Word of Mouth
Progress through Collaboration:
The Lung Cancer Screening Implementation Guide

The United States Preventive Services Task Force recommends lung cancer screening for those considered at high risk, because if caught before it spreads, the likelihood of surviving five years or more improves to 56 percent. Implementing a screening program to support patients is complex, which may be contributing to the slow adoption of lung cancer screening programs in community hospitals and healthcare systems.

The American Lung Association worked with the American Thoracic Society to convene experts from diverse disciplines to develop the Lung Cancer Screening Implementation Guide. The Guide recognizes that a successful screening program requires careful coordination and offers an overview of the general structure of screening programs and topics for consideration, including pitfalls and resources.

Designed to help individuals quickly find the right information as they are tackling a particular issue, the interactive website includes sections on:

- Initiating a Lung Cancer Screening Program
- Radiology Requirements
- Shared Decision Making
- Referring Physicians
- Program Navigation & Data Tracking
- Resources

We know that lung cancer screenings have the potential to save an estimated 25,000 lives if every American at high risk were screened. The Lung Cancer Screening Guide is a bold step to expanding access to lung cancer screening across the country, giving more hope to those at risk of lung cancer.

See the full Guide at LungCancerScreeningGuide.org.
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Reducing Lung Cancer Deaths

ACR’s LCS 2.0 Steering Committee is addressing the barriers, identifying solutions, and empowering radiologists to lead efforts to increase low-dose CT adoption.

There is an ever-growing body of evidence that lung cancer screening (LCS) with low-dose CT (LDCT) is effective. Most in the medical community were delighted when the results of the National Lung Screening Trial in 2011 showed a 20% reduction in lung cancer mortality with LDCT and with the subsequent Grade B recommendation from the U.S. Preventive Services Task Force. This milestone led to insurance and Medicare coverage for LDCT as a preventative service in eligible patients — which means eligible patients could receive LDCT with no cost sharing or co-pay required.

Unfortunately, the uptake of LDCT has been disappointingly low — likely due to the complex eligibility requirements and multiple barriers to access. Social factors, including stigma related to smoking, also discourage patients from seeking screening services. While these are significant challenges, they also represent an opportunity for LCS advocates, and in particular radiologists, to step up and make a difference (read more on page 9). We have an effective screening tool that can save lives but it is not being utilized. We can and must identify strategies to increase the adoption of LCS to decrease the burden of lung cancer on society.

I have had the opportunity to serve as chair of the ACR LCS 2.0 Steering Committee over the past year. With strong support from ACR leadership, the Committee was formed to evaluate and address the barriers to LCS and empower radiologists, along with other stakeholders, to increase the adoption of LCS. Members were recruited from a wide variety of practice environments, including academic, government, and community-based practices from across the country and from metropolitan, suburban, and rural areas. The Committee was designed to be inclusive and diverse and continues to welcome any interested members. The members bring a wealth of experience and share best practices to inform our work. With the help of the amazing ACR staff, our Committee has reached several milestones.

Four workgroups have been formed that focus on specific issues or barriers to LCS: economic/billing issues, community-based LCS, outreach to patients and providers, and clinical resources and incidental findings. The workgroups have addressed numerous topics and created two important quick guides — easy-to-understand reference documents for LCS programs. The guides are focused on economic/billing issues in LCS and managing incidental findings on LDCT, and are based on the valuable ACR white papers on incidental findings. The quick guides are intended for use by LCS program coordinators, nurse navigators, and referring providers, but will also be useful to practicing radiologists.

At ACR 2019, the Committee presented a boot camp on LCS, which was so successful that it was presented again as a webinar series in July and August. The topics included economic issues, program logistics, quality metrics, disparities, Lung-RADS®, and how to build and lead a LCS program. Another webinar series is being planned for the coming year (learn more at bit.ly/LCS_Webinar).

Collaboration and engagement with other LCS stakeholders has been another important accomplishment of the Committee. The group has established strong ties with the American Cancer Society’s National Lung Cancer Roundtable (NLCRT) and a number of the LCS 2.0 Committee members serve on the NLCRT committees. The Committee has worked closely with multiple other organizations, including the GO2 Foundation for Lung Cancer (formerly the Lung Cancer Alliance and the Bonnie Addario Foundation), several state health departments, various cancer coalitions, and (of course) patients who share their stories and guide our efforts.

The Committee has certainly benefited from the extensive experience of the ACR in other screening programs such as mammography. Our colleagues in breast imaging have provided models of how to set up screening programs, how to interact directly with patients, how to manage quality metrics, how to influence payment policy, and how to manage misinformation in the media.

As we acknowledge our accomplishments, we know there are ongoing challenges. We need to help patients navigate our complex and often fragmented healthcare system. We need to address the high-deductible health insurance plans that often hinder patients in getting timely diagnostic follow-up care. We need to find ways to make the shared decision-making requirement less onerous and explore novel approaches. We must do all we can to increase access to LCS services — while ensuring high-quality appropriate care. I am confident we will continue to make progress, together.
Radiology Needs TMIST

Etta D. Pisano, MD, FACR, chief research officer of the ACR, recently spoke at the Association for Medical Imaging Management’s annual meeting in Denver to advocate on behalf of the Tomosynthesis Mammographic Imaging Screening Trial (TMIST). By measuring the relative clinical performances of digital breast tomosynthesis and digital mammography, TMIST will determine which of these two imaging technologies reduces advanced cancers in the population screened — an endpoint that correlates with breast cancer mortality. To generate enough statistical power to answer its primary questions, TMIST will involve 164,946 women, ages 45 to 75, who will randomly be assigned to breast cancer screening, typically in one-year increments during the four- and a half-year trial.

“The most important outcome from TMIST will be the information it will provide to us about how to individualize breast cancer screening,” Pisano said. “We have been using personalized therapies for breast cancer for several decades. We need personalized approaches for screening as well, and this study will give us lots of information on how we can achieve that.”

For more information on TMIST, visit acr.org/TMIST.

Leaders Influence the Future of Imaging

Help the College launch the future of radiology by pursuing an ACR leadership position. Submit your 2019 candidate information form by Dec. 12, 2019.

Learn more at acr.org/CNC2019 or email Amy Shipp at cnc@acr.org for additional information.

RadExam, DXIT, and TXIT, Oh My!

Attention program directors and coordinators: have you signed your residents up for upcoming exams? It’s not too late! To register residents for RadExam, DXIT™, or TXIT™, visit onlineregistration.acr.org/intrainingexam.

For more information, email intrainingexam@acr.org.

JACR Special Issue: Data Science and Quality

The latest JACR® special issue takes on the next big thing in data science. “While image analysis has captured much of our attention, using AI and advanced data analytics tools to improve quality, workflow and patient experience are gaining importance,” write the issue editors, Bibb Allen Jr., MD, FACR, Tessa S. Cook, MD, PhD, and Jacqueline A. Bello, MD, FACR.

