EMBRACING DIVERSITY

Local Economics
Redesigning Care
MACRA and Informatics
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.

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Clarification
On page 6 of the July issue, it was incorrectly stated that the ACR Council Steering Committee (CSC) acts as the College’s legislative arm. The ACR Council — with representation from all 54 chapters, subspecialty societies, and specific membership segments — is the legislative arm of the ACR. The CSC consists of a combination of elected and appointed members to act on behalf of the ACR Council when it is not in session.

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The difference is plain to see
Sometimes Innovation Is Saying No

Aligning college resources with our strategies and priorities

S

tev Jobs once said, “People think focus means saying yes to the thing you’re going to focus on. But that’s not what it means at all. It means saying no to the hundred other good ideas that there are. You have to pick carefully. I’m actually as proud of the things we haven’t done as the things I have done. Innovation is saying no to a thousand things.”

Following completion of our most recent strategic plan in 2014, the ACR embarked on a method to assess its myriad programs against its newly minted strategies and priorities. Our strategic planning consultant, Paul Meyer of Ticker International LLC, facilitated our first strategic program assessment meetings in late 2014 and early 2015. We assessed over 250 individual College programs against the strategic plan by clustering and categorizing them according to the strategic direction each should pursue based on various attributes. The strategic program assessment methodology was originally created by Ian MacMillan, currently professor at the Wharton School, and refined for use by professional societies by Ticker International LLC. This methodology continues to be widely used by organizations to assess their program portfolios. We have continued to use this methodology periodically reasses legacy programs and evaluate all new programs under consideration.

In the ensuing years, I have been impressed by how transferable the program assessment methodology is to circumstances that may arise in various radiology practice circumstances that may arise in various radiology practice.

Program attractiveness: an assessment of how well the program aligns with the strategic plan and meets the vision of the organization.

Competitive position: an assessment of how well the organization is able to effectively execute and support the program.

Alternative coverage: an assessment of the degree to which other organizations may provide the same services or offerings to similar constituents.

By analyzing each individual program according to these three variables, programs can be staged into one of eight strategic directions. These directions range from orderly divestment to aggressive competition. For example, items with high program attractiveness, strong competitive position, and a high degree of alternative coverage require the organization to aggressively compete for success in this space. The organization must maintain its strong competitive position in these areas, as such programs can play a very important role in the organization’s future. Alternatively, programs with high attractiveness, strong competitive position, but low alternative coverage require continued measured growth. Here, the focus area is open to continued dominance by the organization.

Programs with high program attractiveness but weak competitive position and low alternative coverage represent opportunities for the organization to build strength and monitor performance. Programs in this category are often created in response to newly recognized and rapidly growing member needs for which the organization has not yet had the capacity to strongly address. Here, the focus and expertise needed to execute the program can be developed while monitoring the operational and financial performance as the program evolves.

Continued on page 21
Failsafe Program Fosters Radiologist-Patient Communication

A new program that uses letters and phone calls to inform patients directly about incidental findings discovered in the ED — and encourages them to follow up with their primary care physicians — is closing communication gaps between doctors and patients at Penn State’s Milton S. Hershey Medical Center. There, radiologists are using Failsafe, a program in which 70 percent of participating patients reported that they would otherwise not have known about their incidental findings or follow-up recommendations. The program doesn’t rely on referring clinicians to relay important findings, but instead communicates directly with patients. “The program goes beyond the standard of care to ensure patients can address incidental findings in a timely manner,” says Michael A. Bruno, MD, FACR, professor of radiology and medicine and vice chair for quality and safety at Hershey Medical Center. Find more about the program in the case study at bit.ly/Failsafe_Study.

Subspecialists Find Missed Breast Cancer

There are benefits to a second opinion by a subspecialist for patients who have not been diagnosed with breast cancer, a new study has found. Radiology breast subspecialists can detect breast cancers missed on initial screenings, according to experts from the University of Texas M.D. Anderson Cancer Center in Houston. Findings were based on a review of 2,400 studies submitted from outside facilities for a second opinion from January 2010 to June 2014. Of the 2,400 patients, 271 (or 11.3 percent) had a malignancy. After 189 patients (7.9 percent of the total studies) underwent additional biopsies, 24 cases of cancer were identified. Find more at bit.ly/Find_Cancer.

