

Bulletin

Overcoming Barriers to Care

SPECIAL SECTION



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The DIR enables analysis of information about the radiation to which we are exposing our patients to help lower risk while still providing solid image quality to facilitate diagnosis.”

— William F. Sensakovic, PhD, DABR, MRSC (MRSE), DIR Committee Chair and Senior Associate Consultant, Associate Professor at Mayo Clinic Arizona

ACR

Bulletin

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



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RADIOLOGY

QUESTIONS? COMMENTS? Contact us at bulletin@acr.org
Digital edition and archives of past issues are available at ACR.ORG/BULLETIN.



OVERCOMING BARRIERS TO CARE: Opportunities to Take Action

Radiologists are in a unique position to lead efforts to address health disparities and accommodate the needs of diverse patients.

This month's special issue of the *Bulletin* focuses on overcoming the barriers to care. In the pages of this issue, you will read more about how overcoming racial, socioeconomic, and geographical barriers supports high-quality imaging care and vibrant practices.

Barriers to care include health disparities. Health disparities are defined as differences that exist among specific population groups that prevent their attainment of their full health potential. These disparities can be measured by differences in incidence, prevalence, mortality, burden of disease, and other adverse health conditions.¹

Here are some examples:

- Latinx/Hispanic and Black women have higher rates of cervical cancer than other racial/ethnic groups; Black women have the highest death rates from the disease.
- American Indians/Alaska Natives have higher death rates from kidney cancer than any other racial/ethnic group.
- American Indians/Alaska Natives have the highest rates of liver and intrahepatic bile duct cancer, followed by Latinx/Hispanic and Asian/Pacific Islanders.²

One of the most consistent findings in health disparities literature is that place matters. Research shows that there are systematic disparities in morbidity, mortality, and other measures of well-being across different areas of the country — even across small areas that lie relatively close together.³

Although significant progress has been made in narrowing the gap in health outcomes, there is considerable work to be done. Radiologists are in a unique position

to lead efforts to address health disparities and accommodate the needs of diverse patients. Medical imaging utilization continues to increase as imaging becomes the standard of care for diagnosis, intervention, and therapy. Radiologists stand as an important point of contact and source of data for the growing number of people we serve. Anywhere there's a gap or a need in our healthcare systems, that's an opportunity for us to collaborate with our patients, colleagues, and community stakeholders.

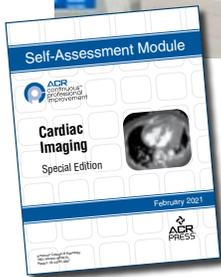
The ACR is in the midst of planning to convene the Radiology Health Equity Coalition ([read more on page 15](#)). Gratefully, ACR BOC Vice Chair Jacqueline A. Bello, MD, FACR, has agreed to champion the effort. ACR President Geraldine B. McGinty, MD, MBA, FACR, will be sharing an update on coalition progress during the presidential address at ACR 2021.

The ACR will be the convener to launch and coordinate this effort. However, this will not be branded as an ACR-specific program. In fact, even at this nascent stage, we have been reaching out to other organizations who might choose to help organize and participate. Longer-term, we anticipate broad participation and leadership from across the radiology community.

For the ACR, the goal to strive toward health equity should not, and will not, be about partisan or identity politics. This is about our moral obligation as physicians and radiologists. This is about standing up for our patients and their individual needs. Health equity is also a significant opportunity to declare that radiology can make a difference. We hope you will join us in taking action and participating in this movement occurring across all of medicine. **B**

ENDNOTES

1. NIH. Health disparities. Last reviewed April 2017. Accessed February 23, 2021.
2. NIH. National Cancer Institute. Accessed February 23, 2021.
3. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. *Communities in Action: Pathways to Health Equity*. Washington (DC): National Academies Press (US). Published January 11 2017.



CPI Releases First Module in Cardiac Imaging

The ACR Continuous Professional Improvement (CPI) program has released its first special edition on cardiac imaging. This new and unique module, authored by cardiology and radiology experts, is designed to be an excellent teaching and learning tool for radiologists at different career levels and includes:

- Cardiovascular MRI to aid in diagnosis and predict outcomes in ischemic and non-ischemic cardiomyopathy.
- CMR and cardiac CT to evaluate congenital heart disease, both pre- and post-operative.
- CMR and cardiac CT to diagnose pericardial disease, coronary artery abnormalities, aortic pathology, and cardiac masses.
- The best technical practices to optimize CMR and cardiac CT
- A variety of patient ages from pediatric to adult cases

Test your knowledge and improve your diagnostic skills with 50 self-assessment questions and earn 8 CME/SA-CME. Choose your format (print or online) and download a free e-book. Members save \$35 per module when bundling six modules via a CPI Select Six.

Learn more at acr.org/cpi.

Register for the SPR 2021 Pediatric Ultrasound Course

The SPR 2021 Pediatric US course will take place virtually April 22–24, 2021. The course will feature three days of didactic lectures and case discussions, covering topics such as MSK US, contrast-enhanced US, and US elastography. At the conclusion of the course, participants will understand basic and advanced techniques in pediatric US — and be able to recognize and apply these techniques for advanced diagnosis and improved management.

To register for the course, visit pedrad.org.

New Study Explores Use of CDS to Expedite Prior Authorization

A new study out of the *JACR*[®] aims to determine if a CDS tool could be used in partnership with a private payer to successfully expedite the prior authorization process for advanced imaging requests. As part of the study, the University of Virginia Health System partnered with Aetna to avoid traditional prior authorization requests in 69% of imaging orders that qualified for expedited prior authorization. They did so by deploying a CDS system that guided ordering providers based on the ACR Appropriateness Criteria[®]. Results of the study showed that physicians voluntarily used the tool on about 15% of orders, with Aetna granting immediate access to exams to facilitate faster patient care.

“The model used in this pilot program has significant potential to be replicated,” write study authors Christopher M. Gaskin, MD, FACR, Amy L. Ellenbogen, MD, Kristi L. Parkhurst, MD, and Alan H. Matsumoto, MD, FACR. “We are actively exploring the potential to expand this program to other private payers, and we believe it could be reproduced at a number of other institutions.”

Each authorization can cost providers about 16 minutes or as much as \$100 to complete; thus, UVA may have saved some 266 hours or as much as \$100,000 during the study.

To read the full study, visit bit.ly/JACR_UVA_AETNA.



New Algorithm Catalog Simplifies Shopping for AI Products

A new searchable catalog of commercially available AI products released by the ACR's Data Science Institute[®] (DSI) simplifies finding the latest commercially available AI tools. The catalog of over 100 FDA-cleared medical imaging AI algorithms dramatically reduces the time required to sort through all of the algorithms available to those in medical imaging.

Searches can be conducted by company, subspecialty, body area, modality, and date cleared. Many models match the ACR DSI Define-AI use cases and are linked under related use cases. Clicking on individual models takes users directly to the FDA summary letter for more details.

To try the catalog, visit models.acrdsi.org.

DSI Publishes Six New Neuroradiology AI Use Cases

The ACR Data Science Institute® (DSI) has released six new neuroradiology use cases, adding substantially to the scenarios DSI provides to the AI community. Developers can freely access 21 neuroradiology use cases on the DSI website.

“Practitioners are expressing tremendous enthusiasm for practical AI tools to improve neuroradiology diagnosis and treatment,” says ACR Vice President Alexander M. Norbash, MD, MS, FACR, chair of the ACR DSI Neuroradiology Panel. “We believe through collaborations with data scientists and by generating use cases, we will secure the role of AI algorithms in clinical practice. This is a crucial time to get involved with AI and bring more applications to clinical practice.”

The ACR DSI use cases are scenarios describing where AI may be beneficial in a clinical setting. They provide structured data elements for training, testing, and monitoring algorithms to help those developing AI to create new models or improve existing products. The neuroradiology use cases, which include disease detection and lesion quantification, cover the following:

- Hemorrhagic Brain Contusion
- Detection of Communicating Hydrocephalus
- CSF Flow Quantification, White Matter Lesion Tracking in Multiple Sclerosis
- Quantifying Carotid Stenosis on CTA
- Identifying Non-Enhancing Infiltrative Tumor in High-Grade Glioma

For more information on the new use cases, visit acrdsi.org.