The issue includes an overview and risk-benefit analysis of AI tools for the radiological sciences, takes readers through the process of evaluating AI models for use in clinical practice, and examines how AI will assist institutions in developing quality improvement activities and peer learning opportunities. You’ll also find case-based examples for real-world context.

Read the special issue online at jacr.org.

Radiologists will need to understand what AI is, how it works, and what it can and cannot do. And the best way to learn is by doing.

— Charles E. Kahn Jr., MD, MS, FACR, professor and vice chair of radiology at the University of Pennsylvania, at bit.ly/RSNA_Kahn

Early Detection Matters

Leveraging leadership practices gained from Imaging 3.0® and the Radiology Leadership Institute®, a radiologist with a private practice in Michigan has led the development of a successful lung cancer screening (LCS) program. Since the program began in 2015, it has served nearly 2,500 patients, with a 3% lung cancer detection rate and a stage IV detection rate that is 8% better than the national average. “Lung cancer detection starts with a CT of the lungs, so the radiologist is at the center of the entire chain of care,” says Samir J. Parikh, MD, MBA.

To encourage maximum participation, the team focused on eliminating potential hurdles for both patients and referring physicians. “We are all passionate about reaching out to our community — especially the lower socioeconomic population where smoking is more prevalent — and encouraging people to get the screening that can save their lives,” says Parikh.

To read the case study, visit acr.org/Early-Detection.
Although applications of AI in medical imaging have the potential to create monumental changes in radiology, it is this human touch that cannot be replaced. Thus, radiologists will always add value, where technology alone cannot.

— Amy K. Patel, MD, medical director of women’s imaging at Liberty Hospital, at bit.ly/ACRDSI_Patel

New Case Study: Alert Focus

Radiologists and hospitalists at UT Southwestern Medical Center in Texas leveraged their structured reports to create best practice alerts in the EHR for deep vein thrombosis (DVT) patients. The alerts ensure DVT patients receive the potentially life-saving anticoagulation treatment they need in a timely manner. Collaboration among radiologists, hospitalists, and IT team members was critical to the success of the program, which generated nearly 100 alerts in the first six months.

“We have a large, complex healthcare system, and information is at risk of being lost as different providers transition care for patients,” says Travis G. Browning, MD, director of quality for the department of radiology at UT Southwestern and deputy medical informatics officers at Parkland Memorial Hospital. “What this system does is identify a potential delay in therapy for what can be a life-threatening disease process. It helps ensure that patients receive the care they need, when they need it.”

To read the Imaging 3.0® case study, visit acr.org/AlertFocus.

Renew Your Membership!

Your involvement in the ACR is extremely important to advancing the profession of radiology. We appreciate your contributions and commitment to providing your patients with quality care. And we are proud to advocate for you on Capitol Hill and the AMA/Specialty Society RVS Update Committee, helping you achieve best practices in patient safety, providing you with participation discounts for required reporting, and giving you access to award-winning publications.

Renew online now at acr.org/renew.

Temporal Disparities in Paracentesis and Thoracentesis Procedures

A new study assesses temporal and patient-level differences in paracentesis and thoracentesis procedures performed on Medicare beneficiaries by radiologists and non-radiologists with respect to overall procedure volume, day of week, and patient complexity.

“For both paracentesis and thoracentesis procedures, we observed an increase over time in the proportion of procedures performed by radiologists compared to non-radiologists,” says Ravi V. Gottumukkala, MD, a radiology fellow at Massachusetts General Hospital. “Additionally, while for both procedures, radiologists increasingly perform the majority of services on both weekdays and weekends, we found that the proportion of the services provided by radiologists was greater on weekdays compared to weekends.”

Gottumukkala and his colleagues found that between 2004 and 2016, the proportion of all paracentesis procedures performed by radiologists increased from 70% to 80%, while thoracentesis procedures increased from 47% to 66%.

Read the full Harvey L. Neiman Health Policy Institute® study, published online in the Journal of Vascular and Interventional Radiology, at bit.ly/HPI_JVIR.
In Memoriam

John H. Harris Jr., MD, FACR

John H. (Jack) Harris Jr., MD, FACR, an ACR Gold Medalist, passed away on April 30. Harris was a dedicated radiologist at Carlisle Hospital in Pennsylvania from 1959 to 1979, serving as departmental chair for 11 years. He also held a professorship in radiology at the Sidney Kimmel Medical College of Thomas Jefferson University in Philadelphia from 1977 to 1979. Harris pursued academic radiology in Michigan, Houston, and Phoenix. In 1980, he joined the staff at Memorial Hermann Hospital in Houston and was chief of emergency radiology and, later, chair of the department of radiology at the University of Texas Medical School at Houston. In 1988, he recognized a need for a new subspecialty in radiology and helped create the American Society of Emergency Radiology. Harris served as president of both the Pennsylvania Radiological Society and the ACR, as well as chair of the ACR BOC. He received the prestigious ACR Gold Medal from the College in 2001. His influence in the field of radiology reverberates today through his numerous books, peer-reviewed articles, and national and international lectures.

To learn more about Harris’s life and work, visit bit.ly/JohnHHarris.

Helmut Diefenthal, MD, PhD

Helmut Diefenthal, MD, PhD, the first ACR Global Humanitarian Award recipient and an ACR Honorary Fellow, passed away on June 30 at the age of 95. Diefenthal survived anti-Semitism in Germany, as well as front-line duty as a medic during World War II. After the war, he went on to earn his German medical degree — with the intent of serving those less fortunate.

Diefenthal’s international work began with a move to Malaysia, following his joining the Lutheran Missionaries — where he remained for four years. The next assignment was to a remote village hospital in the Paré mountains in northeastern Tanzania. He later moved to Minneapolis, Minn., for five years, where he obtained his American medical degree, as well as a specialty degree in radiology. He returned to Moshi, Tanzania, and set up a radiology department there for a brand new hospital — the Kilimanjaro Christian Medical Center (KCMC). After two years, he returned to Minneapolis, where he continued working as a radiologist for the VA Medical Center until he retired.

Diefenthal then returned to KCMC to develop the first sub-Saharan radiology residency program focused on training health personnel in the use of radiology for developing countries in Africa — especially in Tanzania, where he was based. He would go on to teach and serve there as a full-time radiologist for 25 years — until he was 90 — when it was time to return to Minneapolis. Several residents who rotated through his program as part of the ACR Foundation Goldberg-Reeder Travel Grant were awed by his energy and commitment to radiology.

In addition to his work abroad, Diefenthal had a very close relationship with the Minnesota Radiological Society and the University of Minnesota, where he served on staff between 1973 and 1988. Diefenthal was greatly admired for his generosity, his dedication to his patients, and his humanitarianism, receiving numerous awards and international recognition for his work.

To learn more about Diefenthal’s life and work, visit acr.org/HelmutDiefenthal.
A Review of Rule-Making

The Commission on Economics has provided rule-making comments for decades.

