

ACR

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JANUARY 2021 | VOL. 76 | NO. 1

Bulletin



Changing
With the Times

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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.



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



New Year, New Priorities

Ongoing efforts on the E/M reevaluation and certification in radiology exemplify why ACR members volunteer their time and resources to making the College strong and successful.

Welcome to our first *Bulletin* edition of 2021. While 2020 was certainly memorable and unique, we can all agree that we'd like for 2021 to be a little less dramatic.

In this month's column, we will visit two issues. The first is the evaluation and management (E/M) reevaluation. At the time of this writing, any legislative progress made during the lame duck session of Congress remains speculative. Government relations (GR) is one of the core competencies of the ACR. Our radiology community looks to the ACR for its advocacy leadership. Cynthia Moran, ACR executive vice president of government relations and health policy, deserves special recognition. We cannot thank her enough for her years of effort and expertise in establishing our GR team as one of the most respected medical professional advocacy groups in Washington. Our GR success is one reason our members have volunteered their time and invested in dues to make the ACR strong.

We have been dedicating every available resource to the E/M issue because of its wide-reaching and important impact on our practices and access to medical imaging for our patients. Remarkably, our GR team has been able to organize a coalition of more than 70 healthcare provider organizations to lobby for change in E/M reevaluation implementation ([learn more at acr.org/EM](https://www.acr.org/EM)). This achievement cannot be overstated. It is unique in medicine to mobilize anywhere near this size of a coalition to act together for a common cause.

The ACR has also made a significant advocacy impact in Washington. Most notably, the College led an effort in the House of Representatives to gather 229 bipartisan signatures on a letter urging House leadership to stop the impending E/M-based cuts. Encouraged by the letter's tremendous support, the authors (Reps. Ami Bera, MD, D-Calif., and Larry Bucshon, MD, R-Ind.) introduced the legislation H.R. 8702, the Holding Providers

Harmless From Medicare Cuts During COVID-19 Act of 2020, to stop the E/M policy-related cuts — while maintaining its planned increases. Whatever the outcome might be of these congressional initiatives, ACR's efforts will continue in earnest throughout the 2021 year.

The second issue we will visit is certification in radiology. The report from the ACR Task Force on Certification in Radiology was released on Nov. 18 at [acr.org/Certification-Report](https://www.acr.org/Certification-Report) (read more in the *Bulletin's* Q&A with Madelene C. Lewis, MD, chair of the Task Force, on page 13). The Task Force was established in January 2019 in response to grassroots concerns about board certification and maintenance of certification. The ACR has a long-standing collaborative relationship with the ABR. Our priority is, and will always be, representing our membership.

The goals developed by the Task Force were to conduct environmental surveillance of options for certification, not only in medicine but in other professions; to gather data on what our members experience and expect from certification; and to develop recommendations going forward. Important concerns specific to the ABR, both real and perceived, were investigated. This effort was concurrent with the establishment of the Continuing Board Certification: Vision for the Future Commission by the American Board of Medical Specialties. The Task Force invested a tremendous number of volunteer and staff hours toward investigating, discovering, and developing recommendations. Thank you to both Eric B. Friedberg, MD, FACR, and Madelene C. Lewis, MD, for helping to spearhead this effort as chairs.

We all recognize that professional self-regulation through certification is critical to distinguishing ourselves as professionals. Rigorous criteria are demanded by the public and underscore our differentiation as medical imagers from other non-physician providers. As our practices migrate from peer review to peer learning, having our certification processes as part of, if not embedded in, the transition is a significant promise. The proposition of creating new expectations for our specialty through certification, such as data science fundamentals, could serve to advance our community together. Ambitiously, this could be launched not only on a domestic scale but on an international one as well.

On behalf of the College, we wish you and yours a healthy, successful, and safe New Year. We hope you enjoy your first 2021 issue of the *Bulletin*. **B**

ACR Announces 2021 Virtual Annual Meeting

ACR 2021

VIRTUAL MEETING
May 15–19

The ACR CSC has decided that ACR 2021 will take place virtually May 15–19, 2021. The meeting will encompass not only governance essentials, as in 2020, but will also include educational programming and networking opportunities.

“The ACR CSC made this difficult decision in consideration of the safety of all ACR members and their families, as well as ACR staff,” says ACR Speaker Richard Duszak, Jr., MD, FACP. “We also

know that many of our attendees are under travel restrictions and unable to attend an in-person meeting. This virtual meeting format will therefore enable more members to engage in these important governance and knowledge-sharing activities.”

ACR 2021 participants will be able to virtually take part in:

- CME
- ACR Caucus Meetings
- Council Elections
- Consideration of ACR Practice Parameters and Technical Standards
- Consideration of ACR Policy Resolutions
- The Presidential Address, BOC Chair’s Report, and CEO Update
- The Moreton Lecture
- Convocation and Awarding of ACR Gold Medals and Honorary Fellowships

For more information, contact csc@acr.org.

Recognize Your Chapter’s Success

The ACR Chapter Recognition Program was created in 2003 to recognize chapter successes, to facilitate the sharing of ideas among chapters, and to encourage and support the activity of the chapters. Chapters submit award forms for the activities or initiatives they engage in between January and December of the award year. Submissions are made in four categories: government relations, meetings and education, membership, and quality and safety. In addition, the Overall Excellence Award honors chapters who have demonstrated excellence in every award category.

Here’s what chapters need to know:

- Apply in all four categories and be automatically considered for the Overall Excellence award.
- Earn additional points by submitting up to five “Share a Successful Practice” forms to highlight 2020 achievements
- Include all chapter activity from Jan. 1, 2020 through Dec. 31, 2020.

If your chapter has hosted virtual member meetings, engaged in state advocacy, supported Q&S initiatives, or launched member campaigns, be sure to include this information in your submissions. The submission deadline is Jan. 15 for the preceding award year.

For more information, visit acr.org/ChapterRecognitionAwards.
For questions, email chapters@acr.org.

Make ACR Your COVID-19 Resource Hub

Throughout 2020, the ACR provided clinical, leadership, regulatory, and well-being resources to help the radiology community battle COVID-19 and strengthen practices during the pandemic. Our volunteer members have taken on the tremendous task of responding to your needs by creating, distributing, and continually updating tools and resources to help you navigate patient care, practice needs, and economic changes through COVID-19.

You can find helpful information from rare chest cases to how to apply for financial resources for your practice at acr.org/COVID19. These resources are available to you, our members, free of charge as you navigate your practice and career through these challenging times.



ACR Supports CDC Guidance on Wearing a Mask

In a statement released on Oct. 21, 2020, the ACR expressed its full support of CDC’s guidance on wearing masks to control the spread of COVID-19. Further, ACR pointed out in its statement that “as physician leaders, we can set an example and help people understand the risks of transmission through clear and simple communication, rooted in science, showing that masks help stop the spread of COVID-19.”

To read the full ACR statement, visit acr.org/Wear-Masks. Please consider directing patients to the CDC’s Prevent Getting Sick resources section at bit.ly/COVID-Guidance for more lifesaving information and advice on this critical issue.

ACR Experts Advise President's Cancer Panel on Post-COVID Breast Cancer Screening

Etta D. Pisano, MD, FACR, ACR chief research officer, and Ruth C. Carlos, MD, MS, FACR, *JACR*[®] editor-in-chief, were among the experts to advise the President's Cancer Panel during Nov. 16 and 18 public video conferences exploring how to improve and innovate breast cancer screening after the COVID-19 pandemic disruption. The expert group also plans to create a white paper incorporating information and materials discussed during the two days of video conferences.

"The COVID-19 pandemic has unfortunately reduced access to breast cancer screening, which may exacerbate already significant disparities in breast cancer outcomes," says Pisano. The panel, she says, was intended to address how breast cancer screening experts can reduce the risks to women from reduced access to screening services, as well as engage stakeholders in the National Cancer Program to make actionable recommendations to lessen the burden of cancer in the U.S.

The ACR issued Guidelines for the Resumption of Breast Cancer Screening to help resume screening following the COVID-19 shutdown as part of its "Return to Mammography Care" toolkit. ACR and the Society of Breast Imaging advise average-risk women to start annual mammograms at age 40 and high-risk women to start earlier.

To view ACR's Guidelines for the Resumption of Breast Cancer Screening, visit acr.org/breastimaging. For more information on the President's Cancer Panel, visit prescancerpanel.cancer.gov.



There are many small steps you can take that are not time-consuming, such as writing a letter to your congressperson or on behalf of a colleague who is up for promotion. In fact, advocacy is often more about quietly developing long-term relationships and building coalitions with stakeholders.

