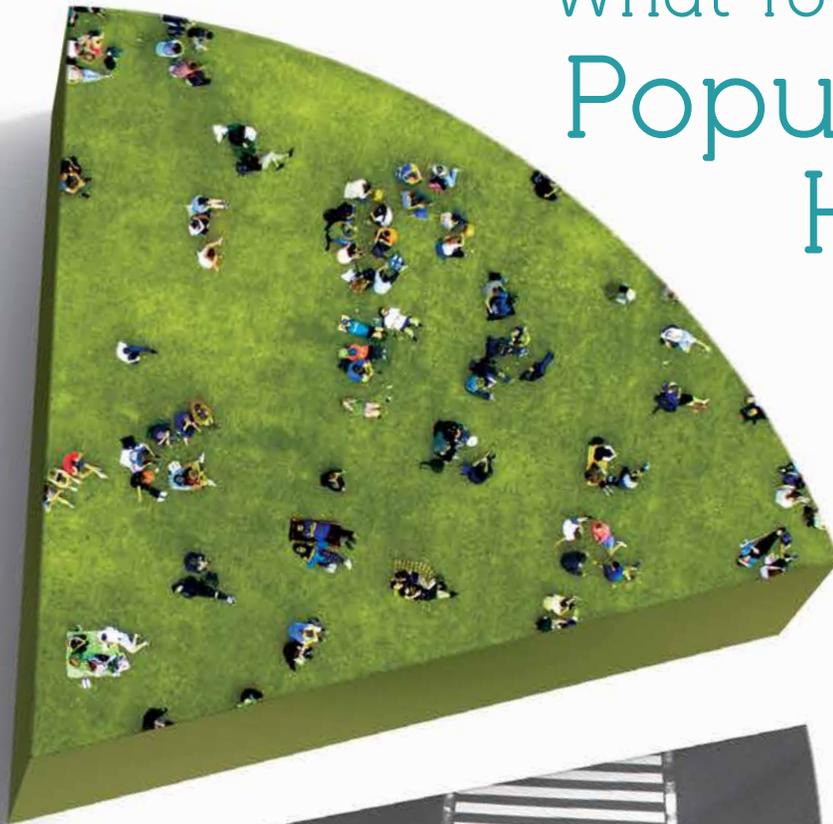


Bulletin

What You Mean To
Population
Health





A GOAL WITHOUT A PLAN IS JUST A WISH

2017 RLI LEADERSHIP SUMMIT

SEPT. 7-10, 2017 | BABSON COLLEGE | WELLESLEY, MA

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ACR Bulletin

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QUESTIONS? COMMENTS? Contact us at bulletin@acr.org
Archives of past issues are available at ACR.ORG

OUR MISSION: The *ACR Bulletin* supports the American College of Radiology's Core Purpose by covering topics relevant to the practice of radiology and by connecting the College with members, the wider specialty, and others. By empowering members to advance the practice, science, and professions of radiological care, the *Bulletin* aims to support high-quality patient-centered health care.



Jennifer E. Nathan, MD
appointed YPS member to
the BOC and past YPS Chair

Growing the YPS

What is the ACR doing to support members entering practice for the first time?

The ACR Young and Early Career Physician Section (YPS) represents a strong segment of the College at around 7,983 members. These members are defined by one of two criteria: in practice and under 40 years of age or within eight years of completion of training. This group of members is extremely valuable to the ACR, not only because they represent approximately 25 percent of dues-paying members, but also for the simple fact that they are poised to lead the organization and foster the continued success and growth of the ACR.

Recognizing the value of this group of members, ACR leadership has placed an emphasis on understanding their motivations for becoming and remaining members. The College is working to increase the level of YPS engagement both at the chapter and national level and develop resources and programming to address the unique needs of this segment of the membership.

From a membership perspective, while the College realizes an overall retention rate of 90 percent, within the YPS retention rates vary from 60 to 70 percent. Understanding the reasons for the significant variance and increasing the retention rate is a priority for the College. To that end, the Commission on Membership and Communications has formed a work group composed of a panel of YPS members who analyze the current retention and engagement rates and develop solutions to better connect with their colleagues and increase membership. Later in 2017, a short survey will go out to individuals who qualify to join the YPS but are not currently members. The survey aims to gain insights into why membership was not retained and what services the ACR could offer young professionals to encourage membership. Results from the survey will be used to provide guidance to both the commission and the YPS as they seek to increase the value of membership and rates of retention.

The College's focus on this important demographic of members, while recently renewed, is not new. The YPS was formally established by ACR Council resolution in

2012 to provide structure for the section, ensure younger members were represented on the Council, and facilitate greater young and early career member involvement in the College. Led by a seven-member executive committee, the section is tasked with working in coordination with the Commission on Membership and Communications to increase membership and volunteerism within the ACR by young and early career professionals.

Since its formation, the YPS has been responsible for coordinating a section meeting and caucus during the annual meeting. Since 2015, YPS has worked with the ACR Program Committee to develop dedicated programming for young members as part of the new all-member annual meeting. The College has also added a YPS social to the annual meeting to provide an opportunity for members to network with leadership and colleagues and discuss issues unique to the section.

In order to share information with members, the YPS has developed a quarterly electronic newsletter and a resource page on the ACR website (acr.org/yps). Both tools focus on topics that are germane to YPS members, including personal finance, contract negotiations, and malpractice. As part of the ACR's new online community, Engage, the YPS also has a dedicated community to allow members to connect with one another to discuss issues of concern and share resources.

With respect to volunteerism, the section has taken an interest in working with leadership to ensure that young professionals are represented on the College's commissions and committees. At the chapter level, the ACR is encouraging leaders to use the additional alternate councilor position they have been allotted to engage even more young members. A new activity is also being piloted at the chapter level to develop an event for young members that includes educational lectures as well as lectures focused on economics, health policy, and government relations. This effort is being sponsored by three chapters as a grassroots effort to connect with members post-training and show the value of continued membership.

Continued on page 21

June

- 5-7 Coronary CT Angiography, ACR Education Center, Reston, Va.
- 8-10 High-Resolution CT of the Chest, ACR Education Center, Reston, Va.
- 15-17 Breast Imaging Boot Camp With Tomosynthesis, ACR Education Center, Reston, Va.
- 19-20 Prostate MR, ACR Education Center, Reston, Va.
- 23-25 Cardiac MR, ACR Education Center, Reston, Va.

July

- 14-16 Body and Pelvic MR, ACR Education Center, Reston, Va.
- 20-22 Musculoskeletal MR of Commonly Imaged Joints, ACR Education Center, Reston, Va.
- 31-8/4 AIRP Categorical Course: Musculoskeletal, AFI Silver Theatre and Cultural Center, Silver Spring, Md.
- 31-8/25 AIRP Correlation Course, AFI Silver Theatre and Cultural Center, Silver Spring, Md.

August

- 21-24 AIRP Categorical Course: Neuroradiology, AFI Silver Theatre and Cultural Center, Silver Spring, Md.

September

- 7-9 Coronary CT Angiography, ACR Education Center, Reston, Va.
- 7-10 RLI Leadership Summit, Babson College, Wellesley, Mass.
- 11-13 ACR-Dartmouth PET/CT, ACR Education Center, Reston, Va.
- 14-16 Breast Imaging Boot Camp With Tomosynthesis, ACR Education Center, Reston, Va.
- 18-19 Breast MR With Guided Biopsy, ACR Education Center, Reston, Va.



James A. Brink, MD, FACR, receives honorary ESR membership.



Richard L. Baron, MD, FACR, receives honorary ESR membership.

ACR Leaders Receive Honorary ESR Membership

At its 2017 annual meeting, the European Society of Radiology (ESR) named two new honorary members, James A. Brink, MD, FACR, chair of the ACR BOC, and Richard L. Baron, MD, FACR, member of the BOC. Brink was recognized for outstanding achievements in imaging and radiation protection. Baron was acknowledged for the advancement of liver imaging and his commitment to research and education. ESR has more than 69,300 members across the globe and hosts the European Congress of Radiology annually in Vienna.