One of the core activities of the Commission on Economics is engagement with CMS on Medicare payment policy. This occurs on multiple fronts, but it largely centers on the regulatory, rule-making process. CMS is required to share updates to its payment systems through annual proposed rules, a process which allows for a public comment period before a final rule is released. Any member of the public may submit comments, and the ACR does so on behalf of our members and the radiology profession. Proposed and final rules are released for the Medicare Physician Fee Schedule (MPFS), the Quality Payment Program (QPP), the Hospital Outpatient Prospective Payment System, and the Inpatient Prospective Payment System, among others. The Commission reviews each of these documents. This task is not a small one. Every year, CMS releases around 10,000 pages of rule-making documents. For 2020, the MPFS and QPP Notice of Proposed Rule-Making (NPRM) document is more than 1,700 pages long.

The Medicare rule-making process follows the same general timeline each year. CMS makes the rule-making documents available to the public via the Federal Register for the following year. The NPRM is released around the beginning of July, with comments due in September. A final rule is released around Nov. 1, with those policies going into effect the following Jan. 1.

Our Commission is quite experienced in this process — having provided rule-making comments for decades. In this column, I describe how our Commission undertakes its review.

Step 1: Notify the Membership Immediately
Our first task is to review the rules within hours of their release, allowing us to have a summary available to our members that same evening. The proverbial “on call” applies here, since we do not know exactly when the rule will drop. To that end, we must have the appropriate resources in place. This initial review requires that ACR staff examine sections related to their respective areas of expertise, with the assistance of our physician volunteers.

Step 2: Conduct a Deeper Dive
Once the initial dust settles, a deeper review starts. We engage many of the same expert volunteers and staff, but the process expands to our broader economics Committees. For instance, RVS Update Committee valuations are reviewed by our Committee on Reimbursement, and the Quality Payment Program is reviewed by our Committee on MACRA. As we review the NPRM, we tap into resources beyond our Commission. The ACR works with several healthcare consulting firms. Their perspectives, longitudinal experience, and database availability are necessary to support our comments and responses.

Step 3: Collaborate With Each Other
We collaborate internally. Many issues overlap with other Commissions within the ACR. For instance, the QPP overlaps considerably with the Commission on Quality and Safety, where measure development occurs. The Commission on Informatics is engaged in matters related to promoting interoperability. And the Commission on Government Relations has a say in how regulations are changed by previous and evolving legislation, both at the federal and the state levels.

We also collaborate externally. We have many issues in common with physicians and healthcare professionals within the house of radiology and outside it. For example, policies that affect our IR, nuclear medicine, and radiation oncology members are also relevant to their respective sub-specialty societies. Likewise, we value the input of our colleagues on the business side of radiology, such as the RBMA. And, of course, the broader house of medicine is important, such as the AMA and state medical societies. Here we may share common issues, such as those related to matters like surprise billing or scope of practice.

Step 4: Combine Collective Efforts
The last step involves bringing everything together for final review, both internally and with the collaborative groups I have mentioned. We share our letter early in hopes that our positions will be included in other societies’ comment letters.

Most of what I describe occurs over a period of eight to 10 weeks. Even after we submit our comments, the job is not done. Often, ACR representatives will meet with CMS during the comment period, or shortly thereafter, to further state their positions. The final product, at the most basic level, is a rule-making letter intended to influence policy. The letter is also a public statement of our position(s). Of equal importance, the document provides a radiology-specific summary of evolving payment policy, sharing where the ACR stands and how our members’ practices may be affected.

The work of the Commission on Economics is used as background material and evidence for ACR congressional and state legislative efforts, as well as communications with CMS, policy makers, and other medical insurers. To learn more, visit acr.org/Econ-Commission.
Lung cancer screening advocates are urging providers to share the message with their patients — low-dose CT saves lives.

The evidence that lung cancer screening (LCS) improves mortality has increased considerably in the past year — yet this lifesaving strategy continues to be underused. This assessment is the impetus for the ACR, many of its radiologists, and a supporting cast of healthcare professionals who are determined to break down the barriers between LCS programs and the patients who need them.

“The number of patients who have undergone low-dose CT (LDCT) lung screening has increased significantly, contrary to some of the headlines that say uptake is low,” says Ella A. Kazerooni, MD, FACC, a cardiothoracic radiologist and chair of ACR’s Lung Cancer Screening Registry and Lung-RADS® Committee. “The largest obstacle remains education of referring physicians and the public in general. We need to reach primary care providers (PCPs) about who is eligible for screening, when to screen, and how to establish a workflow for providing shared decision-making.”
**Telling Numbers**

The evidence that LDCT saves lives is difficult to dispute. The National Lung Screening Trial (NLST) — which launched in 2002, with findings reported in 2010 — looked at more than 50,000 people aged 55 to 74 who were current or former smokers with at least a 30 pack-year history of smoking (equal to smoking a pack a day for 30 years or 2 packs a day for 15 years). The NLST found that patients receiving annual CT screens had a 20% lower lung cancer mortality rate compared with individuals screened using standard radiography. The ACR believes NLST data also showed that annual LDCT scans were more cost-effective than other accepted cancer screening interventions, including breast, cervical, and colorectal.

More recent international findings show even greater benefits. The Nelson Study was presented last fall at the International Association for the Study of Lung Cancer's World Conference on Lung Cancer and showed that LDCT in high-risk patients reduced lung cancer deaths by 26% in men and up to 61% in women (up to a 44% reduction overall if male and female cohorts were evenly split).

Based on the number of lung cancer deaths predicted by the American Cancer Society for 2018, widespread LCS could save up to 65,000 lives in the U.S. each year. Educating PCPs and their patients about these benefits is key when establishing LCS programs. And radiologists are vital to the long-term success of these programs by dispelling misconceptions about the risks versus rewards of LDCT.

**Provider Pause**

"Among the biggest concerns we’ve seen are over false positives," says Charles S. White, MD, FACP, professor of radiology and director of thoracic imaging at the University of Maryland School of Medicine. ‘It’s the idea that you might subject patients to unnecessary additional testing or unnecessary procedures, particularly surgery," he says. "The perception that screening might lead to mortality, or at least morbidity, can cause pushback from providers and apprehension by patients — despite the demonstrated benefits of LCS, White notes. “One of the biggest challenges providers describe when treating patients who undergo LCS is what to do about incidental findings — those unrelated to lung nodules but found on the chest CT report.” To allay some of these concerns, the ACR LCS 2.0 Steering Committee is developing a one-page “quick guide” that identifies the most common incidental findings in LCS and guidelines for follow-up. The recommendations range from “typically no action required” to “follow-up imaging suggested” to “referral to specialist for further evaluation.”

Getting PCPs on board and at ease is just good medicine because LCS cannot be done in isolation, says David E. Midthun, MD, director of the LCS program at Mayo Clinic. “I think that the majority of the referrals should come from primary care,” he says, not another specialist. “It is part and parcel of healthcare for PCPs to talk to patients to make sure they are up-to-date with their colonoscopy, their mammogram, and their LCS, when it’s appropriate.”

