every finding type without new FTEs. **(Stage 3)**

And here is how patients — who now see everything first — become participants in their own follow-up rather than casualties of the gap. **(Stage 4)**

The organizations in this focus group have already proven the components work: navigator programs that cut diagnosis-to-treatment times nearly in half, radiologist champions who drive expansion, governance decisions that end the ownership debate. What no organization described was all of the components, unified, for all finding types. That is the shared vision — and the leaders closest to the imaging report are the ones positioned to carry it forward.

Prepared from a facilitated focus group discussion, July 2026. Participant quotes are anonymized and lightly edited for clarity.