

Bulletin



**Matters
of State**



“I joined the ACR® because I wanted to have my finger on the pulse of radiology.”

Toma Samantha Omofoye, MD
Member since 2020

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The Exceptionalism of Radiology

As the ACR develops its new strategic plan, it is guiding the specialty and the broader community to work together to realize radiology's potential.

Benjamin S. Bloom, a professor of educational psychology at the University of Chicago, published a landmark book in 1985, *Developing Talent in Young People*.¹ According to Bloom, all the superb performers he investigated practiced intensively, studied with devoted teachers, and were supported enthusiastically by their families throughout their developing years. Later research building on Bloom's pioneering study revealed that the amount and quality of practice were key factors in the level of expertise people achieved. Consistently and overwhelmingly, the evidence showed that experts are made, not born.

Many others claim to be experts in the skills that radiologists provide. There have been continuous attempts to commoditize medical imaging and discount the value of radiologists. Yet it is radiology and radiologists that remain exceptional in our commitment and devotion not only to the realized benefits of medical imaging today but to innovation and the promise of its impact on patients and future population medical management.

At times, we may be myopic in realizing the exceptionalism of our chosen profession. We focus on potential threats and commoditization of what we deliver to our patients and referring physicians. No doubt these are important concerns for us to identify and address, especially during our strategic plan development process. Yet, if we step back and look at the macro-environment, it is undeniable that radiology is in an incredible position. Imaging-based care is at the forefront of modern medicine. We are just at the infancy of detecting the information hidden in our digital data. Metabolic and functional imaging techniques are emerging and will be fundamental to how we consider diagnosis and therapeutic options. With emerging modern techniques such as AI, the integration with pathology, and population and personalized health management, the potential is limitless.

So many entities, including big tech, are looking at medical imaging and what we do — for very good reason. Healthcare has always been an attractive industry.

Radiology is in an advantageous position to deliver essential data and micro-interventions for future healthcare paradigms. Embedded in our training and orientation are both short-term and longer-trajectory opportunities to utilize medical data and informatics. Imaging and data are going to be key for the objective assessment and planning of medical care, in whatever future payment systems develop.

As a science, the future is ours to realize. Radiologists are advancing the applications, science, and innovations of imaging, therapy, and interventions. We can reduce costs. We can take a leading role in population health management. As our predictive modeling evolves and matures, we can tell an individual what their risk factors are and guide them through a personalized medical care plan.

Radiology is in an advantageous position to deliver essential data and micro-interventions for future healthcare paradigms.

As a profession, we continue to attract the best and brightest. A brief glimpse at our literature will uncover the innovations that continue to evolve in our space. While some pundits had transiently focused on the potential negative impact of AI on our specialty, most population health management experts understand that imaging and informatics can shift healthcare paradigms to deliver better evidence-based care with greater efficiency and more value.

Exceptionalism does not end at our shores. The international interest and excitement in our specialty is inspiring. Working with international partners, radiologists are raising the profile and awareness of medical imaging — especially in countries where resources are scarce. We are learning best practices as medical imaging is being applied in multiple national delivery systems with various populations and demographics. As medical imaging is being primarily recognized in delivering even basic healthcare needs, we have the opportunity — if not the obligation — to impact global health. This is truly an exceptional time to be a radiologist.

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IMAGING 3.0:

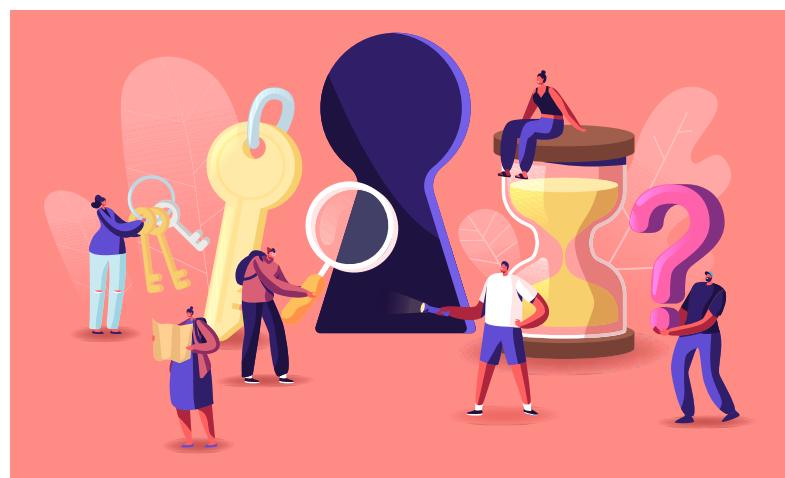
Radiology's Escape Room

Casey Cable, MD, an IR resident at Vanderbilt University Medical Center in Nashville, Tenn., partnered with ACR staff members to co-create a radiology escape room. The team initially designed the escape room as an in-person event to attract medical students to radiology, but as COVID-19 spread nationwide, the adventure moved online. Now, anyone can host the escape room from anywhere.

"In medical school, you don't get much exposure to radiology, and you don't get it early enough in your training to help you decide that it's the right career path for you," Cable says. "Many students don't take a radiology rotation until their fourth year, at which point they've already applied into another specialty. So, I reasoned the escape room would be a great recruitment tool to attract students to radiology earlier in their journey."

Since 2020, nearly 400 participants — including medical students, residents, attending physicians, and other groups — have experienced the creative twist on medical imaging education.

To read the full case study, visit acr.org/RadEscapeRoom-Imag3.