Less Follow-Up for Emergency Patients When Radiologists See Their Ultrasounds

Emergency department patients whose ultrasound images are reviewed by a radiologist versus a non-radiologist are less likely to get more "downstream imaging," says a study published in the *JACR*®. The findings are based on new research by the Harvey L. Neiman Health Policy Institute® and suggest that the higher number of follow-up imaging studies ordered may be explained by non-radiologists' lack of confidence in their interpretations. The study asserts that "making images and interpretations of ultrasound studies interpreted by nonradiologists available for peer review and nonradiologist participation in system-wide quality assurance programs may be helpful" in mitigating the effect on resource use downstream. Lead study author, Bibb Allen Jr., MD, FACR, chair of the Neiman Institute Advisory Board, also noted, "Since emerging federal health reform includes cost and resource use as part of the Medicare Quality Payment Program, emerging patterns of care such as point of care ultrasound should include resource use in outcomes evaluation."

[Read the study at bit.ly/HPI_Ultrasound.](http://bit.ly/HPI_Ultrasound)

Opioid Use Suspected in Bilateral Hippocampal Ischemia Cases Found on MRI

In a recent issue of *Morbidity and Mortality Weekly Reports*, Barash, Somerville, and DeMaria identified an unusual cluster involving 14 cases of recent, complete bilateral hippocampal ischemia on MRI. All patients presented to hospitals in eastern Massachusetts between 2012 and 2016. There was a strong history of substance use in these patients, and 13 of the 14 had either a history of opioid use or a positive toxicology screen for opioids on presentation. Extrahippocampal involvement was noted in a number of the cases. According to the study authors, the "clustering, relatively young age (19–52 years), and significant substance use associated of these patients warrant broader surveillance."

To read the study, visit bit.ly/MMW_Hippocamp.

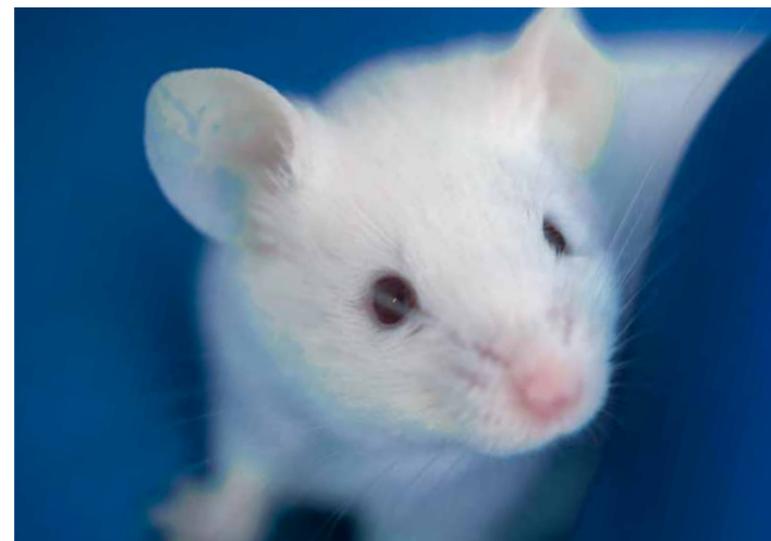
“Radiologists should be re-associating themselves with their patient base and directing care for patients.”

— Ella A. Kazerooni, MD, FACR
Read more at bit.ly/Quality_Rad

What's in a Mouse Brain?

Researchers trying to develop better ways to image the brain have reported new noninvasive imaging of neurons in the subcortical region of an intact mouse brain that they say goes far beyond previous imaging techniques. Chris Xu, PhD, the Mong Family Foundation Director of Cornell Neurotech, said in the *Cornell Chronicle*, "Being able to clearly image the hippocampus could have significant ramifications in the study of a host of brain diseases, including Alzheimer's and Parkinson's." The findings stem from former President Barack Obama's Brain Research Through Advancing Innovative Neurotechnologies (BRAIN) Initiative, designed to help researchers "produce a revolutionary new dynamic picture of the brain that, for the first time, shows how individual cells and complex neural circuits interact in both time and space," according to the National Institutes of Health website.

Read more at bit.ly/Brain_Image.



Language Matters in Reporting Incidental Findings

A new study that examines how radiologists, referring physicians, and patients interpret radiology reports has determined that the language used in the final description of a low-risk incidental finding impacts how the finding is perceived. Study participants were asked to rate their concerns using a graded scale in relation to hypothetical descriptions of an incidental liver lesion. Many of the terms used in the report resulted in negative perceptions from participants. In fact, only the term "benign cyst" led to no concern among the three participating groups.

Read more at bit.ly/Language_Incidental.

“While improvements in cancer detection rates are encouraging, the increased abnormal interpretation rate is somewhat troubling.”

— Brian L. Sprague, PhD
Read more at bit.ly/Mammogram_Trends

Gaps Exist in Mammography Screening

Breast cancer screening rates differ between racial groups in the United States, with minority women being screened less often than white women. Researchers at the Mayo Clinic performed a systematic review and meta-analysis of data from more than 6 million women in 39 studies and found black and Hispanic women are screened less than white women. The disparities exist among black women who are 40 to 65 years old and 65 and older and among Hispanic women who are 40 to 65 years old. There was no difference in mammography utilization between Asians/Pacific Islanders and whites. "It's evident that more work needs to be done to ensure that all eligible women have access to this preventive screening tool," said study author Ahmed T. Ahmed, MB, BCh. Results of the review and analysis are published in the *JACR*® at bit.ly/Meta_Analysis.

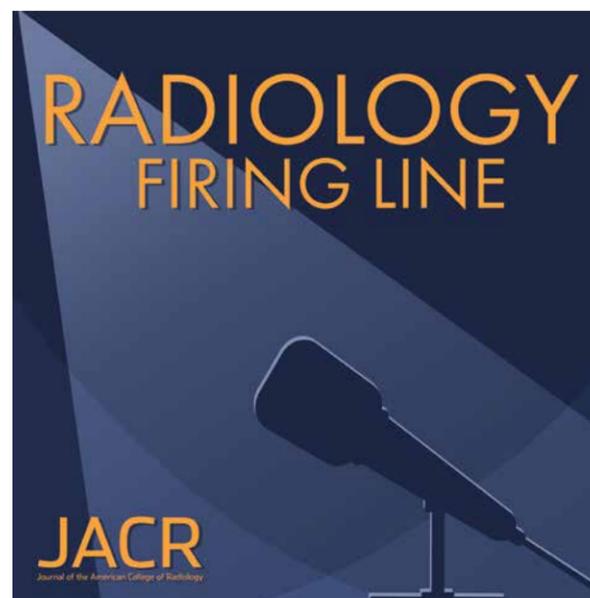
Apply Now for the Goldberg-Reeder Grant

Are you a resident interested in providing health care in low-income countries? Applications for the ACR Foundation Goldberg-Reeder Resident Travel Grant are due June 30. The grant awards up to \$2,000 each year to qualified radiology and radiation oncology residents and fellows to volunteer for at least one month in an underserved country. For more information, visit acr.org/goldberg-reeder.

Tune in to the Radiology Firing Line

Looking for a new podcast to listen to? Try the Radiology Firing Line (RFL). Hosted by Saurabh Jha, MBBS, and C. Matthew Hawkins, MD, the RFL discusses controversial topics that are important to the imaging specialty.

So far in its run, the RFL has covered topics ranging from the future of Watson to women in radiology. Tune in for a debate-style deep dive with experts on a specific topic — all within the less-than-20-minute episode format. You can listen to the RFL on iTunes at bit.ly/RFL_iTunes, or visit jacrblog.org.



Here's What You Missed

The *Bulletin* website is home to a wealth of content not featured in print. Check out blog posts, extra articles, and multimedia content at acrbulletin.org.

Not Your Typical Day

A recent fellow provides a snapshot of a day in the life of a breast imager. Read more about how the mix of screening, diagnostic imaging, and interventional procedures adds variety to her workday at bit.ly/Breast_Imager.

Meet the ACR Leadership

The Resident and Fellow Section catches up with ACR Leadership to get insight into their background and involvement in the ACR. For this installment, ACR CEO William T. Thorwarth Jr., MD, FACR, looks at the future of the specialty and radiology's role in the changing health care environment. Read more at bit.ly/ACR_Leaders.

Four Reasons to Use Social Media

Did you know that radiologists are prolific users of Twitter and other social networks? Learn where serious discussions unfold and true interpersonal connections are cultivated at bit.ly/Use_SocMedia.

“We need to think of imaging as the true entry into the health care system... think about it in that lens... that imaging plays this role in patient outcomes as we're moving from disease-based care to patient-centered care.”

— Miriam Sznycer-Taub, MPH
Read more at bit.ly/Pop_Health



MACRA and Informatics

How do technology tools factor in to new reimbursement models — and what does it all mean for radiology?