**Cohesive Cast**

Getting (and keeping) PCPs involved in LCS requires constant and focused communication between multiple healthcare players. "As a coordinator, I try to periodically update the physicians on the criteria of our program," says Tricia Coatie, RN, MSN, OCN, member of ACR’s LCS 2.0 Steering Committee and thoracic oncology clinic and LCS coordinator at Elkhart General Hospital in Indiana. “I believe it is imperative to stress the importance of educating high-risk patients who are eligible for LCS.”

Elkhart General Hospital formed its thoracic oncology clinic in 2012, recruiting leaders from radiology, cardiothoracic surgery, oncology, pulmonology, and other specialties to get involved in LCS and treatment. "Our physicians do an excellent job of informing and educating our patients about LCS, but there are still some patients who remain unaware of its importance, possibly because they choose not to see their doctor on a routine basis," Coatie says.

Coatie regularly collaborates with radiologists at the hospital to better understand and stay current on LDCT findings. "I sit down with the lead radiologist for our LCS program and he goes over the Lung-RADS assessment categories and recommendations," Coatie says.

According to Kazerooni, radiologists can help by reaching out and providing educational information to PCPs in their area.
“Put educational material in your waiting rooms — including breast screening areas — where patients coming in are familiar with screening,” Kazerooni suggests. If they don’t want or need screening for themselves, they might still share the information with friends and families, she says.

“We as radiologists have to take the first step,” says Samir J. Parikh, MD, MBA, a radiologist at Henry Ford Allegiance Health in Jackson, Mich., who, in 2015, spearheaded a LCS clinic that has served nearly 2,500 patients to date. “Education is most important, but it’s not enough.” PCPs are busy, he says, and when something new is coming down the pipeline, “it can be difficult to wrap your head around.” It’s no different from when radiologists are faced with new technology, he adds. “Sometimes if it doesn’t seem immediately relevant to your practice, it’s difficult to make it a priority,” he says.

Parikh has held meetings and talks with PCPs and other physicians for CME to encourage interest in LCS. While it is challenging to get them to respond to a meeting request, it isn’t because they don’t care about their patients, he says. “They want to learn more about LCS, but they are busy with other aspects of care. If you put together some kind of forum where they have their questions answered on the spot — not searching for answers — it is much better than sending them a flyer.” The goal is to get PCPs talking to as many patients as possible about LCS. “Patients may have certain behaviors or cultural beliefs that prevent them from getting checked — so we need to be mindful of our approach and response,” Parikh suggests.

For certain populations, LCS is as important as breast cancer screening, Parikh believes. Once you get a patient into your LCS program, encourage them to pass along what they have learned to their friends and family. Parikh points out, “Word of mouth is so much more powerful than something you see on a billboard.”

By Chad Hudnall, senior writer, ACR Press

ENDNOTES

Looking for material to share with your referring physicians?
The ACR is your best resource for information on safe, effective lung cancer screening with the latest research, toolkits, and key patient guidance.
• ACR Lung Cancer Screening Resource Page: acr.org/Lung-Screening
• Low-Dose CT Lung Cancer Screening FAQ: acr.org/Lung-FAQ
• So You’re Coming in for Lung Cancer Screening Infographic: bit.ly/Lung_Infographic
• Lung Cancer Screening Boot Camp Web Series (a six-week web series addressing the basics of implementing your own LCS program): bit.ly/LungScreenSeries
• Early Detection Matters (Imaging 3.0® case study): acr.org/Early-Detection
• Lung-RADS® (a quality assurance tool designed to standardize lung cancer screening CT reporting and management recommendations, reduce confusion in lung cancer screening CT interpretations, and facilitate outcome monitoring): acr.org/Lung-Rads
Screen Easier

The medical physics community is leading the effort to simplify the CT protocol.

With all of the daunting obstacles — economic viability, primary care provider buy-in for shared decision-making, and population disparities, to name a few — establishing a lung cancer screening (LCS) program is challenging. However, the medical physics community is championing the effort to simplify at least one element of the LCS program: the CT protocol.

In 2010, the American Association of Physicists in Medicine (AAPM) spearheaded the formation of the Working Group for CT Nomenclature and Protocols. This collaborative committee was created largely in response to misuse and misunderstanding of CT equipment. In addition to a large and diverse group of practicing medical physicists from the AAPM, the committee has representatives from CT manufacturers, the American Society of Radiologic Technologists, the ACR, and the FDA. One of the major deliverables of the committee — now called the Alliance for Quality CT (AQCT) — is to publish safe and reasonable CT protocols in the public domain for select adult and pediatric exams (learn more at bit.ly/AAPM_CT).

Following the U.S. Preventive Services Task Force B grade for low-dose CT in December of 2013, the AQCT first published LCS CT protocols in 2014. The 2014 protocols included CT scanners from Canon (then Toshiba), GE, Hitachi, Neusoft, Philips, and Siemens. These protocols were developed and reviewed in coordination with the CT manufacturers and vetted by clinical physicists with experience in LCS trials. The protocols offer reasonable low-dose scans with image reconstruction settings optimized to provide the required spatial resolution. As LCS volumes increased with the 2015 CMS national coverage determination, these protocols provided a valuable resource for the community to refer to a variety of scanner makes and models. In 2016, the LCS protocol document was downloaded nearly 10,000 times.

The most recent update to the protocols was published in July of this year. The updated LCS protocols are particularly important because they incorporate the latest CT models and software advances from each of the manufacturers, while maintaining a stable of protocols for the large existing install base of older models. These protocols can serve as the starting point for discussion within the CT protocol management team at an institution or across a practice (learn more at bit.ly/CT-Protocol).1

According to Debra Dyer, MD, FACR, chair of ACR’s LCS 2.0 Steering Committee, “The AAPM and the AQCT are important allies in our efforts to increase the adoption of LCS. Their initiatives to optimize CT protocols and minimize dose in LCS provide valuable tools for the implementation of screening programs.”

In addition to developing consensus CT protocols, the AQCT also works to develop educational resources for the CT imaging community. One of AQCT’s current projects is working with CT manufacturers to create updated education slides to help users understand how advanced automatic exposure control (AEC) features operate and can be implemented to optimize image quality and dose. The AQCT originally published CT radiation dose education slides in 2013, with specific details and screenshots for each vendor in a self-contained document. These slides include information on how acquisition parameters and AEC features affect radiation dose and have been downloaded thousands of times. Many institutions utilize the slide sets to help meet Joint Commission requirements on continuing education for RTs. The ongoing work to update the AEC content recognizes the significant changes in technology and features since the slides were first published. The committee expects to finalize the work on the new educational content this year.

The website (bit.ly/CTProtocols) also includes the committee’s lexicon to facilitate translation of vendor-specific names for features to a standard terminology, and educational materials about the operation of CT Dose Check features on scanners. The work of the committee was recognized by the FDA in 2013, when the group was awarded the Center for Devices and Radiological Health Director’s Special Citation Award “for developing CT imaging radiation safety instructional materials through a collaboration of end-users, CT manufacturers, and the FDA.”