Redesigning Radiology: Register for the 2021 Annual Conference on Q&S

The 2021 ACR Annual Quality & Safety Conference, which will be held Oct. 14–16, is a robust and interactive learning program that will change the way radiologists think about current processes and improve upon the new normal.

During three impactful days, attendees will:

- Discover how communicating directly to patients will improve safety and optimize care.
- Develop standards to increase reliability and accountability.
- Value collaboration as a driver of evidence-based care.
- Rethink and update processes.

ACR members can sign up to participate virtually. For more information and to register, visit acr.org/qualityconference2021.



New JACR Study Looks at LCS and Mental Illness

Lung cancer remains the leading cause of cancer-specific mortality in the U.S., with an estimated 135,720 deaths in 2020.¹ Individuals with serious mental illness represent an underserved patient population that experiences significant disparities in lung cancer outcomes and is two to four times more likely to die from lung cancer.² Serious mental illness, specifically schizophrenia and bipolar disorder, affects nearly 13 million U.S. adults who die 15 to 30 years earlier than individuals without it.³ Cancer is the second leading cause of this premature mortality, due to a combination of factors that include inequities in cancer care, fragmentation of healthcare delivery between mental health and primary care services, lack of social support to navigate an increasingly complex healthcare system, and higher smoking prevalence.⁴

Lung cancer screening (LCS) has potential to mitigate existing disparities in lung cancer outcomes among individuals with serious mental illness through early detection. A new study published by the *JACR*[®] aimed to develop a tailored LCS educational intervention for individuals with severe mental illness and assess the feasibility and acceptability of delivering this intervention in a community mental health clinic.

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

ENDNOTES

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3. Dickerson F, Stallings CR, Origoni AE et al. Cigarette smoking among persons with schizophrenia or bipolar disorder in routine clinical settings, 1999–2011. *Psychiatr Serv*. 2013;64(1):44–50.
4. Weinstein LC, Stefancic A, Cunningham AT, Hurley KE, Cabassa LJ, Wender RC. Cancer screening, prevention, and treatment in people with mental illness. *CA Cancer J Clin*. 2016;66(2):134–51.

Thanks to updated screening guidelines, advancements in staging, surgical techniques and biomarker-based targeted therapy, the face of lung cancer is changing from one of doom to one of hope.

— ELLA A. KAZEROONI, MD, MS, FACP,
CHAIR OF THE ACR LUNG-RADS
COMMITTEE AND LUNG CANCER
SCREENING REGISTRY

Building Tomorrow's Healthcare System

Ian A. Weissman, DO, FACP, chair of the ACR Commission on Patient- and Family-Centered Care Outreach Committee and president-elect of the Wisconsin Radiological Society, recently presented at HealthManagement.org's virtual conference, "New Standards of Care: Building Tomorrow's Healthcare System Today." Weissman joined panelists such as Donna M. Prosser, DNP, RN, NE-BC, chief clinical officer of the Patient Safety Movement Foundation, and Peter Kaptein, president of Inspire2Live, to discuss personalized care and how to achieve a global standardized healthcare system.

"The COVID-19 pandemic has demonstrated how global health is interconnected across the world," said Weissman. "The ideal healthcare system of the future will be one that eliminates health disparities and builds health equity. This is why the ACR Commission on Patient- and Family-Centered Care's Outreach Committee and RAD-AID International have formed a collaboration to address morbidity and mortality in women resulting from breast and cervical cancer, which are disproportionately high among women of color in the U.S."

To view the full recording of the conference, visit bit.ly/Tomorrow_Healthcare.

Register for the 2021 RLI Summit

This year's Radiology Leadership Institute® (RLI) Summit will focus on radiology leadership in the healthcare ecosystem. During this two-day virtual event, which will take place Sept. 10–11, participants will discover how to bolster their place in the healthcare value chain among contributors, collaborators, and competitors. They will also have a chance to put their ecosystem learnings into practice during hands-on breakout sessions and an interactive case study review with peers.

2021 RLI Summit participants will:

- Describe examples of ecosystems.
- Discuss the concepts of ecosystems and how they relate to business competition in radiology.
- Review case studies as examples to discuss issues around a changing business environment.

At the conclusion of the Summit, participants will come away with a list of all the entities in their healthcare ecosystem, a diagram that shows the core interconnections within their ecosystem, and a better understanding of the major shifts in key relationships reflected in their ecosystem — including power dynamics, key influencers and alliances, and strategic partnerships.

To register for the 2021 RLI Summit, visit acr.org/RLISummit.

ACR Association Creates Fund to Fight for Patient Safety and Access to Radiologist Expertise

The ACR Association® (ACRA) has established the Scope of Practice (SOP) Fund to safeguard patients and patient access to radiologist expertise by fighting state and federal non-physician SOP expansion legislation. The new SOP fund, with its initial \$225,000 in funding, will be used in conjunction with state radiological societies to proactively educate lawmakers and counter future scope threats to patient safety.



Non-physician provider societies, specifically for advanced practice RNs and physician assistants (PAs), have ramped up their fight to increase their members' SOP and gain independent practice — particularly at the state level. State and national agencies have encouraged use of these physician extenders — especially during the COVID-19 public health emergency.

"Increased PA and NP scope of practice and autonomy may impact care and limit patient access to radiologists and radiologist-led teams," says Howard B. Fleishon, MD, MMM, FACP, chair of the ACR BOC. "Radiologists are uniquely educated, trained, and qualified to practice radiology. PAs and NPs do not have comparable training, competence, or experience. They should not independently supervise or interpret imaging exams."