As I'm sure you've heard, 2017 is the first performance period of the MACRA-derived Quality Payment Program (QPP). The QPP includes two payment pathways, and almost all radiologists will be scored under the Merit-Based Payment System (MIPS). We are receiving special considerations as "non-patient facing" in 2017. In particular, we are exempt from the Advancing Care Information (ACI) performance category, which is the continuation of the earlier Meaningful Use (MU) program. Most interventional radiologists will also be exempt from ACI, based on their status as hospital-based physicians. Thus, we are not required to use certified electronic health records (CEHRT) technology to avoid negative payment adjustments.

From a risk-averse perspective, this is favorable, as the existing ACI measures may be challenging for us to fulfill. But we may not receive this ACI exemption indefinitely. In fact, the MACRA statute and subsequent regulations include numerous references to the use of CEHRT. Therefore, radiologists should take advantage of the time period of our exemption to explore the importance of CEHRT in the QPP and to create ways for radiology to participate more fully. To that end, Gregory N. Nicola, MD, chair of the ACR MACRA Committee, and I attended the ACR Informatics Commission meeting in early February to discuss several topics, some of which I will share in this column.

The American Recovery and Reinvestment Act of 2009 made MU the law, but radiology subsequently received a five-year hardship exemption. Without the fear of negative payment adjustments, the radiology community has been slow to invest in CEHRT. As a result, we are behind other specialties. Should we make that investment in CEHRT now, and does the QPP provide sufficient motivation to do so? Since this investment will involve our entire profession, including the vendor community and providers, the question is far-reaching.

The QPP clearly encourages the use of CEHRT. Within the MIPS Quality Performance category, the use of CEHRT gives us more reporting options and providers receive bonus points for end-to-end electronic reporting using CEHRT. Within the Improvement Activities (IA) performance category, several of the 90 available activities specifically

describe the use of CEHRT. For example, the improvement activity of providing specialist reports back to referring physician states that the interaction "could be documented or noted in the certified EHR technology" ([read more about each activity at qpp.cms.gov/measures/ia](https://www.cms.gov/measures/ia)). CMS will periodically make calls for new IAs. This gives radiologists the opportunity to propose IA favorable to our profession, which could include the use of CEHRT if we are capable. The QPP regulations also allow bonus points for reporting improvement activities with CEHRT.

The long-term goal of the QPP is to evolve into alternative payment models (APMs). As that occurs, CEHRT will be relevant. New APMs will fall into different categories. The most robust form of APM is the Advanced APM, which may provide participants complete exemption from MIPS scoring. One of the three base requirements for an advanced APM is the use of CEHRT. Another form of APM is the Physician-Focused Payment Model (PFP), largely being developed by a MACRA-mandated committee called the Physician-Focused Payment Model Technical Advisory Committee (PTAC). One of the PTAC's evaluation categories for a viable PFP involves "health information technology." This means that CEHRT will be viewed favorably by the PTAC and could be a requirement in some PFPs. Emerging APMs will require radiology services, and those radiology practices that have embraced CEHRT may have a competitive advantage in collaborative APM efforts with other specialties and broader health care systems. For instance, a hospital system implementing a new APM will look for a radiology provider who will help satisfy the requirements for successful reporting, including CEHRT. Put differently, a practice not using CEHRT may not be considered at all.

Our profession remains exempt from the required use of CEHRT. This exemption will likely go away in the future, which should motivate us to explore and expand the use of CEHRT now. This effort will require collaboration between radiologists, radiology IT experts, the vendor community, and policymakers. The use of CEHRT will allow us to better fulfill the requirements under MIPS. And as APMs evolve, the use of CEHRT will better position us to contribute to these future models. More important, CEHRT stands to improve patient care and the overall quality radiology provides. **B**

Terms to Know

ACI = advancing care information

APMS = alternative payment models

CEHRT = certified electronic health records

IA = Improvement Activities

MU = Meaningful Use

PFP = physician-focused payment model

PTAC = Physician-Focused Payment Model Technical Advisory Committee



Radiologists and Internet Transparency: You Can Run but You Cannot Hide

Do you know what your patients are posting about you? It's time to look.

Locked away in dark reading rooms, insulated from patients and referring physicians, radiologists can nearly double their RVU production — and that translates into a hefty income differential.¹ Working in isolation, it might seem, can be quite lucrative. But that's only in the short-term — which is why forward-thinking radiology thought leaders have long admonished their colleagues to not fall prey to the short-term allure of becoming an invisible radiologist.²

Invisibility is the radiologist's fast track to commoditization.³ If your patients and your referring physicians never interact with you — or worse yet, don't even know who you are — then your job and your partners' jobs are all in jeopardy. If you're just an invisible radiologist who does no more than generate reports from a hidden bunker, then it becomes pretty easy to replace you with another invisible radiologist across town, across the nation, or even across the globe. The digitization of medical imaging means that geographic incumbency no longer translates into job security. Radiology groups are being displaced at a faster pace than ever before.⁴

And, if that's not enough, in the era of Google, invisibility carries with it even more risk. Think about your own shopping behavior. Before making a big purchase or going out to dinner, many of us regularly seek out prior customer reviews, leveraging the likes of Amazon and OpenTable. Like it or not, online consumerism has also hit health care — hard and fast.

Patients have now figured out that Dr. Google makes free house calls 24/7/365. As many as three-quarters of patients now seek information online about their medical conditions.⁵ And, before visiting a doctor's office, they increasingly check out that physician online in advance of their appointments.⁶ What this all means is that health care ratings websites have become a big business. If you don't believe me, go check out HealthGrades, RateMDs, ZocDoc, Vitals, or even Yelp and see what your patients have to say about you.

But if you're a radiologist and look yourself up, you're unlikely to find very much. As a general rule, patients only rate the physicians they've seen — not the invisible ones. That's what we found when we initially studied radiologists' online reviews. Of a random sample of 1,000 diagnostic

radiologists, fewer than 20 percent were profiled on any of the five most popular online physician review websites. And only 2 percent were rated on more than one site.⁷

In our subsequent work, we've learned more. Studying RateMDs reviews for 1,891 radiologists across 297 cities, we found that patient responses tended to be either strongly positive or strongly negative.⁸ Patients usually don't have neutral opinions about their radiologists. The message here is an important one: when we make an impression, either good or bad, patients will react accordingly — and emphatically. So make sure it's good!

Invisibility is the radiologist's fast track to commoditization.

But it's not just you that they're rating — it's the whole care environment that surrounds you. In another study of all Medicare self-designated interventional radiologists, we not unexpectedly found that factors such as how well a radiologist listens and how much time is spent during patient encounters correlates strongly with patient ratings.⁹ But so do factors such as office cleanliness and comfort. In fact, the factor correlating most strongly with a physician's online ratings was patient wait times. The message: don't keep your patients waiting. And, if you have to, make sure that the experience is pleasant so the wait doesn't seem so long.¹⁰