Algorithm Alerts Radiologists to Bad Catheter Placement

A team from Massachusetts General Hospital has developed a deep-learning algorithm that presents chest radiographs to detect incorrectly positioned peripherally inserted central catheters (PICC). Radiologists are then alerted to prioritize those cases.

The technology was presented at the Society for Imaging Informatics in Medicine annual meeting and could lessen delays in interpreting cases, one presenter noted. An incorrectly positioned PICC can lead to serious complications, so the final PICC location is confirmed after placement on a chest radiograph. Radiologists have a high accuracy rate for interpreting the location of the PICC on studies, but delays in interpreting the cases can be significant, team members found. Read more at bit.ly/DL_Detect.

Radiologists Back on Top 10 Most Requested List

For the first time since 2007, radiology was among the top 10 most requested specialties for recruiting assignments, according to a yearly review of search assignments conducted by Merritt Hawkins, a physician recruitment firm. The demand for radiologists peaked four years earlier in 2003, when it topped the list of requested assignments at Merritt Hawkins. Since then, the number of positions available has declined after an influx of trainees and reimbursement cuts during the 2000s, according to the report. But recent data shows the job market is now bouncing back. The review was based on more than 3,200 physician search assignments received by Merritt Hawkins and sister companies between April 2016 and March 2017. Find out more from the 2017 physician recruitment report at bit.ly/Rad_Need.

Imaging-Aiding Devices Hit With Ransomware

A medical device used to help deliver a contrast agent that improves the quality of MRI scans was infected with a type of malware at an un-named U.S. hospital, according to a source who alerted Forbes to the cyberattack. A Bayer Medical device, also known as a "power injector," represents the first known instance of a medical device being infected by ransomware, the Forbes article says. The Health Information Trust Alliance, a private company that provides a cyber threat exchange platform for the health care industry, said it had reports of Bayer and Siemens equipments being affected by cyber attacks, the article said.

Find more at bit.ly/Device_Virus.

Shedding Light on Small Tumors

A significant number of small tumors detected during routine mammograms are not necessarily in the early stages of growth, destined to become larger, life-threatening tumors. Authors in a special report of the New England Journal of Medicine involving thousands of breast cancer cases concluded that many small tumors are not small because they were detected early — rather they are just biologically prone to slow growth. The study found that about 22 percent of tumors detected by mammography are “the very slow growing kind.”

Breast imagers warn, however, that this should not be interpreted as a reason to avoid or postpone a mammogram. “There has been general confusion around in both medical and lay press about mammography,” says Delia Montimocico, MD, FACR, professor of radiology at Texas A&M University Health Science Center and section chief of breast imaging at Scott & White Medical Center’s department of radiology. “It’s unfortunate that patients have been given different signals because the truth is that mammography is responsible for a significant reduction in breast cancer mortality — about a 40 percent reduction.” Read more at bit.ly/Small_Tumors.

Medicare Imaging Reimbursement Prone to Raising Flags

A disproportionate number of cuts to have affected reimbursement for diagnostic radiology services, according to a study published in the JACR. And rising imaging utilization coupled with how federal policymakers evaluate relative value units are largely to blame.

The individualized nature of radiology coding makes it particularly susceptible to scrutiny, according to Andrew Rosenkrantz, MD, lead author and associate professor of radiology at New York University School of Medicine, and colleagues. “Disproportionate payments to radiology could stifle investment in technologies that could improve patient experience and outcomes at the same time that new payment models are placing a premium on these metrics,” wrote Rosenkrantz, et al. “Policymakers should consider new approaches to address perceived physician overpayments or to enable higher payment to certain specialties, such as primary care.” Read more at bit.ly/Codes_2017.
Follow-Up Mammography Needed for Asian Women

Categoric ethnic subgroups of Asian women have the longest follow-up times of all women in the United States, according to researchers from several University of California schools. Researchers analyzed demographic data from the San Francisco Mammography Registry and also found that Asian women, in general, experience delays in mammography follow-up. The research was published in Cancer. The authors note, “Certain cultural barriers may contribute to the lengthy time to follow-up… [when] norms regarding modesty and embarrassment have been known to reduce screening utilization in these groups.” Read more at bit.ly/Asian_FollowUp.

Analysis of CT Images Predicts Mortality Rate

Computer-driven image analysis of routine cross-sectional CT imaging may be used to predict patient longevity relative to overall health and risk for disease, according to Nature.com’s Scientific Reports. The article, “Precision Radiology: Predicting Longevity Using Feature Engineering and Deep Learning Methods in a Radiomics Framework,” talks about “new avenues for the application of artificial intelligence technology in medical image analysis” and how that could “offer new hope for the early detection of serious disease, requiring specific medical interventions.”