The new fund will bolster ACR national and state chapter involvement in scope-of-practice legislative, regulatory, and legal activities. As part of this strategy, funds will be used to partner with other physician specialty or state medical societies to amplify the message of patient safety first. The ACR will provide members with more information regarding the SOP fund in the coming months.

For more information, visit acr.org/scope-of-practice.

ACR Releases New Informatics E-Learning Hub

The ACR published the first two modules of a new e-learning hub that offers the medical imaging community practical lessons for bringing AI to practice. The on-demand videos are valuable for those interested in incorporating AI into medical imaging and optimizing its performance, spanning topics from the fundamentals to best practices for incorporating AI.

Subjects covered include:

- Bias and fairness in AI models
- Brittleness of AI models
- Workflow-based AI
- Challenges in executing an AI project
- Evaluating AI for use in clinical practice
- Effective validation of AI models prior to clinical use

The two initial modules include a range of videos related to the topics of “The Basics of AI” and “Bringing AI to Practice.” These will be followed regularly by new modules. The next series of on-demand videos is expected to be published this fall.

To start exploring the e-learning hub and to access the videos, visit bit.ly/e-LearningHub. For more information, contact Stephanie Bossong at sbossong@acr.org.



Submit Data to the New 3D Printing Registry

Improve patient care and characterize resource utilization by joining the new 3D Printing Registry. This registry, developed collaboratively by the ACR and RSNA to address the need for coordinated tracking of clinical 3D printing, collects anonymized 3D printed model case information, clinical indications, intended uses and more.

Data collected are intended to answer questions about:

- Clinical indications and intended uses for printed models
- Source imaging
- Model construction techniques and effort
- 3D printing technique and effort
- Clinical impact of the models

How to participate:

- Register each facility that will participate in the registry
- Complete and return a signed participation agreement to NRDR®
- Submit payment (if necessary), then start submitting your data

To get started with the registration process, visit acr.org/3D-printing.

ACR PP&TS Field Review Comments Needed

Field reviews for the 2022 ACR Practice Parameters and Technical Standards (PP&TS) have begun. The ACR periodically reviews its PP&TS to help advance the science of radiology and improve patient care. Comments on the 2022 PP&TS will be collected during four field reviews: Aug. 23–Sept. 10; Sept. 13–Oct. 1; Oct. 4–Oct. 22; and Oct. 25–Nov. 12.

ACR members are encouraged to review the following documents during the first field review cycle (Aug. 23–Sept. 10):

- CT Equipment
- CT of the Spine
- CT in Traumatic Brain Injury (NEW)
- Functional MRI of the Brain
- Cardiac PET/CT Imaging
- Dopamine Transporter Single Photon Emission CT Imaging for Movement Disorders
- Continuing Medical Education
- MRI of the Wrist

The ACR Council considered a total of 49 resolutions at ACR 2021. There were 31 practice parameters adopted (30 revised and one new). Many of the practice parameters were collaborative efforts between the ACR and 12 other medical societies. These new and revised practice parameters will be available on the ACR website as soon as all final approvals have been received — with the target date of Sept. 1, 2021. The updated practice parameters will be effective on Oct. 1, 2021.

For more information and to comment, visit acr.org/PP-TS.

The ACR and SBI continue to recommend that women at average breast cancer risk begin screening at age 40 but have a risk assessment at age 30 to see if screening prior to age 40 is needed. The societies also recommend that women continue screening past age 74, unless severe comorbidities limit life expectancy.

— DEBRA L. MONTICCIOLI, MD, FACP,
ACR PAST PRESIDENT AND VICE CHAIR OF THE
DEPARTMENT OF RADIOLOGY AND SECTION
CHIEF OF BREAST IMAGING AT BAYLOR SCOTT &
WHITE MEDICAL CENTER-TEMPLE



Uncertain Times

The Medicare Physician Fee Schedule is a broken system that must be reinvented to elevate medicine into the future.

Interpreting the 2022 Medicare Physician Fee Schedule (MPFS) Proposed Rule is a lesson in reading regulation from an agency playing politics. Those of us who have read more of these regulatory tomes than we'd like to admit traditionally head straight for the same place when the newest MPFS rule is released: the specialty impact table. However, this time the impact table is deceiving. The steep cuts to radiology caused by increased valuation of evaluation and management (E/M) services under previous rulemaking are not included in the specialty impact table of the rule, but instead hidden inside a reduction in the MPFS Conversion Factor.

As a refresher, these cuts were estimated to reduce reimbursement for our specialty by 11% to maintain the budget neutrality inherent in the MPFS. Thanks to the strong work of the ACR government relations team coordinating a multi-organizational coalition and the work of the ACR membership in engaging their congressional representatives, these cuts were temporarily reduced via the Consolidated Appropriations Act of 2021. This act infused \$3 billion into the MPFS for one year to reduce the cuts, which would have hit hard amidst a global pandemic. We survived 2021 with lesser (but still unacceptable) Medicare reimbursement cuts of 4% — knowing that if Congress did not allocate additional funds to the MPFS, radiology's portion of the budget-neutral pot of money would once again shrink, and the full brunt of the E/M value increase would be realized.