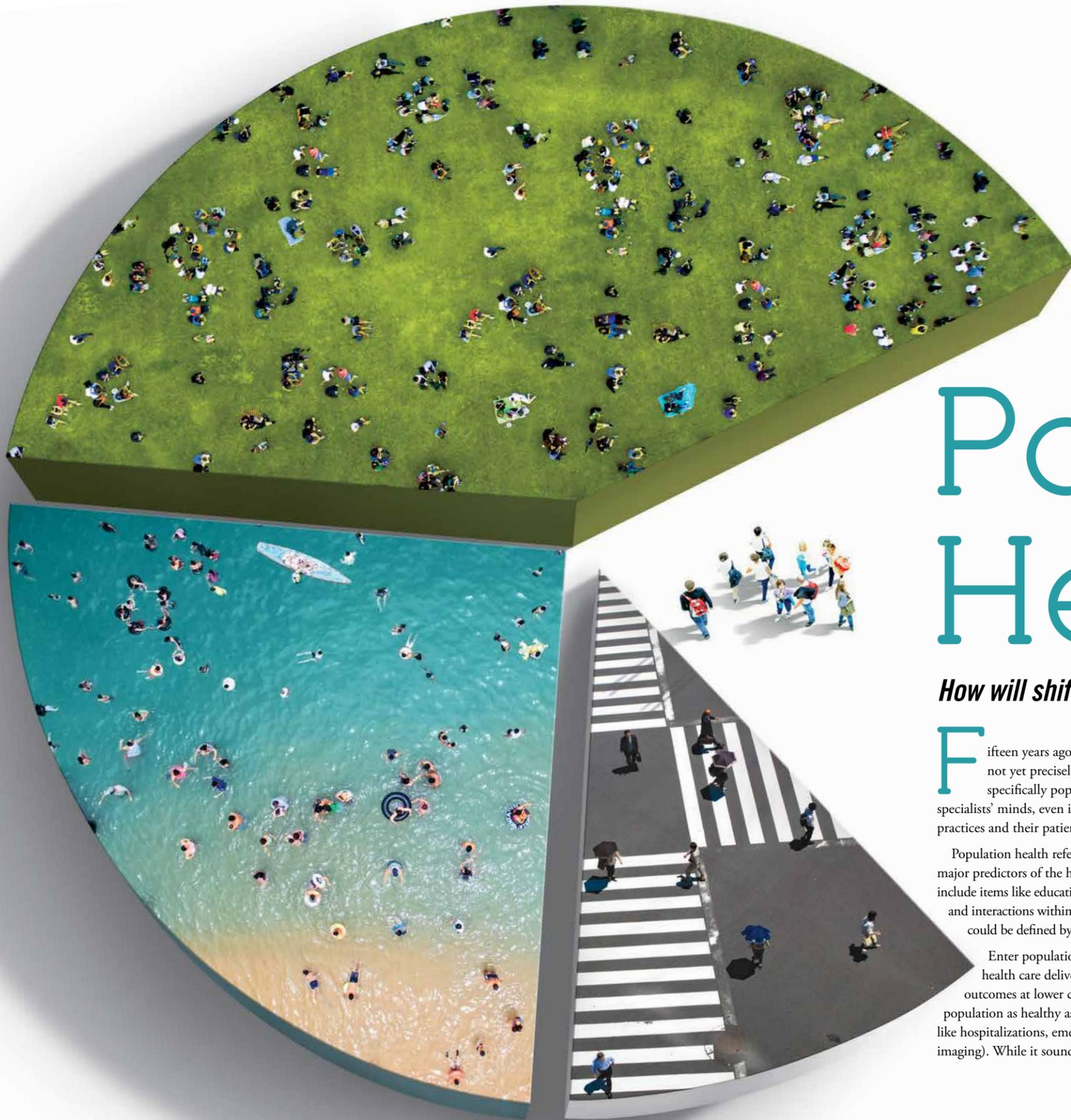
This is all much more than just a touchy-feely academic exercise — it's increasingly about your paycheck. CMS is beginning to use patient experience surveys as a basis for payment under a number of new value-based purchasing initiatives. While future physician payment methodologies are still a work in progress, it's pretty clear that down the road invisibility will not be your friend, and bad scores will be your enemy.

Do you know what your patients are posting about you? It's time to look. And if they're not posting anything at all, that silence should be a deafening wake-up call. **B**

By Richard Duszak, MD, FACR, affiliate senior research fellow at the Harvey L. Neiman Health Policy Institute



Looking to improve your online presence? Check out this Imaging 3.0 case study at bit.ly/img3_SM.



What You Mean To Population Health

How will shifting health care models affect radiology's role in patient care?

Fifteen years ago, population health was a “relatively new term, not yet precisely defined.”¹ Today, population health — and more specifically population health management — is on most medical specialists’ minds, even if they aren’t sure exactly how it will affect their practices and their patients.

Population health refers to a number of social determinants that are the major predictors of the health of a certain population. Those predictors include items like education, income, nutrition, geography, social behaviors and interactions within a community, and access to technology. Populations could be defined by gender, age group, ethnic group, or health condition.

Enter population health management (PHM) as a sustainable health care delivery model aimed at delivering better patient outcomes at lower costs. The goal of PHM is to keep a patient population as healthy as possible while reducing costs by minimizing things like hospitalizations, emergency room visits, and unnecessary care (including imaging). While it sounds simple, implementing system-wide change of

this magnitude will require the coordination of many moving parts. “The challenge of PHM is to do it in a way that scales to the population at large. There are so many people out there that it is difficult to apply individual practices and behaviors on a population scale,” says James A. Brink, MD, FACR, chair of the ACR Board of Chancellors.

A shift to PHM isn’t necessarily intuitive for radiologists. “It’s hard to change what you’ve been doing for 30 years,” says Richard Duszak Jr., MD, FACR, vice chair for health policy and practice at Emory University School of Medicine and affiliate senior research fellow at the Harvey L. Neiman Health Policy Institute[®]. “And PHM is the exact opposite of what many of us have been trained to do.” Under the fee-for-service system, physicians are incentivized to focus on individual transactions. “When I think about PHM, I contrast it with what we have now, which is individual patient disease management. We look at what works for one patient and not holistically. We tend to wait until patients are sick before we take action,” says Duszak. Population health management transforms this approach into one of proactively considering cohorts of patients and their wellness.

“Ideally, we are appealing to people’s altruism and professionalism with PHM. But even for the people with whom that message doesn’t resonate, this comes down to dollars.”

— Richard Duszak Jr., MD, FACR



Patient-Care Transformation

For PHM to work in radiology, it’s going to take both transparency and accountability, according to David B. Nash, MD, an internist and dean of the Jefferson College of Population Health in Philadelphia. That means knowing how often and for which indications imaging studies are being ordered and executed. This is important because the overall cost of health care is directly related to the number of diagnostic tests, including imaging studies, being ordered every year. The literature shows, Nash says, that a lot of unnecessary imaging is being done.² “And that’s bad for everybody,” he says. Historically, PHM has been on the shoulders of primary care physicians, for example, in managing diabetes control, weight loss, or asthma. But as PHM broadens to include entire health systems, radiologists now have a larger role to play.

Because PHM differs from conventional health care by emphasizing value rather than volume, radiologists need to question the value of each imaging study ordered, Nash says. Better utilization of services, more efficient and transparent report writing, ease of access to patient records, and more communicative relationships between physicians are all key elements of PHM.

Also critical in a radiology practice, says Brink, is identifying, reporting, and controlling variations that could improve the overall health of the population. “And if we can ensure consistent and appropriate use of our imaging resources before and after the discovery of key imaging findings, we can optimize health benefits while reducing costs,” he adds. “It’s about finding that sweet spot of appropriate utilization.”

Awareness and Partnerships

Radiologists won’t be as successful in reducing imaging, streamlining utilization, and communicating variations in findings until they recognize that change is upon them. “If I were a radiologist, I think I would welcome PHM,” Nash says. “It elevates the role of the radiologist as a true partner in patient care. As medical

professionals, we all have an opportunity here to be a part of a bigger, more integrated delivery system.”

For PHM to work, forming new partnerships with hospitals and health systems and across departments and specialties is critical. Mergers and partnerships are anticipated side effects of population-based care. “The days of two- or three-radiologist practices are on the way out,” Nash says. More hospitals and health systems are moving toward managing population health, and that’s only going to continue to expand, he says. Radiologists will have to work within these systems, not alone. “There needs to be a framework in place to support collaboration among providers, payers, and community partners.” Community groups and public health agencies can play a valuable role in PHM by helping patients overcome non-clinical obstacles to care to improve health and wellness.

“Partnering translates into job security,” Duszak suggests. “Some radiologists think that their only job is to interpret images, when in fact people expect us to provide diagnostic information that is meaningful and relevant — and that includes much more than just putting out a report.”

Payment and Practice with PHM

Redefining a radiologists’ job in a PHM model is undeniably tied to payment. “Ideally, we are appealing to people’s altruism and professionalism with PHM,” Duszak says. “But even for the people with whom that message doesn’t resonate, this comes down to dollars.”

The Medicare Access and CHIP Reauthorization Act (MACRA) and the Merit-Based Incentive Payment System (MIPS) component set the stage for value-based payments and have already started putting some payment at risk. “Your salary with a penalty or bonus in 2019 under MIPS is contingent upon what you started doing on January 1 of this year,” Duszak points out. “That’s how MACRA was designed: to align behavior with payment.” By 2022, when a full-blown MIPS model is in effect, Duszak says, “the dollar differential between radiologists who are top performers and who maximize their bonuses and the poor performers who

MOVING FORWARD

Looking for more information on population health management and how to get started? Check out these resources:

Most Valuable Radiology Practice Guide at bit.ly/MVP_RAD

The Craft of Patient Communication at bit.ly/Im3_PHM

Providing Higher Value Care Through Population Health Management: What Is the Radiologist’s Role at bit.ly/JACR_RadRole

Carpe Diem: Population Health at bit.ly/JACR_PHM

The Impact of the Patient Protection and Affordable Care Act on Radiology: Beyond Reimbursement at bit.ly/PopHealth_JACR

maximize their penalties will be about 20 percent of their Medicare pay.”