The five-year mortality prediction accuracy rate was nearly 70 percent, the article noted. The analysis technique is a move toward an “effective and efficient testing methodology that can accurately measure the widespread tissue changes predictive of chronic diseases and could quantify preclinical disease, inform treatment choices, and guide research cohort selection.” Read more at bit.ly/Mortality_Predict.

Keep ACR Working for You. Renew Today!

The ACR — which is member-run and member-driven — relies on you and your colleagues to advocate for federal, state, and local levels. The College depends on you to direct and contribute to clinical research, set standards of quality patient care, and ensure that coding and reporting practices are consistent across the healthcare universe. It is with you and because of you that the ACR is successful in advocating for positive legislation on your behalf, helping you to improve your acumen, and protecting your bottom line while elevating your standard of care. Help your colleagues and fellow members help your colleagues and fellow members help you to improve your acumen, and protecting your bottom line while elevating your standard of care. Help your colleagues and fellow members help you to improve your acumen, and protecting your bottom line while elevating your standard of care. Help your colleagues and fellow members help you to improve your acumen, and protecting your bottom line while elevating your standard of care.

Here’s What You Missed

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

How Mentoring Can Benefit the Specialty

Although women make up nearly half of all medical students, they represent a significantly smaller proportion of radiologists — just 21.4 percent. Read more at bit.ly/Mentor_Benefit.

Meet the Moreton Lecturer

Jeffrey C. Bauer, PhD, also offers his talk on the future of health care via his address, “Forecasting Futures of Radiology at the Crossroads: It’s All Downhill from Here on Up.” Read more at bit.ly/Bauer_Lecture.

Deep Learning, Clinical Data Science, and Radiology

What should radiologists think about machines that think? Read how radiologists can adapt in research and in practice to a host of machine learning tools and technology at bit.ly/Deep_Data.

Ace Your Interviews

There are strategies on the web online about preparing for an interview. Get specialty-specific tips from a radiologist on the other side of the interviewer’s desk at bit.ly/Interview_Tips.

Economics Goes Local

Thanks to MACRA, some changes to the way we practice are originating at the regional level before rolling out nationwide.

The goal of the Innovation Center is to test payment and delivery models that result in lower costs and/or improved quality. The impact of the Innovation Center has been far-reaching. CMS estimates that 207,000 health care providers are participating in Innovation Center models and in initiatives serving over 18 million patients. This means that many individuals reading this column provide radiology services at a participating facility. Successful institutions will employ strategies to succeed within their model, and the innovation center is relying on these local data to determine which models will be expanded nationwide. The ACR can serve as a conduit for communication between national policymakers and local entities. The College can also help shape successful strategies and best practices.

The PTAC evaluates stakeholder proposals and provides comments and recommendations to CMS. As of June 2017, the PTAC had reviewed and submitted comments on leading three proposals. Only one of the proposals originated from a large national medical society. The two others came from smaller regional provider groups. For example, Project Sonar, which relates to treatment of inflammatory bowel disease, was led by the Illinois Gastroenterology Group, which employs about 50 physicians. The PTAC recommended Project Sonar for only limited-scale testing. In other words, this model originated from a local domain and will be tested locally. Like the Innovation Center, only locally successful models will be translated nationally. In the future, the ACR may submit a model to the PTAC. In the meantime, it is conceivable that a radiology-specific model could be presented by a more local organization. This creates an opportunity for collaboration between the ACR and such local organizations.

The ACR has had a strong presence influencing national policy. The MIPS is an example. But MACRA is prompting you to more locally driven models, creating a twofold responsibility for the Commission on Economics. We must not only inform our members on MACRA-related policy but also learn from local experience and communicate those that are successful to other radiology professionals and national policymakers. Bidirectional communication will be important in improving radiology patient care.
LEADING IMAGE

So what if you don’t fit the mold of a stereotypical leader? I don’t.

When we picture the proverbial leader, most of the archetypes we go to have a couple of things in common. They’re often white, they’re usually male, and pretty much none of them look like me. But I’m out here teaching, running businesses, and — yes — leading.

In my experience, success comes from doing the best job you can while simultaneously recognizing the biases that exist. Once you know the challenges you’re up against, you can set a strategy to take them on. And I’ve found that the challenges can be surpassed, but you have to recognize that there may be barriers.

