

# Bulletin

Why  
Do  
You  
Ask?

A Doctor's Dilemma

Value Above All

Hidden Figures

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# ACR Bulletin

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The difference  
is plain to see



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## FROM THE CHAIR OF THE BOARD OF CHANCELLORS

James A. Brink, MD, FACP, Chair



# The ACR's Strategic Plan – Time to Refresh and Look Forward

*The updated plan adjusts the College's vision and brings increased focus to AI and data science.*

**A**t the fall meeting of the ACR's BOC and CSC, volunteer and staff leadership met to revise the ACR Strategic Plan. From the beginning, this charter was approached as a living document. When the organization finalized the 2014 plan, it set a three- to five-year window for re-examination. In accordance with this schedule, the October meeting brought together leaders from throughout the specialty to chart a course for radiology's future success.

I am pleased to report that both BOC and CSC members reaffirmed their support for our timeless core ideology.

**CORE PURPOSE:** to serve patients and society by empowering members to advance the practice, science, and professions of radiological care.

**CORE VALUES:** leadership, integrity, quality, innovation.

The process began with an assessment of our environment, looking for trends in radiology and healthcare that may affect College priorities. BOC and CSC members identified the following potential drivers:

### Demographics

- The healthcare workforce is changing, to include a demographic that increasingly emphasizes social media and values diversity.
- Consumerism is rising as patients have an increasing desire for timely communication and care, with a need for more transparency about pricing and quality.

### Economics

- The pace of transitioning from volume to value has been inconsistent and erratic.
- High-deductible insurance plans have led to more consumer awareness.
- Process measures are moving more toward outcome measures with a greater focus on population health.

### Professional Structure

- Practice consolidation, sometimes funded by private equity, has led to disruption to the classic radiology delivery model. Increasing numbers of hospitals are seeking to cluster radiology departments into service lines that are organized thematically rather than along classic specialty boundaries.
- The dedicated IR training pathway may lead to further fragmentation within our ranks.
- The never-ending push to do more with less is leading to an increase in non-revenue-generating activities, which may contribute to burnout.

### Informatics

- The advent of AI is inevitable, but what this new landscape will look like and how it will impact radiologists is uncertain. By acting now, radiology can define the future ecosystem in which our specialty resides.
- The interconnectedness of big data is driving care decisions more, and it is important for radiology to remain in the forefront.
- The gap is widening between radiologists who have skills in informatics and those who don't.

### Technology

- Integration with other diagnostic disciplines, such as pathology, is growing.
- The rise of non-imaging diagnostics, particularly related to genomics, will be an increasingly disruptive force.
- The push for population health management to improve quality with coordinated care at lower costs will continue to affect our specialty in ways never realized before.

With this environmental landscape better defined, the BOC and CSC reaffirmed five of the six goal areas from the 2014 plan:

### Healthcare Payment Policies and Practice Models

- Existing and new practice and payment models will recognize the value delivered by radiology. ACR members will be prepared to adapt and thrive within these models.

### Radiology and Patient-Centered Care

- Radiology professionals will partner with patients and their

*Continued on page 21*

# DISPATCHES

NEWS FROM THE ACR AND BEYOND



## February

- 2-4 Musculoskeletal MR of Commonly Imaged Joints, ACR Education Center, Reston, Va.  
9-11 Abdominal Imaging, ACR Education Center, Reston, Va.  
12-3/10 American Institute for Radiologic Pathology (AIRP®) Correlation Course, AFI Silver Theatre and Cultural Center, Silver Spring, Md.  
24 Radiology Leadership Institute® Kickstart Your Career, DoubleTree By Hilton Hotel, Silver Spring, Md.  
26-28 Coronary CT Angiography, ACR Education Center, Reston, Va.

## March

- 1-2 Transcatheter Aortic Valve Replacement, ACR Education Center, Reston, Va.  
3-4 Value of Imaging Through Comparative Effectiveness (VOICE): A Collaborative Training Program in Biomedical Big Data and Comparative Effectiveness Research, NYU Langone Medical Center, New York City  
16-18 Cardiac MRI, ACR Education Center, Reston, Va.  
19-4/13 AIRP Correlation Course, AFI Silver Theatre and Cultural Center, Silver Spring, Md.  
22-23 Prostate MR, ACR Education Center, Reston, Va.

## April

- 2-5 AIRP Categorical Course: Thoracic and Cardiovascular, AFI Silver Theatre and Cultural Center, Silver Spring, Md.  
6-8 Body and Pelvic MR, ACR Education Center, Reston, Va.  
19-21 Musculoskeletal MR (Elbow, Wrist/Hand, and Specialized Topics), ACR Education Center, Reston, Va.  
23-24 Breast MR With Guided Biopsy, ACR Education Center, Reston, Va.  
26-28 Breast Imaging Boot Camp With Tomosynthesis, ACR Education Center, Reston, Va.

## ACR Calls for Low-Dose Medical Radiation Research

Medical imaging and radiation oncology save lives. That's what ACR BOC Chair James A. Brink, MD, FACP, told Congress when urging more funding for research on low-dose medical radiation effects that will inform future safety practices. "There is a compelling need to improve science's direct understanding of low-level exposure and to apply new knowledge to radiation safety practices, professional guidelines, and regulatory policy," Brink said. Brink praised the work of the National Academies Board on Radiation Effects Research, which addresses the health effects of exposure of human populations to low-dose, low-linear energy transfer ionizing radiation. However, he noted that the last report was published in 2006. Brink urged a critical assessment of more recent data in both epidemiologic and experimental research.

For more information, visit [bit.ly/Brink\\_Testimony](http://bit.ly/Brink_Testimony).

## Choosing Wisely Campaign Impacting Overuse

For five years, Choosing Wisely® — an initiative of the American Board of Internal Medicine Foundation in partnership with Consumer Reports — has been advancing a national dialogue on reducing and eliminating unnecessary medical tests and procedures. And now the Choosing Wisely recommendations are even more actionable as part of the ACR's R-SCAN® program. R-SCAN advances the education of members and enables referring clinicians and radiologists to collaborate on projects to improve imaging usage based on 11 Choosing Wisely recommendations.

"We saw an opening to work with our peers to explore why providers order unnecessary imaging and ways to better align patient care with evidence-based practices," says Max Wintermark, MD, chief of neuroradiology at Stanford University and clinical advisor for R-SCAN. Also of note, the American Urological Association is in talks with the R-SCAN team to investigate adding new urology-related Choosing Wisely topics to the R-SCAN program.

Read more about Choosing Wisely and R-SCAN at [bit.ly/Use\\_RSCAN](http://bit.ly/Use_RSCAN).

**R-SCAN™**

Radiology Support, Communication and Alignment Network

## What Radiologists Should Know About Pricing

A host of factors affect the variations in list prices for radiologists' services — especially for services that serve more complex conditions. A recent *JACR*<sup>®</sup> study suggests a surge in interest in prices charged and payments made for health services. "A growing number of online price comparison tools are now available from a wide range of sources; a recent national survey demonstrated that most Americans access price information before receiving healthcare services; and the appropriate use of such pricing tools is uncertain, given that patients and other stakeholders may not recognize that charges (or 'list prices') for medical services are often vastly different from what patients and insurers actually pay," the study states. As more price transparency initiatives permeate the healthcare landscape, radiologists should be aware of how their list prices compare with local and national benchmarks, the authors note.

Read the full *JACR* article at [bit.ly/Price\\_Factors](http://bit.ly/Price_Factors).



## An Ethical Approach

Radiologists can provide added value through participation on hospital boards and committees. At Mercy Hospital Jefferson in Festus, Mo., one radiologist is having a meaningful impact as a member of the hospital's ethics committee. In this role, which requires no special training, James A. Junker, MD, FACR, often reviews images with patients and families facing difficult care decisions and helps guide the institution's policy decisions.

Learn more in this Imaging 3.0<sup>®</sup> case study at [bit.ly/anethicalapproach](http://bit.ly/anethicalapproach).