So as reimbursement moves toward value versus volume, and specialists find themselves being held financially accountable for patient health outcomes, reimbursement is going to revolve around infrastructure and improving care and wellness, Nash believes.

Using health information technology and promoting interdisciplinary teamwork are cornerstones to a successful PHM approach — and a healthier patient population. “We want to believe we’re making a difference,” says Duszak. “And there are resources to help you get there.” For example, radiologists need to use structured reporting to make their findings clear to both referring clinicians and patients. And they should participate in qualified clinical data registries to benchmark their facilities’ performance around specified clinical processes and outcomes (see sidebar). Registries allow practices to capture evidence-based data that helps radiologists make the best care and treatment decisions and compare the performance of other health care providers on patient outcomes.

“Radiologists need to roll up their sleeves and look at the resources the College has been providing on how to be successful under MACRA and alternative payment models,” says Duszak. Nash agrees, also suggesting that reimbursement will be obviated when people use a lump-sum payment to use technology in a different way. “We’re going to get paid if there is higher patient satisfaction.”

He envisions increasing use of technology tools to connect patients with their physicians. Online consultations are being used in some facilities, allowing patients to ask questions of their specialists in place of an in-person visit. Providers can

also offer virtual follow-up using Skype or similar media platforms. Making electronic health records easily accessible also promotes transparency, can save time, and empowers patients to better manage their own health and wellness. And taking action to streamline services within a single facility improves efficiency and the patient experience.

Patient satisfaction as a metric is important now, says Duszak, when patient- and family-centered care is a focal point of how health systems and providers are evaluated. There is no substitute, Duszak says, for making the time to interact with others. “Radiologists are going to have to interrupt their time in the bunkers reading film,” he says. “They need to talk to referring clinicians and patients. They need to commit.”

Whatever steps you take, it’s important not to wait until the consequences of not changing are already upon you, Duszak cautions. “To be successful under PHM, your job is to provide the most meaningful and relevant diagnostic information available. You should interpret well and in a timely manner, but the information you report needs to be relevant and appropriate.” **B**

By Chad Hudnall, managing editor

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ACR has a host of tools for radiology professionals looking to bolster their practice’s efforts in reducing imaging variances, securing selection assistance, and ensuring appropriateness guidelines.

For more on ACR’s informatics tools (including ACR Select®, ACR Assist™, and ACR Connect®), visit acrinformatics.org.

To check out ACR’s Data Registries, visit acr.org/NRDR.

Find the ACR’s Appropriateness Criteria® at acr.org/ac.

Cambodia's Lost Generation

Radiologists trace the collapse of Cambodia's health care system and the road to recovery.

In December 2010, Morlie L. Wang, MD, sat on a flight to Phnom Penh, Cambodia, reading a Lonely Planet travel book. Busy with preparation, it was the first time she had been able to read about Cambodia's history, despite her plans to spend a month in the small Asian country on a Goldberg-Reeder travel grant.

Wang, passionate about traveling and working with the underserved, first learned about radiology in Cambodia from an ACR volunteer profile of radiologist Michael R. Paling, MD. Wang contacted Paling and he put her in touch with a Cambodian radiologist in Phnom Penh. Soon after, she was boarding the plane to Cambodia, where she would train medical students and assist radiologists in interpreting studies on the area's first CT scanner. As she sat, reading passages describing the brutality of the Khmer Rouge, however, she recalls, "I started reading the history and thought, 'Oh my gosh. Where am I going?'"

On April 17, 1975, the Khmer Rouge took control of Phnom Penh, the capital city, and declared "Year Zero" in Cambodia, signifying the dawn of a new and classless society based on communist agrarian reform. The rebel group forced villagers at gunpoint into what are now called "the killing fields" to work long hours with little rest and next to no provisions.

Cambodian radiologist Vannarith Chea, MD, the same radiologist with whom Wang spoke before traveling to Phnom Penh, was just 13 years old when his family was

forced from their village. Forty years later, he recalls the events. "We were slaves," says Chea. "We worked hard, more than 15 hours a day, but received only two bowls of rice soup a day."

While the Cambodian people planted and reaped the harvest, the Khmer Rouge sowed terror throughout the country. The group targeted those deemed most likely to resist the cause: the wealthy and educated. "It was said that wearing eyeglasses was a sign of being an intellectual," says now-retired Paling, who volunteered in Cambodia from 2008 to 2014 and now volunteers at Hospitalito Aritlan in Guatemala. "You were shot straight away."

An estimated 1.7 to 2.2 million people were killed between 1975 and 1979 in Cambodia, nearly a quarter of the population at the time. Under the Khmer Rouge, the health care and education systems also collapsed. By 1979, only 45 physicians survived, many of whom left the country after the Khmer Rouge was expelled that year.¹ Though the Khmer Rouge was gone, Cambodia was desperate for physicians, medical supplies, teachers, and basic health care.

Despite an interrupted high school education and years spent working in construction and picking cotton under the Khmer Rouge, Chea entered nursing school in 1980. Three years later, he graduated as part of the first class of nursing students since the Khmer Rouge collapsed.

While working as a nurse, Chea stumbled into radiology. Even though the health care system was being reestablished, the specialty was nearly nonexistent. "Most people in the radiology department at the time were from fields like cleaning or security. It was rare for people who had medical backgrounds to work in radiology," Chea says.

In 1987, Chea entered medical school at the Faculty of Medicine in Phnom Penh. Though Chea became fascinated with radiology, there was little time to learn and very few teachers. "I took a little time at lunch to stay with my radiology professor, but it was not enough," he says. With no access to formal radiology training and no radiology textbooks in Khmer, the Cambodian native language, there is little opportunity for Cambodian students to study the specialty.

In 1996, after almost two years of correspondence with a Cambodian radiologist in Canada, Chhem Kieth Rethy, MD, PhD, Chea secured a fellowship to study radiology for 18 months at Montreal General Hospital and Montreal



Hôtel Dieu Hospital. "There, I started to understand what modern radiology includes," says Chea, who is now the head of radiology at Preah Angduong Hospital in Phnom Penh. "I was very impressed with MRI and CT. In my country, we didn't have these modalities."

The majority of Cambodian people live in rural areas without access to modern medical care. An estimated 40 to 50 percent of the population relies on traditional medicine, mostly due to lack of financial resources.²

"Patients come in with problems that are unimaginable to those of us who mainly practice in developed countries," says Paling. Cancer, for example, remains mostly untreated in Cambodia. Though Sihanouk Hospital Center of HOPE received the country's first CT scanner in 2010, resources are still minimal for treatment. "If you are diagnosed with cancer, your choices are limited here," says Paling. There is one radiation therapy machine, which is currently broken, and few can afford chemotherapy. According to Chea, the typical cancer diagnosis accompanies a three-year life expectancy at best.

"The Khmer Rouge wiped out a whole generation of doctors, and that affected the next generation and the generation after," says Wang, who now works for Northwestern Medicine Central DuPage Hospital in

Winfield, Ill. Though the number of medical students in Cambodia has increased exponentially, the system still struggles to find its footing and lacks experienced attendings to train current medical students.

Each year, Cambodia receives volunteers from around the world who work in hospitals and clinics. However, Paling, Wang, and Chea agree that the best way to help Cambodia is for physicians to share their knowledge. "We need more experience and skill," says Chea. "We need support from developed countries." When Paling returns to Cambodia, he spends a large amount of his time lecturing and working with junior doctors one on one. "If you see an opportunity to start teaching, seize it," he says.

Though Wang has not returned to Cambodia since 2010, she continues to offer online one-hour radiology lectures to Chea and his students once a week using Skype. When lecturing, Wang insists, "You have to find innovative ways to approach things. Instead of saying, 'Make sure you check the biopsy clip placement,' I have to say, 'Do you have biopsy clips?'"

Wang encourages radiologists to consider ways to share their expertise, even if they can't travel abroad. "People are starving for knowledge," she says. "Here, we take it for granted that we can just ask people. The knowledge you can give is priceless." **B**

By Chelsea Krieg, freelance writer for the *ACR Bulletin*

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GET INVOLVED

For more information on how you can volunteer, feel free to contact:

- Morlie Wang, MD
mlwang@alum.mit.edu
- Vannarith Chea, MD
vannarith.chea@yahoo.com
- Michael Paling, MD
mpaling06@yahoo.com

The Sihanouk Hospital Center of HOPE's website (sihosp.org) also includes volunteer information.