The group is committed to continuing to develop additional protocols and educational materials to serve the imaging community and welcomes input for potential new projects or feedback on existing materials. Dyer adds, “We are very fortunate to have the expertise and commitment of the medical physics community to keep our radiology practices and staff updated on the technical advances to enhance our CT protocols and, ultimately, patient care.”

ENDNOTE
Managing the Misinformation

A newly launched mammography toolkit will help providers identify reliable breast cancer screening.

What is the best age to start breast imaging? How often should patients be screened? Do you even need to worry about mammograms if you do not have a family history of breast cancer? While these questions might seem simple, finding definitive answers is complicated. Even more troublesome is when entirely capable and trustworthy providers are also peddling information that is not informed.

According to ACR President Debra L. Monticciolo, MD, FACR, “Having regular mammograms will cut breast cancer death by at least 40% — likely more — and that is a huge impact on the most common cancer in women and one of the biggest causes of cancer death in women.” With more than 30 years of experience as a breast imager, Monticciolo has seen the grave impact misinformation can have.

According to Monticciolo, misconceptions persist that mammograms are excruciatingly painful, unnecessary, or only important for those with a family history. However, the bottom line remains the same: average-risk women should be getting yearly mammograms starting at age 40 — even earlier for African-American and Ashkenazi women. On top of that, tumors are more aggressive in younger women and early detection can mean the difference between life or death. “There are a lot of naysayers, but mammograms make a big difference,” says Monticciolo. “Early detection leads to better treatment options, less surgery, and better chemotherapy outcomes — something that is not widely understood by patients and their doctors.”

Monticciolo notes that to combat the misinformation, the ACR and the Society of Breast Imaging (SBI) have created the “Talking to Your Patients About Breast Cancer Screening” CME Toolkit — a free resource with customizable materials to help providers identify breast cancer screening and outcomes data, discern actual risks versus benefits, and discuss with patients when to be screened (acr.org/CME-Toolkit). The toolkit, compiled by a broad group of breast imagers around the country, was designed so that all the information could be digestible and accessible to its audience — both patients and providers. Radiologists are asked to share these materials with their referring providers, on their practice websites, and in their waiting rooms and lobbies. The toolkit will also be promoted directly to referring providers through a digital and social media advertising campaign.

“Providers may not know what to tell women regarding when and how often to be screened,” says Monticciolo. “We feel if women and their healthcare providers understand the facts, they are going to be better able to make an informed choice and we are confident that regular screenings will be that choice.”

Dana H. Smetherman, MD, MPH, FACP, chair of the ACR Commission on Breast Imaging, agrees. “Over the years, I have encountered not only patients but colleagues in other specialties, particularly in primary care, who do not understand why the ACR and SBI recommend starting mammograms at age 40,” says Smetherman. Smetherman believes that as a result of the new CME Toolkit, the national conversation around mammograms can start to shift in the right direction. “With every woman who is educated and provider that finds a deeper understanding of breast imaging, lives are saved,” she says.

Both Smetherman and Monticciolo believe the toolkit is going to continue evolving — with new information being added and plans to reach out to patient advocacy groups to incorporate their expertise. Their hope is to get the toolkit materials into the hands of medical students and radiologists-in-training to increase their knowledge of breast imaging right from the start.

“We want to make sure that the material and information is out there so that any patient who really wants to understand and make an informed decision is able to do that,” says Smetherman. “The most important thing is for patients to be well-informed and be their own advocates.”

By Ivana Rihter, freelance writer, ACR Press

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Lung Screening Solutions

North Dakota radiologists collaborate with referring physicians to administer lung CT screening for high-risk patients.

When radiologists at Sanford Medical Center in Fargo, N.D., heard about their hospital’s plan to offer low-dose CT (LDCT) lung cancer screening (LCS) for high-risk patients in 2012, they were a bit apprehensive. The radiologists knew that lung cancer screening would require a great deal of coordination and were concerned about the time and complexity associated with monitoring patients who enrolled in the program.

“We recognized the immense potential of screening to identify lung cancer in the early stages, when it’s most treatable, but without the right follow-up procedures in place to make sure no one fell through the cracks, we thought we’d actually be doing our patients a disservice,” says Martha S. Kearns, MD, radiologist at Sanford.

To ensure LCS patients would receive the necessary longitudinal care, the radiologists partnered with a multi-disciplinary team of primary care and internal medicine physicians, nurse navigators, pulmonologists, radiation oncologists, and oncologists to establish a dedicated lung nodule clinic to track and monitor LCS patients.

Now, with a dedicated nurse navigator, the team manages patient exams, results communication, and follow-up, with radiologists providing clear and consistent recommendations based on custom guidelines that the radiologists founded in part on the ACR Lung-RADS® reporting system. With this approach, Sanford’s LCS program has grown significantly over the years.

Since the program began in 2013 — with a hiatus in 2015 for proposed Medicare changes — over 300 different providers throughout the region have referred more than 3,900 patients for LCS. Among these patients, the radiologists have identified 44 cases of cancer, 24 of which were detected in stages I and II, when the disease is still treatable.

Starting the Program

The idea to start a LCS program at Sanford began during a 2012 lung care oversight committee meeting, when administrators asked physicians: What can our cancer center do to elevate its performance? Radiation oncologists and oncologists at Sanford’s Roger Maris Cancer Center noted an uptick in the number of lung cancer patients they were seeing and suggested that LCS could help detect cancer cases sooner, while also bringing more patients to the center.

They pointed to the National Lung Screening Trial (NLST), which found that patients who underwent annual LDCT screening had a 20% lower lung cancer mortality rate compared to those screened with chest X-rays.1 One of Sanford Fargo’s sister locations in Sioux Falls, S.D., had recently launched its own LCS program. “We knew that if we were going to keep up with other health systems and better serve patients, we had to start our own screening program,” says Sharri M. Lacher, APRN, who eventually became the program’s lung nodule nurse navigator.

As the lung care committee considered starting a LCS program, members evaluated Sanford’s existing CT technology for LDCT calibration and agreed that patients would need a referral from their PCPs to enroll in the program. They also decided on both the eligibility requirements and a self-pay fee of $150 for patients, since lung cancer screening had not yet been approved for insurance reimbursement.

The team’s use of existing CT equipment and exam space kept the program’s operating costs low. Given the program’s minimal overhead — and high potential for patient benefit — hospital administrators wholeheartedly endorsed launching the screening program for high-risk patients in March of 2013.

Working with Referrers

Referrer involvement was critical to generating a steady volume of eligible screening patients. Unfortunately, many PCPs and other family physicians did not understand the significance of the landmark NLST or the potential benefits of LCS for high-risk populations. To overcome this, Sanford specialists partnered with Lacher to educate referrers across the region about screening and to encourage them to enroll patients in the program.