## RADCAT Shows Promise in Categorizing ER Reports

Brown University radiologists and emergency department (ED) physicians are using radiology reports to categorize the images of ED patients using a new pilot system called RADCAT. The radiology report categorization system is still being evaluated for usability and performance, but initial findings based on 400 radiology reports in the ED suggest the "RADCAT" system is understandable between radiologists and ED physicians for categorizing a wide range of imaging studies."

Read more at [bit.ly/RAD\\_CAT](http://bit.ly/RAD_CAT).

## Nominate Now for ACR Residents and Fellows Elections

The ACR RFS Nominating Committee is looking for impassioned, self-motivated, and dedicated volunteers to be part of the next RFS Executive Committee. Individuals who are recognized as leaders in their training programs, eager to be involved in forming the policies and framework for the profession of radiology, and wish to improve resources for all residents and fellows are strongly encouraged to submit their nomination for consideration. For full descriptions of the available positions on the RFS Executive Committee, please visit [bit.ly/RFS\\_Position](http://bit.ly/RFS_Position). The deadline for submissions is March 14, 2018.

Submit your nomination at [bit.ly/RFS\\_Form](http://bit.ly/RFS_Form).

## Injured Congressman Brings Spotlight to Critical IR Care

The medical care that U.S. Rep. Steve Scalise (R-La.) received after a shooting during a congressional baseball practice last year was highlighted during a Society of Interventional Radiology panel discussion — including the use of imaging guidance and minimally invasive procedures by IRs. Arshad A. Khan, MD, a senior IR at MedStar Washington Hospital Center in Washington, D.C., treated Scalise and stopped hemorrhaging with the use of embolization. "It's remarkable, the work that they did to keep me alive," Rep. Scalise said. "I appreciate the work of our trauma doctors, especially Dr. Khan."

Read more at [bit.ly/IR\\_Trauma](http://bit.ly/IR_Trauma).

## New Trial to Study 2D/3D Screening

The Tomosynthesis Mammographic Imaging Screening Trial, led by the ECOG-ACRIN Cancer Research Group and the National Cancer Institute, will compare two types of digital mammography for as many as 165,000 healthy women who enroll through the year 2025. It is the first trial of its kind to compare traditional 2D mammography to 3D tomosynthesis and could confirm the life-saving benefits of 3D screening. The study led by principal investigator Etta D. Pisano, MD, chief science officer of the ACR Center for Research and Innovation, is expected to provide insight on how to screen women most effectively for breast cancer and to aid patients in making healthcare choices about future screening procedures.

Read more at [ecog-acrin.org/tmist](http://ecog-acrin.org/tmist).

## Patient-Assisted Mammography Debuts at MGH

Approved for clinical use by the FDA late last year, Massachusetts General Hospital's Breast Imaging Division is offering women a first-of-its-kind patient-assisted mammography system designed to give patients control over the application of compression during the exam. During the procedure, patients use a wireless handheld device to adjust compression after a technologist positions the breast. Leaders at the facility hope the technology will combat fear and discomfort as reasons for avoiding a mammogram.

Find out more at [bit.ly/Assisted\\_Mammography](http://bit.ly/Assisted_Mammography).



## Study Supports More Active Engagement to Boost Women Radiologists

There's been little change in the percentage of women interested in a career in radiology in nearly three decades, according to researchers from the University of Massachusetts Medical School in Worcester. Their research, published in *Current Problems in Diagnostic Radiology*, aimed to increase medical student exposure to radiology and coincidentally aligned with university interventions that are "suggested to have the biggest impact on female medical students." The most recent statistic of women participating in diagnostic radiology was 26.9 percent in 2013, compared to 25.5 percent in 1990, the study says. "The preliminary findings suggest that early exposure during preclinical education increases overall medical student interest in radiology, not specifically female interest," the authors state. "This increase in interest occurred preferentially in males despite the fact that the 'patient-centered' electives were intended to appeal to female medical students — demonstrating that simply offering the electives is not enough."

Read more at [bit.ly/Women\\_RadInterest](http://bit.ly/Women_RadInterest).



## Renew Your Annual Pledge to Image Wisely

Now is the time to renew your annual pledge to optimize radiation dose in your medical imaging. Image Wisely<sup>®</sup> is a joint program of ACR, RSNA, AAPM, and ASRT that provides current information and guidelines on radiation safety with the objective of lowering the amount of radiation used in medically necessary imaging studies and low-value procedures.

Visit [imagewisely.org](http://imagewisely.org) to renew.



## Here's What You Missed

The *Bulletin* website is home to a wealth of content not featured in print. Check out blog posts, bonus articles, and other multimedia content at [acrbulletin.org](http://acrbulletin.org).

### A Moving Target

As patients assume more responsibility for financing their own healthcare, price transparency should be on every radiologist's mind. [Read more at bit.ly/Patient\\_Financing](http://bit.ly/Patient_Financing).

### New Blog Series from the ACR Data Science Institute<sup>®</sup>

The AI Assistant blog offers valuable information and perspectives from radiologists, patients, data scientists, and other stakeholders about AI in medical imaging. [Read the latest posts at acrdsi.org](http://readthe.acrdsi.org).

### A Quick Lesson on #Radvocacy

A Rutherford-Lavanty Fellow finds out how the government relations team works directly for radiologists and patients on pertinent issues that will affect practice. [Read more at bit.ly/Radvocacy\\_Lesson](http://bit.ly/Radvocacy_Lesson).

### 2018 Transitions and Opportunities for Preparation

This year, two important transitional CMS initiatives should be on your radar: Appropriate Use Criteria for ordering and patient relationship categories and codes. [Read more at bit.ly/2018\\_Opps](http://bit.ly/2018_Opps).



We highly encourage further work exploring personal accomplishments (PA) because increasing the degree of PA [among] radiology residents may have a substantial impact on reducing the degree of radiology resident burnout.

— Jeffrey P. Guenette, MD, and Stacy E. Smith, MD, of the department of radiology at Brigham and Women's Hospital in Boston at [bit.ly/PA\\_Burnout](http://bit.ly/PA_Burnout).

By Ezequiel Silva III, MD, FACP, Chair



# Cost – Rarely Understood but Highly Relevant

*Practices may review their Quality and Resource Use Reports to better understand how they are doing with cost.*

**C**ost, cost, cost. More and more, we hear that physicians are being held accountable for cost. Within the fee-for-service payment model, the Merit-Based Incentive Payment System (MIPS) includes a performance category devoted entirely to cost, which accounts for 10 percent of our MIPS score in 2018. And almost all new payment models require that participants either control costs or face a penalty.

Despite this growing emphasis, it is interesting to note how little physicians understand about how they are scored on cost. And, many of us overlook the fact that we have already been evaluated on cost for the past two years, thanks to the Affordable Care Act-mandated Value-Based Payment Modifier (VM). How did you and your practice perform in terms of cost, as it relates to the VM? It is relatively easy to find out with the Quality and Resource Use Report (QRUR).

### Understanding Your Quality and Resource Use Report

Follow these steps to pull your practice's report and see how you're doing in terms of the Value-Based Payment Modifier (VM) and how you might fare under new payment models.

1. Acquire your Quality and Resource Use Report by contacting your business manager or billing entity. The QRUR indicates performance on the quality and cost measures used to calculate the VM payment adjustment. The recently released QRUR is based on performance in 2016 and affects payments for 2018.

2. Check the risk levels of your patients. The VM allows upward adjustments based on how sick our patients are, referred to as "patient risk." The average risk of our patient population is presented as a nationwide percentile. A higher percentile indicates patients with higher risk, such as those with multiple chronic conditions. By looking at this metric, radiologists easily gain a glimpse into how sick their patients are compared with the rest of the country. Generally, higher risk results in increased cost, which must be factored into cost measures and is referred to as "risk stratification."

3. Find out how you did with cost. For almost all radiologists, the only measure that applies is the Medicare Spending per Beneficiary (MSPB). This measure captures resource use (cost) surrounding a specific hospital stay, from three days before admission to 30 days post-discharge. This measure is based on past billing claims to Medicare. The only time a radiology group would be assigned a specific inpatient admission is when a radiologist has more charges than any other physician for that patient. While not common, this can occur when a patient has a lot of imaging, IR procedures, or radiation oncology treatments but few or no treatments by other specialties. Because some practices have hundreds of admissions assigned to them, the MSPB is a measure worth following.