Radiology Champions

The specialty's first champion was selected based on his focus on reducing unnecessary imaging for ICU patients.

Jeffrey P. Kanne, MD, was recently named radiology's first champion in the American Board of Internal Medicine Foundation's Choosing Wisely Champions program. To select a champion, the ACR convened a group of patients under the Commission on Patient- and Family-Centered Care. The patients established the criteria and then selected the winner from the nominations. Kanne, a professor, chief of thoracic imaging and radiology, and vice chair of quality and safety at the University of Wisconsin (UW) School of Medicine and Public Health in Madison, spoke to the *Bulletin* about his efforts to reduce unnecessary imaging.

Q: What are some examples of what you're doing at UW School of Medicine and Public Health to reduce unnecessary imaging and radiation exposure for patients?

A: We first worked on routine chest radiographs in the medical ICU. Studies have shown that "on-demand" chest radiography performed for a specific reason in the ICU (rather than routine chest radiographs) can reduce patient radiation exposure and costs without deleterious effects on care. To change the entrenched practice of ordering routine radiographs without consideration of the patient's clinical status, I discussed the issue with our intensive-care physicians regularly. Once they agreed that the literature supported a change in practice, I met with the medical director of the ICU, the nurse manager, and an internal medicine resident interested in quality improvement. Together, we came up with a plan to alter the practice and ultimately stopped performing routine chest radiographs on medical ICU patients.

The other issue we worked on was inappropriate preoperative chest radiographs. Most patients undergoing surgery do not need this procedure in the absence of symptoms related to lung disease (as supported by the ACR Appropriateness Criteria®). After some investigation, I discovered these were being ordered because surgeons thought the anesthesiologist wanted them. The primary care physicians thought the surgeons wanted them. So again, I met with the appropriate stakeholders and we all agreed that most of the radiographs were indeed not necessary. Still, getting physician buy-in was not enough — many of the surgery clinics still had chest x-ray on their preoperative checklists, some of which had not been updated in years. Involving clinic managers and medical directors was key in reducing these unnecessary tests.

Q: Do you see your model as unique to UW, or could it be implemented elsewhere?

A: Our approach would work in any institution. The key is to ensure that all stakeholders are involved in the discussion. This means radiologists, radiology technologists (who do the

lion's share of the work related to these studies in the early hours of the morning), radiology managers (who are tasked with ensuring adequate staff and available equipment), referring clinicians, and nursing staff. Talking with nursing staff was particularly key because they must be aware that practices have changed and that a missing order for a daily chest radiograph is not, in fact, an oversight.

Q: How do you go about including other departments in your goals?

A: The best approach to involving other departments is to identify providers who share an interest in quality improvement. Each department at our institution has a physician leader responsible for heading up quality improvement activities. Involving midlevel providers and trainees is also important so that there is a clear understanding of, and broad support for, any new initiatives to reduce unnecessary imaging.

Q: What have been the most significant outcomes thus far, and what do you hope to accomplish down the road?

A: Reducing the number of routine ICU radiographs by about 20 per day has been our biggest success. In the future, I hope we can work with the surgical services to reduce their routine chest radiographs as well. We've had some resistance in that area, despite our success in the medical ICU.

Q: What's your best advice to other radiologists looking to make a difference with their own efforts, similar to what you've accomplished?

A: Persistence is key. First, get support from your own team: colleagues, managers, and technologists. Second, open a dialogue with the relevant clinical services and provide them with current guidelines and relevant data. Then, keep moving forward. Follow up with clinical contacts. Ask what you can do to help — whether it is attending a small group meeting or presenting information during their departmental meetings. Try to provide baseline data whenever possible, so that your contacts understand the scope of the problem. Finally, share any successes with your partners so they feel like the whole team made a difference.

Q: What is your philosophy about patient-centered care?

A: My philosophy about medical imaging is very simple: If the results are going to alter how one cares for a patient, then imaging is appropriate — as long as you are sure to perform the most appropriate test for that reason. Otherwise, if care management will not change, the test should not be done. This can be applied to any diagnostic test in medicine. **B**

Antitrust in Medicine

Recent legal changes are altering the competitive landscape in health care.

In the past, we have written extensively about the concept of antitrust law while noting that the government seemed to show little interest in using it to regulate consolidation in the hospital and medical insurance areas.^{1,2}

In the last few years, things have changed dramatically. ACR members are now experiencing an increasing number of mergers or attempted mergers among hospitals, health systems, and insurers.

Most recently, proposed mega-mergers involving four major insurers have taken center stage. Anthem and Cigna planned a \$48 billion deal, while Aetna and Humana announced a merger worth \$37 billion.

However, in January 2017, a federal district judge in Washington, D.C., blocked the Aetna merger. Then in February, a different federal district judge disapproved the Anthem deal.^{3,4} In both cases, the U.S. Department of Justice sued to stop the mergers, and both judges ruled that the proposed deals would harm consumers by restricting competition in the medical insurance marketplace.

On the hospital front, the Federal Trade Commission (FTC) sued to block several proposed mergers. In a case involving Penn State Hershey Medical Center, and an unrelated case involving Advocate Health Care Network, two different federal courts of appeal overturned district-court rulings permitting the proposed mergers.⁵ The appellate courts sided with the FTC in blocking the mergers based on the negative impact they would have on prices and availability of medical care in the relevant markets.

In each of these four cases (and in most such cases), the enforcement authorities argued that the proposed combinations would ultimately disadvantage consumers, including patients. Note that no one mentioned the impact on physicians or other providers. Neither federal nor state authorities see antitrust laws as designed to protect or benefit physicians. Nevertheless, the failure of the proposed mergers may make it easier for physicians to deal with the insurers or hospitals involved as long as two or more such entities continue to operate in the same geographic area.

So, other than that, why should ACR members care about antitrust law? It's because, as we wrote in our previous articles, federal and state authorities use antitrust law to regulate physician practices in the same manner as hospitals and insurers. Whether physicians attempt to join a larger practice or health system voluntarily as employees or a bigger player tries to absorb a private practice or hospital, the government is watching.

In 2015, a federal appellate court upheld a district court's decision that invalidated a proposed acquisition by St. Luke's Health System in Idaho of a physician group, including radiologists.⁶ St. Luke's wanted to expand its footprint by

taking over the state's largest independent multispecialty physician practice. But a competing medical group — along with FTC and the Idaho attorney general — objected that competition would suffer via higher premiums and out-of-pocket costs.⁷ The two courts agreed, ruling that although the health system had a "pro-competitive" motive of enhancing quality care, it should have pursued a different way of achieving that objective — perhaps through a joint venture.

ACR members also have to act prudently when doing business with payers and health systems. An appellate court in 2008 affirmed FTC's decision that a North Texas specialty practice unlawfully engaged in price fixing by negotiating agreements among its participating physicians.⁸ This group also violated antitrust laws by refusing to deal with insurers except on collectively agreed terms and imposing a minimum fee schedule for payer offers to physicians. The court rejected the practice's claim that it was a clinically integrated legal entity exempt from antitrust restrictions.

Last January, FTC settled allegations that a Minnesota health system's proposed acquisition of a physician group. Similar to the Idaho case, the government deemed the transaction to be anticompetitive because payment rates to the physicians might increase, while patients could have lost quality and service benefits from that practice. Notably, FTC required the system to permit several physicians to leave and work for other local professionals or set up their own area practice.

As the Trump administration shapes its health care agenda, antitrust enforcement looms as a major, if unheralded, area that ACR members must heed. Communicate with a qualified lawyer who can advise on pending and current arrangements with other physician groups and health systems. **B**

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Want to be your own Choosing Wisely champion? Participate in R-SCAN at rscan.org

Structured for Care

An academic tertiary care center implements structured reporting, achieving 94 percent compliance among radiologists.

Shlomit Goldberg-Stein, MD, a musculoskeletal radiologist at Montefiore Medical Center, and Meir Scheinfeld, MD, PhD, director of Montefiore's Division of Emergency Radiology, both completed training at an institution that used department-wide structured reporting. The experience gave them a great appreciation for the benefits of consistent, quality reporting.^{1,2}

So when Goldberg-Stein and Scheinfeld began working together at Montefiore in 2014, they enthusiastically proposed replacing the radiology department's traditional reports with structured templates. The challenge was getting their colleagues to agree to the change.