The adage that women and minorities have to be twice as good to get half as far unfortunately holds some truth. Multiple studies have confirmed that women and minorities are evaluated more harshly because of their gender or race. Recent examples include resumes with names perceived as belonging to African-Americans receiving fewer callbacks for interviews and female professors being rated lower than male counterparts (even in online courses in which two groups of students are told differing genders for the same professor). The net result is that women and minorities face implicit biases that require them to always work harder than their white male counterparts to receive the same or better leadership opportunities.

One of the most common reservations I hear from leaders is, “I read management advice, and I just can’t see myself actually doing that or doing this.” The idea that you can’t be this or that needs to be re-examined — or just thrown out. This erroneous belief that you can’t do a certain thing is when the situation calls for it is beautifully illustrated by a famous Far Side® comic strip.

In the first panel of the comic, a group of cows stand in a pasture. But instead of standing on four legs, they are all upright on two legs in a circle, clearly having a conversation. One of the cows acts as a lookout and yells to the others, “Car!” In the next frame, a car full of people drive by and the cows are now on four legs, grazing peacefully.

The lesson here is when the cows are put in the position of having to act in a certain way — in this case, when they need to prevent the expected behavior of a farm animal — they do it. They know what to do and, even though it may not be something they are comfortable doing, they do it when they need to.

I often hear people say things like, “That’s not me. I’m not an assertive person. It doesn’t feel authentic to me to behave that way.” This comic strip illustrates a key idea that I have lived by and that I teach in my leadership classes: You can be what you need to be! If you don’t think you have a strong voice, or if you don’t think you can manage staff, you can do the same. You can teach yourself to flip a switch. You’ll often hear people say, “Oh that’s not me. I always go back to them and say, ‘That can be you.’” Changes are more than just actions; they are about the behavior of a farm animal — they do it. Sometimes when acting as a leader,

You can do the same. You can teach yourself to flip a switch. Or, Oh that’s not me. I always go back to them and say, “That can be you.” Changes are more than just actions; they are about the behavior of a farm animal — they do it.

At first you might not feel comfortable behaving like a leader, but it may be the best thing you ever do professionally. Sometimes you have to act like the cow when the car comes by.

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ENDNOTES

By Lakshmi Balachandra, MBA, PhD, assistant professor of entrepreneurship at Babson College and Radiology Leadership Institute® faculty.

Hear More
Check out a Radiology Leadership Institute® podcast with Amy K. Patel, MD, who shares her experiences as the first female chief resident in her program. To listen visit radiologyleaders.org/podcast.

ACR.ORG 11
In Good Conscience: Everyone is Guilty of Unconscious Bias. How can you disrupt the pattern?

In the late 20th century, orchestras had a gender problem. More specifically, in 1979 the top five orchestras in the U.S. were made up of fewer than five percent women. But as time went on, female participation rose to 10 percent in the 1980s and then 25 percent in 1997.

The change was not immediate, but it was certainly a step in the right direction. However, there was still a long way to go.

What changed between 1979 and 1997? Orchestra leaders realized that they had fallen victim to unconscious bias, and they took steps to correct it. Beginning in the 1970s, candidates would audition behind a screen so that juries could not see them. Sometimes juries would even urge performers to remove their shoes to hide the telltale sound of high heels clicking against the floor. These blind auditions not only increased the number of women auditioning, but also led to a jump in the number of women who were hired.

"Unconscious bias, also known as implicit bias, is a bias individuals are not actively cognizant of," says Amy K. Patel, MD, member of the ACR Commission for Women and Diversity. "It is a bias our brains are hard at work to create on the fly to decide who we find trustworthy, or competent, or even to sort out whether we like someone or not. It's the default setting of our brains, our unthinking reactions that affect our decision-making on a regular basis. And it's the reason why we often act as if we are colorblind, even when our actions reveal our colorblindness in ways that we don't even recognize.

"Unconscious bias can also extend to the physician-patient relationship," says Johnson B. Lightfoote, MD, FACR, chair of the ACR Committee for Diversity and Inclusion. "It can lead to devastating results on the patient's part.3,4 Unconscious bias can lead to critical health care disparities, says Patel. Studies have noted that physicians more frequently mistreat pain management in both racial minorities and women — which can lead to devastating results on the patient's part.1,2

Although these examples illustrate why unconscious bias can be a problem, the effects can go even further, says Lightfoote. "There’s often the potential for loss of talent," he says. "We may unintentionally prejudice a female as not being as competent as most or many males." He adds that, in addition, teams may lose perspective on situations. If you’re discounting a new perspective because of race, gender, or other attributes, you will lose a whole side of the conversation.