— ACR VICE SPEAKER AMY L. KOTSENAS, MD, FACR



New App Offers Mobile Access to O-RADS



Download the ACR Guidance app for mobile access to the Ovarian-Adnexal Reporting and Data System (O-RADS[™]) quality assurance tool. This interactive app allows easy access to standardized descriptions for managing ovarian/adnexal pathology.

The new app is now available in the Apple[®] App Store or Google Play[™] store. *Learn more at acr.org/ORAD.

*Google Play[™] is a trademark of Google Inc.

New Fund for Collaborative Research in Imaging Grant



Do you have a compelling, innovative clinical research idea that could ultimately advance the practice of radiology? Apply today for the new ACR[®] Center for Research and Innovation[®] (CRI) Fund for Collaborative Research in Imaging (FCRI)

Grant. Projects to be considered for the FCRI Grant are pilot or seed grant-type projects that test a new idea or help support a new area or direction of clinical research in radiology. These grants address a specific hypothesis and generate preliminary data that could be used to justify or strengthen subsequent comprehensive applications to national peer-reviewed funding agencies.

"As radiology touches nearly all patient care, this grant can empower ACR member researchers to move medicine forward," says Pamela K. Woodard, MD, FACR, chair of the ACR Commission on Research. "We are proud to offer this funding at a critical time for radiology and the patients we serve."

ELIGIBILITY:

- Applicants must be current members of the ACR and in good standing.
- Individuals or groups may submit proposals.
- Grants are available to full-time faculty and trainees with an MD, DO, PhD, or equivalent degree from an educational institution within the U.S.
- Applications must have support from the chair of an ACR Research Committee.

Applicants must submit their complete application to research@acr.org by 5 p.m. ET, Jan. 15, 2021. For more information, visit acr.org/FCRIGrant.

IMAGING 3.0[®]:

Bridging the Communication Gap

At Weill Cornell Medical Center in New York, a radiologist and gynecological surgeon partnered to develop a program to allow families to talk to hospital patients anytime and from anywhere. The pair leveraged app-based walkie-talkies to help concerned families connect with ICU patients through a program called the VoiceLove Project. Social workers in ICU and palliative care extended the service to families who can't physically visit their relatives in the hospital during the pandemic, enabling them to connect anytime from anywhere in the world.

"The solution had to be immediate," Marc H. Schiffman, MD, explains. "Everyone knew that if we didn't act fast, people were going to miss their chance to say goodbye to their relatives in isolated care."

Read the full case study at acr.org/Comm-Gap.

AIRP Accepting Applications for 2021 MSK Fellowship

The American Institute for Radiologic Pathology (AIRP®) Fellowship Program is now accepting applications for its 2021 MSK fellowship. The fellowship, which has been in existence since 1994, provides a well-rounded experience allowing transition to either private practice or academics with a unique exposure to the pathologic basis of MSK disease.

Throughout the course of the fellowship, clinical work is performed two to three days per week at the Walter Reed National Military Medical Center in Bethesda and one day a week at the Washington Hospital Center with an active MSK oncology practice. Fellows will get experience with a high volume of sports medicine MR (fellows typically read nearly 1,500 cases annually), as well as radiographs, CT, and US. The fellowship also includes three monthly conferences with rheumatology colleagues and several arthroscopy correlation conferences.

Additionally, the fellow will help review the over 300 MSK cases that are submitted to the AIRP annually. These cases, as well as consultation cases from throughout the U.S., are reviewed with AIRP's pathology colleagues at two to three conferences per week. Fellows are expected to perform research and present their work at either the Society of Skeletal Radiology or American Roentgen Ray Society meetings.

To apply, visit bit.ly/AIRP_MSK2021.



Taking the Lead: Representative Leadership

The Radiology Leadership Institute® Taking the Lead podcast explores the challenges that transform everyday radiologists into today's leaders. In a recent episode, guest host and ACR President Geraldine B. McGinty, MD, MBA, FACR, speaks with ACR Commission for Women and Diversity Chair Johnson B. Lightfoote, MD, MBA, FACR, about his journey to becoming a leader. Lightfoote discusses how his parents' emphasis on education shaped his early years and recalls the transformative nature of his educational experiences in light of the civil rights movement, student activism around the Vietnam War, and ongoing conversations about social and health equity.

To listen to the podcast, visit acr.org/RLIPodcast.

Millions have become uninsured during the COVID pandemic due to loss of employer-sponsored coverage. As a nation, we need to consider what we value and how best to achieve those goals. The answer is not to disincentivize physicians with pay-cut after pay-cut. Rather, we should focus on how best to provide healthcare coverage and how to most appropriately incentivize high-value care. This is the time to invest in our people and our systems.

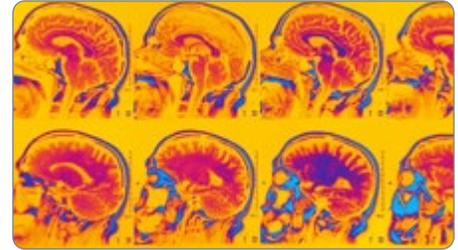
— RICHARD E. HELLER III, MD, MBA

HEARD ON SOCIAL MEDIA



GREGORY NICOLA
@GREGORYNNICOLA

"Apps that detect traces of a disease in an image are useful, but they don't dramatically change the human-dominated work of treating a patient" Glad @WIRED captured this key point during our interview. @RadiologyACR



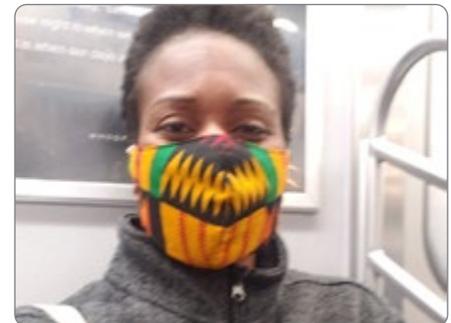
👍 🔄 ❤️ ✉️

NOV 11, 2020



Onyinye Balogun MD
@GlobalRadOnc

I #MaskUp @WeillCornell @nyphospital @NYPBrooklyn to protect my family, friends, community & especially my hardworking colleagues @ED_WCMC & throughout the hospitals. I challenge @jana_ivanidze @KemiMDRad @Osborne10Joseph @DrGMcGinty @IamDrVivian @MeliD32



👍 🔄 ❤️ ✉️

NOV 12, 2020



K Elizabeth Hawk, MS, MD PhD
@HawkImaging

I think we all need to ask the hard uncomfortable question: who did I lift up today? And was it someone other than myself? Look to the leaders on digital media that authentically elevate others. Let's all build a culture based on lifting one another up.

👍 🔄 ❤️ ✉️

OCT 27, 2020



Timothy A. Crummy, MD, MHA, FACR

Vice Chair, ACR Coding and Nomenclature Committee

Until AI's role in radiology is better understood, it is difficult to design a payment model; until payment exists for AI, its development and role will remain unclear.

Into the Unknown

Much remains to be seen regarding how AI will affect our practices, patients, and bottom lines.

Nearly all radiologists have faced the unknown. Common scenarios include encroachment upon one's turf, decisions on whether a new cardiac-capable CT scanner will be located in radiology or cardiology, and practice mergers changing competition in regional markets. Handling these situations requires acknowledging that change is coming without knowing what form it will take and realizing its potential effects on your practice's operations and income.

There's no blueprint to handle the unknown. To set themselves up for success, radiologists can navigate these waters by gaining expertise, becoming involved in decision-making, and shaping the ultimate outcome.

AI is another example of the unknown. We have heard predictions that it might replace radiologists someday. In reality, no one knows where AI is going or the course it will take.

Similarly, how AI will be reimbursed remains unknown. In fact, the lack of payment policy is a contributing factor to the unpredictability of AI integration into clinical radiology practice and sets up a "chicken and egg" conundrum. Until AI's role in radiology is better understood, it is difficult to design a payment model; until payment exists for AI, its development and role will remain unclear.

Many factors contribute to the lack of established payment policy for AI. First, AI technology development is changing faster than the existing payment policy process, which is oriented toward traditional technologies that evolve slowly. Second, the term "AI" means different things to different people and is often used in an all-encompassing manner. It is applied to algorithms that are autonomous and function independently of the radiologist, to technologies that identify imperceptible findings that actually increase complexity and interpretive tasks of radiologists — and to everything in between. A one-size-fits-all approach is limiting and problematic.

A successful AI payment policy needs to recognize and incorporate how AI is applied clinically and its effect on radiologists' work. For example, a well-designed payment system would distinguish among AI technologies that complement radiologists, supplement radiologists, or function autonomously.