4. Delve into the MSPB. When requesting your QRUR, be sure to ask for Table 5 of the "Accompanying Tables," which relates to the specific episodes assigned to a practice. Find an inpatient admission assigned to you, and review the imaging and care provided to that patient, obviously respecting and acknowledging the patient's confidentiality. Although every case is different, there may have been opportunities to reduce cost, such as by avoiding unnecessary imaging and procedures or a longer hospital stay than was necessary. Until we look for and identify areas to improve, systematic implementation will be difficult.

5. Engage in a data-driven discussion with your hospital about working together to improve performance on cost. The MSPB is one of the many measures applied to hospitals. Hospitals have their own value program, called the Hospital Value-Based Payment Purchasing Program. The results are reported on the Hospital Compare website ([medicare.gov/hospitalcompare](http://medicare.gov/hospitalcompare)).

Being proactive on increasing our knowledge of cost may better inform our actions to control spending, while still maintaining quality, subsequently increasing our value and maximizing our payments. Under the Quality Payment Program, MIPS includes four performance categories. Most physicians will score well on quality, advancing care information, and improvement activities. This means that our performance on the fourth category — cost — could be the differentiator between a bonus and a penalty. **B**

# Why Should Radiologists Use a Certified Coder?

*An ACR coding expert explains the ins and outs of this radiology-specific certification.*

**P**hysicians know that accurate coding can be critical to a practice's survival. If you under-code, there's lost revenue. If you over-code, you run the risk of possible fraud and abuse charges. Radiologists grappling with coding may want to consider hiring a certified coder to manage the nuances of a complex and ever-changing process.

In a recent interview, Diane Hayek, former director of the ACR Economics and Health Policy Coding Section and past industry director of the Radiology Coding Certification Board® (RCCB), outlined the job duties and skill sets of a radiology certified coder.

**What exactly is a radiology certified coder?**  
A radiology certified coder has earned the Radiology Coding Certification (RCC) designation which recognizes an accepted level of competency and expertise in radiology-specific coding and compliance with federal regulations. A number of coding certification exams are available (e.g., the Certified Professional Coder exam), however, the RCC designation is specific to radiology. Radiology certified coders may include physicians and managers.

**What role does a certified coder play in the chain of care?**

A certified coder ensures the procedures ordered and performed are appropriately billed according to industry guidelines. The coder would also confirm that documentation is adequate to support the codes reported. Accurate and complete documentation is essential as we move to a value-based compensation system under the Merit-Based Incentive Payment System. The certified coder helps to ensure the radiology practice will be reimbursed appropriately for services rendered and can protect the practice against fraud and abuse charges.

**Is there currently a shortage of certified coders in radiology?**

Yes, there are currently only about 900 RCC-certified coders. I continue to hear from a number of practice managers that they have difficulty finding RCCs. If you want to ensure you have competent coders, go to [www.rccb.org](http://www.rccb.org) to learn more about the RCC certification and how your coders can become certified.

### How is the radiology certification process unique?

While a number of coding certification exams are offered, they only offer a few questions specific to radiology coding. Because of this, a radiology-specific exam was developed in 2000 by the RCCB. Now, because of the increasing complexity of IR coding, the RCCB is developing an IR-specific certification exam.

### What are some of the benefits of having a full-time coder on staff?

A radiology-certified coder on staff can discuss issues directly with physicians, identify problems specific to each site, work with a compliance officer, and provide customized auditing and training for the radiology practice.

### How can practices justify the cost of a coder?

Certified coders who appropriately capture revenue for services rendered should more than pay for themselves by avoiding denied claims, underpayment, or no payment at all. Revenue lost by inappropriate coding could be even greater and quite substantial if the practice is subjected to fines for violating billing regulations.<sup>1</sup> Certified specialized coders may require a higher salary compared with other coders; however, the level of expertise and training required makes them a valuable resource for practices.

### Some radiologists won't work at a practice where there isn't a certified coder on staff. Why is that?

The financial climate is continuously changing and having a certified coder directly available to radiologists to answer coding, billing, and documentation questions is invaluable. Although documentation is the radiologist's responsibility, a certified coder can educate and inform where other coders may not have that skill set. Even with automation or off-site coding, there is no replacement for in-person oversight, auditing, and training. **B**

By Chad Hudnall, managing editor, *ACR Press*



The Radiology Coding Certification Board (RCCB) offers its exam several times each year, with dates and details outlined on their website at [www.rccb.org](http://www.rccb.org).

# Why Do You Ask?

Collecting accurate and actionable data starts with a patient-centric strategy.

Patient surveys aren't new, take precious time, and may not always reveal actionable results. Beyond asking the right questions, finding the answers you're looking for from patients requires commitment, genuine curiosity, and a solid understanding of how you are going to use the information you (hopefully) obtain.

"The structure of a patient survey really begins with how you plan to use the data you collect," says James R. Duncan, MD, PhD, professor of radiology at Washington University School of Medicine in St. Louis. "If the goal is to improve the patient experience, you need ongoing data collection — preferably collected frequently and with enough granularity — to assess whether or not your intervention has led to a measurable improvement."

For nearly a decade, hospitals have been using the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to capture and report patients' perceptions of their hospital treatment experience.<sup>1</sup> Information collected from

HCAHPS is reported to CMS and used by the agency for hospital incentives around improving quality of care, transparency, and accountability for services provided. Hospitals that fail to report HCAHPS patient perspective survey results can see their yearly payments reduced.

Now, with CMS tying patient satisfaction to reimbursement under the MACRA Quality Payment Program, it's critical that clinicians understand how to meet patient expectations and accurately report patient satisfaction. The Beryl Institute defines a patient's experience as "the sum of all interactions shaped by an organization's culture that influence patient perceptions across the continuum of care."<sup>2</sup> Capturing that impact can be particularly challenging in radiology — where patients aren't always sure what their radiologist does for them.

## Asking for Understanding

A patient's experience and relative satisfaction with imaging can encompass the perceived effectiveness of services offered and received, empathy shown by physicians and other staff, comfort level, cost, convenience, and many other facets of the healthcare delivery system. With so much ground to cover in a survey, it's important to pin down what is important to patients and what they are willing to share.

The obvious reason for patient surveys is that they provide feedback on how well you are accomplishing your goals toward patient outcomes and experiences, says James V. Rawson, MD, FACP, chair of the ACR Commission on Patient- and Family-Centered Care. "But they can also validate that your activities toward improving the patient experience are successful from the patient's perspective," he says. "Survey data can help to identify things that you are either not addressing or not addressing well."

When you ask the right questions, you might learn how and why patients make certain healthcare decisions, what they value, and what they are willing to trade off, says Mary Jo Tarrant, ACR's director of portfolio planning and environmental intelligence.

"Survey data can help to identify things that you are either not addressing or not addressing well."

— James V. Rawson, MD, FACP

"We ask patients questions and observe their responses to better understand what drives their decisions, engagement, and loyalty," she says. "And the more we understand the patient in the healthcare delivery model, the more proactive we can be in delivering programs, tools, and solutions that impact patients in a positive way."

## Building a Survey

The Medical Group Management Association reports the overwhelming majority of its top performers — those who excel in operations, profitability, productivity, and value — use patient satisfaction surveys.<sup>3</sup> So, if you aren't surveying patients already, you probably should be. A good starting point in designing a survey is recognizing that the purpose of researching patient experience is dependent on the actions you are willing to take based on your findings, says Tarrant.

"Radiology staff and leadership should take an active role in adopting and promoting surveys to assess patient satisfaction in both inpatient and outpatient settings."