And behavior like that can further lead to a loss in morale. Lightfoote says, "If a person’s opinion is consistently discounted, they may feel less inclined to contribute." Patel agrees. "You need to acknowledge unconscious bias as an issue in order to continue building mutual respect among colleagues. If someone is being discounted, that respect isn’t there."

What can you do about unconscious bias? Start by recognizing it in yourself, which is not such an easy task. "The key is to hold yourself accountable. Do a daily self-check of any situations where you may have demonstrated bias and determine what you could have done differently. Take the next time to ensure you don’t perpetuate the pattern," suggests Patel. She notes it’s important to remember that unconscious bias occurs in everyone, male and female. "There are stereotypes about every gender, race, and class. And even though you may be a minority, there are still biases you may hold about other individuals," she points out.

Peter Kalina, MD, FACR, member of the ACR Commission for Women and Diversity and radiologist and head of the diversity initiative at the Mayo Clinic in Rochester, Minn., also recommends teaching colleagues about unconscious bias using real-world examples — things that you have actually seen or overheard. Otherwise, he says, "The response tends to be ‘That would never happen here’ or ‘We don’t speak to each other like that.’"

Both Patel and Kalina agree that one way to combat unconscious bias is to hold other colleagues accountable and have them hold you accountable. "It can be as simple as having someone ask you about the situation or call you out if they observe you displaying such behavior," says Patel. Adds Kalina, “Calling someone out shouldn’t be combative either. Remember that the behavior is likely unintentional. You can say something as simple as, ‘Ouch. You know, that really hurts.’ You can also say, ‘I don’t think you meant to say that.’”

Amy L. Korzena, MD, president of the Minnesota Radiological Society and member of the ACR Council Steering Committee, recommends taking active steps during the hiring process to address unconscious bias. "Review the various aspects of your hiring process. Is the wording in the job description discriminatory? Is the selection committee diverse?" she says. "These can both affect who applies to the job and who proceeds to the next step. Another action to take is to consider screening the resumes that come through. Have someone remove the names and other details that might reveal the applicant’s race or gender so that it’s not even an issue when it comes before the selection committee."

Ultimately, Patel says that while it’s important to recognize and be knowledgeable about unconscious bias, the best way to combat it is to do something. "A consciousness is certainly a start, but we must also hold ourselves accountable and devise solutions that can cause meaningful change," she says. "This is not easy and will take years of recalibrating the way we perceive others, how we make decisions, and more. However, it is necessary if we are to make any kind of progress."

By Meghan Edwards, freelance writer for ACR Press

ENDNOTES

1. Rice C. How blind auditions and“Say you have a female African-American radiologist who has braids or dreads, and she’s youngish. She may run into an administrator who asks her, ‘How do you manage a CT tech here?’" when in fact she’s chair of the department. Although the administrator meant no harm, he could have interpreted the radiologist as a technologist because of his own unconscious bias.

Unconscious bias can also extend to the physician-patient relationship. Lightfoote describes patients who have asked female physicians when the doctor would arrive. And even though you may be a minority, there are still biases you may hold about other individuals," she points out.

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By Meghan Edwards, freelance writer for ACR Press
THE CULTURE OF RADIOLoGY

Does your reading room look like your waiting room?

There’s a lot of talk about what the future of radiology will look like. Usually, that discussion revolves around the role technology will play as machine learning and artificial intelligence enter the practice. But the diversity of a radiology practice, some say, may prove to be the best indicator of its ability to keep pace with the needs of a changing patient population.

“Often a physician says, ‘I have been successful so far.’ But how much more success might you enjoy if you had more diversity and different ways of thinking in your practice?” says Andrea Borondo Kims, a physician advocate, JACR associate editor, and retired aerospace engineer. Diversity in the workforce includes age, race, ethnicity, gender, religious affiliation, sexual orientation, and disabilities. And when it’s time to hire new staff, it may even apply to personality and thinking styles.