Complementary AI technology improves a radiologist's performance by acting as a separate set of eyes

(conducting a task that human beings can accomplish). Computer-aided detection (CAD) in mammography is a long-standing example; the computer and radiologist both search for microcalcifications and other actionable findings and therefore complement each other. Interestingly, payment policy for CAD has existed for more than a decade and is incorporated into mammography billing codes.

Supplementary AI technology adds to what a radiologist can accomplish. Technologies exist that identify findings below the threshold of human perception; examples include detecting otherwise imperceptible early changes of emphysema or vertebral body compression fractures. This AI information adds work by requiring the radiologist to analyze and interpret those additional findings in the context of an individual patient. A well-designed and fair payment system would recognize and pay for the additional work resulting from incorporating AI into clinical care.

Autonomous AI systems analyze imaging data and generate reports. Despite some predictions, this would most likely change the radiologist's role rather than obviate it. In fact, radiologists might become more integral to patient care if these models involve integrating data from multiple clinical sources, such as amalgamating imaging findings with pathology results and oncologic notes.

AI payment policy is in its infancy and its future is unclear. Where it ends up will undoubtedly affect radiologists' operations and reimbursement. As these tools evolve, the ACR is helping radiologists do what they do best. The College is enabling us to become experts, involving us in the decision-making process, and positioning us to influence the course and outcome of AI payment policy.

Specifically, the ACR's Data Science Institute[®] works with industry leaders to shape AI technology in a radiologist-friendly manner. The ACR Commission on Economics' Coding and Nomenclature Committee crafts CPT[™] codes and represents radiologists' interests to the AMA's CPT Editorial Panel that is charged with approving these codes. The Relative Value Scale Update Committee advocates for appropriate reimbursement for these approved codes. Finally, the Commission on Governmental Relations monitors regulations affecting utilization and reimbursement of new technology.

AI is coming and will change how radiologists work and how we are reimbursed. At this time, the future of AI reimbursement is unknown. However, the ACR is positioned to influence the payment process and represent its members' interests in this new frontier. **B**



Changing With the Times

As the COVID-19 pandemic ramped up, the ACR empowered members to care for patients during the global crisis — without losing focus on its pre-pandemic mission. BY CHAD HUDNALL, SENIOR WRITER, ACR PRESS

“When my group first realized we were in a crisis with COVID-19 last spring, we had to act quickly to adjust our policies, staffing, and protocols to keep ourselves, our patients, and our community safe,” says Jennifer L. Kemp, MD, FACR, body imaging subspecialist and vice president of Diversified Radiology in Denver. “The ACR was with us every step of the way.”

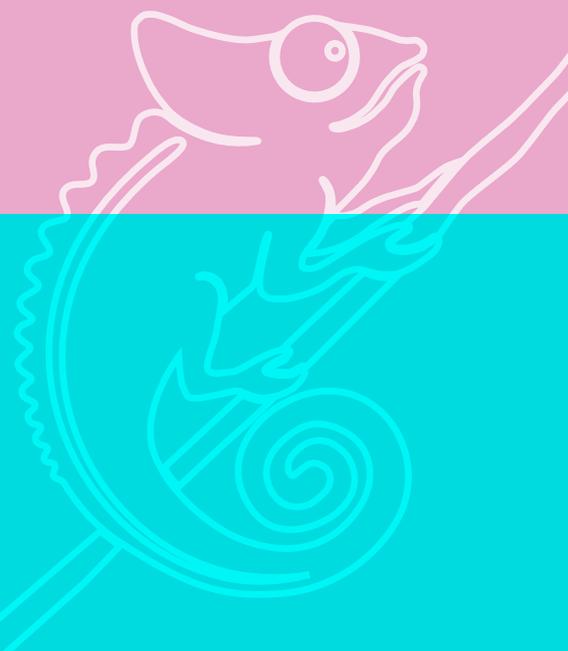
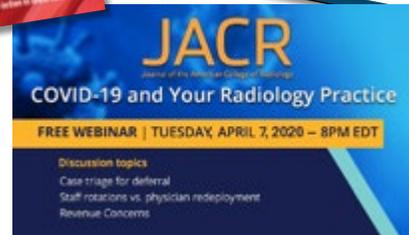
The pandemic has been a stark wakeup call. Healthcare professionals were compelled to rethink daily operations and the safety of colleagues and patients overnight — searching for reliable information to help them battle an unprecedented threat.

“As the head of operations for a 65-person private practice, I had to adapt to this new world without warning — communicating with multiple hospitals and outpatient imaging centers,” Kemp recalls. “I used the ACR’s resources for each challenge we came up against, and they were available to us immediately when the pandemic struck.”

“The ACR’s role as the voice of radiology — to payers, policymakers, and patients — has been critical in making sure radiologists are part of the national conversation on how to deal with COVID-19,” ACR President Geraldine B. McGinty, MD, MBA, FACR, says. “The pandemic may have been unpredictable, but that doesn’t prevent us from being in the best position possible when preparing our members for the future.” As the world moves through this crisis, the ACR continues to adapt to member needs with the resources spotlighted here, keeping patient-centered care at the heart of ACR’s core purpose — now and beyond the pandemic.

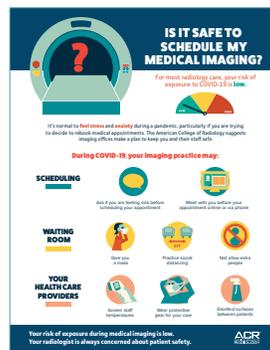
SHARING KNOWLEDGE QUICKLY

The College moved quickly to keep members informed during each stage of the pandemic, while also connecting practices throughout the country to share knowledge and disseminate lessons learned. A library of resources is available at acr.org/COVID19.



“With strong leadership throughout the pandemic, the College has enhanced its recognition as an international leader. Thank you to all our volunteers and members as we look forward to better times in 2021.”

— ACR BOC CHAIR
HOWARD B. FLEISHON, MD, MMM, FACR,



CHARTING A RETURN TO CARE

While everyone was reeling from the first and second waves of the pandemic, radiologists focused on getting out in front of the crisis and anticipating the needs of patients and their healthcare providers, ACR BOC Vice Chair Jacqueline A. Bello, MD, FACR, says. “Thinking ahead, we assembled a team to look at resuming routine care beyond the pandemic,” she says. “That culminated in recommendations that were published in the *JACR*^R soon after the outbreak.”¹

The authors of the *JACR* article represented a diverse group. “Age, gender, specialty and practice type, and geographical areas of the country were counted,” Bello says. “Contributors came from the areas hardest hit by COVID-19 — with the goal of sharing lessons learned during the crisis to address critical care and climb back toward vital routine screenings. The effort was emblematic of the ACR — member-driven, fair and balanced, and focused on urban and rural areas alike.” In the spirit of that fairness, ACR’s Quality and Safety (Q&S) arm has been working with facilities seeking accreditation by extending time needed to meet requirements and payments. Q&S has also shared resources from the FDA and the Society of Breast Imaging through its COVID-19 Resource Workgroup.

“Our members needed to know that we were relying on science, synthesizing a rapidly evolving environment, and doing everything we could to ensure a safe environment for staff and patients,” says McGinty. “It was important that we spoke with a unified voice as a radiology community.”

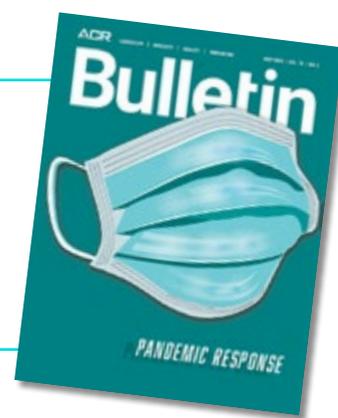
In tandem with the practice-focused guidance, the ACR released an infographic for a patient audience, explaining the safety measures radiology groups are taking ([available at bit.ly/ReopeningSafe](http://bit.ly/ReopeningSafe)). “These types of infographics — in a one-page format that can be shared among radiologists, their staff, and patients — are a great way to ensure we get patients back safely,” says Arun Krishnaraj, MD, MPH, chair of the Commission on Patient- and Family-Centered Care.

“I think most people still trust their physician and health system more than they trust politicians,” Krishnaraj says. “Radiology can play a lead role by letting people know the truth, not politicizing the virus.”

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

FOLLOWING SCIENCE

The ACR has been vocal in its support of CDC guidance on wearing masks and keeping distance from those residing outside of their own households to protect against COVID-19. The College's position to date is that, as physician leaders, radiologists should set an example — helping the patient population understand the risks of transmission through clear and simple communication that is rooted in science.