— Jason N. Itri, MD, PhD

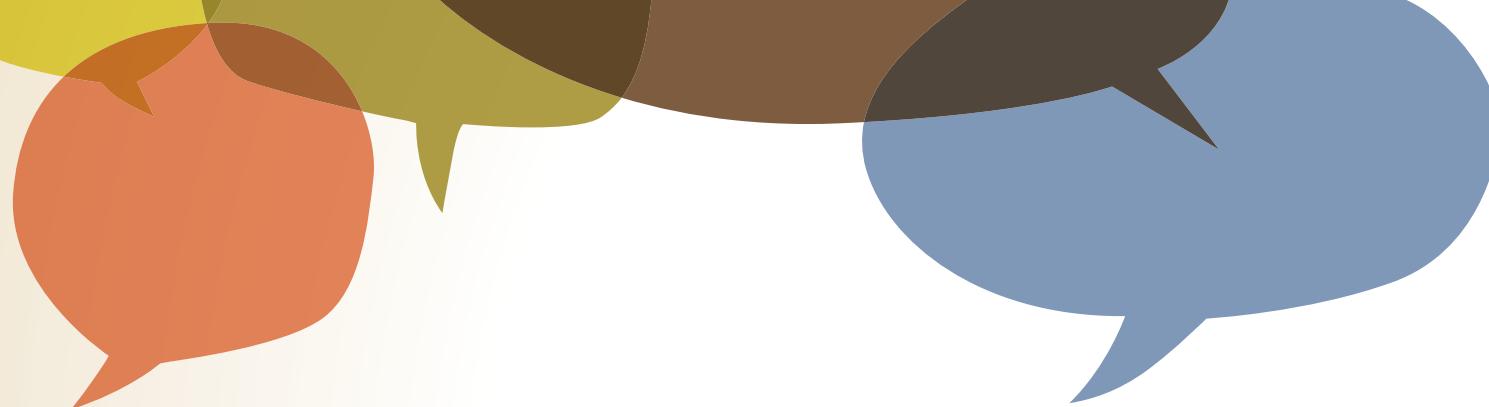
"Radiology staff and leadership should take an active role in adopting and promoting surveys to assess patient satisfaction in both inpatient and outpatient settings," says Jason N. Itri, MD, PhD, a University of Virginia Medical Center radiologist. Survey data can help practices respond to patient complaints, gather benchmark and comparative data, and determine baseline performance measures to study the impact of service and quality initiatives, Itri says.

By Timothy L. Swan, MD, FACP, Speaker, and  
Richard Duszak Jr., MD, FACP, ACR Vice Speaker



"A well-constructed survey should take no longer than 10 minutes — 15 tops."

— Mary Jo Tarrant



The Radiology Process Model, for instance, was developed at Massachusetts General Hospital as a survey to assess patients' experiences with radiology services.<sup>4</sup> The pilot survey has shown that patients' answers reflect four main components: the patient's interaction with the patient-centered aspects of a facility, physicians, and staff; time-sensitive aspects of the care process; painful aspects of the exam; and fear or anxiety.

### Choosing a Methodology

Consumers in the U.S., including patients, are most often surveyed using some type of online methodology, according to Tarrant. Patients are sometimes contacted and interviewed by phone, but that number is shrinking.

Research has shown that surveys conducted using kiosks in the medical or imaging facility where patients receive services lead to higher response rates than online surveys.<sup>5</sup> Survey completion rates can be further improved by placing kiosks next to elevators.

Qualitative techniques include face-to-face exchanges, digital conversations through online bulletin boards and virtual focus groups, and hybrid surveys using both. Qualitative information is not meant to draw conclusions but rather to probe a question or an issue. Quantitative surveys are less personal and typically track concepts such as loyalty and satisfaction, with the goal of identifying levels of awareness, the positive or negative attitudes towards a behavior, experience ratings, and degree of satisfaction or feeling of connection.

Regardless of the type of survey you use, your sample group should reflect the characteristics of the population it represents. Without a representative sample, practices cannot form accurate conclusions from the data they have collected, Tarrant says.

When sending out your survey, it's important too that your sample size is sufficient. Generally, a sample should be no smaller than 50 to ensure that the results are stable and your conclusions are reliable, Tarrant suggests. A well-constructed survey, she adds, should take no longer than 10 minutes — 15 tops.

### Recognizing the Challenges

Choosing the right type of survey to make results actionable won't make your task obstacle-free. It's worth noting, for example, that every stage of conducting a survey has an associated cost. "And the relatively high cost of surveys means they are typically done only periodically," says Washington University's Duncan.

In addition, it is important to realize that when you survey patients, you create an expectation that you will take their responses seriously, Duncan says. "Patients may become frustrated or discouraged if the information they have shared appears not to make a difference in practice or policy."

There is always the danger that the data you have collected are not shared with the right people, says Rawson, or that "no one is sure how to react to the data, and, as a result, no changes are made." Survey data must be reviewed in multiple settings and with multiple stakeholders (radiologists, staff, and administrators), he says, to gain understanding and create a plan.

Trying to glean more about what a patient wants, beyond their surface response, can help you tweak your practice in their favor, Tarrant says. For instance, look at all aspects of a patient's interaction with staff during a visit. One bad experience with one member of a healthcare team can lead to negative feedback that isn't representative of all services being provided.

Patient satisfaction is a measure of the quality of care you provide. It gives clinicians insight into various aspects of medicine, including the effectiveness of their care and their level of empathy. "Understanding patients as consumers," Tarrant says, "including their behaviors, attitudes, and motivations for radiology and general wellness decisions, is integral to delivering the best patient care." B

By Chad Hudnall, managing editor, ACR Press

#### ENDNOTES

- Hospital Consumer Assessment of Healthcare Providers and Systems. Available at [hcphsonline.org](http://hcphsonline.org).
- The Beryl Institute. Available at [bit.ly/Beryl\\_Patient](http://bit.ly/Beryl_Patient). Accessed Dec. 5, 2017.
- MGMA benchmarking report: Almost 80 percent of practices deemed 'better performers' conduct patient-satisfaction surveys. Available at [bit.ly/MGMA\\_Benchmark](http://bit.ly/MGMA_Benchmark). Accessed Dec. 5, 2017.
- Swan JS, Furtado VF, Keller LA, et al. Pilot study of a patient-centered radiology process model. *J Am Coll Radiol*. February 2017;14(2):274–281. Available at [bit.ly/Patient\\_Centered](http://bit.ly/Patient_Centered). Accessed Dec. 5, 2017.
- Boos J, Fang J, Snell A, et al. Electronic kiosks for patient satisfaction survey in radiology. *Am J Roentgenology*. 2017;208(3):577–584. Available at [bit.ly/Electronic\\_Kiosks](http://bit.ly/Electronic_Kiosks). Accessed Dec. 5, 2017.

## What's Next for the Annual Meeting?

*The format at ACR 2018 will re-emphasize governance and the business of advocating for radiology.*

**T**he ACR Bylaws charge the Council with the duty to make policy for and thereby guide the direction of the organization. The Council is a representative body made up of 351 elected members from 54 chapters and councilors from 31 radiology societies. The Council conducts its business at the annual meeting of the ACR held in the spring each year in Washington, D.C.

Beginning in 2015, the ACR experimented with an all-member educational meeting tied to the annual governance meeting. The goal was to expose the broader ACR membership to the governance functions of the College and increase participation in advocacy efforts on Capitol Hill. This format provided high-quality educational content, attracting new members who had not previously attended an ACR annual meeting. However, the educational content competed directly with governance activities.

Realizing that the quality and quantity of educational content was detracting from the main purpose of the annual meeting (the governance of the College), the CSC recommended, and the BOC accepted, a change. At ACR 2018, the focus will be back on the governance activities of the organization. Given space and time limitations, that decision results in a significant reduction in broad-based educational content. This year's meeting will be more targeted to meet the needs of our members and their elected Council representatives. Educational content in 2018 will be directed toward chapter leadership, state government relations, and economics. High-quality educational content formerly presented at the annual meeting will be rolled into other educational events (e.g., the ACR Annual Conference on Quality and Safety, American Institute for Radiologic Pathology correlation courses, the ACR-RBMA Practice Leaders Forum, and Radiology Leadership Institute® programs).