It's time for patients to #ReturnToCare and get screened. Colorectal cancer is nearly always treatable, if caught early, and can even be prevented through timely screening.

— JUDY YEE, MD, FACR

ACR Education Center Launches Virtual Micro-Courses

The ACR Education Center is expanding its offerings to include a series of micro-courses covering a variety of specialties. Each micro-course begins with one-week online access to pre-recorded lectures and cases for a self-paced deep dive on the most challenging topics in a chosen specialty — followed by a virtual two-hour group case review and Q&A with faculty via Zoom and two additional days to review the case content.

“The in-person courses at the ACR Education Center are the world’s best radiology simulator,” says Mark D. Murphey, MD, FACR, one of the Education Center’s course directors. “By adapting to the COVID-19 pandemic and expanding its offerings to include these virtual micro-courses, the ACR Education Center continues to offer high-quality radiology training in a new way that’s accessible to all and protects the health of these physicians and the patients they serve.”

Registration for the virtual micro-courses is now open at acr.org/micro-courses. All virtual micro-course participants will have the opportunity to earn AMA PRA Category 1 Credits™ and SAM credits. Additional course specialties will continue to be offered throughout the year.

HEARD ON SOCIAL MEDIA



Dan Chonde, MD-PhD
@DanChondeMD

While you're here, check out @PeoplesArtProj which is dedicated to reimagining our clinical spaces through art and design to promote health equity.

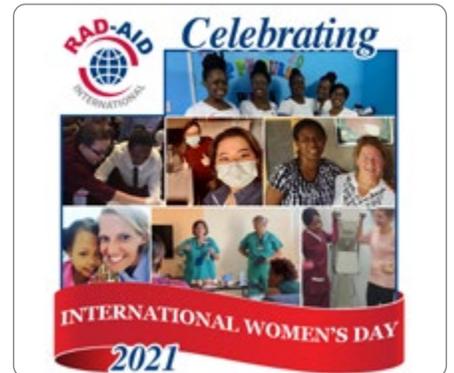


FEB 9, 2021



Geraldine McGinty
@DrGMcGinty

The #radxx of @RADAIDintl do incredible work all over the world, celebrating them this #IWD2021



MAR 8, 2021



Kristin Porter
@KPorterUAB

Replying to @amykpatel and @RadiologyACR
Loved seeing my daughter able to see herself in radiology! #changemaker #radxx @AAWR_org



FEB 3, 2021



Lauren P. Golding, MD
ACR RUC Advisor
Guest Columnist

The Unraveling of MIPS

Radiologists should look for ways to incorporate measures that incentivize the reduction of disparities and improve patients' access to high-quality care.

Most radiologists are familiar with the acronym-laden MACRA legislation and its offspring, the Quality Payment Program (QPP). Now entering its fifth year, the QPP, in many ways, has fallen short of achieving its goals of improving quality and reducing the cost of healthcare. Widespread criticism of the QPP and its pay-for-performance arm, the Merit-Based Incentive Payment System (MIPS), has escalated over the program's short lifespan. Critics point to the overly burdensome reporting requirements, the difficulty in comparatively scoring clinicians across specialties on different measures, and the financial resources required to "play the game" successfully.

CMS responded to criticism of MIPS by changing the program in ways intended to reduce burden and increase focus on improving outcomes of patient care. Some of these updates to MIPS include the "Patients over Paperwork" initiative — in which CMS reduces the number of available quality measures by removing measures felt to be too easy, low-value, or focused on process improvement instead of patient outcomes. Unfortunately, these changes come with consequences that do little to substantially improve the program and specifically disadvantage radiologists.¹ The only ways for radiologists to score perfectly in MIPS — allowing them to share in the maximum exceptional performance bonus — are to either make up the gap in their quality score by accruing bonus points for submitting extra high priority measures, submitting measures using end-to-end electronic reporting, or reporting non-capped measures using a qualified clinical data registry (QCDR), such as the ACR's National Radiology Data Registry.

QCDRs have their own challenges with strict and ever-changing CMS approval requirements and a labor-intensive measure development process. Another revision to MIPS was the implementation of a new participation framework called the MIPS Value Pathways (MVPs) that was initially slated to begin in the 2021 performance period but has been delayed until 2022. The goal of MVPs is to move away from siloed activities and measures in the four relatively unrelated MIPS performance categories and move toward an aligned measure

set to better prepare clinicians for alternative payment models (APMs). The applicability of MVPs to radiologists is not yet clear. In the absence of meaningful quality and cost measures, the MVP framework is unlikely to solve the problems of MIPS.

The shortcomings of MIPS predated COVID-19, but the pandemic further exacerbated its unraveling. The last thing physicians have had on their minds over the past year is satisfying complex reporting requirements and devising scoring strategies. To the credit of CMS, the agency recognized this and agreed to hold clinicians harmless from a negative payment adjustment for the 2019 and 2020 payment years. However, this too has detrimental consequences to the program. Because MIPS is a zero-sum game in which the losers pay the winners, removing all risk of losing means there is no money available to pay the winners and negates the entire pay-for-performance paradigm. With already minuscule bonuses for high performers in 2017 and 2018, further dilution of the available bonus pool does nothing to incentivize buy-in from clinicians trying to maximize their performance in MIPS. Furthermore, by exempting large numbers of clinicians from MIPS in 2019 and 2020, many of the quality measures will no longer have historical benchmarks — leaving CMS unable to score measures that have always been plagued by imprecision and questionable relevance. By statutory requirement, MIPS will reach its full implementation next year with the 2022 performance period. This means that in the absence of legislative intervention, the performance threshold — or the score below which a clinician receives a negative payment adjustment — must be set at either the mean or median of all participants' scores. In the aftermath of the pandemic, with no valid benchmarks and myriad uncertainties, such a high-performance threshold will be untenable.

One clear opportunity for improvement in the remaking of MIPS would be to include measures that address the disparities in healthcare. Although pay-for-performance programs may lead to overall improvements, there is some evidence to suggest that they may inadvertently exacerbate health disparities for marginalized populations.² Certainly, small and rural practices have struggled to perform well in MIPS, despite provisions in scoring designed to level the playing field. Most MIPS measures capture clinical effectiveness, whereas few attempt to capture aspects of access, patient experience, or interpersonal care. These gaps suggest that MIPS, as it currently exists, may fail to measure the broader aspects of healthcare quality and may even risk worsening existing disparities. **B**

ENDNOTES available in the digital edition at [acr.org/bulletin](https://www.acr.org/bulletin)

Overcoming Barriers to Care

Every radiologist and radiology organization can play a part in ensuring that all patients have access to high-value imaging care.

Inaccessible, fragmented, and siloed care is a chronic challenge facing patients and healthcare providers, resulting in low-value and inequitable outcomes that are more likely to affect underserved populations.¹ For racial and ethnic minorities in the U.S., health disparities take on many forms — including higher rates of chronic disease and premature death, compared to the rates among Whites. It is important to note that patterns are not universal or stagnant. Some minority groups — most notably, Latinx/Hispanic — may have better health outcomes than Whites in certain measures.² Mortality rates for Native Americans are almost 50% higher than those of their White counterparts.³ Additionally, Native Americans have an infant mortality rate that is 1.5 times the rate of Whites.⁴ The CDC reports that nearly 44% of Black men and 48% of Black women have some form of cardiovascular disease.⁵ And Black and American Indian/Alaska Native females have higher rates of stroke-related death than Latinx/Hispanic and White women.⁶

Medical imaging impacts most patients at some point in their care journey, and radiologists have the potential to be unifying change agents across an inequitable healthcare system. Overcoming racial, socioeconomic, and geographical barriers supports high-quality imaging care and vibrant practices.

How can we, as radiologists, help patients overcome the barriers to care? We can take a human-centered approach and ask questions to ensure that we're providing high-quality care. We can ask patients how they were treated before, during, and after their appointments. We can ask about their follow-up care and understand any obstacles they are running into.