This brings us back to why our first glance at the 2022 MPFS Proposed Rule was confusing. Inside the 1,700 pages of regulatory hurdles is a specialty impact table stating that radiology would face a 2%

Understanding the 2022 MPFS

CMS uses the Medicare Physician Fee Schedule (MPFS) to reimburse physician services. The MPFS is funded by Part B and is composed of resource costs associated with physician work, practice expense, and professional liability insurance. Under the MPFS, each of these three elements is assigned a relative value unit for each CPT® code. The ACR staff has prepared and posted summaries of the 2022 proposed rule at acr.org/MPFS-2022.

reimbursement cut. Mathematics experts will be quick to point out that we have only realized 4% of the prescribed 11% projected Medicare radiology payment reductions. We know that 3% of the 11% reduction will come when the delayed implementation of a controversial add-on code paying extra money to office visits expires at the end of 2023 — but that would still only account for 7% of the expected 11%. Our policy experts expected projected cuts for 2022 approaching 4%, not 2%. Well, here comes the kick in the gut: Medicare decided not to include the 4% cut to the Conversion Factor in the specialty impact table — later justifying that the impact estimates only incorporated reimbursement adjustments made by CMS in this rulemaking cycle. Dishearteningly, this also means the 2% radiology fee schedule reduction is a new, unexpected reduction set on top of the 11% cut already well on its way to being phased in. At the time of this writing, Medicare has prescribed a 13% reduction in payments to our specialty over the next three years, and we still haven't seen what is in store for us during the 2023 rulemaking cycle.

The MPFS is a mess and has become a convenient tool for policy makers from both political parties to significantly redistribute income away from specialty medicine, including radiology.

The MPFS is a mess and has become a convenient tool for policy makers from both political parties to significantly redistribute income away from specialty medicine, including radiology. Maintaining the obligatory budget neutrality requirements inherent in the payment system also means that innovation in the MPFS is stifled, as there is no new money to support new services. Instead, new services only detract from innovation in other services. This is a broken system.

This fall, you will be asked to support the ACR government relations team as we once again ask Congress to fix this mess so that all specialties can benefit from a cycle of innovation — as we continue to strive toward our goal of moving radiology forward and bringing high-quality healthcare equitably to all. **B**

Matters of State



The ACR backs state chapter efforts to preserve and advance critical issues in radiology.

As Washington's partisan divide continues, many state legislatures are increasing their activist legislative policymaking," says Cynthia R. Moran, ACR's executive vice president of government relations and health policy. "This just underscores our need to ramp up our state-level activities. The ACR is willing to commit the resources to work with our state chapters even more aggressively than in the past."

The ACR will continue its partnership with its active, well-organized chapters and commit new resources to those chapters who have been less focused on advocacy, Moran says. "Expansion of non-physician scope of practice is a major issue facing state legislators, but other challenges include Medicaid coverage of imaging services, as well as coverage battles by private payers using punitive prior authorization programs, are a few other issues facing not only radiologists, but most other providers (and specialists in particular)," Moran notes ([see sidebar](#)).

The ACR chapters are very diverse, not only in membership-size, but also in size of practices, prevalence of academic members, radiology subspecialties, business models, hospital affiliations, and

local politics," says Eugenia Brandt, ACR's director of state affairs. "If radiology is considered well-positioned politically in any state, in large part it is because the chapters in that state have a long history of volunteers who have dedicated their time and worked diligently to build on successes."

There is a pattern to state success stories, Brandt says. "While political fundraising is a critical part, it's only one part. Being successful in state-level advocacy takes consistent effort, a proactive strategy, and linking arms with colleagues in other specialties to present a unified front," she says.

There are many important issues that affect radiology, and state chapters are involved in most of them. "To be successful," Brandt says, "we have to join or form coalitions. There are issues that face the house of medicine as a whole, and our chapters cannot exist in a vacuum."

In many instances, if a state chapter does not have a lobbyist, the chapter leaders shoulder the responsibility for representing radiology interests in their state, Brandt says. "They are in the trenches, and we tailor our support to amplify and recognize their hard work," Brandt says. "The ACR also supports the grassroots efforts of state chapters and their leaders in their endeavors in local politics, local partnerships, and local diversity efforts. This is where the rubber meets the road."

"This is a critical time for the ACR to partner with all of our physician colleagues, across all specialties, to present a united front against national organizations that are using states to expand their own agendas," Moran says. "The ACR has always worked with our membership to advocate for what is best for our specialty and our patients, and adding new resources for our chapters to access will increase our existing effectiveness."

"We recognize the vital role that state chapters have in our advocacy strategy," says Howard B. Fleishon, MD, MMM, FACR, chair of the ACR BOC. "More initiatives are being decided in local jurisdictions that can become models for other states and even federal legislation. Our commitment is to represent radiology and our patients at every opportunity to promote access to quality medical imaging by radiologist-led teams."

State advocacy leaders who work with the ACR face constant challenges to the best practice of radiology for the patients in their states. The *Bulletin* has highlighted the work of a handful of diverse states — in their own words — to show the depth and results of ACR chapter advocacy.

Interviews by Chad Hudnall, senior writer, and Cary Coryell, publications specialist, ACR Press

Illustration: Josep Serra / Ikon Images

Staying Vigilant on Physician Extender Scope of Practice

To protect patient access to safe, high-quality care, the ACR tracks and acts on hundreds of bills nationwide, including those regarding physician-extender scope of practice. The ACR has long worked with state chapters to advocate at legislative, regulatory, and administrative levels for clear, sensible definition of scope for allied health professionals. Learn more about these efforts by visiting the newly updated, interactive ACR Scope of Practice page at acr.org/scope-of-practice.

Taj M. Kattapuram, MD

VICE PRESIDENT OF THE COLORADO RADILOGICAL SOCIETY AND MEMBER OF THE ACR CSC



Each year, multiple bills are introduced in the state of Colorado that could significantly affect radiologists. It is important to note that while some bills can be very specific to imaging, a large number of bills affect the entire house of medicine.