This coming May, the ACR Council will consider several resolutions that will guide the future direction of the College, including governance issues and support for the ACR Data Science Institute™. The CSC remains actively engaged in its annual review of policies, technical standards, and practice parameters, which will also be considered by the Council in May. Members of the CSC continue to communicate with and solicit ideas and suggestions from chapter leaders and the membership to help guide the College into the future. B



Ivey R. Royall, MD, Kimberly M. Beavers, MD, and Ashley G. Grindol, MD, participate in Hill Day at ACR 2017.



James A. Brink, MD, FACP, delivers the BOC Chair Report to the membership at ACR 2017.



ACR President Bibb Allen Jr., MD, FACP, presents the Gold Medal to Bruce J. Hillman, MD, FACP, founding editor in chief of the *Journal of the American College of Radiology*.



ACR 2018 will feature programming designed to support the needs of Council members, chapter leaders, the RFS and YPS. Browse the program at [bit.ly/2018\\_AnnualMeeting](http://bit.ly/2018_AnnualMeeting).

# Hidden Figures

*Although diversity and inclusion have improved in medicine overall, the radiology profession faces continuing challenges and special opportunities.*

Marcus F. Wheatland, MD, was the first African-American radiology specialist and the 11th president of the National Medical Association, the largest and oldest national organization representing African-American physicians and their patients in the United States. When William E. Allen, Jr., MD, FACR, arrived for his ABR examination in 1935, he was directed to take the freight elevator because the hotel manager said African-Americans could not share one with the white guests. Allen rode to the top floor, took the oral exam, passed it, and became the first black diplomate of the ABR. He later became the first black member of the ACR, the first black fellow in 1945, and an ACR Gold Medalist in 1979. Leslie L. Alexander, MD, FACR, made medical history when he was elected as the first black vice president of the ACR BOC. Granville C. Coggs, MD, FACR, Tuskegee airman, inventor, and radiologist, was accepted to Harvard University and went on to receive the

**"Emphasizing opportunities for patient contact and education in radiology may attract more minorities."**

— Sharon E. Byrd, MD, FACR

Congressional Gold Medal. Ivy O. Brooks, MD, followed her dream to become a physician at Meharry Medical College in Nashville, Tenn., and later served as secretary to the National Medical Association's Section on Radiology. She was the first woman appointed chief of radiology at the Tuskegee Veterans Administration Medical Center.

Despite the trailblazing work done by these black pioneers in the field of radiology and radiation oncology, a shortfall remains in the number of African-Americans entering the

medical profession, specifically the radiological sciences. In 1955, the Association of American Medical Colleges first acknowledged that a problem existed in the underrepresentation of blacks in medicine.<sup>1</sup> The academic medicine community began studying and actively promoting the enrollment of more diverse and representative medical students, noting in 1968 that "medical schools must admit increased numbers of students from geographical areas, economic backgrounds, and ethnic groups that are now inadequately represented." At least in part as a result of this commitment, the representation of African-Americans in medical schools increased rapidly from 2.4 percent of all U.S. students in 1968 to 6.3 percent by 1974. However, representation has improved only marginally since then, standing at 6.9 percent in 2012 (the most recent year for which data are available).<sup>2</sup>

## Barriers Start Early

Although many initiatives supported by foundations, medical schools, and government have contributed to increasing diversity in the physician pipeline, the number of applicants from one major demographic group — black men — has not increased since 1978. Despite an overall increase in the number of black male college graduates over the past three decades, the number of black male applicants to medical school dropped to 1,337 in 2014 (from 1,410 in 1978). The number of enrollees also has declined, with 542 black male students enrolled in 1978, compared with 515 in 2014.<sup>3</sup>

"What we are seeing is the extinction of black men in medicine," says Raymond B. Wynn, MD, FACR, vice chair of network operations in the department of radiation oncology at Loyola Medicine in Maywood, Ill. "African-Americans are essentially becoming hidden in medical education."

Wynn is the only African-American academic radiation oncologist in the city of Chicago. He believes barriers occurring before medical school deter black students from applying for and being accepted to radiology programs.

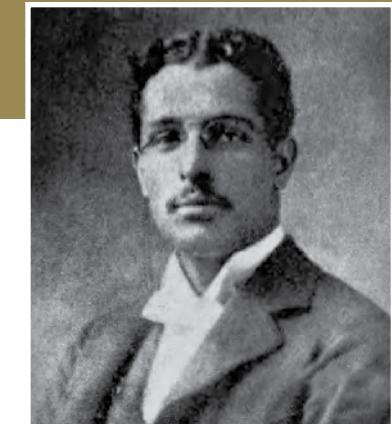
"When you look at the science, technology, engineering, and mathematics (STEM) education system and who pursues STEM careers, you can see some implicit and explicit bias," says Wynn. "Institutional and systemic racism also exists. People tend to choose those with whom they are familiar and who have similar pedigrees to them. In highly-ranked universities, if you don't have black students already attending, then prospective black medical students are less likely to be selected when applications are reviewed. These factors make the pipeline tighter and smaller. It's the elephant in the room."

Blacks and Hispanics have a greater likelihood of attending medical schools affiliated with historically black colleges and universities, which, though quite diverse in student composition, still educate a higher proportion of underrepresented minorities (URMs) than do other medical schools. Typically, because these universities lack radiology and radiation oncology training programs, students are less likely to be exposed to those fields in clinical rotations and electives or to interact with radiologists and radiation oncologists as faculty and mentors.<sup>4</sup>

According to Johnson B. Lightfoote, MD, FACR, a neuroradiologist at Pomona Valley Hospital Medical Center in California, another barrier to entry is the fact that radiology residencies look for participants who have publications, posters, and papers for meetings, and direct participation in radiology. Without mentors from within radiology, "these minority students may not be aware early as to what the preparation is to be accepted to radiology residencies," says Lightfoote. "And, therefore, they don't properly prepare for acceptance."

## Perception Matters

Radiology and radiation oncology are two of the five subspecialties with the fewest URMs of all medical specialties.<sup>4</sup> Lightfoote points out the misconception that radiology does not have a direct impact on patient care in the way that obstetrics and gynecology or family medicine does. With many minorities entering medicine wanting to have an effect on patients in their local communities, some medical students may not consider radiology, not understanding the patient-facing qualities and the direct impact the specialty has on all levels of disease.<sup>5</sup>



Marcus F. Wheatland, Sr., MD, in 1899

Read "Diversity 3.0: Are We There Yet?" a report from Katarzyna J. Macura, MD, PhD, FACR, chair of the ACR Commission for Women and Diversity, at [bit.ly/ACR\\_Diversity](http://bit.ly/ACR_Diversity).

1. Granville C. Coggs, MD, FACR, staff radiologist at Brooke Army Medical Center at Fort Sam Houston in Texas, evaluates a mammography X-ray searching for abnormalities. (Image courtesy of Andricka Hammonds, U.S. Department of Defense.)

2. Ivy O. Brooks, MD 3. William E. Allen, Jr., MD, FACR, and Leslie L. Alexander, MD, FACR, at the first Allen Lecture of the National Medical Association Section on Radiology in 1978.



William E. Allen, Jr., MD, FACP,  
and Mrs. Allen with his  
ACR Gold Medalist portrait.

Sharon E. Byrd, MD, FACP, chair of the department of diagnostic radiology and nuclear medicine at Rush University Medical Center and College in Chicago, agrees with Lightfoote. She notes that studies suggest women and minorities often enter medicine wanting patient contact, and, therefore, the specialty could seem overly removed from the patient.<sup>6</sup>

"I chose neuroradiology as my subspecialty because it allows me the patient contact through performing diagnostic procedures on patients," says Byrd. "Emphasizing opportunities for patient contact and education in radiology may attract more minorities."

**"ACR is making the house of radiology not only appear more diverse, but actually be more diverse in terms of gender, ethnicity, and culture."**

**— Raymond B. Wynn, MD, FACP**

According to Byrd, the ACR Commission for Women and Diversity is taking several steps to do just that, including founding the Pipeline Initiative for Enrichment of Radiology (PIER) mentoring program to increase minority medical student exposure and preparation for radiology postgraduate training. The PIER program, in collaboration with Nth Dimensions — an educational non-profit organization helping to increase diversity in orthopedics and other subspecialty fields — began in 2017 with an initial group of five rising second-year URM students who are being prepared to enter radiology residencies.