CREATING A DATA RESOURCE CENTER

A silver lining to the challenges of the COVID-19 pandemic are radiology collaborations that have emerged in response to the crisis. Organizations taking on distinct roles for a singular purpose has resulted in valuable initiatives, such as the Medical Imaging and Data Resource Center. The open-source database contains thousands of COVID-19 images and helps physicians better understand, diagnose, and treat patients with this new disease. This is a multi-organization effort, created by the ACR, RSNA, and the American Association of Physicists in Medicine, hosted by the University of Chicago, and funded by the National Institute of Biomedical Imaging and Bioengineering. Learn more at bit.ly/MIDRC.



MEETING VIRTUALLY

Just as the 2020 annual meeting went online to keep the business of the College moving forward, ACR 2021 will take place virtually in May. The College's decision was made with the safety of members, their families, and staff in mind, says ACR Speaker Richard Duszak, Jr., MD, FACR. "With so many anticipated attendees still under travel restrictions, a virtual platform will engage more members in governance, knowledge-sharing, and networking activities," Duszak says.



TARGETING ADVOCACY

"The ACR is providing financial guidance on top of clinical guidance during the pandemic," Samir B. Patel, MD, FACR, founder and director of the value management program at Radiology, Inc., in Mishawaka, Ind., says. "There are economic and regulatory updates you can access as an ACR member. This information alone is a significant immediate return on investment of membership."

The ACR has been fighting reimbursement cuts set to take effect starting this month related to the upwards reevaluation of evaluation and management (E/M) code changes in the Medicare Physician Fee Schedule (MPFS). Changes to the MPFS mean radiologists and other providers face massive cuts, and jeopardize patient access to vital services. The College and other medical societies have supported legislation that — while including important pay increases for primary care physicians and others — would avert reimbursement cuts to other physician and non-physician providers. Throughout the pandemic, the ACR has maintained that financial stability for Medicare providers is critical as they strive to meet the continued needs of patients during COVID-19 and beyond. Learn more at acr.org/EM.

CONTRIBUTING TO A NEW IMAGING REGISTRY

COVID-19 Imaging Research REGISTRY

The ACR Center for Research and Innovation™, along with the ACR Data Science Institute® and the Society of Thoracic Radiology, created the COVID-19 Imaging Research Registry (CIRR). The

CIRR aggregates diagnostic imaging and clinical information, providing real-time integrated data that serves as a public health surveillance tool.

Immediate uses for the CIRR data include education, AI algorithm development, and research studies. In addition, assembling this type of aggregated and easily accessible data can inform a long-term strategy for individual practices. On a longer-term scale, the ACR can also leverage the aggregated data from its registries to approach payers around reimbursement.

Participating sites will contribute demographic information, clinical data on signs and symptoms, imaging exams, and laboratory test data and outcomes. Complete the form at acr.org/COVID-Registry and a member of the ACR CRI team will follow up with you.



SUPPORTING THE NEXT GENERATION OF RADIOLOGISTS

Online learning has been an adjustment for the next generation of radiologists during the pandemic. With many radiology residents and medical students displaced from their clinical learning environments, traditional education has moved online. With virtual resources like Radiology-TEACHES® (an online resource hub that uses case vignettes integrated with the ACR Select® CDS tool), radiology students have been able to stay informed and engaged. Radiology-TEACHES covers everything from case studies to imaging protocols. A COVID-19 module was developed and made available across the nation, ensuring that students, residents, and radiologists have the most up-to-date information.

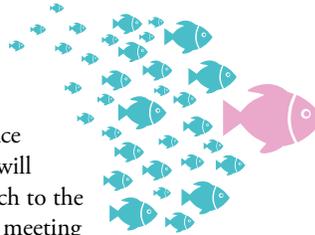
“President John F. Kennedy noted that the symbol for ‘crisis’ in Chinese has two characters, one for ‘danger’ and the other for ‘opportunity.’ ACR’s response to COVID-19 has kept our members well informed on how to respond to the danger, while also ensuring that we and they have looked for every opportunity to improve the practice, science, and professions of radiological care.”

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

LEARNING FROM LEADERS

The ACR-RBMA Practice Leaders Forum, taking place online Jan. 22–23, 2021, will explore radiology’s approach to the pandemic (register for the meeting at acr.org/PLF). Attendees will have an opportunity to exchange personal experiences with navigating COVID-19 and hear from a panel of experts on how to ensure patient safety — while adopting COVID-related practice management strategies that can strengthen business and performance.

Sessions will also focus on supporting diverse teams during stressful times, whether that’s a global pandemic, a practice-level crisis, or a personal issue. “You have to look at the individual needs of your colleagues,” notes Bello, “because the best PPE can be the morale of the team.”



CONNECTING WITH COLLEAGUES

The COVID-19 pandemic is having a profound impact on radiology practices across the country. We Are ACR is available to you, your colleagues, your patients, and patient advocates to contribute uplifting stories and personal testimonials of how you’re battling the effects of the pandemic. These stories are meant to inspire you and exemplify just how important your work is. Please take a moment to submit your picture and written story, a soundbite or short video clip — share how COVID-19 has impacted your practice. Please write a short piece — 1,000 words or less — or record a brief video to share your thoughts and action items so that your ACR community can learn more about your work. Visit acr.org/WeAreACR to share your story.



Being Well Together

CARING FOR OURSELVES

Self-care is a critical part of well-being — but how do you make time for yourself in the middle of a pandemic? Visit acr.org/wellbeing to find a list of resources, activities, webinars, podcasts, and more to combat the toll of COVID-19. If you have a resource you’d like to share, please contact copllstaff@acr.org.



SCREENING FOR LUNG CANCER

Unfortunately, lung cancer doesn’t wait for COVID-19 — and a delay in care may result in negative outcomes, a delay in diagnosis, or increased cancer burden on hospitals. To resume screening at hospitals where it’s possible, the ACR LCS 2.0 Steering Committee has prepared a new toolkit at acr.org/lcs, containing vital information and template documents for both referring clinicians and patients. **B**

Transforming Board Certification

A newly released report aims to support the ABR in improving board certification for radiology.

Certification has been a topic of discussion throughout medicine — including radiology as a critical component of “professional self-regulation.”¹ Certification in radiology administered by the ABR has a long history under the auspices of the American Board of Medical Specialties (ABMS). However, changes in certification have led to concerns by ACR members. Responding to such concerns early in 2019, around the same time the ABMS Vision Commission issued its recommendations (available at bit.ly/Vision_Commission), the ACR leadership established the Task Force on Certification in Radiology. The Task Force was charged with researching the history of certification; examining best practices for certification; determining ACR members’ opinions on certification; and formulating recommendations on how certification might further advance continuous learning, support the profession, and improve patient care.

In November, the Task Force released a report (available at acr.org/Certification-Report) to aid discussions on continuing certification (formerly called maintenance of certification, or MOC) improvement. The *Bulletin* spoke with Madelene C. Lewis, MD, professor of radiology at the Medical University of South Carolina and chair of the Task Force, to learn how ACR leaders will collaborate with the ABR to move these suggestions forward.

How does this new report address opportunities for improvement in radiology certification?

The mission of the ABR is to certify that diplomates demonstrate the requisite knowledge, skill, and understanding of their disciplines to the benefit of patients. The organization is accountable to both the public and to the medical profession.

One opportunity for collaboration between the ACR and ABR is sponsoring independent research to assess the validity of certification methods in measuring competence and improving patient care. Currently, there is a paucity of scientific evidence demonstrating the value of continuing certification including improved patient outcomes. Successful certification programs undertake early and independent research of assessment tools prior to implementation. This is an important step to ensure the accurate assessment of both learner competence and patient outcomes. We should not be limited by legacy methodology. Our specialty has the opportunity to lead in this area.

What are some of the opportunities for collaboration and improvement that align with the ABMS Vision Commission’s recommendations?

The ABMS acknowledged concerns raised by diplomates regarding MOC programs, including the burden, cost, and lack of

relevance to everyday practice. In addition, some ABMS boards’ MOC programs had not adequately adapted to the degree of sub-specialization in practice that was occurring — nor did MOC programs sufficiently integrate advances in education and assessment science or offer alternative methods for assessment to foster learning. Recognizing that an overhaul to the current continuing certification process was required, ABMS decided to review both the framework and purpose of continuing certification of physicians and launched a process called Continuing Board Certification: Vision for the Future (also known as the Vision Initiative).