The pages of this special issue illuminate the many ways radiologists are taking action to ensure quality care for all members of their communities. We will examine how the COVID-19 pandemic has revealed and exacerbated structural barriers. We will identify the ways in which financial toxicity creates barriers to receiving timely care. We will explore how technology can be leveraged as a tool to promote health equity by improving communication between providers and patients from underserved communities. And we will discover how, by working together, we will address the systemic challenges in imaging care and make tangible improvements in the lives of all of our patients. **B**

BY REBECCA L. SEIDEL, MD, CHAIR OF THE ACR *BULLETIN* ADVISORY GROUP AND ASSOCIATE PROFESSOR IN THE DEPARTMENT OF BREAST IMAGING AT EMORY UNIVERSITY SCHOOL OF MEDICINE

ENDNOTES available in the digital edition at acr.org/bulletin



PROMOTING HEALTH EQUITY

The October 2021 issue of the *JACR*[®] will look at radiology through the lens of health equity and social justice and will explore how provider-led initiatives can create a just health system that serves all patients. Stay tuned for the issue at [jacr.org](https://www.jacr.org).

Rural Repose

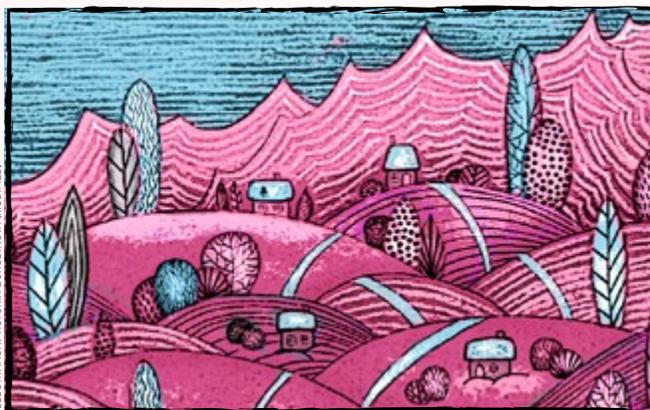


ILLUSTRATION: VICTORIA BORODNOVA (MODIFIED)

Small town radiology needs strong local alliances and thoughtful recruitment strategies.

Radiologists disenchanted with the idea of practicing in a smaller, rural setting may not be seeing the potential upsides — including a more desirable work-life balance, a broader connection with the community, and the ability to have a larger influence on the care and business models of their practice.

For years, small hospitals and rural communities have struggled to recruit and retain specialists compared to their urban counterparts. To survive and thrive, rural radiology groups need to make the landscape more appealing. That means building strong local alliances to weather hard economic times and honing telehealth services to fill coverage gaps, according to Eric B. Friedberg, MD, FACR, vice chair of the ACR's General, Small, Emergency, and/or Rural Practice (GSER) Commission and associate professor of radiology in the community division at Emory University in Atlanta.

"We're talking about a whole lot of people in need of services," Friedberg says. "Approximately 20% of the U.S. population lives in rural areas — that amounts to more than 60 million potential patients."

The GSER Commission supports radiologists practicing general radiology within small communities and rural areas. "General" refers to fellowship-trained subspecialists who spend a significant portion of their time interpreting studies outside of their subspecialty. Veterans Affairs and military hospitals fall under the GSER's purview — as do radiologists serving in a teleradiology capacity for rural communities. The growing demand for 24/7 radiology services, increasing clinical volumes, expectations for robust patient access in rural and critical access areas, and an emphasis on containing costs and boosting efficiency could be met by hiring general radiologists with particular skill sets.¹

MINDFUL RECRUITMENT

"There is more work to do now than ever in radiology — and from a recruitment angle we have fewer people competing for

positions," says Ivan M. DeQuesada, MD, chair of both the ACR's Rural Practice and Critical Access Hospital Subcommittee and Radiology Associates of North Texas' (RANT) recruitment committee. Job-seeking radiologists may not realize their best option might be difficult to spot on a map.

While rural locations are sometimes stereotyped as undesirable, all of that may be changing. "Smaller private practice groups in rural areas may end up having an easier time recruiting radiologists than their large, urban counterparts, especially if they are still entirely owned by their radiologists, which is increasingly rare in big cities," DeQuesada says. "I run recruitment at RANT and see the benefits of joining rural community practices."

"For some people, being too far away from a metropolitan area is a nonstarter when looking for a job," DeQuesada says. Many rural practices and small emergency hospitals, however, have more control over how much they pay, what they invest in, and how much time off employees get, DeQuesada says. "The venture capital-backed groups with high overhead — because they have considerable debt or a lot of shareholders to pay who aren't radiologists — may not be as well-positioned when it comes to recruitment," he says.

Regardless of location, recruitment for all radiology groups is being stymied at the medical school level. "Radiology in medical school programs often takes a back seat to other specialties — and students definitely don't hear good things about being boots-on-the-ground radiologists in rural areas serving small hospitals and private practices," DeQuesada notes. "That makes it difficult to attract the best and brightest to smaller communities."

"In my role in the GSER Commission, I interact with many private practice doctors, and I get to share and hear positive stories about what it's like to be a doctor in a small practice," Friedberg says. These stories can be very impactful for young career physicians, because many of them are not exposed to radiology as medical students, he says. "Even if they choose radiology, as residents they still are not getting commonly accurate, firsthand, positive accounts of what it is like to be in a rural practice."

"It is great to see more medical students attending ACR's annual meeting in the last few years," Friedberg says. "It is a chance to see presentations on rural radiology and interact with others practicing in and/or supporting rural communities — which may help them learn things that might change their perception of living and practicing in smaller communities."

One of the challenges in changing perceptions is a fear of corporatization and consolidation, Friedberg says. "Small, rural hospitals are failing at an unprecedented rate. The number of rural hospitals that we have lost since 2005 is ~179 and ~135 since 2010, and counting, according to the Cecil G. Sheps Center for research at UNC."² But that does not mean there are not opportunities for sustainability and success.

LOCAL ALLIANCES

The size of radiology groups has morphed in recent years through consolidation and corporate activities. "Many rural practices are — and for a long time now, have been — in an economically constrained situation, with competitive forces coming their way," Friedberg says. "Several decades ago, a 60-person group was big. Now you have groups with several thousand radiologists."

As another challenge, Friedberg points to chronic government

“We’re talking about a whole lot of people in need of services, approximately 20% of the U.S. population lives in rural areas — that amounts to more than 60 million potential patients.”

— Eric B. Friedberg, MD, FACR

underfunding for anyone practicing in the rural space. “We can’t afford to wait for the federal government to do a better job at granting money and providing loan programs for rural America — specifically those that assist with healthcare infrastructure including radiology,” he says.

“People are always talking about lessons learned throughout the COVID-19 pandemic,” Friedberg says. “A big one would be for anyone who has not already cultivated a strong relationship with their local financial institutions, to do so.” Local lenders have a stake in helping during times of financial hardship. “Hospitals are often the largest employers in these small communities,” Friedberg notes. When a local bank has an opportunity to obtain the business of professionals who are the economic linchpins of the community, it makes good business sense, he says. “When a hospital goes down, patients lose access to care, people lose jobs, real estate values go down — there is a horrible domino effect, and that is not conjecture,” says Friedberg.

“Right after the first shutdown from COVID-19 in March 2020, we were talking to people from all parts of the country who practice in rural and critical access facilities,” DeQuesada says. “The folks who had good relationships with their local lenders were able to access emergency funding more readily than some urban groups who had relationships with large, national banks.”

“I heard stories from tiny groups — one in Wyoming — about getting access to funds that really saved them during that critical period,” DeQuesada says. “So, in spite of the fact that this slice of radiology has been suffering for years with narrowing hospital margins and imaging cuts in general, this particular group was able to weather that shutdown period surprisingly well.”

LARGE PARTNERS

Contracting with larger radiology groups can also be a lifeline. And working with private equity entities can bolster business for smaller rural groups and alleviate the burden of managing the business side of their private practice or hospital, while securing access to subspecialists.

“With the current norm of immediate 24/7 coverage, and with the complete reliability of other physicians on imaging assessments to treat their patients, no small or even medium-sized hospital could afford that kind of coverage,” says Catherine J. Everett, MD, MBA, FACR, president and managing partner of Coastal Radiology Associates, PLLC.

“We are now providing an integrated radiology network option that I think has proven very valuable for groups that exist in a rural space,” DeQuesada says. “We provide administrative support for groups operating with only a handful of radiologists in very remote

parts of the state — and provide 24-hour coverage for services they cannot provide locally.”