"The commission has been a major step forward in bridging the divide," says Wynn, who is one of ACR's two radiation oncology delegates to the AMA. "In fact, one of our white papers was referenced at the Minority Affairs Section meeting, during which the AMA resolved to address bias and inclusion in medical education."

While Wynn says that there remains a long way to go, he notes that the ACR is committed to literally changing the face of the organization.

"ACR is making the house of radiology not only appear more diverse, but actually be more diverse in terms of gender, ethnicity, and culture. A lot of groups create the perception but not truly the reality of diversity. I see other organizations stating that they value diversity, but the ACR is actually doing something about it. The rubber is meeting the road, and I've never seen it in all my days in medicine until now." **B**

By Nicole B. Racadag MSJ, managing editor, *ACR Bulletin*, and Dara L. Fox, freelance writer, ACR Press

#### ENDNOTES

1. Cobb WM. Association of American Medical Colleges acknowledges problem. *J Natl Med Assoc*. 1955;47:73–4.
2. Lightfoot JB, Fielding JR, Deville C. Improving diversity, inclusion, and representation in radiology and radiation oncology part 1: why these matter. *J Am Coll Radiol* 2014;11:673–80. Available at [bit.ly/Diversity\\_Part1](http://bit.ly/Diversity_Part1). Accessed Dec. 8, 2017.
3. American Association of Medical Colleges (AAMC). Altering the course: black males in medicine. Washington, D.C.: AAMC; 2015.
4. Lightfoot JB, Fielding JR, Deville C. Improving diversity, inclusion, and representation in radiology and radiation oncology part 2: challenges and recommendations. *J Am Coll Radiol* 2014;11:764–70. Available at [bit.ly/Diversity\\_PartTwo](http://bit.ly/Diversity_PartTwo). Accessed Dec. 12, 2017.
5. Association of American Medical Colleges (AAMC). Minorities in medical education: facts & figures 2005. Washington, D.C.: AAMC; 2005.
6. Saha S. Taking diversity seriously: the merits of increasing minority representation in medicine. *JAMA Int Med*. 2014 Feb 1;174(2):291–2. Available at [bit.ly/Minorities\\_Medicine](http://bit.ly/Minorities_Medicine). Accessed Dec. 13, 2017.

Unless otherwise noted, all images are courtesy of the National Medical Association Section on Radiology and Radiation Oncology.

## A Doctor's Dilemma

### ***Should we treat patients like our family — or treat our family like patients?***

**T**reat each patient as if they are your family. We hear this wisdom taught in medical school classrooms, whispered in ward corridors, and echoed in our own heads. Rarely do we pause, however, to meditate upon what might happen if we were actually to treat each patient as a member of our own family...I remember when I was first taught this, in my first year of medical school, before I became a wife and a mother.

A certain calm, polished, calculated demeanor is the sign of a seasoned physician. While the casual outside observer might mistake this for simple callousness, this carefully sculpted approach to patient care is deeply multidimensional and allows the delivery of impeccable medical care. In pivotal moments, irrational emotions rarely result in productive therapy.

The ability to calmly keep one's own sense of sadness, grief, or even joy in careful check allows for the patient to be at the center of care. And while a doctor can deeply experience a range of emotions while caring for a patient, these feelings are carefully processed internally. Over the years of medical school and residency, we learn when it is appropriate and safe to cry with patients and when it is fitting to celebrate with them. Yes, we keep the patient at the center of our actions and reactions, but we are guided by reason, evidence, and years of training.

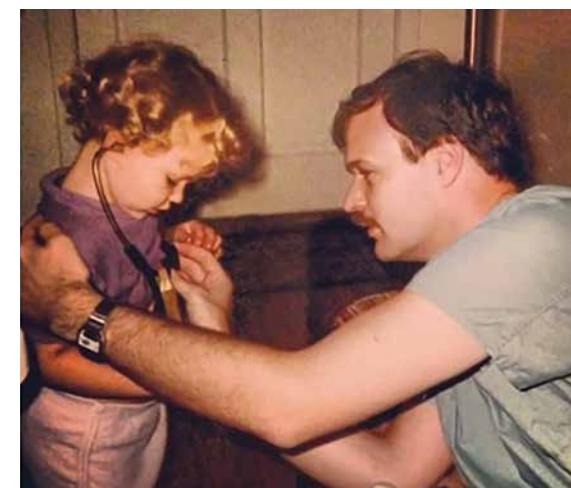
Emotional intelligence and disciplined control are ingrained in us, but our limits can be tested. What happens when the patient is literally a member of our family? What happens when the person before us is our parent, sibling, or child? Whether we're asked for casual advice at the dinner table or to interpret a formal staging CT, we may all face a situation like this at some point in our career. Common sense warns us to simply avoid treating family. However, the lines we imagine should never be crossed are often blurred, bent, and traversed in real life. Perhaps the best approach we can take is to treat family as if they were our patients.

I have found myself navigating this uncharted territory between family and patient. I've come to realize that those two very precious titles are often not mutually exclusive.

In our work as radiologists, we wouldn't allow irrational emotion to trigger a biopsy of a benign incidental finding on the very unlikely chance that a cancer is present. We don't allow our judgment to be swayed to avoid a potentially painful but necessary procedure. We offer the best possible advice based on available evidence, within the context of each patient's specific situation. We owe it to the people most dear to us, our families, to offer the same excellent care that we provide patients every day.

Can we approach the care of our loved ones with the calm, polished, calculated demeanor of a seasoned physician? Will we allow a family member's experience to set the tone of the moment and appropriately curb our own emotional response? Will reason and experience guide our actions? Although quite difficult, in the pivotal moments of my family's medical journey, treating my family as I would my patients is perhaps the most loving act I can offer.

As a daughter and a wife and a mother, who also happens to be a doctor, I know that the most selfless way I can provide excellent patient-centered care is by treating each person — family or not — with the same art of caring that I continue to sculpt on my journey through medicine. **B**



Kristina E. Hoque, MS, MD, PhD, and her father Robert S. Bray Jr., MD, a neurosurgeon, in 1984.



**Kristina E. Hoque, MS, MD, PhD,** is a neuroradiologist and nuclear medicine physician, practicing in Los Angeles.



The Radiologist's Toolkit for Patient- and Family-Centered Care offers practice-specific online resources to help radiologists enhance patient-engagement skills and offer more patient-centered care. Access the toolkit at [bit.ly/ACR-PFCC](http://bit.ly/ACR-PFCC).

# Behind the Curtain

**Ohio radiologists collaborate with a patient advocate to implement a direct-results delivery program that decreases patient anxiety.**



Dianne Hater,  
patient and family  
advocate in Cincinnati  
Children's Hospital's  
radiology department.



David C. Mihal, MD,  
diagnostic radiology  
resident at the  
University of Cincinnati  
Medical Center.

**W**hen David C. Mihal, MD, diagnostic radiology resident at the University of Cincinnati Medical Center, began working on his practicum for the Radiology Leadership Institute® he knew he wanted to use the opportunity to make a real difference for patients and families. But before Mihal could improve the patient experience, he needed a better understanding of how patients and families perceived radiology.

Mihal turned to Dianne Hater, patient and family advocate in the Cincinnati Children's Hospital's radiology department, to help him focus his efforts on meaningful change in patient care. "I approached Dianne because she was deeply entwined in patient and family relationships at Cincinnati Children's, and I wanted to make some sort of real difference that would directly benefit them," Mihal says.

Hater, who became an advocate after navigating the healthcare system during her own daughter's illness, began talking with the hospital's frontline staff (including technologists, registration personnel, patient advocates, and child-life specialists) about their interactions with patients and families who had undergone imaging. From these conversations, Hater found that many patients and families were noticeably nervous during and after their imaging exams, and the technologists often felt helpless because they were unable to share results with patients and families.

Read "Why Do You Ask" on Page 10 for more information on building and executing an effective patient survey.