Here are a few of the Vision Commission’s recommendations that align with the ACR Task Force’s recommendations:

- The ABMS and ABMS boards must demonstrate value to diplomates, including supporting their learning and helping them be better doctors in service to patients — while reducing the burden associated with fulfilling continuing certification requirements.
- The boards must regularly communicate with their diplomates about the standards for the specialty and encourage feedback about the program. Communication should be open and bidirectional — promoting engagement between the boards and the diplomates.
- The boards must facilitate and encourage independent research to build on the existing evidence based on the value of continuing certification.
- The boards must comply with all ABMS certification and organization standards, including financial stewardship. ABMS boards need to be efficient in the conduct of their operations and fully transparent with their diplomates about financial matters.
- The boards should collaborate with specialty societies, the CME/continuing professional development (CPD) community, and other expert stakeholders to develop the infrastructure to support learning activities that produce data-driven advances in clinical practice.
- Finally, the boards must collaborate with professional and/or CME/CPD organizations to share data and information to support diplomate engagement in continuing certification. These results and trends will assist in optimizing education and assessment to advance the specialties.

How will the ACR collaborate with the ABR to help affect reform?

The ACR has been in dialog with the ABR for some time regarding certification but there are now regularly scheduled standing meetings with ABR leadership. These meetings, along with the work of the Task Force and the Vision Commission recommendations, will serve as a starting point toward making improvements in the certification process for our specialties. The ACR is committed to representing its members in a collaborative effort and working with the ABR as it continues to work toward implementation of the Vision Commission’s recommendation. **B**

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

Data-Driven Decisions

ECOG-ACRIN is urging radiologists to help with a study comparing approaches for monitoring pancreatic cysts — to learn which method leads to better outcomes for patients.

The question of how to handle incidentally found pancreatic cysts continues to challenge physicians, as rapid growth in the use of CT and MRI has led to a surge in detection in recent years. More than 50% of scans show some incidental findings; between 3% (via CT scans) and 15% (via MRI) of patients that have abdominal imaging for a separate reason are found to have an unexpected pancreatic cyst.¹

According to David S. Weinberg, MD, MSc, chair of the department of medicine at Fox Chase Cancer Center in Philadelphia, this is not an infrequent problem for radiology — or for the primary care providers who get the reports back. “Somewhere between 2% and maybe even as high as 30% of people over the age of 60 will have some form of pancreatic cyst,” says Weinberg. “We’re talking about tens of millions of people.”²

So, what is the optimal use of imaging in the surveillance of a pancreatic cyst? A new study, led by Weinberg, out of the ECOG-ACRIN Cancer Research Group — a multidisciplinary, membership-based scientific organization that designs and conducts biomarker-driven cancer research — aims to answer that question.

Differentiating Between the Guidelines

“One of the fundamental challenges is that there are a variety of guidelines that currently exist for the management of these pancreatic cystic lesions,” says Hanna Zafar, MD, associate professor of radiology at the Hospital of the University of Pennsylvania and contributing author to the study. “For example, there are the Fukuoka consensus guidelines, which are very aggressive, and then there are the American Gastroenterological Association guidelines, which are less aggressive. When you have a heterogeneity of guidelines, and there’s no evidence to support the clear use of one management pathway over another, you can imagine the variability of follow-up that is going to ensue.”

Zafar notes that depending on where you are in the country, or which provider you see, or which guideline they’re using, the same patient with the same cyst is going to get treated very differently. “Anytime you have that kind of heterogeneity, you’re introducing an opportunity for suboptimal patient outcomes, because we’re not treating people in a standardized fashion,” she says.

To address the disparate approaches, an upcoming ECOG-ACRIN study compares the two primary guidelines in regular clinical practice for monitoring pancreatic cysts to learn which method leads to better outcome for patients. “Sometimes we just don’t know the best way to handle patients,” says Ruth C. Carlos, MD, MS, FACR, editor-in-chief of the *JACR*[®] and contributing author to the study. “Are we missing something if we

do something that is less invasive? Or are we over-diagnosing and over-treating if we do something that’s more invasive? That’s the problem we’re trying to solve with this study.”

Guiding Research With Patient Feedback

Another unique aspect of the ECOG-ACRIN study is the inclusion of the patient voice. “As health equity and financial toxicity of care become even more important, we want to understand the added cost of incidental findings — not just to the system, but to the patient,” Carlos says. “Testing is not a benign procedure. When we expose patients to more testing than they need, we run the risk of inducing unnecessary anxiety — and unnecessary cost.”

Zafar agrees. “This trial is designed to collect patient outcomes like their out-of-pocket costs or psychological worry associated with more or less intensive surveillance, in addition to the clinical information. That’s an equally important part of what we’re doing and an equally important reason why we are hoping that more sites will become engaged in the trial.”



“My hope is that radiologists who share our frustration over the lack of high-quality evidence will feel inspired to help us.”

— HANNA ZAFAR, MD

Drumming Up Support

In the spring, Weinberg, Carlos, and Zafar were making inroads with the study when COVID-19 hit. “If you wanted to create the perfect storm to hamper enrollment for a very common clinical problem, it would be COVID-19,” Weinberg says. “Patients are getting less healthcare, so we’re encountering reduced incidental identification of these lesions. We could really use the help of radiologists around the country to do this.”

Zafar agrees. She hopes radiologists can approach the gastroenterologists and surgeons that they work with to let them know about the trial. “We want to promote awareness of the trial, and also help the study coordinator identify any eligible patients whose scans they have interpreted,” says Zafar. At the end of the day, it’s about making sure patients are getting the best care possible, says Zafar, and that should be driven by evidence, not expert opinion or conjecture. “My hope is that radiologists who share our frustration over the lack of high-quality evidence will feel inspired to help us,” she says. “We have the ability to really make a significant mark on patient care.” **B**

BY CARY CORYELL, PUBLICATIONS SPECIALIST, ACR PRESS

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

Process Improvement

A CSC workgroup is exploring new avenues for authentic and robust member contribution to the PP&TS process.

While your current CSC faced tremendous challenges, changes, and chance over the course of 2020, it has truly been our choices that have defined us. As we shifted to conducting the business of the College remotely and digitally, it has been inspirational to see the robust discussion that has traditionally defined us as a body persist, and thrive, in our new normal.

Although ACR 2020 was not our time-honored traditional Washington, D.C., gathering, the virtual Council discussion was filled with a diversity of passionate opinions. Many new voices were able to be heard for the first time. As a CSC, we have continued to look for ways to improve the structure of our Council sessions so that our members can focus on productive debate and decision-making.

We currently have a CSC workgroup focused on the processes surrounding practice parameters and technical standards (PP&TS). The workgroup will concentrate on the following:

- Reviewing the current process by which PP&TS are created, vetted, and approved
- Reviewing prior changes to that process
- Assessing whether the current process is as efficient and relevant as possible
- Suggesting changes to make the process as meaningful as possible

The PP&TS approval process is multifaceted, interdisciplinary, and collaborative. The current PP&TS Development and Revision Handbook provides details on this and the many different scenarios that may arise along the process of PP&TS formation. The simplest pathway — the creation of the ACR-only PP&TS — is composed of seven phases.

PHASE ONE: Drafting Documents

During this phase, existing documents up for renewal are reviewed or ideas for new practice parameters are considered. This process prepares documents for upcoming field review.

PHASE TWO: Conducting Field Review

Four cycles of three weeks each allow for ACR membership to review and comment upon the documents. These critical periods are our members' opportunity to actively contribute to shaping the content of the PP&TS.

PHASE THREE: Reconciling Draft Documents

During this phase, a CSC Subcommittee is formed for the purpose of reconciling all field comments into one congruent document.

PHASE FOUR: Informing Leadership

The PP&TS are then distributed to the BOC to ensure that each relevant Commission is aware of the content and potential Council decisions at hand. Communication with appropriate collaborative societies also occurs during this phase.

PHASE FIVE: Finalizing Draft Documents

Each PP&TS is assigned a resolution number and a reference committee and is then made available to membership via the online portal.

PHASE SIX: Approving the PP&TS

Each PP&TS, as an individual resolution, is then discussed during the Council session at the ACR annual meeting. Reference committees deliberate on comments and prepare a final report. The Council then has the power to “adopt,” “not adopt,” or “refer” the PP&TS for additional revisions.

PHASE SEVEN: Disseminating the PP&TS

At the conclusion of the annual meeting, the approved PP&TS are posted on the ACR PP&TS web pages and become effective and available for practices to use.

In review of this detailed process, there is ample space for substantive member contributions to PP&TS content during Phase Two. However, in recent years, discussion and detailed reworking of PP&TS has often shifted to Phase Six and has sometimes dominated time and energy during the annual meeting — a process that many attendees find inefficient and dissatisfying.