“Several of the corporate models have at least some physician ownership and therefore partnership,” Everett notes. “Sometimes loss of autonomy is hard, but consistency of clinical guidelines, expertise in new regulations, skilled human resources people, and representation in national committees of subspecialty physicians for clinical value standards are very positive things.”

“I was so relieved that I had a corporate structure to deal with the pandemic,” Everett says. “I don’t think my partners and I could have functioned as financiers and an HR department, figured out the rules of engagement, and gotten all of our work done at the same time.” In normal times, too, she says, it is beneficial to have structured IT services and physician resources.

VESTED INFRASTRUCTURES

“Those groups who have invested in infrastructure — particularly in the telehealth space — will have more creative opportunities to develop strategic alliances,” Friedberg says. Those groups who demonstrated during the pandemic that they could support their own activities, while supporting others when they ran into difficulty, will start to emerge in rural areas. “We are starting to see some symbiotic relationships,” Friedberg says. “The investment in teleradiology capabilities is crucial when you consider efficiencies, economies, specialty support — the whole 24/7 and 365-day-a-year coverage.”

Teleradiology has afforded specialists employment in rural areas where only a generalist might normally be hired. “Many hospital administrators, unfortunately, are stuck in the ‘80s and want ‘their’ radiologists onsite,” Everett says. “They remember the era of films and the relative lack of after-hours radiology services. The pandemic has demonstrated to hospital administrators that we can easily do required work with minimal or no onsite time.” That allows for consolidation of services and better specialty coverage for patients, she says.

“The ACR and the Society of Interventional Radiology have formed a task force to look at ways to improve IR services, and therefore radiology services, in rural hospitals,” Everett says. “IR and diagnostic radiology are going to have to work together to provide innovative models to serve rural patients.”

“When we don’t have enough radiologists, we open ourselves to geographic labor gaps in coverage,” Friedberg says. “If we don’t have boots on the ground and depth on the bench, we will see those gaps, particularly as it relates to needle- and catheter-procedural-based work. We must show medical students, residents, and fellows the value of small and medium-sized hospitals and the opportunities rural private practice may afford them.”

“Our goal now should be to find radiologists who will provide the highest quality of care — and to do that thoughtfully with eyes to the future,” Friedberg says. “When younger physicians predominantly desire to live in a metropolitan area, it feeds the rural labor challenges. For all the radiologists who grew up in small towns but practice in dense, urban areas, the draw to go home could be a powerful thing.” **B**

BY CHAD HUDNALL,
SENIOR WRITER, ACR PRESS

ENDNOTES available in the
digital edition at acr.org/bulletin

No-Visitor? No Fear

COVID-19 ushered in an era of no-visitor healthcare, but what are the impacts on patients — and what can radiologists do to help?

“I will never forget the times my husband was hospitalized for treatment and complications for stage III rectal cancer,” says Jennifer L. Kemp, MD, FACR, associate professor of radiology at the University of Colorado. During each 24-hour period as an inpatient, their lives revolved around the 10 minutes each day the attending physician would stop by to check in and update them on the care plan. “I would save all my questions and have my wording for each question and comment lined up for the physician when they entered the room. My husband would also have his list handy. Then, after the physician left the room, the vicious cycle would start again — When is the doctor going to come by next? What questions do we need to ask next? I couldn’t believe that here I was, a physician, and I was shell-shocked with anxiety and white coat syndrome every time one of my husband’s treating physicians entered the room!”

The scenario described above is a common one for many patients in healthcare settings who find themselves overwhelmed and leaning on loved ones to help them recount clinical history, remember details, ask important questions, and advocate for them. Once COVID-19 hit, reliance on loved ones as advocates became a non-option in most cases — as many patients were directed not to bring anyone to appointments. In addition to Kemp, the *Bulletin* spoke with Arun Krishnaraj, MD, MPH, chair of the ACR’s Commission on Patient- and Family-Centered Care; Linda Sample, CPXP, founder and president of Empowered Healthcare, LLC; and Linda Dowling, RN, BSN, program manager and nurse navigator at Rush Lung Center, Rush University Medical Center, about the impacts that COVID-19-related restrictions on visitors have had on patients — and what radiologists and their teams can do to help.

How is care impacted when patients are unable to bring loved ones to in-person healthcare appointments?

Dowling: The physical aspects of getting to appointments have presented a challenge for patients since the pandemic hit. We’re a big facility, and our cancer center is on the 10th floor. So patients have to first deal with getting transportation to the facility, then they have to get from the parking lot to the building, and then from the lobby up to the cancer center — for many patients, that’s a lot of ramps and walking. We had a strict no-visitor policy at the beginning of the pandemic, so for patients who rely on family for physical help with their appointments, this was hard. Some of these patients are dealing with a new diagnosis of lung cancer, for example, and then to be told they’ll have to navigate their appointments alone was scary.

Another challenge we’ve faced involves patients’ access to, and ability to navigate technology. Many of our elderly patients, for example, either aren’t tech savvy or don’t have access to smart

phones — some don’t even have access to computers. And they now need to use an app to facilitate their care through our patient portal. In the beginning, we were trying to do video visits, but in some cases it just wasn’t possible. So that was really hard and frustrating for patients.

“When patients can’t bring a care partner to an appointment, there’s often a higher sense of anxiety, fear, and even self-doubt.”

– Linda Sample, CPXP

Sample: When patients can’t bring a care partner to an appointment, there’s often a higher sense of anxiety, fear, and even self-doubt. As a result, patients may postpone appointments or even forgo recommended screenings.

Kemp: In many cases, a loved one is the patient’s healthcare advocate or at least a key decision-maker. That loved one will have their own interpretation of the visit discussion and recommendations. That loved one will often have their own questions, which may be different from what the patient might think of. Often the patient can be overwhelmed and stressed at the visit. They may forget key components of their history. Patients’ stress also can limit the amount of information their brain can process at once. Having that second person there to help remember important information, ask the right questions, and absorb all relevant information from healthcare personnel is critical for some patients.

What can radiologists and their teams do to minimize these impacts for patients?

Kemp: I think the radiologist’s primary goal during this pandemic is to make sure everyone — the patient, their caretaker, radiology staff, etc. — is as safe as they can possibly be. Although I laud the benefits of including family members in patients’ care, I put safety first during a deadly pandemic. Thus, we need to look for alternate methods of communication — to include telehealth conferencing as well as being more available for phone, email, or patient portal questions.

Krishnaraj: The key for radiology and radiologists is to make themselves available. Imaging is a vital component of most patients’ care and yet radiologists are often absent from the conversation with patients when decisions are made. Making yourself available via email, phone, or video chat together with the entire care team can improve care decisions and outcomes as well.



Sample: I think there are opportunities for additional training for radiologists and their broader care teams around empathy and communication. The RTs, front office staff, and everyone who interacts with the patient in some capacity has the potential to impact a patient’s experience and sense of well-being. If a patient seems anxious, reaching out by saying, “It seems like you may be feeling anxious; what can I do to help?” can make a big difference. Sometimes we just need someone to communicate with us and ask us the right questions.

Dowling: We need to provide a lot of reassurance and communication to help patients feel they can get to their imaging — whether that is offering wheelchairs or making sure an extra staff person is available. We also decided to take the additional step of working directly with patients who needed assistance using technology to navigate our patient portal. Our IT team drafted instructions, and then we had our medical assistants work with the patient or the family member to try to get the portal set up. Then they even took it a step further, as they were seeing the patients were still struggling with it. They started asking patients if they’d like to do a “dry run” by phone once they got home, to make sure they would be able to connect when the time came for their actual appointments. It was extra work on our end but ultimately saved a lot of work and confusion downstream.

I would also recommend helping facilitate videoconferencing for patients and their families, using apps like Skype or FaceTime. Whether that’s assisting a patient with videoconferencing their family while they’re physically in the appointment or helping the patient set up videoconferencing so that they can include loved ones in telehealth appointments later — videoconferencing can be an incredibly useful tool to allow loved ones to participate in patients’ care safely.

How can radiologists help patients and their loved ones for whom English is not a first language?