Many groups are underrepresented in radiology. For instance, whilst women represent nearly 51 percent of the U.S. population, they account for just over 20 percent of the country’s radiology workforce. The overall makeup of the nation’s health care workforce, in fact, doesn’t reflect the diversity of the population. While people of color make up approximately one-third of the U.S. population, they account for only about 10 percent of the health care workforce. Fewer than 10 percent of radiologists are people of color.

The National Academies of Sciences, Engineering, and Medicine notes that increasing diversity among health professionals is critical because it leads to improved access to care, greater patient choice and satisfaction, and a better educational experience for health professionals.

Diverse Expectations

“There is an expectation on the part of consumers of all products and services that businesses will provide professional staff that at least reflect the range of diversity that exists in the geographical area in which the business operates,” says Betina Deynes, vice president of human resources and diversity and inclusion at the Society for Human Resource Management. “Medical practices are not any way exempt from this expectation.”

Many HR leaders agree that ensuring diversity in the workplace will dominate hiring trends in the next decade. It’s important because hiring managers must ensure that they’re hiring the best candidates — not necessarily the ones who look like the same sex as senior staff.

“If in a radiology practice, all of the senior staff are straight white men, it’s going to be harder for women, younger radiologists, people of color, or members of the LGBTQ community to feel welcome as part of the practice,” says Borondo Kims. At the same time, radiologists must consider their own biases. Studies have shown that many patients are more comfortable with doctors who perceive to be more like themselves. Women, for instance, may feel more comfortable seeing female doctors.

Studies show that shared race or ethnicity between patient and physician may improve patient satisfaction, compliance with medical recommendations, and overall health care outcomes.1 When considering the broader health system, minority physicians are more likely to practice in underserved communities, which often include rural areas and communities made up of people of color. For example, African-American physicians are more likely to practice in areas with a high proportion of African-American residents. Likewise, Hispanic physicians tend to work in communities with twice the proportion of Hispanic residents when compared to their non-Hispanic colleagues. The contributions of physicians in these communities is expected to go a long way in meeting the pending health care needs of a growing, diverse society.

Hiring Times

For those in charge of hiring the best and brightest new radiologists, the time is now to be mindful of diversity. Close to a quarter of practicing radiologists are approaching retirement age, and newly available jobs for radiologists increased by around 16 percent last year compared to 2015.2 These shifts in the workforce present radiology practices with an opportunity to re-examine the makeup of their staff and adjust their hiring practices.

“Everyone has a tendency to hire people that most resemble themselves,” Deynes says. “No one is suggesting that businesses hire people who are not the best qualified. But if you don’t attract a pool of candidates that is reflective of the desired culture, then you’re not fully exploring your recruitment possibilities.”

Increasing numbers of women and underrepresented minorities are already in the medical school pipeline — offering immense opportunities for practices eager to foster a more diverse staff. Borondo Kims points out, “If you hire people with different thinking and different experiences of the world, you are more likely to create a system of solutions.”

Practices that hire a diverse group of physicians may develop better solutions to the many issues and challenges facing radiologic practice and science,” says James A. Brodie, MD, FACP, chair of the ACR’s RBC. “Understanding and respecting the many features that make each person unique enables us to provide more effective and equitable care.”

Considering Practices

Any business, including a medical practice, will face challenges in establishing and maintaining an organizational culture that reflects the needs of its patient and staff. But it’s important to remember not to go it alone. Radiologists need to look across specialties to see what other doctors are doing, says Borondo Kims. “If radiologists aren’t part of a multidisciplinary team, they aren’t going to perform as well,” says Borondo Kims. “Having diversity across a team makes it possible to capitalize on different ways of thinking using different approaches for a common goal.”

When hiring a new staff member, there may be situations in which there are only one or two underrepresented minorities in a position. When a hiring committee comprises several members who do not have a history of interacting with or hiring staff, these members should not become the “representatives for diversity,” caution researchers from the University of California, Berkeley.

“Employers and managers can be utilized to great advantage when it comes to working hours, working locations, fractional employment, specialty differentiation, and customer service,” say the commission’s Johnson B. Lightfoot, MD, FACR, medical director of radiology at Pomona Valley Hospital Medical Center in Calif. “Welcome, leverage, and creatively employ the diverse professional capabilities of your team — and enjoy the resulting return to your bottom line!”

Chad Hudnall, ACR Press managing editor

Endnotes


Get more information on medical careers, education efforts, and diversity at diversityMD.com
A Puzzling Pay Gap

Gender Pay in Academics
Findings from a JAMA Internal Medicine study of physician salaries revealed that significant differences exist for salaries of men and women, even after accounting for age, experience, specialty, faculty rank, and productivity.