During the 2021 session, a standardized health benefit plan was introduced, HB21-1232. It was attractive

in its intent of creating a new coverage option for Colorado residents, but the bill would have had a significant impact on reimbursement and physician practices. As introduced, the bill language included a premium rate reduction and a mandatory provider participation provision. Private insurers and hospitals potentially could use the reduction to leverage future reimbursement negotiations in their favor with private physician practices. Mandatory participation involved a punitive stipulation — non-participation by physicians triggered a reporting requirement to the state regulatory board which, in turn, prompted fines on physicians in annual fees. The potential loss of revenue and possibility for disciplinary action fueled strong opposition from physicians. The Colorado Radiological Society followed the lead of the Colorado Medical Society and our lobbyist teams collaboratively to modify the measure prior to passage. As a result, all enforcement, fines, and reporting to regulatory boards for healthcare providers were removed from the bill. The cumulative premium reduction target for the plan was reduced to 15% from 18%.

Additionally, there was a bill introduced to alter supervision requirements for physician assistants in Colorado. Again, while noble in intent, it would have increased the scope of practice for non-physicians in healthcare. Radiologists are feeling the brunt of this increasing scope and independent practice movement as imaging orders are on the rise. Together with the support of many representatives within the house of medicine, we strongly opposed this bill. Our lobbyists joined forces with the Colorado Medical Society again. After extensive testimony from radiologists — along with other specialty physicians, trainees, and medical students — the bill was defeated.

I urge all ACR members to get involved in a broad range of issues, not limited to insurance and economics and not solely imaging related, like cancer screenings. You may have heard the saying, "If you don't have a seat at the table, you risk being on the menu." When radiologists share meals with the entire house of medicine, non-radiologists are more likely to support state legislation that is specific to imaging. Sharing resources and working together has fostered incredible relationships. The Colorado Radiological Society encourages radiologists in other states to participate in their state medical societies and be on the lookout for other collaborators in radiology advocacy.

Loralie D. Ma, MD, MA, PhD, FACR

CHAIR OF THE ACR STATE GOVERNMENT RELATIONS COMMITTEE



In the last five years, we have faced multiple scope of practice issues — in medicine in general, but with implications for radiology in particular. One of our recent issues in Maryland involved registered cardiovascular invasive specialists (RCIs), who assist cardiologists but have less training than nurse practitioners or physician assistants.

Cardiologists argued that the RCIs should be able to operate fluoroscopy independently, with only a cardiologist on site, and not in the room. They also wanted the RCIs initially to be able to order and interpret diagnostic imaging examinations. I should add that, in the state of Maryland, physician assistants are not permitted to operate fluoroscopy, the state requires a radiographer license.

After a two-year legislative battle, we won our case on this issue. The RCI is able to help position the patient for fluoroscopy, but only a physician or RT can push the peddle and operate the fluoroscopic equipment. The ordering or interpretation of diagnostic imaging by RCIs is not allowed.

On the general medicine front, we have faced repeated bills from naturopathic doctors who want to prescribe prescription drugs, including opioids. We argued that residency training and a more extensive pharmacologic background should be required for anyone seeking to prescribe.

In addition, this year the podiatrists in our state wanted to

Maryellyn Gilfeather, MD, FACR

PRESIDENT, UTAH RADILOGICAL SOCIETY



Around 85% of the two million citizens of Utah live within a 15-mile range along the Wasatch Front — a string of cities in the north-central part of the state. Outside of this moderately dense section, the large rural areas in our state face unique healthcare issues and challenges.

Our state has an active but small ACR chapter, with about 150 members. We are a tight group that closely follows what happens at the state level — and always manages to get their teeth into the tough issues that may impact radiology. Although we are too small to have our own lobbyist, we have developed a workaround — we have a longstanding relationship with the Utah Medical Association, which provides lobbying help whenever we need it.

This year, an issue came up around the physician assistants (PAs) in Utah attempting to increase their scope of practice. A proposed bill, SB27, included a line that stated: PAs would be permitted to order, perform, and interpret diagnostic studies and therapeutic procedures. The PAs were looking to increase their scope of practice

change their name to podiatric physicians. Although they testified that a name change was inconsequential, we felt it was important that anyone identifying themselves as a physician should complete the full coursework required from a medical school. This bill did pass in the Maryland House; however, we were able to win this battle, in part because of our close relationships with legislators on the Senate side and in large part because we have a dedicated team of physicians who volunteer their time for advocacy efforts and who excel in educating lawmakers about our profession. Having great lobbyists is also extremely important.

Ongoing close relationships with legislators are very important because legislators will be less receptive to your issue if you have not established a level of familiarity and trust. As physicians, we can provide valuable information to our legislators, and we need to take the time to build and strengthen these bonds.

Scope of practice issues will continue to dominate the legislative landscape. So much of this is at the state level rather than the federal. When the scope of practice of a mid-level practitioner can be changed in one state, it sets a fire that can spread to other states.

For example, Connecticut had a big win recently by having a radiology resident testify on scope of practice. The legislators were greatly swayed by a young person in training, who testified to the extent of the training and asked what it would mean if the training were simply unnecessary to do their job.

I believe that for us to win scope of practice battles, we must be creative and reach out to our legislators to explain who we are, how much we have trained in medical school/residency/fellowships, and what we do on a daily basis to provide the best possible care to our patients — before the change occurs. We make use of the ACR's centralized scope of practice website to track what

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with the argument that in Utah we have large underserved rural areas that would benefit from PAs working independently. The Utah Radiological Society had several members at the hearing who were able to educate legislators about the language in the bill and its reach. In the end, the bill passed — but without that language.