Convincing even a small group of radiologists to abandon their traditional reports for structured ones, which organize findings in a standard way and use consistent language to describe common findings, can be difficult. Change is hard for everyone, and structured reporting requires a major change for radiologists to overhaul the product at the heart of their work — their imaging reports.

At Montefiore, the challenge was even greater because its imaging department is no small group and is also physically separated across several hospitals and outpatient centers. The department has well over 100 radiologists, including more than 80 attendings, more than 35 residents, and about a dozen fellows, who serve four hospitals and 11 outpatient facilities for the academic tertiary care center in the Bronx, N.Y.

"We have a large faculty and many of our members have been dictating reports their individual way for 20, 30, 40, or more years. Even some of our young attendings have very strong opinions about how their reports should look," says Goldberg-Stein, who is also director of imaging report quality and an assistant professor in the department of radiology at Albert Einstein Medical Center. "We knew our biggest challenge would be getting everybody on board to standardize our reports across the sprawling enterprise."

In 2014, with strong support from radiology department chair E. Stephen Amis, MD, FACR, Goldberg-Stein and Scheinfeld committed to overcoming this challenge. They became co-chairs of the department's Structured Reporting Committee and launched a performance improvement project to develop and implement structured reporting templates for all cross-sectional imaging exams. Within two years, the team released templates corresponding with 95

percent of dedicated exams by volume, and the department's radiologists were using the templates 94 percent of the time.³ (See a sample template at bit.ly/Img3ReportTemplate) Here's a look at how the team at Montefiore achieved this difficult task.

Identifying the Problem

Before Montefiore instituted structured reporting, its radiologists typically used traditional narrative reports. Goldberg-Stein says the problem is that narrative reports are highly variable, and the actionable information within them may be hidden. "Some radiologists believe their personal reporting style and idiosyncrasies are valuable," she says. "But the intended subtleties may not be appreciated or understood by referring physicians. If radiologists as a group don't communicate findings clearly and consistently, that can be detrimental to patient care and can lead to inappropriate treatment down the line."

This is especially true when it comes to emergency medicine, where minutes often matter. Danielle B. Weinman, MD, emergency medicine attending physician at Montefiore, says she spent a lot of time scouring the unstructured reports to find the information she needed to care for patients. "I felt like I was reading on and on, looking for the meat within the text," she says. "As an ER physician treating a high volume of patients who have varied needs, I don't have time to hunt for information in a report."

Goldberg-Stein and Scheinfeld knew structured reporting could resolve many of these issues. With this in mind, they began working together to develop a plan for instituting structured reporting within the department and pitched the idea to Amis, who was immediately receptive to the proposal.

"I thought it was a great idea, because every so often I would sit down and review about 100 of our reports, and they were all over the place," says Amis, who is also a professor in the department of radiology at Albert Einstein College of Medicine. "With structured reporting, our reports are consistent, and we confirm that the interpreting radiologist has gone through everything in a structured way and has recorded exactly what he or she saw."

Defining the Scope

After giving his approval for the project, Amis worked with Goldberg-Stein and Scheinfeld to outline three project

criteria: First, the project would focus on CT, MRI, and ultrasound reports. (X-ray reports were excluded from the project's first phase because they were generally succinct.) Second, they would develop the templates using a consensus approach, with input from radiologists throughout the department. And finally, while findings would be presented in a structured order within the report, the radiologists would still be able to describe the findings in the manner they wanted (no standardized lexicon was mandated).

"We established these criteria because we wanted to make sure we had complete buy-in from the faculty," Amis explains. "Structured reporting can be pretty onerous if you don't approach it in the right way. It was extremely important to me that we got input from the members of each division and that we gave them some latitude in how they phrased their interpretations. I didn't want to just shove this down their throats."

Educating the Radiologists

Once the ground rules were established, Goldberg-Stein and Scheinfeld drove the project. Their first step was to educate their colleagues about structured reporting. They delivered presentations during staff and resident meetings, publicized the goals of the structured reporting initiative through internal communication channels, disseminated examples of structured reports, and shared several peer-reviewed papers and other literature about the benefits and challenges of structured reporting.

From there, Goldberg-Stein and Scheinfeld asked the radiologists to provide their impressions of structured reporting through an online survey. Eighty-two radiologists participated in the survey, the results of which indicated that while 79 percent of residents favored instituting structured reporting, only 39 percent of attendings approved. Twenty three percent of attendings and 7 percent of residents opposed the move, and the remaining respondents were unsure how they felt about structured reporting.

Mordecai Koenigsberg, MD, FACR, director of ultrasonography and director of the residency program at Montefiore, was one of the radiologists who were initially skeptical of the initiative. "I have very strong feelings that reports should be organized in a certain manner, and I was concerned that one person would determine how the reports would be structured and then everyone else would

just have to follow along," explains Koenigsberg, who is also a professor of radiology at Albert Einstein College of Medicine. Koenigsberg quickly realized his assumptions about the process were inaccurate.

Testing the Templates

After gauging Montefiore radiologists' initial impressions of structured reporting, Goldberg-Stein and Scheinfeld recruited approximately 35 representative radiologists from all of Montefiore's sites to serve on the Structured Reporting Committee. The committee was then divided into six subcommittees that corresponded with the six primary subspecialties that perform cross-sectional imaging: abdominal, cardiothoracic, musculoskeletal, pediatric, ultrasound, and neuroradiology. These subcommittees were responsible for crafting the initial drafts of the reporting templates.

As the subcommittees created the draft templates, they rolled each template out for a limited trial with the radiologists who read those exams most often. Based on the feedback the radiologists provided during this limited trial, the subcommittees revised the templates before releasing them again, this time for a site-wide trial open to all of the department's radiologists, including trainees.

During this second two-week trial, the co-chairs again collected feedback from the radiologists and shared it with the subcommittee members, who voted on whether to implement each suggested change. They then shared the voting results with the entire department. "We took everyone's comments seriously and addressed every comment by either accepting or rejecting it," Scheinfeld says. "For those comments that we rejected, we provided a reason why they were rejected. This transparent approach was critical to getting everyone to go along with the project." **B**

By Jenny Jones, Imaging 3.0 content specialist

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To read the rest of this case study, visit

bit.ly/Img3Structured.

From Practice to Policy

How the RAN influences legislation affecting radiology, and how you can get involved

The Radiology Advocacy Network (RAN) launched in 2012 to educate radiologists about important issues and guide their participation in legislative advocacy. In this issue, Howard B. Fleishon, MD, MMM, FACR, who helped establish the RAN, and David C. Youmans, MD, FACR, president of the New Jersey Radiological Society and the RAN's incoming director, discuss the monumental impact the RAN has had on radiology legislation and how practicing radiologists can join in that effort.

Why is it important for radiologists to get involved in the RAN?

Fleishon: The ACR is widely recognized throughout the industry and by Congress for being credible and highly effective in representing the interests of patients and radiologists. Most organizations in radiology look to the ACR's government relations team to carry out the profession's advocacy mission. The RAN is a vital part of that effort. Congressional representatives want to hear from their constituents. When legislation is pending in Congress that affects radiology and a call to action is circulated by the ACR, the RAN is activated to encourage members and other stakeholders to contact their representatives.

Youmans: We entered medicine to take excellent care of patients in their time of need. As part of that mission, it is imperative that we track, analyze, and guide legislation that affects patients and physicians in general and radiologists and radiation oncologists in particular. Successful advocacy relies on planning and participation. The ACR and state chapters leverage their experience and connections to direct the specialty's efforts, but not much can happen without participation from individual radiologists and radiation oncologists.

What are some of the successes of the RAN?

Youmans: Some recent achievements include gaining coverage for CT lung cancer screening and CT colonography screening, as well as retaining coverage for women's annual mammography screenings. With the support of our membership, we also helped reduce the multiple procedure payment reduction from 25 percent to 5 percent.

What is the RAN currently working on?

Fleishon: The RAN was founded to focus on improving the response rate to calls to action. Along the way, its

mission has expanded to develop other tools to enhance the advocacy effort. We released an app to provide information to radiologists going to Capitol Hill during annual meetings (watch for it again at ACR 2017). We also send out a quarterly email update covering state and national advocacy efforts to members of each state's RAN network.