Krishnaraj: At UVA, we have worked with the Holvan Group, which offers patient prep videos in both Spanish and English. Spanish-speaking patients are given a tablet with pre-recorded videos to help them understand the procedure they are scheduled to undergo. Additionally, radiologyinfo.org has ample Spanish language content that is very useful for patients and is 100% free.

Kemp: All hospitals have policies that patients need to be provided a medical translator and, at least in my experience, medical translators (even when remote) are available 24/7.¹ Unfortunately, people often don’t take the time to use the translator, as this can slow down the process. So planning in advance for when a translator will be needed and making sure all staff are comfortable accessing a translator and communicating via a medical translator is paramount to success. The process needs to be as easy as possible without causing significant workflow disruption. **B**

INTERVIEWS BY CARY CORYELL, PUBLICATIONS SPECIALIST, ACR PRESS

ENDNOTE

1. Health and Human Services Department. Nondiscrimination in health programs and activities. *Federal Register*. 81 FR 31470. Published May 18, 2016. Accessed March 5, 2021.



Focusing on Health Equity

In a new *ACR Bulletin* podcast episode, ACR President Geraldine B. McGinty, MD, MBA, FACR, discusses the formation of the Radiology Health Equity Coalition (see page 15) and its mission to ensure the best care is provided to every patient, regardless of background or income level. Listen to the episode at bit.ly/HealthEquityCoalition.

Paying the Price

A growing number of patients are avoiding critical care because they cannot afford it. Can radiologists help find the answer?

In a national survey conducted by the University of Utah, patients were asked the one thing they valued most from a healthcare provider. The answer — overwhelmingly — was “affordable out-of-pocket costs.”¹ Unfortunately for many patients, affordable out-of-pocket costs aren’t always in reach. A survey by the West Health Institute and the National Opinion Research Center at the University of Chicago found that 40% of patients skipped a recommended test, treatment, or follow-up appointment within the last year because they could not afford it and were more concerned about the cost of treatment than getting sick. Many of these individuals are also having difficulty paying for necessities such as food, heat, and housing already, and cannot keep up with rising healthcare costs.² These patients and their families are suffering from financial toxicity of care.

“Financial toxicity is the financial burden imposed on patients and their caregivers and it greatly affects access to care,” says Ruth C. Carlos, MD, MS, FACR, professor and assistant chair of clinical research in the department of radiology at the University of Michigan and editor-in-chief of the *JACR*.³ “There are data that show that even a \$5 increase in out-of-pocket costs can lead to patients not filling their necessary prescriptions.”³ She adds that even services fully covered by insurance, such as screening mammography, may be avoided because of the worry that the test will be positive, leading to additional screening or care patients cannot afford. “As a result, financial toxicity’s avoidance of care aggravates existing health inequities in a society,” says Yoshimi Anzai, MD, MPH, associate chief medical quality officer at University of Utah Health.

And that’s not the only burden it leaves on patients, says Anzai. Financial concerns can also cause a great deal of stress for patients. “Imagine having to decide whether to put food on the table or pay for your son’s chemotherapy,” she says. “The stress of these out-of-pocket costs can impact a patient’s health as well.”

Although the work in addressing financial toxicity has just begun, radiologists may be able to help find some of the answers. As radiologists integrate themselves more fully into patient care, they need to be aware of the broader consequences to patients and the multifactorial causes — not just the things that radiologists perceive as directly under their control. “Patient care is not only understanding a patient’s condition, but also the factors affecting a patient’s health and overall well-being — and that includes outside factors, such as their financial situation,” says Carlos.

Financial toxicity and its burdens also directly affect radiology services, says Anzai. “Imaging is perceived as a very expensive service, not only by patients but by referring physicians,” she notes. “Our specialty is an area where patients may ignore care or may shop

around to find significantly cheaper imaging, even if it means going to lower quality clinics.”

One way to help address financial toxicity among patients is to screen patients for medically induced financial distress, Carlos suggests.³ “It could be as simple a question as, ‘Are you worried about your out-of-pocket costs for your test today?’” she notes. From there, a practice or department can develop referral programs where patients who are identified as financially stressed can be referred to financial counselors or navigators to case manage these situations, Carlos says. “Places such as these can help patients optimize insurance plans and navigate financially induced burden,” adds Anzai. “Finding a way to help patients by using an imaging encounter to screen for financial burden increases the value of care even before we image the patient. Reducing financial burden can also potentially increase the amount of cost share that patients are able to pay, which is a system benefit,” says Carlos.

Price transparency — making the prices of procedures available to the public — continued to gain ground as a tactic against financial toxicity. Proponents argue that more informed consumers will make smarter consumers, allowing patients to shop around and make choices that will put less strain on their finances.³ However, some work has to be done before price transparency tools are effective for radiology, according to Carlos and Anzai. “Price transparency tools need to become more actionable for the patient,” says Carlos. Most public health costs are chargemaster costs, and therefore don’t reflect the actual prices that patients would be paying for procedures. These prices are often overinflated and serve as the starting point of negotiation between hospitals and private payers.¹ “If a patient just looks at that, they’re likely to get sticker shock,” says Anzai. “The patient will see a huge number and look for other places or continue to avoid care altogether. This is why the University of Utah Hospital has developed online, interactive, out-of-pocket estimate tools for our patients.”¹

Current price transparency lists don’t always accurately present the care being given either, because while it reflects the dollar cost of the procedure, it doesn’t take into account the quality of the care being delivered — whether it’s patient-centered care, an ACR Diagnostic Imaging Center of Excellence™, or other factors that affect care, both Carlos and Anzai say. “Price is quantifiable — it’s easy to describe. Quality, however, is multifactorial and may be difficult to convey. When you tell patients you’re giving them higher quality care than other facilities, what does that mean to them? It’s potentially something different to everyone,” says Carlos. “More patient education, research, and outreach has to be done for quality to be effectively communicated. Quality practices, such as being enrolled in the ACR Dose Index Registry®, are incredibly important — but your average patient may not understand why, especially if they’re just looking at a price transparency tool.”

Regardless, the push for price transparency and against financial toxicity is here to stay, says Anzai. “We need to take the lead on this. Not only is it the ethical thing to do, but we should be proactive rather than reactive in understanding patient finances and their effects,” she says. “Fewer patients are accepting care just because a physician says so, and more are demanding affordable prices. Healthcare is moving forward with it, whether we like it or not.” **B**

BY MEGHAN EDWARDS, FREELANCE WRITER, ACR PRESS

ENDNOTE available in the digital edition at acr.org/bulletin



Health Equity: Radiology's Lane

The ACR will serve as convener for the house of radiology to focus on the specialty's unique opportunity to promote health equity.



Geraldine B. McGinty, MD, MBA, FACR

Reducing health disparities has long been on medicine's radar, but COVID-19 has put a brighter light on how structural inequities directly impact access and outcomes for a wide swath of patients. Until recently, there has been relatively little focus on the issue when it comes to radiology — but radiologists have a significant role to play.

The *Bulletin* spoke with ACR President Geraldine B. McGinty, MD, MBA, FACR, about the College's plan to convene the Radiology Health Equity Coalition to drive imaging equality across healthcare. The coalition, which will be championed by BOC Vice Chair Jacqueline A. Bello, MD, FACR, will be formally announced by McGinty during her presidential address at ACR 2021 in May.

What was the impetus for the ACR forming the coalition?

As we looked at the disparities highlighted by the pandemic, as well as some of the social justice protests of the last year, we realized that we needed to more actively leverage the unique opportunities that radiology has to make a difference in health equity. The ACR's history of concretely demonstrating and ensuring the value of high-quality imaging care across stakeholders is well-established. Focusing all aspects of imaging on improving access to care, identifying missed care opportunities at the community level, and reducing imaging outcomes variability has the potential to reap benefits across the continuum of care and position radiologists as stewards of population health management (learn more in the [population health management recorded webinar, "Understanding and Pursuing Health Equity: Opportunities to Take Action,"](#) at acr.org/PHM).

What are some of the outcomes disparities that the coalition will address?

The coalition will address well-documented outcomes disparities such as higher cancer deaths for underserved populations (due to reduced access to screening and screening recommendations based on flawed data); variations in care based on race and ethnicity, as well as rurality and zip code; and documented discrepancies in life expectancy and outcomes that could be affected by access to imaging care. Lung cancer screening presents a significant opportunity because we know we're not screening nearly enough people. There is a specific opportunity in communities of color, where the impact of lung cancer is higher and where we're not necessarily reaching patients the way we should.