Through careful assessment of these phases and in looking at other alternative approval pathways — such as those used by the radiation oncology and medical physics groups — this newly formed CSC workgroup plans to introduce a proposal to improve this process. We will be working with ACR staff and other commission and committee leaders to gather a wide variety of perspectives.

Our goal is to propose a new process that preserves space for authentic and robust member contribution to the formation of PP&TS. We also hope to create a process that no longer dominates our annual meeting. This would ultimately allow our Council sessions to remain a place for spirited discussions about other critical and timely issues at hand — and preserve space for our councilors to debate and make impactful decisions. Of course, the product of this CSC workgroup will be presented to our Council for review at ACR 2021. At that time, it will be the choice of the Council that shapes the destiny of this process.

In the meantime, your CSC welcomes your ideas, comments, and input. We are honored to serve you through the current challenges — and across these new digital spaces. **B**

K. ELIZABETH HAWK, MS, MD, PHD, A NUCLEAR MEDICINE PHYSICIAN AND NEURORADIOLOGIST, SERVES AS CLINICAL ASSISTANT PROFESSOR AT STANFORD RADIOLOGY. SHE IS ALSO A MEMBER OF THE ACR CSC. FOLLOW HER ON TWITTER @HAWKIMAGING.

Laying Out a Plan

A consultation appointment helps patients arrive at their nuclear medicine treatment more prepared and comfortable.

Thyroid cancer therapy has a high success rate, with five-year survival rates as high as 99% for most patients. But the path to that success feels uncertain, unfamiliar, and, in many ways, terrifying for patients. Words like “nuclear” and “radiation” understandably evoke fear — especially on top of a cancer diagnosis.

“Just the idea of coming to the nuclear medicine department is scary to patients,” says Renee M. Moadel, MD, MS, associate professor of radiology and director for the nuclear medicine residency program at Montefiore Medical Center in the Bronx, N.Y. “In most patients’ minds, the word nuclear is usually followed by disaster. It’s not a word associated with healing.”

To help patients feel more comfortable and prepared for treatment, Moadel developed a groundbreaking patient consultation program in the nuclear medicine clinic at Montefiore in 2005 — before the term ‘patient-centered’ was a common part of the medical lexicon. Moadel meets directly with patients several days or weeks before their initial treatments to explain their care plan, address their concerns and questions, and ensure that they are mentally, physically, and emotionally equipped to deal with the realities of undergoing nuclear medicine treatment.

Even when patients don’t explicitly express fears, anxiety can affect their care experience and make it difficult for them to follow the precise preparations that nuclear medicine treatment requires. As a 2018 research project later confirmed, the consultations resulted in a smoother, less stressful treatment process for patients and physicians and quickly became the standard of care at Montefiore for thyroid cancer therapy as well as other nuclear medicine treatments. “I try to ensure that everything is laid out and planned appropriately so that patients can be treated in an orderly fashion,” Moadel says. “I try to treat every patient as if they were my family member.”

Preparing for Treatment

Moadel conceived the idea for the consultation program soon after she became an attending physician in nuclear medicine at Montefiore. She noticed that at least 50% of thyroid cancer patients arrived for their first appointments unprepared and uninformed about their treatments, leading to frustration, rescheduled appointments, and wasted time and resources.

Thyroid cancer therapy often involves radiopharmaceuticals, which sometimes sound scary to patients but are usually safe and effective when proper precautions are followed, according to Moadel. At Montefiore, nuclear medicine physicians and their teams take steps to ensure efficient treatment before patients arrive for their appointments. Administrative personnel coordinate with the patient’s insurance company and facilitate communication between the care team and the patient. On the day of the appointment, the nuclear medicine technician orders and prepares the



“Just the idea of coming to the nuclear medicine department is scary to patients. In most patients’ minds, the word nuclear is usually followed by disaster. It’s not a word associated with healing.”

— RENEE M. MOADEL, MD, MS

medication and has it ready when the patient arrives.

Patients must also take steps to prepare for the treatment. These may include starting or stopping certain medications, modifying their diets, and, for women of childbearing potential, undergoing blood testing to rule out pregnancy. Patients also need to secure a place to self-isolate after their treatments to avoid exposing roommates or family members to radiation. In doing so, patients sometimes need to adjust their living arrangements, arrange for childcare, and take time off from work. “It’s a big process; there’s a lot the patient has to do,” Moadel says.

If all of the pieces aren’t in place, the appointment must be rescheduled, delaying needed care, causing undue stress for the patient, and wasting medical resources. As Moadel saw patients repeatedly arrive unprepared for their appointments, she knew something needed to be done and conceived the idea of meeting with patients prior to their treatments to explain what they needed to do to prepare for their appointments and ease their concerns.

Moadel pitched the idea for the consultation program to the chair of the nuclear medicine department (nuclear medicine was a separate department from radiology at the time). With their blessing, she began scheduling her first patient consultations using a spare conference or exam room.

Increasing Care Coordination

A few weeks before their scheduled treatment, Moadel meets with patients in a room that is set up more like an office than an exam room to help patients and their family members feel comfortable and allow time for questions and concerns about the recommended treatment. During the 45-minute consultations, Moadel reviews the treatment timeline with patients, using lay terms to ensure patients understand what they need to do and why, while giving them reassurance about what lies ahead.

At the first few appointments, Moadel wrote the treatment timeline on a piece of paper so that patients could visualize the treatment steps, but she soon developed a form she can

“The important part of the consultation for me was what the treatment pathway was going to be, how they were going to approach the treatment, what the outcomes were, and what I was going to have to do to manage myself in going through this treatment.”

— TERENCE MA

easily fill out and share with patients. In it, she outlines what patients should do and expect before, during, and after treatment, including possible side effects. Patients use the form as a resource to help them stay on track with their treatment plans.

“The important part of the consultation for me was what the treatment pathway was going to be, how they were going to approach the treatment, what the outcomes were, and what I was going to have to do to manage myself in going through this treatment,” says Terence Ma.

When possible, Man Yu Chen, radiation safety officer at Montefiore, joins the consultations to determine whether patients have safe places at home to self-isolate or if they need to be admitted to the hospital for treatment. Finding a place with their own bedroom and bathroom can be difficult for many members of Montefiore’s patient population, half of whom qualify for Medicaid and another 10% of whom have no insurance. “You can’t send a radioactive patient home where there are five people living in a one-bedroom apartment,” Moadel notes.

While most patients arrive with lots of worries about the long- and short-term side effects of radiation treatment and the possible impacts on their family members and co-workers, they usually leave the consultations feeling relieved and empowered to manage their care, Chen says. Ma agrees, saying, “The thing that was impressive about what happened at Montefiore was that the physicians kept very close track of what was going to happen and when.” The reassurance, he says, helped increase his confidence in the treatment and his care team.

Helping Referring Physicians

Although Moadel designed the program with patients in mind, she quickly realized that referring physicians also appreciated the consultations. She shares each patient’s treatment timeline with their referring physician and enters it into the electronic health record as a reference for the care team. “I’ve had referring physicians tell me that we’ve taken a huge load off of them. They’re overjoyed that we’re coordinating care and that patients understand what’s going on,” she says.

In fact, soon after Moadel started the consultation program, referring physicians began asking the other nuclear medicine

physicians at Montefiore if they offered a similar service to patients. The idea took hold at Montefiore’s two campuses, and the nuclear medicine department applied it to other treatments it offers, including those for liver, prostate, and neuroendocrine cancers.

Now, four nuclear medicine physicians conduct these consultations with 200 to 300 patients annually. Each physician tailors the consultations to their patients’ unique needs and treatment plans.

Moadel says that she and her colleagues continually update the content of the consultation and improve delivery of the information to patients and referring clinicians. The program has the full support of the division head, and it aligns with the radiology department’s emphasis on patient- and family-centered care and Montefiore’s comprehensive team-based care approach.

Planning Ahead

Since Moadel and the other physicians started the consultations, the department no longer has to reschedule appointments because patients are unprepared.

While the extra time that the nuclear medicine physicians spend conducting these patient consultations is not billable, Moadel still documents the visit in the record. Moadel believes programs like this have the potential to advance the recognition that radiologists and nuclear medicine physicians are patient-facing providers, especially as payers shift to value-based reimbursement.