Beyond being in the legislative fight for best possible outcomes for radiology, we have other sources of pride here. Our state society does really well in donating to RADPAC®, the bipartisan political action committee of the ACR Association®. We have won the RADPAC award for highest participation in donating several times.

The Utah Radiological Society has an active RFS — and we encourage our members to be aware of and become involved in state advocacy and our Society has achieved a great track record with participation of young physicians. We are also very involved in the work of the ACR RFS Journal Club. The club covers AI and economics issues and allows trainees to interact directly with ACR leaders to gain perspectives on their areas of expertise. I help the residents and fellows network with radiology groups in Utah — those who are looking for jobs and want to stay in Utah.

I also take three residents to Washington, D.C., every year to attend the ACR Annual Meeting. I've been doing it long enough that I see former residents — who joined me in Washington — who are now attending ACR meetings on their own and who have become very active in their state societies.

Gaurang V. Shah, MD, FACP, FASFNR

ACR CSC MEMBER AND PAST PRESIDENT OF THE MICHIGAN RADILOGICAL SOCIETY



The Michigan Radiological Society (MRS) was established by pioneering radiologist Preston Hickey, MD, who was also the founding editor of the *AJR*. The MRS has always maintained a strong legislative presence including committing a portion of the membership dues towards hiring a full-time attorney and lobbyist.

The Michigan Radiology Political Action Committee (MRPAC) was

established in 1994 to support the advocacy efforts of MRS and the society prides itself on generous contributions to MRPAC, which in turn regularly supports our initiatives during electoral battles. We also observe a legislative day in the fall when a team of radiologists visits numerous state senators and congresspersons to acquaint them with issues important to radiology. The residents have their separate legislative day, making many of the same rounds and attending a session of the state Congress not only to get familiar with the legislative process but to have a younger generation of leaders joining the legislative battles.

MRS fights many legislative battles, and things don't always work out the way the radiology advocates would like. For instance, we fought a corporate practice law that ended in a court decision and appeals court assertion that we are not an entity and so couldn't be considered under the law. The ACR provided invaluable legal resources during the push to change the corporate practice law — even advising after the appeals court outcome. We decided to fight the battle another day. Then there are the victories — the legislative fruit of your labors.

One of the most recent battles was SB 481, a bipartisan bill citing a shortage of physicians in the state and seeking to grant wide powers to advanced practice registered nurses (APRNs) across multiple specialties. Proponents claimed the legislation would increase access to healthcare services for rural and remote communities. The bill was supported by a coalition of the Michigan Nurses Association, a few public health foundations, and multiple healthcare corporate entities.

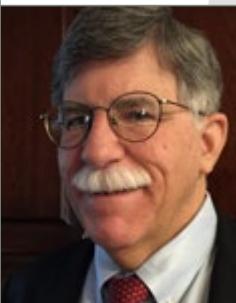
The bill proposed that APRNs should be able to "order, conduct, supervise and interpret" imaging, independent of supervision by radiologists. While there was no particular provision in the bill to serve remote communities, there were plenty of economic opportunities for corporate entities — including insurers and hospitals. As written, the bill would have empowered APRNs to start their own radiology service and we had concerns about the ability of APRNs to provide independent imaging interpretations.

SB 481 was a clarion call for the MRS and MRPAC, prompting many of the members to contact their local legislators and to express their opinions. The MRS joined a coalition of medical societies in opposing the bill and coordinating legislative efforts. Radiologists also volunteered to testify in front of the state's health policy and human services committee. In my role as the government relations chair for the society, I did a lot of

continued on page 22

Tilden L. Childs III, MD, FACP

**CHAIR OF THE LEGISLATIVE COMMITTEE OF
THE TEXAS RADILOGICAL SOCIETY**



In 2021, the Texas Radiological Society (TRS), working with our allies at the Texas Medical Association and the other specialty societies, realized one of the most productive legislative sessions in recent memory. The many years that TRS members and TRS PAC contributors have spent building relationships with influential legislators and backing good candidates for office who support our patients are really paying off in a big way.

Top priorities for the TRS include continuing to monitor the implementation of the SB 1264 balance billing legislation from the previous legislative session, including having been prepared to actively participate in any discussions regarding this issue in the recently completed 2021 legislative session. Additionally, we continue to be vigilant on scope of practice issues, particularly the issue of independent practice of non-physician practitioners, such as the California AB 890 regarding expanding the scope of practice for nurse practitioners that became law last year. We are also monitoring and participating with the Texas Medical Association on prior authorization, telemedicine/telehealth, and Medicaid expansion.

By the time the TRS concluded its 2021 legislative session in May, bills that seemed like longshots just a few years ago had been passed and signed into law. These included bills to expand mandatory coverage for diagnostic imaging for breast cancer and screenings for colorectal cancer, bills to limit health plans' use of prior authorization and utilization review to deny and diminish payments for radiology services, and legislation to clarify that the utilization of third-party billing services for medical claims submission would not be subject to sales tax in the state of Texas.

The TRS has played some really good defense as well, keeping our opponents from realizing their own legislative agendas. For example, the TRS and its allies were not only successful in defending against the continued attacks from the health plans and their allies on payment issues, but we were also able to stop the mid-level providers from realizing their misguided efforts to authorize the independent practice of medicine without direct oversight of a physician.