Who are some of the stakeholder organizations that the ACR will partner with?

I foresee every radiologist and every radiology organization playing a part in ensuring that all our patients have access to high-value imaging care. Radiology specialty societies have a track record of cooperation and rapid changemaking when the stakes are high. Our patients are facing pressing issues that can only be solved by a unified and full-strength effort across the radiology community. By building on the expertise that each of our sister societies brings to the challenge of health disparities, we will magnify our effect to make measurable impact and change the current imaging inequities.

We also plan to work with our organized medicine conveners like the AMA and the American Hospital Association to get input from their experiences and experts. I want to be clear that the ACR doesn't want to own this coalition — we want to work across the entire profession of medicine as we try to influence policy. We want to bring everyone together around a shared set of goals.

How can ACR members get involved with the coalition?

As the April 2019 issue of the *JACR*[®] demonstrates, there are opportunities for all radiologists to drive high-value imaging care for all Americans ([read more at *jacr.org*](#)). The ACR is committed to having opportunities for our members to volunteer in health equity efforts. At the chapter level, there are state chapters with diversity committees — that is a great way to get involved in making our radiology workforce more diverse. There are other issues that come up, such as renewal of the protections for coverage for mammography screening — and every ACR member can be involved by asking their elected representative in Congress to support that effort.

Do you anticipate the current divisions in American politics to affect the work of the coalition?

The representative and collaborative nature of the ACR offers a place for all perspectives, while retaining the core of healthcare professionals' desire to care for all members of their communities of practice, regardless of their ability to pay, as noted in the FACR pledge. To me, that transcends any political leanings. We may all have different ideas on how to effect change but that healthy exchange of ideas is exactly what we're hoping to get from this coalition. **B**

INTERVIEW BY NICOLE B. RACADAG, MSJ,
MANAGING EDITOR, ACR *BULLETIN*

Relative Value



Ezequiel Silva III, MD, FACR, FSIR, FRBMA, RCC

AMA's RUC chair sees new role as a nod to radiology's relevance within the house of medicine.

The ACR is better served when its members are also members of the AMA. The more AMA members we have, the more voices radiology has throughout the house of medicine," says Ezequiel "Zeke" Silva III, MD, FACR, FSIR, FRBMA, RCC. In March, Silva assumed the role of chair of the AMA's Multispecialty Relative Value Scale Update Committee (RUC). Silva, who is immediate past chair of the ACR's Commission on Economics and Harvey L. Neiman Health Policy Institute[®] founding board member, is the first radiologist appointed to chair the RUC.

Nearly three decades ago, the AMA created the RUC to address the transition to a Medicare physician payment system based on the resource-based relative value scale (RBRVS). The RUC is a multispecialty committee of roughly 30 members (mostly physicians) tasked with communicating the resources required to provide physician services — which CMS considers in developing relative value units (RVUs). The RUC's relative value recommendations to CMS drive the values assigned to new or revised Current Procedural Technology (CPT[®]) codes. There are approximately 10,000 CPT procedure codes, and the RBRVS is updated annually to reflect new and revised codes. The RUC, in essence, gives medical professionals a voice in shaping relative values for Medicare procedures — but CMS makes all final decisions about what Medicare payments will be.¹

Silva recently told the *Bulletin* what it means to serve as RUC Chair, why the clinical expertise of its members is so important, and how growing more radiology leadership roles will move the needle on innovations that ensure quality patient care.

How significant is it that a radiologist now chairs the RUC?

I am extremely proud to have been nominated and appointed to this role. It is a credit to the respect the ACR and all of radiology have within the broader house of medicine — which I see as a broader credit to the quality of the ACR and the quality of radiology in general. The ACR has had a permanent seat on the RUC since its inception and we have been important contributors to the RUC and its commitment to quality patient care. When you look at the challenges collectively facing medicine, it is significant that a radiologist was selected to lead that effort.

How does the ACR fit into the RUC process?

The ACR is visible in all parts of the RUC. The members of the RUC are part of a multispecialty group and each sit in their own specialty seat. However, each RUC member functions independent of their specialty. In fact, RUC members may not advocate on behalf of their specialty at any time. That means when RUC members vote on a procedure performed by their specialty, they are not voting on behalf of their specialty, but as an independent participant.

ACR also has an advisor and an alternate advisor serving on the RUC's Advisory Committee and Specialty Society Committees. Anytime a radiology code is valued, the ACR RUC advisor prepares recommendations for the RUC — which are discussed and potentially modified before the RUC presents its final recommendation to CMS. The ACR RUC advisor works with an expert panel, often including clinical experts in the procedure at hand. This group prepares and submits recommendations that are clinically appropriate and clinically credible. Because independent RUC members are not radiologists, they often pose specific questions about the procedure and valuation recommendation. The ACR advisors interpret survey data randomly gathered from ACR members to inform their recommendation to the RUC. The Relativity Assessment Workgroup is a subcommittee of the RUC, which identifies potentially misvalued services. For example, CT of the abdomen and pelvis has been revisited several times, as well as multiple IR procedures.

My main goal as chair is to facilitate the RUC effectively doing what it has always done. That is, bring clinical expertise to the valuation process in a way that ensures patients receive the best possible care from their physicians.

Are there areas of the RUC's work you would like to build upon?

My main goal as chair is to facilitate the RUC effectively doing what it has always done. That is, bring clinical expertise to the valuation process in a way that ensures patients receive the best possible care from their physicians. An important strength of the RUC is its ability to help integrate healthcare innovation into physician payment system. A great example within radiology is innovative imaging techniques, IR, nuclear medicine, and radiation oncology. There is also a lot happening with telehealth, augmented intelligence, and digital therapeutics — to name a few areas for reimaging care. For instance, the COVID-19 public health

“Dr. Silva’s outstanding collaborative work and contributions in the fields of medicine and healthcare economics have earned the respect and trust of physicians and allied professionals across the house of medicine. I can’t think of a better choice to lead the AMA Multispecialty Relative Value Scale Update Committee into the future.”

— ACR CEO WILLIAM T. THORWARTH JR., MD, FACR

emergency has brought telemedicine, including teleradiology, to the forefront of care and we want to make sure these types of services continue to have a place in Medicare and in medicine in general. I also want to ensure the clinical expertise the RUC brings to shaping policy stays at the highest standard. CMS and other policymakers have always given a nod to our expertise — how it fairly and appropriately informs valuation for patient services.

How does clinical expertise drive future policy?

A perfect example from a few years back is fetal MRI. It is a very complex procedure, and we are fortunate in our specialty to have radiologists who have dedicated significant parts of their academic and professional careers to taking care of this population of patients. When only a select group of radiologists perform this study, you have to assume when you walk into the RUC that members from other specialties will not understand the procedure and its importance. I firmly believe that the clinical expertise within the RUC is what makes it possible for patients to receive the most effective, up-to-date care available because their doctors have the resources to provide it. The fact that a group of radiologists are contributing to and helping shape healthcare policy through this process is perfectly indicative of what the ACR does to empower its members.

Why is AMA membership important for ACR members?

The number of delegates we have in the AMA House of Delegates (HOD) is directly proportional to the number of individual ACR members who are also members of the AMA. Delegates vote on policy, and some of that policy directly affects radiology. The HOD includes representatives from state medical associations, national medical specialty organizations, professional interest medical groups, and federal services. The ACR currently has eight delegates, and that number is expected to grow. We have a strong radiology specialty caucus within the AMA, and ACR’s delegation

is the largest. It is vital to enable more radiologists to contribute as thought leaders — this is one way to accomplish that.

What lies ahead for the RUC under your leadership?