“Lung cancer isn’t going away. As radiologists, it is our job to find it early, so we can reduce mortality, and LCS is the best way for us to do that.”

– Martha S. Kearns, MD

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Still, many PCPs felt ill-equipped to manage the increasing volume of lung nodule patients that screening would identify. “We were worried we were going to lose patients to follow-up,” says David Glatt, MD, chair of the department of family medicine at Sanford Health. “As far as we were concerned, radiologists and pulmonologists were the nodule experts and had a much better understanding for where the patients should go next.”

Radiologists, who had similar concerns about patient follow-up, committed to monitoring patients through the continuum of care as part of the lung nodule clinic. “If patients had abnormalities, like a lung mass, we agreed to help primary care triage them to pulmonology or IR or send them for subsequent CTs — wherever the patients needed to go,” Kearns says. “We became a safety net to make sure the patients were being taken care of, so the PCPs had one less thing to worry about.”

### Meeting CMS Requirements

While the self-pay model brought in a moderate but steady stream of over 200 patients in 2014, 2015 was a different story. In February of that year, CMS announced a national coverage determination for Medicare beneficiaries who meet certain eligibility criteria. The decision also outlined specific dose parameters, standardized reporting requirements, and other conditions for reading radiologists and participating imaging facilities. Sanford’s screening program — and LCS programs nationwide — was suspended until it met the new requirements and CMS finalized its reimbursement codes.

From there, Sanford began implementing new processes to meet the CMS requirements for LCS, including the institution of dose reduction techniques as part of the ACR Lung Cancer Screening Registry (LCSR) and patient flow improvements within the lung nodule clinic. The on-staff radiologist would interpret the CT, share the standardized report with both the PCP — who would deliver the results to the patient — and Lacher, who, as the nurse navigator, would monitor the patient to ensure care continuation for subsequent scans.

### Expanding the Reach

The referrer education outreach efforts, along with integration of LCS eligibility within the EMR, spurred a significant increase in the program’s patient volume. After Medicare reimbursement for LCS was approved in late 2015, the year brought 466 patients into the program, followed by 681 patients in 2016.

As the program gained momentum, Lacher and Kearns began helping rural Sanford sites in the region adjust screening processes to meet Medicare’s requirements for a covered LDCT program and participation in the ACR LCSR. “I’ve met with various leaders of rural clinics to discuss what we’ve implemented here at Sanford and to help guide them in offering screening and follow-up access for high-risk patients in rural areas,” Kearns says.

Sanford’s LCS volumes have continued to increase with its expanding presence in the region and within referrers’ offices, with 1,211 high-risk patients undergoing screening in 2018. Over the duration of the program, numerous lung cancers — 24 of them early stage — as well as additional cancers, were identified in 44 patients, increasing their chances of survival via various treatments.

Kearns says that the program’s success can be attributed in part to radiology’s consistency in process, open-mindedness about applications, and a willingness to be hands-on in a way that demonstrates the specialty’s value. “Lung cancer isn’t going away,” she says. “As radiologists, it is our job to find it early, so we can reduce mortality, and LCS is the best way for us to do that.”

By Kerri Reeves, freelance writer, ACR Press

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**We knew that if we were going to keep up with other health systems and better serve patients, we had to start our own screening program.”**

— Sharri M. Lacher, APRN

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**Imaging 3.0 in Practice**

The Imaging 3.0® in Practice special collection from the Imaging 3.0 case study library includes discussion questions and additional resources to help your practice implement its own value-added initiatives. View the collection at acr.org/I3inPractice and find the next issue, “Lung Screening: Winning strategies for developing a lung cancer screening program,” in your mailbox in November.

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A Living Streak

A patient recounts his journey undergoing treatment for lung cancer — and how it changed his outlook on life.

A fter 723 days of running every day with my German shepherd, Branko, I didn’t have time to be sick. But I was sick. I had just returned from a business trip out West and I felt awful. My family doctor diagnosed me with bronchitis and the flu and I needed antibiotics to get over it. He ordered a chest X-ray to rule out pneumonia. While the X-ray didn’t show pneumonia, it did reveal a mass — about the size of a tennis ball.

As a lifelong never-smoker, I had never thought about having lung cancer. The 40 days that followed my diagnosis involved a great deal of information and preparation. We decided the best course of treatment was to remove the mass, which appeared to be contained to the lowest lobe of my right lung. A lobectomy was scheduled. The preparation for this serious surgery included updating legal documents, meeting with our financial advisor, talking with the human resources department at work, and having countless conversations with family, friends, and colleagues. I wondered if I would be able to continue running after surgery.

My running streak ended on day 763. My family joined me for what was an emotional but optimistic day. The day after my lobectomy, on what would have been running streak day 764, I learned a hard lesson: never-smokers can and do get lung cancer.

Several second opinions confirmed our belief that the surgery was curative. There was no need for additional treatment. We simply needed to do CT scans every six months to stay vigilant and monitor for potential recurrence.

During the year that followed my lobectomy, I ran intermittently but never restarted a running streak. In fact, I was happy to take a break from running.

Five days short of my one-year cancerversary, a CT scan showed a recurrence. There were 13 new cysts. Two weeks later, a portion of my remaining lung was surgically removed for biopsy. It confirmed the doctor’s assumption: the cancer was back.

My chemotherapy infusions began about four weeks after the surgery. I had four rounds of carboplatin, Alimta®, and KEYTRUDA® every 21 days. I was fit and healthy. My body tolerated the chemotherapy well.

My wife and I quickly collected second opinions from several nationally renowned cancer centers on the East Coast. The choice presented was either a pneumonectomy (removal of the entire right lung with the cysts) or maintenance chemotherapy for an indefinite length of time. After a lot of thought, prayer, and consultation, the decision was made to keep the lung and do the chemotherapy/immunotherapy.

Two weeks after the biopsy, the doctors gave their consent for me to try running again. That was the beginning of my current running streak. Those were some of the hardest but happiest runs of my life. To be back running was a joy — even though I was in pain. I was much slower than before — but I was able to run!

Fast forward to August 2019 — I hit day 764 for the first time ever. There was something special and symbolic about getting to and past that number.

Today, my running streak continues. While the runs of this streak have been more challenging than before, they have also been more appreciated. I realize what a privilege it is to be able to run. In the cancer survivorship journey, there is so much that you can’t control. I’ve found running gives me a little sense of being in control.

Running and finding a cure for lung cancer have a few things in common. Both take determination. You must decide it is a priority and act accordingly. Both can be tiring and require tenacity. Cancer researchers face hurdles, failures, and roadblocks every day. More than anything, both require an unrelenting need to keep moving forward.

James Hiter Jr. is a member of the ACR’s Lung Cancer 2.0 Steering Committee. He is the founder of Streak for a Cure — a patient advocacy group that aims to change the face of lung cancer one run at a time.
A New Frontier

The Society of Breast Imaging’s journal is moving the needle forward on the science of breast screening to improve patient care.