Regardless of the availability of reimbursement, Moadel insists that meeting with patients to ensure the highest quality and most timely care is the right thing to do and encourages others to take a similar approach to patient care. “Whether or not the consultations were recognized as reimbursed was never the point,” she says. “The point is to ensure that treatment goes as seamlessly as possible for patients. Hopefully, we alleviate their fears when we talk to them about the therapy beforehand, and patients’ cancers are treated in the process.” **B**

BY EMILY PAULSEN, FREELANCE WRITER, ACR PRESS

Adding a consultation helps reduce anxiety for patients, ensuring care coordination and streamlining the care process.

Follow these steps to begin implementing a patient consultation program at your institution.

- ▶ Meet with patients to review their care plans and address their concerns prior to treatment.
- ▶ Develop a timeline form that patients and referring providers can use as a reference throughout the treatment process.
- ▶ Increase patients’ confidence and comfort with diagnostic and treatment procedures by preparing them beforehand and reviewing results in person afterwards.
- ▶ Document these efforts, even if no procedure code exists for it, to help create an appreciation and culture of patient-centeredness.

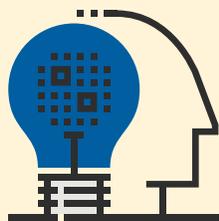
Learn more in the video about Montefiore’s nuclear medicine consultation clinic at [acr.org/Laying-Plan](https://www.acr.org/Laying-Plan).

Tracking the Pandemic



In the wake of COVID-19, the Harvey L. Neiman Health Policy Institute® studied imaging utilization in different settings over the course of 2020.

With the sudden onset of the pandemic in March, radiologists were eager to know whether the impact observed at their practices was also being seen throughout the country. Furthermore, policymakers and their constituents needed to understand the indirect consequences of the pandemic. With Americans advised (or ordered) to stay at home, and fearful of COVID-19, it was important to understand changes in imaging that could translate to gaps in care, missed diagnoses, and delayed treatments — and, conversely, whether increased case rates of COVID-19 were driving up imaging in some categories. The five studies completed to date tell a story of dramatic declines in imaging that started immediately after the first COVID-19 cases were diagnosed in New York.



Advancing radiology practice and improving patient care through research is a core objective of the ACR. **Research Rounds** is a new *Bulletin* column aimed to keep members up to date on the College's research initiatives. In each bimonthly article, ACR leaders from

two leading research centers — the Harvey L. Neiman Health Policy Institute® (NHPI) and the Center for Research and Innovation™ (CRI) — will share the latest in research that is advancing clinical practice and promoting policy that supports effective and efficient healthcare delivery and improved patient care.

Northwell Health, New York's largest healthcare provider and a Harvey L. Neiman Health Policy Institute® (NHPI) research partner, presented a perfect case study of the first U.S. COVID-19 hot spot. Therefore, Northwell data offered a leading indicator of what might occur in other parts of the country.

Two additional approaches evaluated how imaging was impacted in other parts of the country. First, data was collected from community practices across all regions of the U.S. Next, a survey of 228 radiology practices explored broader concerns from the practice perspective.

At Northwell, during the first seven weeks after COVID-19 hit last spring, there was a 28% decrease across all imaging, compared to 2019. Strikingly, outpatient imaging dropped by 88% and ER imaging by 46% — in contrast to the 14% inpatient decline. By modality, mammography took the biggest hit, with a 58% decline. In mid-April, mammography hit its lowest point, coming in 94% lower than the previous year.¹

A second study explored Northwell's inpatient imaging in more detail and found that the changes in most imaging modalities — CT, MRI, and mammography — were comparable to the global changes. The key exception was radiography, which exhibited a small 4% increase in the inpatient setting and a smaller decline in US. In the inpatient setting, US declined by 33% (compared to the 47% drop across all settings).² Lung X-ray and US have been key to identifying and treating respiratory problems stemming from COVID-19, such as pneumonia, and may have accounted for the lesser drop in the inpatient setting.

From a policy perspective, it is important for national, state, and local leaders to understand the unintended consequences of the pandemic on other aspects of health. The observed decline in mammography is a key example of how COVID-19-related restrictions — or personal choices to reduce risk — could translate to adverse health consequences for an unrelated disease.

A separate study of potential health disparities found that the pandemic also created distinct changes in the demographics and socioeconomics of patients receiving imaging. Imaging services at Northwell increased in groups that have historically received less imaging but are known to be more susceptible to the coronavirus infection: men, minorities, lower income, and the uninsured.³

The analysis of national community practices was no less bleak. There was an overall 52% decrease in imaging in the first week of April, which was slightly higher in the outpatient setting (66%). Mammography was down by 92%, which was

almost equivalent to the 94% drop observed at the nadir at Northwell. CT and radiography both decreased by about 30% in community practices.⁴

Not surprisingly, radiology practices endured major challenges as a result of the pandemic. Revenue for all types of practices in April was cut by more than half, on average, according to survey data. More than 70% of practices applied for financial relief, but 87% still had to cut positions or reduce salaries. In response to the pandemic, almost a quarter of surveyed practices developed teleradiology capabilities.⁵

From a policy perspective, it is important for national, state, and local leaders to understand the unintended consequences of the pandemic on other aspects of health. The observed decline in mammography is a key example of how COVID-19-related restrictions — or personal choices to reduce risk — could translate to adverse health consequences for an unrelated disease. For example, cancelled or deferred mammograms could result in a swift rise in

breast cancer cases identified too late to avoid progression.

Promoting safe protocols for patients to get the imaging they need to stay healthy is clearly critical as COVID-19 cases are still rampant across the country. However, the extra resources, staff, and PPE required to ensure safety pose additional costs to practices. CMS should consider reimbursement that accounts for these extra expenses.

Finally, as we look toward recovering from the pandemic, public health campaigns need to encourage patients to reschedule any missed appointments, screenings, or treatments. These campaigns, combined with communications from healthcare and insurance providers, will be critical to minimize the indirect and broader consequences of this crisis for public health. **B**

BY ELIZABETH Y. RULA, PHD, EXECUTIVE DIRECTOR OF THE HARVEY L. NEIMAN HEALTH POLICY INSTITUTE®

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

The Harvey L. Neiman Health Policy Institute® studies the value and role of radiology in evolving healthcare delivery and payment systems, including quality-based approaches to care and the impact of medical imaging on overall healthcare costs. Learn more at neimanhpi.org.



HPI COVID-19 Studies

To understand the impact of COVID-19 on radiology in a variety of care-delivery settings, the Harvey L. Neiman Health Policy Institute initiated a series of studies from an integrated healthcare system in New York and community radiology practices, and analyzed data from a national survey of radiology practices. The results demonstrate the huge impact of COVID-19 on imaging volumes and radiology practices. However, the level of impact was different across settings and imaging modalities.

NORTHWELL HEALTH — A LARGE INTEGRATED HEALTHCARE SYSTEM IN NEW YORK

March 1 to mid-April, 2020, compared to same time in 2019¹

Decline in Total Imaging Volumes:
28%

Decline in Mammography:
58%

Decline by Place of Service:
88% for outpatient setting
46% in emergency departments
14% in inpatient imaging

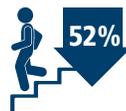
Modality	Total Imaging Volume 7-wk Change ¹	Inpatient Imaging Volume 7-wk Change ²
MRI	-51%	-49%
Ultrasound	-47%	-33%
CT	-35%	-27%

¹Haidich J, Boleynov A, Wang J, Chuaid J, Hughes D, Savello PC. Impact of the Coronavirus Disease 2019 (COVID-19) Pandemic on Imaging Case Volumes. *J Am Coll Radiol*. 2020 Jul;17(7):855-872.
²Haidich J, Boleynov A, Wang J, Chuaid J, Hughes D, Savello PC. Coronavirus Disease 2019 (COVID-19) Pandemic Shifts Inpatient Imaging Utilization. *J Am Coll Radiol*. 2020 Oct;17(10):1289-1298.

COMMUNITY PRACTICES IN ALL U.S. CENSUS REGIONS

First week of April, 2019 to first week of April, 2020

Decline of Total wRVU:



Decrease by Site of Service
66% in community outpatient settings

Decline by Modality Type
92% in Mammography
57% in CT
55% in Ultrasound

¹Ozask R Jr, Maze J, Senoz C, Fishman HB, Golding LP, Nicole GN, Hughes DR. Characteristics of Coronavirus Disease 2019 (COVID-19) Community Practice Declines in Radiologic Diagnostic Imaging Professional Work. *J Am Coll Radiol*. 2020 Jul;17(7):846-850.