**"Speaking with patients is an excellent reminder that we are diagnosing real people."**

- Alexander J. Towbin, MD

Recognizing an opportunity to improve the patient experience through better communication, Mihal initiated a direct-results-delivery pilot project that would allow patients and families to review their exam results with a radiologist immediately after image acquisition. Since its inception in 2015, the project has drawn praise from patients and families, with 92 percent providing positive feedback on surveys. In addition, 84 percent of participating radiologists and technologists reported increased job satisfaction — leading the department to adopt it as an ongoing initiative.

## A Face to Radiology

To get the program off the ground, Mihal approached Brian D. Coley, MD, radiologist-in-chief and professor of radiology and pediatrics, and Bernadette L. Koch, MD, pediatric neuroradiologist and associate chief of academic affairs. Coley and Koch were both excited for the opportunity to reemphasize quality patient care and to give patients a chance to speak directly with radiologists. "This program provides patients with more positive experiences in radiology and puts a human face to the profession, helping patients understand the important role that radiologists play in their care," Coley says.

In addition to humanizing radiology for patients, the project also offered the chance for the department's radiologists to connect with their patients and feel more fulfilled as a result, says Alexander J. Towbin, MD, associate chief of clinical operations and radiology informatics and pediatric radiologist at Cincinnati Children's Hospital. "Oftentimes, as radiologists, we get detached from our patients. We are looking at pictures all day. We see the body parts and the disease, but we don't always see the child on the other side of the picture," Towbin says. "Speaking with patients is an excellent reminder that we are diagnosing real people."

## A New Beginning

Mihal began rolling out the project slowly and purposefully, in part to win support from his colleagues, many of whom were initially concerned that they would be unable to keep up with the volume of patients opting for the service. In fact, only seven of the department's 40 radiologists volunteered to participate in the project at first. "As the program expanded and faculty saw how little time it actually took, it was much easier to get more radiologists involved," Koch says.

To get patients involved, technologists simply asked whether patients wanted to speak with the radiologist. If the patient and family opted for a consultation, the technologist located a radiologist from the volunteer pool, assigned the study to that radiologist, and informed the patient that the radiologist would be in soon to discuss the results. The radiologist would then read the study and deliver the results directly to the patient in the exam or consultation room. Wait time for the patient was typically less than 10 additional minutes.

In feedback surveys, patients and families were overwhelmingly satisfied with the service and reported feeling relieved and at ease after receiving their results from a radiologist. Comments included, "Made my day!" and "It immediately eased my mind and assured me everything was OK to return to work and school."

As an imaging technologist and quality improvement coach at Cincinnati Children's Hospital, Erin Adkins values the opportunity to help lessen the anxiety patients and families often feel. "When you see patients and families enter the room who are visibly nervous, you can immediately put them at ease by offering to find a radiologist to speak with them," she says. "A lot of what we do is so quick, and this provides some closure and more connection with the patients. It gives you satisfaction in knowing that you are part of improving the patient experience."

In addition to increasing job satisfaction, most of the radiologists and technologists involved in the program

report little increase in their workloads as a result. "If anything," Coley says, "spending time with patients minimizes physician burnout. It personalizes what radiologists do and allows them to connect more directly with patients."

## Plans for the Future

Cincinnati Children's Hospital has now integrated the pilot project into the regular workflow as an ongoing program for outpatients undergoing imaging. "There's no doubt how much patients and families appreciate it when they can get their results and have their questions answered immediately," says Hater. "It saves them from so much worry and allows them to move more quickly toward treatment and healing. This kind of patient-centered care is the way of the future, and radiologists are well positioned to lead this effort." **B**

By Chelsea Krieg, freelance writer, ACR Press



Alan S. Brody, MD, a radiologist at Cincinnati Children's Hospital, consults with a young patient about a procedure.



**Call For Case Studies**

ACR's Imaging 3.0™ initiative is a roadmap for transitioning the practice of radiology from volume-based to value-based imaging care.

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To share your own experience with Imaging 3.0, complete the form at [http://bit.ly/case\\_submit](http://bit.ly/case_submit).

# Value Above All

**The ACR Annual Conference on Quality and Safety assesses radiology's value in an ever-changing health system.**

The importance of demonstrating and expanding value as radiologists was the central theme of the ACR Annual Conference on Quality and Safety, held in Boston this past October. Jonathan B. Kruskal, MD, PhD, FACR, chair of the department of radiology at Beth Israel Deaconess Medical Center in Boston and chair of the ACR Commission on Quality and Safety's Quality Management Committee, opened the conference by discussing the present state of radiology. "We currently exist in a disconnected state," he said. "We are a small cog in the wheel of value-based healthcare, and we cannot afford to overestimate our contributions nor how others perceive our value proposition."

Despite some early adopters and initiatives emphasizing the improvement and recognition of this value, many have not embraced the act of cultivating radiology's value, according to Kruskal. Why? Given the current political climate, many are justifiably uncertain about the future of the Affordable Care Act and how it will impact healthcare, reimbursement, and the fee-for-service paradigm. Another, perhaps less complicated, reason is that many don't know how to define value and are unsure how value truly impacts their organization's outcomes.

## The Big Picture

Providing a perspective on the U.S. government's role in healthcare, Gregory N. Nicola, MD, vice president of the Hackensack Radiology Group in New Jersey, presented in a session titled "What's Driving the Shift to Value? Our Economic Imperative." Nicola described the economic forces behind radiology's overall move away from fee-for-service. The U.S. spends more of its gross domestic product on healthcare than any other country, he noted, but it ranks lowest in health system performance overall among advanced countries, according to data from The Commonwealth Fund (available at [bit.ly/CFundStats](http://bit.ly/CFundStats)).

To rein in spending and establish measures for value, CMS has incentivized the move from volume to value through its MACRA program, its endorsement of public-private partnerships, and the "massively complex" Quality Payment Program (which encompasses the Merit-Based Incentive Payment System and alternative payment models). In addition, payers, such as Anthem, are attempting to control costs themselves by placing blanket restrictions on specific imaging services.

## Defining Value

To help define value, David B. Larson, MD, MBA, associate professor of radiology at Stanford University Medical Center, during his presentation titled "Creating and Capturing Value for our Stakeholders," stated that value is something that provides worth to an individual to fulfill a need or desire. Value often depends on what recipients must sacrifice versus the quality and service they receive. Therefore, the receiver, not the provider, determines value. In such an environment, he noted, understanding the receiver's perspective is critical.

Larson noted that radiologists may find it difficult to understand the perspective of the end customers (patients) because radiologists are so far removed from them. It may be equally difficult for radiologists to understand the perspective of the direct customers (referring providers), because specialists, emergency providers, and primary care providers have such disparate needs. In addition, technology can be a disruptor in the care continuum because of variables such as staff changes, preferred methods of communication, and even changes to the technology itself.

## Creating a Strategy

To overcome these obstacles, Kruskal recommended several strategies designed to help radiology thrive and increase its value in today's healthcare system.

**Engage your customers.** Radiologists must understand and show their customers — referring providers and patients — how they contribute to patients' health. To do so, radiologists must understand how health is defined and measured and establish ways to collaborate and become more customer-centric. "We don't get to define the metrics that reflect our value proposition, but we still have the opportunity to manage them," Kruskal noted.

**Deliver excellent service through continuous quality improvement.** Implementing continuous quality improvement requires time and resources. It cannot be delegated or outsourced, and it should not be viewed simply as performance and quality improvement checkboxes, a committee, or a line item in the annual operating plan. "Service excellence cannot and should not be purchased or outsourced. Own the service that your customers expect, or they will outsource you!" Kruskal admonished.

*Continued on page 21*

## 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](mailto:careercenter@acr.org).

**Nebraska** — Creighton University School of Medicine is recruiting a full-time faculty position for its division director of thoracic radiology at the assistant or associate level. The School of Medicine sponsors an ACGME-accredited radiology residency program. A genuine interest in education and research are prerequisites along with teaching and mentoring.