Our credibility as a specialty continues to grow as radiologists assume more national leadership positions. The ACR has always done a very good job at looking beyond existing policy and payment systems to explore what is coming next. I oversaw the College’s economics team for a long time and would always stress the importance of pondering future trends. At the same time, I was always thinking about next opportunities for the ACR — how to allocate resources appropriately and advance the best interests of the specialty. Even though I am now leading an independent group like the RUC, I remain as confident as ever in the ACR and its future role. My goals as RUC chair mirror what the ACR has always embodied — innovation and quality patient care. **B**

INTERVIEW BY CHAD HUDNALL, SENIOR WRITER, ACR PRESS

ENDNOTE

1. AMA. RVS update committee (RUC). Accessed February 23, 2021.

New Representation at the RUC

Under the leadership of Gregory N. Nicola, MD, FACR, chair of the ACR Commission on Economics, the ACR is announcing the following additional changes to radiology representation at the RUC:



William D. Donovan, MD, MPH, FACR, is the Radiology RUC Representative, a position previously held by Silva.



Lauren P. Golding, MD, is the new ACR RUC Advisor. She has served as the ACR Alternate RUC Advisor since 2018.



Andrew K. Moriarity, MD, is the ACR Alternate RUC Advisor. He also serves as the current YPS member of the ACR BOC.



Kurt A. Schoppe, MD, is the new Radiology Alternate RUC Representative.

[Learn more at \[acr.org/RUC-Reps\]\(https://www.acr.org/RUC-Reps\).](https://www.acr.org/RUC-Reps)



Looking Back, Looking Forward

As the country passes the one-year mark of the onset of the pandemic, radiology leaders reflect on lessons learned and their hopes for the future.



Leading in Times of Crisis

In the wake of the unprecedented health, social, and economic turmoil of the past year, several radiology leaders shared their perspectives of what was happening on the ground in their locations and their strategies for coping. Watch the recorded RLI Leadership Town Hall at acr.org/Leading-Crisis.

“Clearly, none of the things that happened in 2020 were at all on our radar,” says Dana H. Smetherman, MD, MPH, MBA, FACR, chair of the department of radiology and associate medical director at Ochsner Medical Center in New Orleans. “We know how to handle the diseases that we usually treat: We know cancer, we know the flu, we know strep infections. I think the entire country struggled and is still struggling with COVID-19 because it’s an entirely new pathogen. We had so much to learn, all of us — and we had to learn it quickly.”

Looking back over the last year, how did radiology fare? Three leaders in the field take stock of the first year of COVID-19 and discuss where healthcare goes from here.

What Worked: Response Time

“I think a lot of the workflows we implemented early on really did work,” says Mahmud Mossa-Basha, MD, associate professor and vice chair in the radiology department at the University of Washington (UW) Medical Center. “Within healthcare systems across the nation, when we implemented changes at a rapid rate, they really were successful.”

Michael P. Recht, MD, Louis Marx professor and chair of the department of radiology at NYU Langone Health in New York City, agrees. “The pandemic allowed us to take that time to really look at everything we were doing, and we found some things that we could do better,” he says. “The urgency brought on by the pandemic forced us to accelerate our MR protocols, and we were able to go faster — which is going to be better for patients and radiology departments as we go forward.”

What Worked: Adaptability to Virtual Platforms

According to Recht, at NYU Langone Health, everyone who wanted one was provided with a home workstation at the beginning of the pandemic. “Over the past year, we’ve learned that we can work remotely and still get our work done,” Recht says. “That’s going to have real benefits, namely for work-life balance.” Smetherman agrees. “I think we’ve had our eyes opened as to how we might actually incorporate people working remotely in our department,” she says. “The last year has forced us to do things in ways we hadn’t earnestly considered before.”

Mossa-Basha expects the flexibility around remote work to stick, too. “It’s a balance of providing the best care you can, while keeping both patients and healthcare workers safe,” he says. “And beyond their personal health and preventing COVID-19 exposure, it’s also important to keep people’s morale up, keep them focused, and make sure they stay happy, healthy, and productive.”

According to Smetherman, remote radiology education has also exploded. “We used to think that the only way we could teach a resident was to sit right next to them and go through the cases together,” she says. “I realized there’s more than one way to be an effective educator and provide real value through virtual education.” Smetherman envisions this will continue post-pandemic. “I definitely see our department continuing to use remote educational tools — things like virtual visiting professors, expanding our multidisciplinary conferences to include other facilities or experts in other regions — in the future,” she says. “We are even considering recruiting attending radiologists who could work for our department from other geographic regions, but still be involved in our academic activities, including resident teaching.”

Along with increased remote options for work and education, remote meetings have gained traction at many institutions — and this holds potential for increased engagement, Mossa-Basha says. “Being able to engage a larger group of people that may be geographically dispersed allows people to attend meetings they otherwise couldn’t and contribute to those discussions, which is definitely a positive step,” he says.

What Worked: Increased Communication

According to Mossa-Basha, “Overall, engagement and communication within departments, from all faculty, have increased in a lot of places. We changed our operational structure and there is a lot more input that goes into decisions than there previously was,” he says. “I think the lesson learned is really to just maximize communication. Regardless of how many times you’ve communicated — more communication is usually needed.”

Radiologists didn’t just boost communication within their institutions, but with patients and families as well. NYU Langone initiated a program called NYU Family Connect, says Recht, to keep patients’ and their loved ones updated while visitations were restricted due to COVID-19 protocols. The program, which was discontinued once visitor restrictions were modified, paired radiologists with medical students to review patient charts, virtually attend interdisciplinary rounds, and proactively call families with daily patient updates. Program volunteers spoke with more than 3,000 families as part of the program, ensuring that family members remained involved in care decisions during the height of visitor restrictions ([learn more at *acr.org/family-connect*](https://www.acr.org/family-connect)).

At UW Medical Center, they disseminated COVID-19 information to patients through avenues like social media videos, says Mossa-Basha. “These videos highlighted COVID-related precautions being taken to protect patient health, and were shared via the UW Radiology YouTube site (bit.ly/UW_ForOurPatients), Twitter, and in a video link texted to patients as part of the scheduling confirmation text sent through our automated patient texting portal, CareWire®,” he says.

Meeting the Moment

A collection of Imaging 3.0® case studies focuses on crisis management and the COVID-19 response. In it, you will find examples of how leaders have leveraged experience and creativity in the face of incomplete data to enable teams to act decisively in these uncertain times. Browse the collection at [acr.org/Meeting-Moment](https://www.acr.org/Meeting-Moment).



What Didn't Work: Inconsistent/Ineffective Messaging

“Nationally, it has been a challenge that all of these issues became politicized,” Smetherman says. “The lack of a uniform message that we’re all in this together; that we’re all fighting a common enemy — around things like mask wearing, lockdowns, potential treatments, vaccine development and access — that hasn’t been as effective as it could have been.”

“We weren’t able to communicate as effectively as we needed to just how important it was to follow the CDC’s guidelines,” Recht says. “As healthcare providers, we just haven’t found a way of convincing people. Part of that is politics, part of that is just communicating how to follow these guidelines — so we can beat this pandemic.”

What Didn't Work: Decreased Collaboration

While the pandemic ushered in new pathways for increased communication at some institutions, at others teamwork took a hit. “I think we learned to appreciate what we already had that maybe we took for granted at the time,” Recht says. “At NYU Langone Health, we have always had a special culture. As academic radiologists, we work in teams. We’re in reading rooms together, we have residents and fellows, and we interact with our referring clinicians. While we can do our basic jobs working from home, it’s not the same as it was before. We’ve lost something significant as an academic culture — and that’s the collaboration.”

Mossa-Basha agrees. “Academic radiology environments are collaborative and social working environments, where we work with other radiologists on a daily basis, seeking help on difficult cases, reviewing cases side by side with residents and fellows, taking part in multidisciplinary conferences with ordering providers, and meeting with these ordering providers to individually discuss cases, specifically diagnoses, next steps, and treatment approaches,” he says. “Radiology directly engages with so many facets of the hospital system due to our central role in diagnosis and treatment.” Unfortunately, some elements of this uniquely collaborative and social culture simply can’t be replicated virtually, Mossa-Basha says.

Smetherman echoes this concern. “I think the pandemic challenged us to rethink how we could collaborate,” she says. “Meeting together in a conference room, sitting next to a trainee to teach, and giving a lecture to a live audience are natural and familiar. Human beings are social animals, and we need to be very

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Clinical Integration

At an academic medical center, IRs and neuroradiologists are embedded in patient clinics and collaborating at the point of care.