In the world of academic publishing, there is no shortage of journals. However, surprisingly, none were breast-imaging specific — that is until the Society of Breast Imaging (SBI) and Oxford University Press announced a partnership in March to publish the *Journal of Breast Imaging (JBI)*, the first and only peer-reviewed journal to focus solely on breast imaging (bit.ly/SBI_JBI). The *JBI* aims to publish original research from around the world with the ultimate goal of saving lives and minimizing the impact of breast cancer.

The *Bulletin* recently spoke with the founding editor of *JBI*, Jennifer A. Harvey, MD, FACR, who has served on the board of directors for the SBI since 2016. Harvey, a professor of radiology at the University of Virginia Health System in Charlottesville, discussed what she hopes the new journal will bring to the field — for radiologists, physicians, and patients alike.

**What is your vision for the journal in its first year?**

For me, much of this journal is about the science. I am a research geek at heart, and research is an extension of patient care. Research is the way that you keep making things better. Previously in breast imaging, we were very limited as to where we could publish. There’s *Radiology*, the *American Journal of Roentgenology*, and *The Breast Journal*, but these journals are either geared towards general radiologists, surgeons, and medical oncologists — not breast imagers. So the number of articles on breast imaging has been limited. We really wanted to be able to expand our platform.

**What are some highlights and features of the journal that separate it from other journals of its kind?**

We have an article in every issue about screening. The screening topics for the first three issues include the history of screening mammography, the importance of screening women in their forties, and overdiagnosis. Screening has been so controversial since I started over 20 years ago, and we have not had a great voice thus far. By having dedicated articles about screening, we’re hoping to provide really good science about it on a much more public platform. For example, when you have a primary care doctor who says, “Well, I don’t order screenings because of overdiagnosis,” you can hand them a *JBI* article about the topic. Or when a doctor asks, “So few cancers occur in patients in their forties — why should I have women start screening then?” you can give them an article on screening in the forties that’s solidly backed by science.

*JBI* has a scientific review every month on other topics to help educate our readers. Original science is a major focus — where we have not had a very large venue in the past. We have clinical practice articles on how to talk to patients who need a biopsy or the ergonomics of breast imaging — topics that are focused directly on patient care. Breast imaging is very patient-facing, but not all breast imagers have necessarily had training in interacting with patients.

The journal also has articles on training and education to prepare the next generation of breast imagers — for example, how do you teach a resident to do a US-guided core biopsy? The goal with this assortment of articles is moving that needle forward on where the science is, and then educating our practitioners with the scientific reviews and the clinical practice articles. “Research is an extension of patient care. Research is the way that you keep making things better.”

**How will the *JBI* advance the global field of breast imaging for the betterment of patient care?**

As breast imagers, our job is to save lives. With the *JBI*, we hope to do this through science; to keep charting that new frontier by asking “what’s next? How can we do better?” Disseminating that knowledge broadly to breast imagers is one way we can do that. Everybody who’s a member of the SBI gets the journal for free, including international members. So people in all continents get this journal and then can implement this very high-level knowledge within their practices. I think it’s going to really have a profound impact globally.
Global Reach

When Lara L. Hewett, MD, a radiology resident at the Medical University of South Carolina (MUSC), spent time at the Masindi Kitara Medical Center in Uganda, she learned a new definition of the term “on-call.” “The medical staff would literally call us in the middle of the night if they needed an ultrasound,” says Hewett.

For Hewett, her two-week trip to Uganda was just the first phase of a larger plan she had developed with several colleagues from MUSC, all of whom shared a passion for global health within the sphere of radiology. It was more than just an opportunity to gain first-hand experience in another country — her goal was to educate the local community and develop sustainable educational solutions that would reverberate long after she went home, from setting up study materials to be used long-term by medical students and residents, to developing a relationship with new staff.

Hewett’s responsibilities rotated between hands-on imaging work and archiving countless cases for future use in studying — demonstrating the very reason radiology can be so critical in care. After some administrative changes took place in the medical center, there was a risk that many case studies would be lost. Hewett made it a priority to compile old cases and file them away for study — from both Uganda and back in the United States. “So much of that information and those learning opportunities would have been lost,” says Hewett.

The culmination of Hewett’s time in Uganda was a 90-minute presentation that covered all the important cases from her trip. And because the presentation was open to all, the audience was comprised of everyone from sanitation workers to attending physicians. She had to find a way to relate all the information in a comprehensible way, so she began with what she knew everyone could relate to: the real people she and the staff cared for on a daily basis. She conducted a deep dive into patient stories and went through each case diligently, presenting her findings and making sure the audience was invested in the work. And they were — they responded so favorably to the presentation, in fact, that what started as simply a summary of her findings turned into a send-off for Hewett that she won’t soon forget.

“It seemed like I genuinely did teach some people something, and that was really great because they taught me so much.”

— Lara L. Hewett, MD
According to Kaleigh Burke, MD, the weeks she spent in the pediatric ward of the Kamuzu Central Hospital in Lilongwe, Malawi, provided her with a rich cultural experience she will long treasure. Burke, then a radiology resident at the University of North Carolina, recalls the unique challenge of trying to treat a pediatric patient who was sharing a bed with two other patients, and the joy of spending more time at the bedside talking to that patient’s parents in an effort to really get to know the local community, day in and day out. “We don’t usually get that level of interaction with the families here in the U.S.,” says Burke.

The intimate care she was able to provide impacted Burke greatly and gave her a sense of perspective when it came to the sheer amount of resources available stateside. As with all trips, there were trials and tribulations along the way. “A lot of the times you are propping up the machine on a pillow or a bench or anything you can find,” says Burke.

Burke’s main focus in Malawi was creating a pediatric renal US curriculum, and she worked tirelessly to educate local physicians on everything they needed to know about pediatric US across the board. During her four weeks there, Burke did everything from giving lectures to local medical students on pediatric US to providing care on-the-go. “We had a WhatsApp group and the pediatricians would text me if they had any questions or if they wanted ultrasound,” she says. “I would pack up the portable US and go to them, which is so different than in the U.S., where patients come to us.”

Burke believes the trip had a lasting effect on the way she interacts with patients — even now as she continues her work in North Carolina. “I try to call ordering physicians on the phone more and hear from them about what is going on, and incorporate that, as opposed to relying on the chart,” says Burke. “And it’s really nice to see just how appreciative they are when you do that.”

“I would pack up the portable US and go to them, which is so different than in the U.S., where patients come to us.”

— Kaleigh Burke, MD
Physicians First

A long-time radiology advocate has always seen the value in connecting with patients.

Many radiologists are faced with being more isolated and more disengaged with patient care. This is a reality that shouldn't be ignored — and one the ACR is working to change, says Raymond K. Tu, MD, MS, FACR, who was recently recognized by the Council of the District of Columbia for his work on healthcare disparities and the underserved.