Women earn $344k
Men earn $408k

Physicians
Radiologists

$2,000

Endnotes:
decade ago, retired Army Col. Jim Stapleton underwent a State Department physical that revealed a lump in his throat. He would not be going to Iraq for contract employment as planned, but instead would be fighting an unexpected foe at the Emory University School of Medicine’s Winship Cancer Institute in Atlanta: head and neck cancer.

Visualization of the head and neck (H&N) region is a complex and challenging area for imaging, according to Patricia A. Hudgins, MD, FACR, director of H&N radiology at Winship Cancer Institute. “The lesions are small, the anatomy is difficult to navigate, and everything is in close proximity to the brain. The risks are huge.”

Given the gravity, Stapleton wanted to learn about his squamous cell carcinoma from the person who could best see it — the radiologist. “Initially, my doctor talked to the radiologist and then relayed the information to me, but I wanted to talk to the radiologist directly,” he says. “I wanted to ask ‘What’s that’ on the images.”

Patient Understanding

Providing patients with an opportunity to interact directly with radiologists is exactly what Ashley H. Aiken, MD, associate professor in the neuroradiology division of Emory’s Department of Radiology and Imaging Sciences, had in mind when she envisioned an environment that would allow radiologists to take a more active, consultative role in the treatment of H&N cancer patients. To turn that vision into reality, Emory embarked on an initiative to add workstations for face-to-face treatment meetings with ENT surgeons, radiation oncologists, and medical oncologists.

Face-to-Face

In March of 2016, radiologists also decided to add direct-to-patient consultation to the care pathway by utilizing the ENT patient exam room as space adjacent to the clinic reading room. To create the patient consult program, the Emory team realized they needed to get a patient’s perspective to ensure they were delivering true patient-centered care.

Stapleton, who had been treated at the H&N clinic in 2007 and developed close relationships with his ENT physicians and radiologists, had volunteered to serve as radiology department liaison for a patient and family advisory board. Aiken then invited him to serve on a patient advocacy panel that focused on patient perceptions of the radiologist’s role. He also offered his unique perspective about the ideal way to communicate with patients during their consultations.

As a result, the team quickly determined that one of the most important aspects of that direct interaction was helping patients understand the role of radiologists. “When we first began consulting with patients, they didn’t originally think of radiologists as their doctors,” explains Aiken. “To overcome that perception, we start by introducing ourselves and saying, ‘We are your head and neck radiologists. We look at all of your scans before and after treatment to ensure that there are no deep abnormalities that your ENT surgeon cannot see.’ You can instantly see it makes patients feel better.”

Stapleton agrees. “There’s something powerful about meeting with an expert who’s interpreting the images of your anatomy,” he says. “I could point to the image on the screen and directly ask the neuroradiologist my questions and get immediate answers.”

Aiken says a direct, communicative approach to engaging patients will change the way radiologists — and all physicians — practice medicine in the future. To begin driving toward that future, Emory Healthcare has committed to training the patient experience, elevating the help of former patients like Stapleton as patient advocates, to advise clinicians (including radiologists) on the best way to talk to patients about their care.

Program Design

Before launching the ENT clinic, Emory radiologists worked with a multidisciplinary group of surgeons, radiation oncologists, and medical oncologists to create a template that reflected a consensus for next steps in managing patients undergoing surveillance for H&N cancer. In 2016, their Neck Imaging Reporting and Data System (NI-RADS)1 was published to standardize templates for image reading and dictation. This helped quantify “big picture” recurrence and management concerns for radiologists to successfully engage — both with surgeons and in direct patient consultation, Hudgins explains.

Mihir R. Patel, MD, assistant professor of neuroradiology at Emory, helped radiologists identify key points that would be ideal for the direct patient consultation program: those being treated for H&N cancer and under surveillance with contrast-enhanced CT (CECT), or CECT combined with PET, with the case reported via the NI-RADS template. Due to regular communication regarding treatment images, radiologists have always been a part of the ENT clinic to some degree, Patel explains, so having them consult directly with patients was a “natural step.”

Here’s the collaborative process the Emory team designed to ensure a seamless patient consultation:

• After an H&N cancer patient has undergone definitive treatment (either surgery, chemotherapy, radiotherapy, or a combination of these), he or she typically undergoes CECT combined with PET/CECT.