In 2013, a 62-year-old man from a rural county in the Central Appalachia region of Tennessee was diagnosed with a large, biopsy-proven hepatocellular carcinoma. Due to his lack of trust in the medical system, he delayed further assessment and treatment of the tumor for nearly three years. In early 2016, with symptoms worsening, the patient finally arrived at the University of Tennessee (UT) Medical Center's Cancer Institute.

Keith D. Gray, MD, MBA, then associate professor and chief of the division of surgical oncology, immediately ordered new scans and realized that the man's right-sided liver cancer had grown to approximately 15 centimeters. Chemotherapy is not typically effective for a hepatocellular carcinoma, so Gray turned to the UT Medical Center's multidisciplinary clinic for patients with liver and pancreatic diseases. The clinic was established in 2015 with instrumental guidance from the department of radiology and its then chair, Laura K. Findeiss, MD, who is an IR.

"IR is a key player in providing that type of personalized care for our patients," says Gray. "Whether it is preparing for surgery or determining an alternative to surgery or helping us with complications related to surgery, we view the IRs as a part of the team."

Every Monday, a team of oncology caregivers — including surgical, medical, radiation, IR, gastroenterology, and nurse navigators — participates in a same-day clinic for liver and pancreas patients. In a multidisciplinary conference beforehand, providers gather to review the imaging and treatment options for each of the patients. For patients, the clinic means they can see all caregivers in one visit, which is especially important for those who are constrained by socioeconomic pressures and remote locations. "With the clinic, it's a long day for the patient, but it's all done in one trip," says Findeiss. "It's one day off work, one tank of gas."

Navigating the Pathway

In the case of the wary liver cancer patient, that collaborative approach proved invaluable. "We knew if he was a candidate for resection, he would need hypertrophy of his liver remnant via a portal vein embolization," says Gray. "But if we did the portal vein embolization, that would preclude us from doing regional therapy if he turned out not to be a candidate for surgery. It's a pretty complex pathway, and we were dealing with a patient who didn't trust the system. We were on the fence when we first went into the clinic, but we worked through all the questions together and had a plan going into the afternoon."

A laparoscopic US found occult liver disease in the left side, which precluded the patient from surgical intervention. Then Findeiss scheduled the patient for a minimally invasive radio-embolization (Y90) to the right side of the liver. "The

patient showed up for his treatment with Dr. Findeiss, and now he's on his way," says Gray. "Thanks to the clinic, it went off without a hitch — whereas if the patient had to come back for five different appointments, he may not have engaged further and received the proper treatment."

Establishing a Footprint

The weekly clinic grew out of the IR clinical practice that Findeiss and her team established at the Cancer Institute in 2014. "Initially, a lot of our IR work was cancer-related, so we asked the cancer center about leasing clinical space to see patients in their clinic. At first, it was a half-day a week, then we progressed to a second half-day, then a third," says Findeiss. "The goal was to establish a footprint. This is our day to see patients; we're not getting pulled into IR procedures. That's also the challenge, because you're not generating revenue at the outset. The others in your practice need to have faith that it will grow and add value — without a lot of cost."

"We view Dr. Findeiss and her IR team as a collaborative partner — as an integral member of the team, not as an adjunct," says Gray. "IR is involved in day-to-day decision-making about complex oncology patients. They're approachable, they're knowledgeable, they're available, and they're engaged. As she continues to build her team, she brings in like-minded people to expand that footprint. This is the approach to transform into the next generation of patient care."

As word of the IR clinic's success spread, the IR team began making changes to optimize the clinical practice of interventional neuroradiology (INR). "One of the neurosurgeons who performs a lot of vascular neurosurgery asked if we could see patients concurrently in the neurosurgery clinic," says Findeiss. "Now our INR specialists have a combined clinic with them one morning a week where they work side-by-side with the neurosurgeons."

Ultimately, Findeiss says the joint clinical practices provide convenience for the patient and for the referring physicians. "Once we put the IR doctor into the clinic, everything goes through our process," she says. "We're pre-authorizing patients, setting appointments, and handling everything on the back end, so it takes some of the burden away from overworked office staff. The patients are happier, and the physicians and their staffs are happier." **B**

BY LINDA SOWERS, FREELANCE WRITER, ACR PRESS

Read more case studies like this in the upcoming May issue of *Imaging 3.0® in Practice*.



How can radiologists and their team members help patients overcome barriers to care?

In the imaging department, there are many possible barriers to care that the patient may face, depending on their ability to speak and understand English, their socioeconomic status, family support, and underlying disabilities. For example, if a patient cannot understand that they must take a breath in and hold during the exam, then they will be at higher risk for a compromised exam. Forethought in seeking to understand any potential barriers that a patient may have prior to and during their imaging exam is paramount to providing adequate and optimal patient care.

— Anu Brixey, MD, assistant professor in the cardiothoracic imaging section in the department of radiology at Oregon Health and Science University



In addition to changing the way pre-procedure care is provided, radiologists must hire more diverse clinical and administrative team members (LGBTQIA+, Black Americans, Latinxs, etc.) so that patients will feel more comfortable when receiving care and be less likely to become victims of receiving inferior care. While the pandemic has been extremely destructive, it has also helped radiologists — particularly IRs — and other healthcare providers remove some of the barriers to patient care through the implementation of a telemedicine platform.

— Janice M. Newsome, MD, division director of IR at Emory University



LOOKING BACK, LOOKING FORWARD

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careful that we do not lose our empathy, connection with one another, and the creative energy that comes from working with others while in-person opportunities are not safe.”

What Didn't Work: Cancelled/Deferred Imaging

According to a *JACR*[®] study on the impact of the pandemic on imaging case volumes, many patients decided to delay imaging last year out of fear of contracting COVID-19. Mammography was down by 59% at the beginning of the pandemic, for example, and reached a 94% decline at one point in the summer.¹ The downstream consequences of this delayed or missed imaging have yet to be fully understood, says Smetherman. “We’ve experienced three surges, and we’ve seen the consequences to patient care each time,” Smetherman says. “If you don’t have patients coming in for their mammograms, you have this backlog of exams. And then you have patients presenting at more advanced stages of their disease.”

Recht shares this concern. “I think people realize that the risk of not getting imaged when it’s necessary, is greater than the risk of contracting COVID-19,” Recht says. “The effects of delaying or skipping screening altogether is that you don’t pick up a cancer in time.”

Looking Beyond the Pandemic

Smetherman, Recht, and Mossa-Basha are all optimistic about what the rest of 2021 will look like for radiology and healthcare in general. Radiology’s response to the pandemic shows that many — often long-awaited — changes can happen faster than previously imagined. “It was really nice to see, in the setting of a crisis, how quickly people who

normally may not band together can convene to accomplish something,” Mossa-Basha says. “Normally it may take a long time for a decision to go through bureaucratic processes, but in the last year, those changes became rapid. That was a big victory and I hope we can maintain that.”

Smetherman also expects her institution to maintain many of the new safety protocols that have been instituted due to COVID-19, like mask requirements, social distancing, and sanitizing equipment, which will need to continue for the time being. And, she points out, it’s important to not let your guard down when it comes to safety protocols — and to communicate this to patients. “We have to make sure that patients really understand that it is safe for them to come in, because I do think we run the risk of seeing imaging not being utilized as strongly,” she says. Mossa-Basha agrees. “Institutions should continue to create infrastructures that facilitate and support patient safety,” he says, “like one-way entries and exits or continued growth of portable imaging to be used for patients with communicable diseases.”

According to Smetherman, the last year was a learning experience for radiology — and now there is work to be done to implement the lessons learned. “I think it would be a mistake to try to go back to where we were on Jan. 1, 2020,” she says. “My hope is that we will come out of this crisis with a greater focus on overall wellness, a firmer commitment to helping our patients have better access to preventive screenings, and a stronger emphasis on continuing all the process and safety improvements we’ve made over the last year.” **B**

BY CARY CORYELL, PUBLICATIONS SPECIALIST,
ACR PRESS

ENDNOTE

1. Naidich JJ, Boltyenkov A, Wang JJ, Chusid J, Hughes D, Sanelli PC. Impact of the coronavirus disease 2019 (COVID-19) pandemic on imaging case volumes. *J Am Coll Radiol*. 2020;17(7):865–872.

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