**Contact:** To apply, please contact or email CVs to Jennifer Vandament at [Jennifer.vandament@alegent.org](mailto:Jennifer.vandament@alegent.org).

**Michigan** — Northern Imaging Associates is looking for a radiologist at the Four Seasons resort community in the Petoskey-Harbor Springs area in lower Northern Michigan, a premier vacation destination. The position entails a full range of diagnostic imaging provided by a progressive radiology group serving three hospitals. Partnership track offered to board-eligible or ABR/AOBR-certified candidate.

**Contact:** To apply please contact or send CVs to Anthony R. Pucci, DO, at [leprechaun21@charter.net](mailto:leprechaun21@charter.net).

**Wisconsin** — The department of radiology at the University of Wisconsin-Madison School of Medicine and Public Health is seeking a full-time radiologist interested in pursuing an academic career in abdominal imaging and intervention at the rank of assistant, associate, or full professor.

**Contact:** For consideration, visit <https://jobs.wisc.edu/> and search for 91040 or 91041.

## CONTINUED

### Value Above All

*Continued from page 20*

**Provide data-driven care and know how to measure value.** Radiologists should ask themselves, "Is radiology improving human health?" What metrics do radiologists have for determining the answer to that question? Measuring value is not easy because there is no single metric that fits all situations, customers, and stakeholders. Also, effective metrics will continuously evolve. Nevertheless, the value equation can be defined as a vision statement that encompasses such themes as appropriateness, outcomes, experience, quality, and cost.

**Communicate unambiguously.** The imaging report is the radiologist's "product." There are ways to standardize reports and provide more value to customers. For example, the phrase "satisfactory biopsy" is vague, whereas "adequate diagnostic material" conveys a more specific impression.

**Engage in appropriate and efficient care.** Sometimes the best care for the patient is to do nothing. It is important to determine if a study is necessary and will answer the specific clinical question being asked.

**Be available, accessible, and affable.** Radiologists should "leave the basement" and go to "the floor where care is provided," explained Kruskal. They should find their patients and encourage their clinical colleagues to visit the reading room.

**Learn and improve, always.** Radiologists should be transparent about reporting, analyzing, and sharing their errors and near misses. "Any process that minimizes, delegates, or obscures this legitimate improvement effort and culture should be avoided at all costs," Kruskal said. **B**

By Brett W. Hansen, CAE, Assistant Director, ACR Press

integral part of how the ACR is run, the organization's finances are in sufficient order for a sustainable future. Based on the environmental assessment the group created a new goal related to data science:

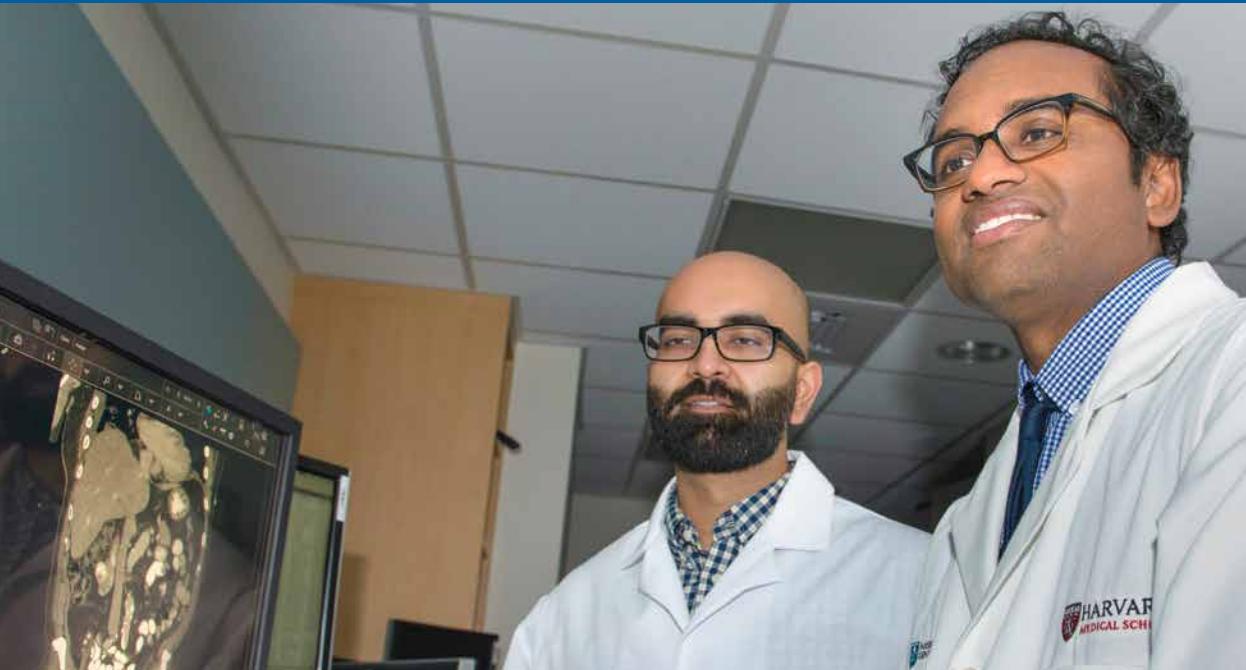
### Data Science

- The College will advance data science as core to clinically relevant, safe, and effective radiologic care. Specifically, we intend to establish the ACR as a global leader in advancing appropriate data science solutions and ensure that the benefits of AI are clear for all radiology professionals, patients, and the greater community. The ACR will facilitate the development of AI solutions that are free of unintentional bias and develop external relationships that support and extend the ACR's data science goals. Moreover, the ACR will promote educational initiatives that provide the skills needed to implement and adopt data science solutions.

Overall, the revised ACR Strategic Plan is more expansive and emphasizes new payment models, population health management, diversity and inclusion, and AI. I am confident that the revised and updated plan will guide us effectively in the future as we continue to address both the short-term and long-term issues that affect our profession on a near daily basis. **B**

Stay current on the latest in quality and safety by subscribing to *Inside Q & S*, the quarterly newsletter for medical imaging and radiation oncology professionals, at [bit.ly/Inside\\_QS](http://bit.ly/Inside_QS).

## FINAL READ



Anand M. Prabhakar, MD, MBA, reviews emergency radiology cases with Hemang M. Kotecha, DO, an emergency radiology fellow at Massachusetts General Hospital.



Anand M. Prabhakar, MD, MBA, is an assistant professor of radiology at Harvard Medical School.

## What advances in the field of radiology do you find most exciting?

To me, the most exciting aspect of radiology is the fact that we, as radiologists, have a tremendous opportunity to improve the experiences of the patients we serve. Several hundred million imaging exams are performed annually in the United States, and each one of these has several phases that could be modified to take advantage of conveniences that are available in our personal lives, such as Uber, Airbnb, and live chats with customer service representatives.

For example, mobile platforms or chatbots could streamline scheduling or provide instructions before an exam. During an exam, advanced translation digital applications could ensure that we are doing our best to communicate with patients from all backgrounds. Finally, our commitment to the patient continues even after an exam is performed. Providing a timely and relevant report is essential, in addition to making ourselves available to the patient directly. Recent advances in AI could also help facilitate a better patient experience. For example, automated scheduling could allow the patient to choose the exam time and location, subsequently reducing the wait time and improving the overall experience.

Although there are many changes expected for radiologists, new technologies will provide us with more tools to take care of our patients and improve the efficiency of our practices. **B**

Our commitment to the patient continues even after an exam is performed.

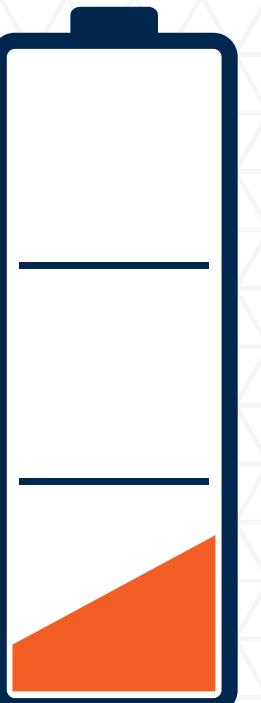
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