The ACR plays an integral role in the accomplishments of our chapter's legislative efforts. It is very valuable to have the ACR's dedicated tracking of all bills that are relevant to radiology and dedication to keeping states updated regularly. Having the ACR staff available for assistance to check proposed legislation against College policy, get state-by-state updates on legislative activities, or even just to talk things through is particularly beneficial.

Bonnie L. Litvack-Penn, MD, FACP

**NEW YORK STATE RADILOGICAL SOCIETY COUNCILOR
AND IMMEDIATE PAST PRESIDENT OF THE MEDICAL
SOCIETY OF THE STATE OF NEW YORK**



Our top legislative priority in the New York State Radiological Society (NYSRS) at this point is scope of practice of non-physician personnel and I think that scope of practice is a prominent theme in state legislatures throughout the country. At NYSRS, we believe the best way to deliver healthcare is through physician-led teams. Unfortunately, there has been an increasing number of disruptive measures introduced in the state capitol that seek to dilute the physician-led teams. In response, the NYSRS has been working very closely with the Medical Society of the State of NY on numerous issues related to scope of practice. The ACR has been terrific in its support and has helped defeat the non-physician personnel expansion of scope proposals.

The regular 2021 state legislative session in New York recessed in June. The top priorities for the NYSRS were protecting patient health by defeating scope of practice expansions for non-physicians, opposing legislation to increase medical malpractice liability premiums, supporting prior authorization reform, supporting collective negotiations by healthcare providers, and educating elected officials about concerns with single-payer legislation.

Medical liability is an issue that's always on the docket for the NYSRS — both the cost associated and the arcane system around medical malpractice. One of the recurring legislative proposals the physicians oppose every year is regressive liability, a measure supported by the trial lawyers to increase the discovery date in the existing medical liability statute. Another theme that's been coming back over the last few years is a proposal to reduce physicians' due process rights when it comes to the Office of Professional Medical Conduct of the NY State Department of Health. Under the current structure, anyone can send a complaint to that department, but only 2–3% of cases are deemed actionable. While the meetings of the state regulators evaluating complaints are currently closed-door, a proposal this year aims to make all of the complaints discoverable to the general public in the state of NY — without any vetting process. If this measure passes, this could cause significant damage to physicians' reputations, careers, and practices. The proposal was defeated this session, but the issue seems to come back year after year.

The ACR has been really great about getting all of the state societies together to talk about the issues in each state — because there's a wave of things that come through the country. If there's an issue here in New York, something similar may happen tomorrow in Nevada. Coming together helps states stay ahead of the curve and better equips us to adapt and respond appropriately. It is a very important part of what the ACR does for the states — to make sure that the practice environment for radiologists is improved throughout the country.

Drifting Away

What happens when your top-notch decision-making AI becomes average—or worse?

In radiology AI, generalizability means that a decision-making machine can provide the same quality of decisions about new, previously unseen data in different settings, with different scanners, protocols, and groups of patients. In radiology machine learning for image evaluation — also known as computer vision machine learning (CVML) — generalization is a vexing hurdle, because new images and other medical data being input to the CVML model are not exactly the same as the data the model was trained on. This is known as distribution shift, also referred to as dataset shift or covariate shift.

New Settings

Suppose I build a model that makes decisions like an A+ radiologist when I use exams conducted with my specific image acquisition machines, my protocols, and my patients' unique phenotypes. If you install my model to your setting — with your different brands or versions of imaging machines, different protocols, or different patient populations — it might continue to work like an A+ radiologist, but it might also work like a C, D, or even a failing radiologist.

In my own setting, if I change protocols, update scanner software, get a new X-ray tube, or change something about the patient population, my model could fall to average or even worse-than-average performance. Even if a CVML model works well at the start, the imaging data generated will inevitably drift over time due to changes, such as:

- Protocol tweaks
- New image acquisition and reconstruction software and hardware
- Patient phenotypes and genotypes
- Demographic variations
- Social, cultural, and environmental modifications

Concept Drift

Concept drift is a change over time in the relationship between input data and the output decision, or output data. COVID-19 offers an example: Suppose in 2019 we built a model to diagnose different types of pneumonia on chest CT, and we classified patchy ground glass opacities as influenza. This would have worked fine until early 2020, when those input findings no longer accurately predicted that answer — and instead meant an entirely new disease.

Concept drift can change acutely (as in the case of COVID-19), gradually, or even cyclically — such as with changing seasons or economic cycles, when people face varying environmental exposures. For radiologists, changes in practice patterns over time can cause concept drift. For example, the 2016 WHO definition of brain tumors changed how radiologists label some brain tumors, and the gradual evolution of high-resolution CT — and

the knowledge and classification of idiopathic interstitial pneumonias — changed how they are described.

Close Monitoring

Because today's CVML products work variably depending on local data, can we trust them to provide accurate and appropriately actionable decisions in our setting? In a word, no. We cannot trust them blindly. Nor should we rely on FDA clearance as it exists today, since it currently offers no assurances about how well a CVML product will work on our own data.

Before using a CVML product in busy clinical practice at scale, it is imperative to understand when, how, and why the product is expected to be clinically useful and trustworthy — and under what conditions it might not work as expected. We want to verify that the product works in our individual setting, with data from any input device — which can require weeks or even months of closely monitored trial use. At a minimum, the trial should include input data from a robust portion of all imaging devices in our system that would provide data to the CVML product, using all protocol variations or tweaks used clinically.

Once we verify a product in our setting, it should be monitored closely and continuously for drift in the decisions the product is making. This is similar to medical physicists who evaluate radiation therapy systems, with frequent calibrations and regular full simulations, or clinical laboratories' QA policies and procedures.