Tu, an active member of the ACR, councilor for its Washington, D.C. chapter, and president of the Medical Society of the District of Columbia, was appointed by Mayor Muriel E. Bowser of Washington, D.C. to represent nearly 12,500 physicians on the District's Commission on Healthcare Systems Transformation. Tu is also the new chief medical officer at United Medical Center (UMC) — the first radiologist to serve as its physician executive. The Bulletin recently had an opportunity to learn more about Tu's patient-centered philosophy.

What has been some of your work in the underserved areas of Washington, D.C.?

The recognition I’ve received has been for the work I and other stakeholders, such as the Ward 8 Health Council and the Rodham Institute, provide our communities east of the Anacostia River. For example: several years ago, my medical staff peers at UMC, a safety net hospital that largely serves Medicaid and Medicare patients, recognized my unwavering pledge to provide the best care possible to all. The Council of the District of Columbia and DC Health are steadfast in their commitment to the health and protection of the public. UMC serves a community with many challenges, such as poverty, illicit drug use, behavioral health issues, obesity, asthma, cancer, stroke, and other conditions that are prevalent at the east end of the nation's capital.

What does it mean to you, as a radiologist, that your work has not gone unnoticed?

While the problems that face underserved areas aren’t unique to radiologists, we need to be physicians first and radiologists second. Being involved locally and regionally with state medical societies, radiology organizations, and boards of medicine are all stairs available to us to climb. In the beginning, being the chair of radiology for three hospitals in the most underserved regions of Washington, D.C. was not in my comfort zone. I gained invaluable experience as a radiologist, physician, and patient advocate. The greatest personal honor I have each year is hooding a medical student (many of whom have chosen radiology) from The George Washington University's School of Medicine and Health Sciences at its annual commencement ceremony.

What are some of the challenges facing radiologists who want to be more patient-centric?

As reimbursements decline, so will margins. And with no margin, there is no mission — as mentioned at the ACR 2019 Economics Forum organized by Economics Commission Chair Ezequiel Silva III, MD, FACR. Some radiology groups have responded to decreased margins by putting more emphasis on volume over value, which will sideline the future of the specialty and interest in physician engagement. All organizations must embrace radiologists who have the skill and expertise to represent our specialty, build our brand, and maintain our value.

What is the value of fighting for payment integrity?

When your radiology team of volunteers participates at the Current Procedural Terminology editorial panel and AMA/Specialty Society Relative Value Scale Update Committee, their effort to argue on behalf of payment integrity is their personal sacrifice of time from their practices — and all radiologists benefit. Physician volunteers are grateful to the ACR for the resources, and dedicated staff time, provided to us.

Do you think radiology may be undervalued or overlooked as a specialty?

Radiology is both an interpretative and non-interpretative specialty. Some current value calculators measure...
the "worth" of a radiologist with a case/shift formula. A misapplied ruler to achieve a preconceived result is perilous. Non-interpretive expertise not accurately measured will create physician demoralization and burnout.

How can radiologists make a difference in patients' lives?
It might come down to a handshake, really. You need to introduce yourself, provide content and resources, and get your radiology group to embrace patient-focused thinking. For my part, reading cases and communicating critical results with a physician and patient are essential priorities.

What are things radiologists can do outside the office?
A passion and willingness to speak in your community and specialty societies is a start. I accept every invitation to speak on television, radio, at churches, community centers and senior centers. The ACR provides several resources for volunteer opportunities. We should be looking for ways to connect with patients, peers, and students. Be the radiologist who says, "yes!" Begin with opportunities in your comfort zone, such as your local ACR state chapter. Seek opportunities to meet with other physicians in your medical office building or hospital. Engage your local state insurance programs to educate their staff; you may be invited to be a medical reviewer for them. Get to know your state Medicaid medical director. Speak at patient focus groups. Many patients are beneficiaries of the excellent radiology care they have received from you — and the emotions that arise from meeting "that doctor" who impacted their lives cannot be measured.

JOBS LISTINGS

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Hawaii – A private out patient Imaging Company is seeking a fellowship trained MSK radiologist to perform MSK MRI exams and MSK CT and joint injections. Additional required skills are general CT and plain film skills. No call schedule.

Contact: Call 808-591-1504

California – Established private practice radiology group in a desirable coastal Los Angeles location seeking a highly motivated general radiologist who can perform women's imaging, advanced cross-sectional imaging, and is comfortable with occasional general IR procedures. The group enjoys a great work-life balance with very competitive compensation. Full-time partnership track.

Contact: Email radjobsocal@gmail.com

Iraq – An exciting and rewarding opportunity to work in Iraq's most trusted medical center: Medya Diagnostic Center, Erbil, Kurdistan Region of Iraq. We are seeking a highly skilled, board-certified Radiologist to join our healthcare team to make use of imaging technology to diagnose and treat patients.

Contact: Email Ariz Askari at ariz.askari@medyadc.com or call 009647502411983

Wisconsin – Gundersen Health System in La Crosse is seeking a board-certified/board-eligible breast radiologist in an established group with 30 radiologists in a multi-specialty clinic setting with the ACR Breast Imaging Center of Excellence award. The health system conducts over 8,500 diagnostic and 25,000 screening exams per year using Hologic 3D. The position requires weekdays only with no nights, weekends, or call. Gundersen Health System offers an excellent work environment, competitive salary, and great benefits package.

Gundersen Health System is also seeking a general radiologist to join an established team. This position includes a percentage of service to outreach satellite facilities in Southwest Wisconsin, Southeast Minnesota and Northeast Iowa. www.gundersenhealth.org/careers

Contact: Kalah Haug, Medical Staff Recruitment, at kjhaug@gundersenhealth.org or 608-775-1005.
How can radiologists become champions for lung cancer screening?

“At our institution, the implementation of a multidisciplinary lung cancer screening (LCS) program has been key to improving appropriate utilization of LCS. By tying our LCS program into existing lung cancer infrastructure — including multidisciplinary tumor boards and dedicated pulmonary nurse navigators — we have been able to streamline the follow-up process for our patients who have positive results without burdening referring primary care physicians.”

— Jennifer Buckley, MD, chief resident at the University of Missouri in Kansas City

“Radiologists have a history of screening with the intent of ensuring healthy populations, starting with mammography. We can learn from and build on those experiences when facing our populations at risk for lung cancer. Help initiate or embed yourself within high-risk lung clinics. Being a known face in our community of primary care providers, pulmonologists, and thoracic surgery colleagues will only further those efforts. Additionally, voice your expertise alongside your congressional representatives, both at the state and federal levels, to preserve access to life-saving screening exams.”

— Christopher R. McAdams, MD, assistant professor in the department of radiology and imaging sciences at Emory University in Atlanta
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- For each follow-up screening for insured women, TMIST pays sites $150 on top of insurance payment

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  - This total $288.17 TMIST payment ($150 + $138.17) for each follow-up exam for uninsured women may be triple that paid by major breast cancer care charitable organizations

Move Breast Cancer Screening Forward

- TMIST is necessary to inform tomosynthesis clinical and payment updates

  - Decision makers rarely update policy without a randomized controlled trial

Start here: acr.org/TMIST
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