• The surgeon or nurse practitioner lets the radiologist in the clinic know when there is a patient who might benefit from a consultation.

• The radiologist reviews images and images of the head and neck region. The surgeon lets the radiologist know whether the patient might benefit from a consultation.

• After joining the patient in the consultation room, the radiologist briefly explains his or her role in the patient’s care, reviews the images on a virtual desktop PACS, and gives the patient an opportunity to ask questions about anatomy, findings, and post-treatment changes — all in five to 10 minutes.

Implementation Challenges

Is creating a patient consultation program in the ENT clinic as easy as it might sound? Not necessarily, says Richard Driscoll, MD, FACR, professor and vice chair for health policy and practice in the Emory University Department of Radiology and Imaging Sciences, who advised the team on the practical implementation of patient consultations and the operational scope of the pilot program. “The concept of radiologists communicating results directly to patients is often considered foreign in radiology, with the exception of breast imaging and interventional radiology,” he says. “Patients are increasingly asking us to do something that many of us haven’t been formally trained to do. Without support, infrastructure, and education, a concept like this could be doomed to fail.”

Fortunately, the Emory team was able to overcome these obstacles, largely by leveraging Hudgins’ and Aiken’s roles as on-site champions. Over the years, and enhanced by their onsite presence, Hudgins and Aiken had developed strong working relationships with both their referring physicians and their office staff members. Although Emory’s achievements were the result of a team effort that included active engagement of administrative and faculty leadership, clinical champions were vital for success.

“ENT providers feared that we would add work to their already busy schedules, but that wasn’t the case at all,” Aiken explains. In fact, Patel emphasized that with radiologist-patient interaction, he actually has more time available for other work.

“Having our neuroradiology team review the details of a surveillance scan helps patients who are feeling anxious about the progress of their disease. This helps us tremendously because I can spend more time with other newly diagnosed patients discussing prognosis and treatment,” Patel adds.

Radiologists were also worried about adding to their already full workloads, but Hudgins reports that after reading 35 to 50 H&N scans daily, her staff has become quite efficient with interpretation. As a result, the radiologists are able to work smarter and connect more intimately with patients. Fulfilling this niche with both speed and precision offers practices a huge opportunity to grow and market themselves as care providers, Hudgins notes. At Emory, the days of a faceless, nameless radiologist are long gone, she says. She also notes that radiologists’ morale has greatly improved as their role on the care team has deepened. “What we do matters,” she stresses.

- By Kerri Ilenyes, Imaging 3.0 freelance writer

ENDNOTE

Understanding MACRA and Informatics

A quick-start guide to leveraging today’s technology to survive and thrive in the value-based future

W hen it comes to leveraging innovative technology, radiology has always been a leader in medicine. But the advent of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) has changed the reimbursement landscape, and radiology must adjust its approach.

Due to the challenges of implementing certified EHR technology (CEHRT), radiology received an exemption for MACRA’s performance measurements during its useful run time and has (thus far) avoided negative payment adjustments. That “free pass” has allowed most radiologists to ignore CEHRT in the hope it would go away.

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Sometimes Innovation Is Saying No

Continued from page 4

By Linda Sowers, freelance writer for ACR Press


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Sometimes Innovation Is Saying No

Continued from page 4

By Linda Sowers, freelance writer for ACR Press

What does being an ACR member mean to you?

The terrific thing about being a radiology resident is that the second we matriculate into our programs, we are automatically members of the ACR. With this membership, we are a part of a very large organization of residents, fellows, attending physicians, and retired physicians who have made their mission entirely about securing our future and advocating for radiology. After learning about the opportunities that the ACR had to offer, I knew that this would be a perfect venue for me to apply my skills and knowledge of medicine, radiology, and politics.

As a first-year resident attending my first ACR conference and running for a seat on the RFS nominating committee, I had no idea of the vast opportunities there were to get involved. Additionally, the comradery that comes with the annual meeting is carried forward for the remainder of the year. Every committee on which you serve, lecture you attend, or new resident or attending physician you meet, will have an impact on your future practice in some way.

The choices and sacrifices in service to your fellow members will pay you back in the end, and so my decision to serve the RFS members in a leadership role is truly an honor and a privilege. I have just recently attended my second ACR conference and would encourage everyone to attend, or new resident or attending physician you meet, will have an impact on your future practice in some way.

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