SURVEY OF RBMA MEMBERS/PRACTICES

March 1 to April 30, 2020
First eight weeks of the pandemic

Reported Decline in Revenue⁴

100% of imaging centers
96% of hospital-based organization
100% of mixed practices
94% of other facilities and breast centers

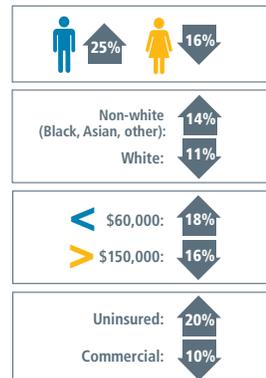
Financial Impact on Practices
72% sought financial relief
22% developed new teleradiology capabilities
87% reduced salaries or headcount
90% decline in elective procedures

⁴Mahholtra A, Wu X, Fishman HB, Ozask R Jr, Shiva R, Jod, McGinty GB, Bender C, Williams R, Pashley M, Stangl CR, Haidich J, Hughes D, Savello PC. Initial Impact of Coronavirus Disease 2019 (COVID-19) on Radiology Practices: An ACR/RBMA Survey. *J Am Coll Radiol*. 2020 Aug;45(5):461-464.

TOTAL IMAGING BY SOCIOECONOMIC STATUS⁵

March 1 to May 31, 2020, compared to same time in 2019

Northwell Health Patient Characteristics



⁵Haidich J, Boleynov A, Wang J, Chuaid J, Rula E, Hughes D, Savello PC. Imaging Utilization During the COVID-19 Pandemic: Highlights Socioeconomic Health Disparities. *J Am Coll Radiol*. 2020 October 28. doi: <https://doi.org/10.1016/j.jacr.2020.10.016>.

The Value of Debate

The January special issue of the *JACR*[®] has already caused a stir — which is exactly the goal of scholarly discourse.



“Rarely do we start an issue of the *JACR*[®] with a trigger warning,” write the editors of the journal’s January special issue. However, the articles in the January special issue are meant to spark debate around some of radiology’s most fraught topics. Editors Caroline Chung, MD, Reed A. Omary, MD, MS, FACR, and Christoph I. Lee, MD, MS, MBA, have pulled together perspectives from across radiology to start the conversations that will move the specialty forward.

Representing the diversity of perspectives, including those that may be controversial, strengthens the specialty. The journal’s mission is to continually earn reader trust and engagement by publishing content that educates, engages, entertains, and occasionally provokes.

Confronting preconceived notions is uncomfortable. This special issue will present controversial ideas across the five pillars of the journal — health services research and policy, clinical practice management, leadership, data science, and training and education. By presenting a variety of perspectives, these articles will provide an opportunity for the journal’s readership to discuss potential out-of-the-box approaches for expanding the reach of the specialty.

It’s also worth pointing out that the views presented in the special issue are entirely those of the individual authors and do not reflect the views or positions of the ACR. “Although associated with the College by its name, the journal was established with editorial independence as a core concept,” writes Howard B. Fleishon, MD, MMM, FACR, chair of the ACR BOC, in his January editorial. “This is by design.” **B**

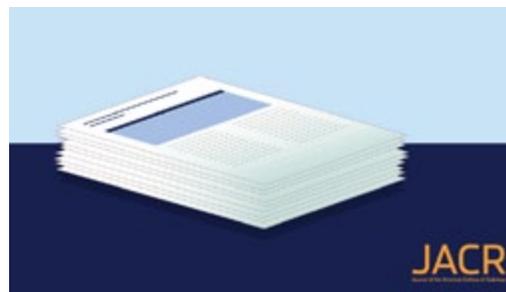


What’s Inside?

The January special issue delves into a broad selection of topics. Here are a few articles you’ll find.

- “Why Wellness Fails”
Brown B, et al.
- “Call for a New Radiology Subspecialty in Imaging-Based Screening”
Milch HS, Haramati LB
- “Vertical Integration: The Case for Combining Emergency Radiology into Emergency Medicine”
Mezrich JL
- “How ‘Rad’ is a Trip to Space? A Brief Discussion of Radiation Exposure in Suborbital Space Tourism”
Gorog Jr. JM, Elgart SR, Lerner DJ

Access the whole issue at jacr.org.



JACR Call for Papers

The *JACR* runs on the contributions of ACR members — and the journal wants your data-centric proposals. The new “Data, Distilled” series takes on previously unanswered questions through an exploration of the published literature. Have an idea for an original systematic review and meta-analysis? Head to acr.org/data_papers.



Mythbusting the FACR

The College debunks some misconceptions on the criteria for becoming a Fellow.

The highest level of ACR membership is the Fellow of the ACR (FACR). This distinguished award is bestowed upon members who have achieved accomplishments in areas beyond work responsibilities and advanced the field of radiology with evidence-based achievements. The information below is designed to bust some myths and misconceptions, while providing accurate information on becoming an FACR.

Cumulative count of membership years determines minimum eligibility to apply.

TRUE

- A complete membership profile is used to calculate all post-training membership years. The eligible years are no longer required to be at least 10 **consecutive** membership years.
- Note that candidates applying at the 10-year level must have achieved extraordinary levels of professional achievement as detailed in the nomination criteria at acr.org/FACR.

A chapter officer must nominate a member for a member to apply.

FALSE

- Although a chapter-nominated member is a stronger candidate, an eligible member may independently apply with the following:
 - » At least one accomplishment among the nomination criteria in the current membership year group from either service, teaching, and/or research/teaching
 - » At least 10 post-training membership years

» At least two letters of endorsement

These criteria are among the minimum eligibility components but do not guarantee automatic approval of the award.

Academic candidates have a greater likelihood of receiving the honor.

FALSE

- The FACR honor is bestowed upon members who have completed accomplishments beyond the scope of employment.
- For those candidates in academic careers, accomplishments in research and teaching must be above and beyond the levels accepted as routine part of employment.

Radiology achievements in the local community do not carry enough merit for FACR consideration.

FALSE

- There are many ways to achieve recognition in the category of Service. Each year group has an assessment standard from international through local achievements. Refer to the Pathway to FACR link at acr.org/FACR to identify your current placement.
- One or more leadership roles increase a candidate's likelihood for the award among any of the year groups. Consult the nomination criteria at acr.org/FACR to compare your achievements to the standardized rubric.

Visit acr.org/FACR for eligibility requirements, application submission deadline, and the link to apply. Email inquiries to FACR@acr.org. Look for an article in the February issue of the *Bulletin* to guide your professional journey in attaining this level of membership. **B**

BY JULIE HUXSOLL, MS, FACR ADMINISTRATOR, ACR

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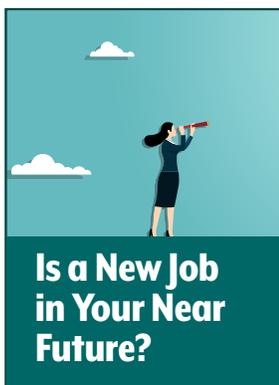
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Is a New Job in Your Near Future?

The ACR Career Center, one of the most accessed member benefits, is actively responding to the evolving transition of employment among radiology professionals.

Post your resume online today to make sure you're noticed — whether you're supplementing income because of reduced hours or are seeking a brand new opportunity as communities reopen.

Creating an account will allow you to access resources, take advantage of the CV review service, and receive customized Job Alert emails applicable to your specialty and location interests. In addition, you may pursue career counseling that includes interview advice at your convenience.

Find a job today at acr.org/CareerCenter.

As the country approaches a year into the start of the pandemic, how have ACR's COVID-19 resources helped you navigate this ongoing public health crisis?



“The ACR has been thoughtful and cohesive in its response to the pandemic. The COVID-19 Resources Center allows for easy access to guidelines and data and provides us with a readily available way to be updated. As a breast imager, I have found the information on the policies regarding ‘non-essential’ screening tests — how they are being formed and implemented in the various states — particularly helpful. This information provides me with a telescopic, yet comprehensive, way of learning about practices across the country — enabling me to optimize the care of my patients locally during a challenging time.”

— Jessica W.T. Leung, MD, FACR, FSBI, president of the Society of Breast Imaging, professor of diagnostic radiology and deputy chair of the department of breast imaging at the University of Texas MD Anderson Cancer Center



“The ACR has played a leading role in creating guidelines for appropriate use of COVID-19 imaging. As the radiology community responded to the pandemic by temporarily halting screening tests and non-urgent interventions to maintain patient safety, the ACR strove to explore multiple avenues to address the subsequent economic hit. I have found the ACR’s COVID-19 resources to be extremely helpful in staying connected and understanding how radiology departments and individuals at healthcare institutions across the nation are coping during the pandemic.”

— Ragni Jindal, MD, radiology resident at NYU Langone Winthrop Hospital

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