Youmans: The Radiology Advocacy app provides an easy platform for physicians to receive and respond quickly and easily to calls to action. It provides a legislative directory allowing for easy identification of legislators and their contact information based on state, address or geographic location, making it easier than ever for us to contact them about important issues. App users can also find talking points related to specific legislative issues that are important to radiology, which are very useful when speaking with legislators or simply for getting up to speed quickly on important issues. And for the increasing number of annual ACR meeting attendees, the RAN app provides up-to-date information on events and schedules. Overall, the app is a big step forward for us.

We are also developing a social media presence (including a Facebook page that radiologists will be able to check for important issues) and are launching a digital forum that will allow for active exchange of information and ideas relating to advocacy at both state and national levels.

How can radiologists get involved in the RAN?

Fleishon: Become a RAN representative in your state. Volunteer to be a contact person for your practice. Encourage your state chapter and practice to have advocacy as a standing meeting agenda item. Have your practices host facility visits or fundraisers for local candidates. The easiest and least time-consuming way to get involved is to join the RAN and reply to calls to action.

Youmans: Take a moment and download our app or like our new Facebook page. Respond to calls to action when they come your way, and encourage your colleagues to become engaged.

Fellow radiologists work tirelessly to support legislative goals, but successful efforts require support. When you get more comfortable with the RAN and its processes, which you will, take the knowledge you have gained and become an advocate yourself. If you need help or guidance, we're here to help you succeed. **B**

JOB LISTINGS

CLASSIFIED ADS These job listings are paid advertisements. Publication of a job listing does not constitute a recommendation by the ACR. The ACR and the ACR Career Center assume no responsibility for accuracy of information or liability for any personnel decisions and selections made by the employer. These job listings previously appeared on the ACR Career Center website. Only jobs posted on the website are eligible to appear in the *ACR Bulletin*. Advertising instructions, rates, and complete policies are available at <http://jobs.acr.org> or e-mail careercenter@acr.org.

Michigan – Grand Traverse Radiologists, PC, is seeking a fellowship-trained MSK/general diagnostic radiologist. Responsibilities include MSK and other modalities, including breast imaging services. Some regional travel required. Founded in 1938, the private practice is located in an area with incredible recreational opportunities. Visit grandtraverseradiologists.com and traversecity.com for more info.
Contact: Jennifer Coleman at jkcgr@gmail.com.

Ohio – Drs. Hill & Thomas Co., is a full-service 13-member private imaging group located in the eastern suburbs of Cleveland, Ohio. We're looking for a full-time, board-certified, fellowship-trained breast imaging radiologist. Practice covers two private hospitals approximately 15 miles apart. This is a partnership-track position with competitive salary/benefits.
Contact: Dawn Donich, MD, at 440-479-4151 or dawndonich@hotmail.com.

South Carolina – (Radiology) Locum Tenens, start date: ASAP. Available Shifts: 8 Hour/Friday in Myrtle Beach, SC. The total daily volume is 60 to 70 studies per day (MRI, CT, X-ray, and ultrasound).
Contact: Email CV to cniproimaging@gmail.com

West Virginia – Stable, well-established general radiology group in northern West Virginia is looking to fill a part-time position. The group covers multiple hospitals, some of which are in proximity to the greater Pittsburgh area. We are seeking personable and motivated applicants who are proficient with multiple imaging modalities.
Contact: Submit CV via email to radiologistopening@gmail.com

Wisconsin – Aurora Health Care is seeking a breast-imaging specialist to work at our Aurora West Allis Medical Center, located just 15 minutes from downtown Milwaukee. Large radiology group, flexible position, competitive compensation, comprehensive benefits package, and relocation assistance.
Contact: Alison Burki at 414-389-2543 or alison.burki@aurora.org.

Wisconsin – Aurora Health Care in Milwaukee is seeking a body-imaging specialist to work at facilities south of and in the Milwaukee metropolitan area. Large radiology group, state-of-the-art modern technology, no overnight call. Competitive compensation, comprehensive benefits package, relocation assistance.
Contact: Alison Burki at 414-389-2543 or alison.burki@aurora.org.

CONTINUED

Growing the YPS

Continued from page 4

An increased focus on this membership demographic is already starting to yield results. The number of YPS members holding positions at the chapter and national level has increased by more than 15 percent each year since 2012, demonstrating an increased level of activity and inclusion. Attendance at the annual meeting increased by 3 percent from 2015 to 2016, and a new speed-mentoring session has been added to the 2017 meeting program specifically for the growing young member audience. And while an overall goal to increase retention rates within this demographic has not yet been realized, we can report that rates have remained stable over the past four years.

“What you plant now, you will harvest later,” wrote Og Mandino. This quote fits perfectly with the College's efforts to foster the YPS and focus on increasing both membership and engagement by our young members. The programs and initiatives that we are working on now, and in the near future, I believe are laying the groundwork for a strong section and vibrant membership. If you are interested in getting more involved in these efforts, contact me at Jnathan8@jhmi.edu or our YPS executive committee at YPS@acr.org. **B**

By Jennifer E. Nathan, MD, appointed YPS member to the BOC and past YPS Chair

You Can Run but You Cannot Hide

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This article was originally posted on the Harvey L. Neiman Health Policy Institute™ website. Check it out at bit.ly/Neiman_Commentary.

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MOVING FORWARD

Look for more information on the radiology advocacy network (RAN)? Find out how to get started.

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Download the RAN app at bit.ly/RAN_itunes on the app store, or at bit.ly/RAN_Android on the Google Play store.

To contact the RAN, email Melody Ballesteros, Assistant Director of Grassroots and Advocacy at MBallesteros@acr.org.



Mentor, Captain Dick Dobbins, MD



Raymond E. Bozman, MD, FACR, Captain, Medical Corps, US Navy (Retired), Radiologist, Naval Medical Center, Portsmouth, Va.

What would you say to a medical student considering radiology?

It was the summer of 1978 and the rising second-year medical student was beginning an elective rotation in radiology at the National Naval Medical Center in Bethesda, Md. After being introduced to Captain Dick Dobbins, MD, his proctor for the rotation, the medical student was asked a simple question: “Son, is radiology your intended career choice?” The general surgeon/pediatrician/emergency physician wannabe replied that it was not. Undeterred, Dr. Dobbins remarked that he would turn on the light for me and hoped the student would choose to follow it. You’ve probably realized by now that student was me.

The next six weeks were filled with thousands of radiographic interpretations, an equal number of cases from Dr. Dobbins’ comprehensive teaching collection, and a daily reminder of why radiology was simply the best specialty in medicine. If you cherish patient contact, Dr. Dobbins reminded me, many radiology subspecialties — including ultrasound, mammography, interventional, and pediatrics — give you all you could want. For example, if you like technology and constant change, radiology has sophisticated equipment that is upgraded continually and replaced by even more advanced imaging technology.

Although he had a storied 45-year Navy career including service as a hospital corpsman and the first medical officer on the Navy’s first nuclear submarine, Dr. Dobbins was most proud of the hundreds of medical students and interns he inspired and recruited for a career in radiology. I consider myself fortunate to be among them. **B**

The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, or the United States Government.

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To contact a member of the *ACR Bulletin* staff, email bulletin@acr.org.

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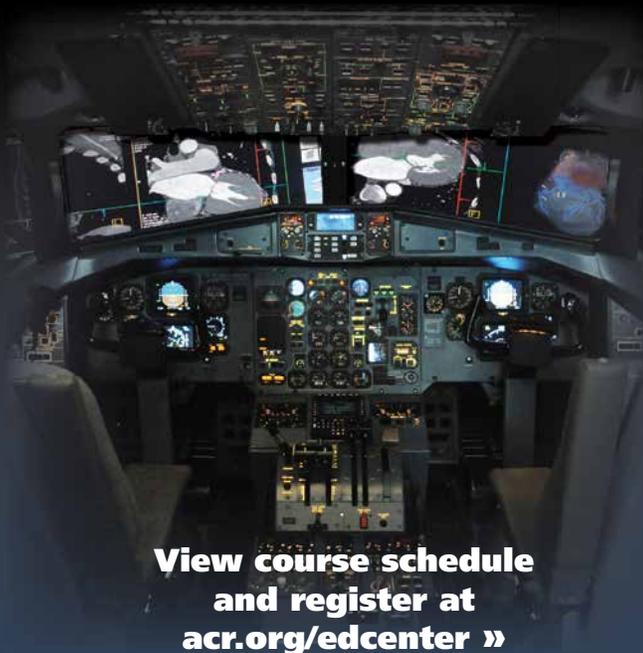
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