Because AI tools are so new, we don't yet know how best to monitor them as they run in busy clinical practice. We don't currently understand how to monitor output decisions on a continuous or semi-continuous basis, similar to performing peer review on every 10th or 50th case. These are hot research topics among highly technical academic and industry computer scientists and systems engineers, and many questions remain.

One possibility the ACR is working on would monitor models with interpretive functions, using clinical data registries to record the AI model inference, radiologist agreement or disagreement, and metadata about the examination including patient demographics, equipment manufacturer and protocol, and other relevant parameters. Data from the registry could be filtered to assess performance on individual machines — which in a busy practice could help drill down a specific problem. Even so, CVML relies on tens or even hundreds of thousands of patterns (or features) of clusters of pixels in each image, so at some level we will need to monitor image pixel data at a much more granular scale than we've ever done. It is still unclear how best to do that, but radiologists must be involved to ensure the safety of our patients.

If you purchase a CVML product today, your vendor might offer to fine-tune it on your existing exams, because their product doesn't generalize to your data right out of the box. 'Existing' is a key word here because, as your data changes over time, it is up to you to be sure your AI model continues to work as expected. **B**

J. Raymond Geis, MD, FACP, is a senior scientist with the ACR Data Science Institute® and adjunct associate professor of radiology with National Jewish Health in Denver.

Facilitating Research and Innovation

New ACR funds will provide members with the opportunities to make meaningful contributions to research that advance the College's mission.



"As radiology touches nearly all patient care, the FCRI Grant Program can empower ACR member researchers to

move medicine forward. We are proud to offer this funding at a critical time for radiology and the patients we serve."

— PAMELA K. WOODARD, MD, FACP,
CHAIR OF THE ACR COMMISSION ON RESEARCH

The ACR strategic plan includes the specific objective to engage in imaging clinical research that will continue to advance the practice of radiology. The College's investment in science and research is intended to facilitate innovation — including opportunities that invest back into the membership with grants that fund research to help the ACR achieve its objective.

This fall, ACR members will have two opportunities to apply for research grants through two research centers at the College: the Harvey L. Neiman Health Policy Institute® (NHPI) and the ACR Center for Research and Innovation™ (CRI). The *Bulletin* spoke with **Christine R. Davis**, senior director of clinical research administration at the CRI, and **Elizabeth Y. Rula, PhD**, executive director of the NHPI, to discuss how the upcoming funding opportunities will facilitate future practice innovations through research and education for the benefit of patient outcomes, patient experience, and population health.

Why is it important for CRI to have a grants program?

CD: It is important for the College to invest back into ACR members to engage them in advancing the ACR mission. It is evident that there are research initiatives important to the ACR that, with seed-funding investments from the College, may mature into externally funded projects of importance to the field of radiology and the ACR. To offer such investments in radiology research, the ACR has developed the ACR Fund for Collaborative Research in Imaging (FCRI). The use of these funds is guided by a research selection committee, comprised of ACR members, to ensure that funded projects contribute to the mission of the College. Successful proposed projects require collaboration with ACR and overall project sustainability. Applicants must be current, in-good-standing members of the ACR. Individuals or groups may submit proposals, and applications must have support from the chair of an ACR Research Committee.

What kinds of research will the FCRI program fund?

CD: The FCRI Grant Program is designed for unique, one-time investments in the most compelling and innovative research ideas that ultimately lead to advancement of the practice of radiology. Projects are typically pilot or seed grant-type ventures that test a new idea or help support a new area or direction of clinical research in radiology. The grants generally 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.

Why is this research objective important for ACR members?

CD: The ACR has committed to engage in imaging clinical research that will continue to advance the practice of radiology. The ACR value chain is comprised of staff, systems, and projects covering primary research through monitoring systems like Q&S registries, and those monitoring systems can generate new hypotheses or questions to answer that go back to primary research. The FCRI investment is kicking off primary research ideas that have potential for future expansion into other ACR programs.

Why it is important for NHPI to have a grants program?

ER: The NHPI was established nearly 10 years ago to fill a need for peer-reviewed research and data to inform the health policy debate to improve the quality and value of health care. Despite the lack of data, grant opportunities are sparse — particularly if the research is perceived to have the potential to advance the economic interests of a certain group, such as radiologists.

Today, the NHPI publishes over 30 peer-reviewed studies a year primarily through our academic research centers at Emory University, Georgia Tech, and Northwell Health, that provide a foundation for evidence-based advocacy. Even with this robust portfolio, we can have the greatest impact if we involve additional researchers in the work that will help us achieve our mission. Furthermore, offering grants allows us to tap into outside expertise and data to answer research questions that we otherwise couldn't answer. The NHPI grants program is intended to address these needs, increase the cadre of researchers in radiology health policy, and further expand our focus to new and emerging topics.

What kinds of research will the NHPI grants program fund?

ER: The NHPI grants program is intended to facilitate novel, empirical research that contributes directly to the NHPI mission. We want to publish evidence that promotes the effective and efficient use of healthcare resources and to improve patient care via health policy and radiology practice. Other

important funding criteria include pertinence to current policy priorities and the potential for impact, plus a robust design using methods, population, or data that extend what the NHPI can accomplish. NHPI grants will further our work to create an evidence base that will pave the way for advances in radiological practice that improve patient outcomes, reduce health disparities, inform the appropriate use of that care, and demonstrate value to support adequate reimbursement needed to ensure patients have access to a high level of care from trained radiologists.

What else can you tell us about the upcoming funding opportunities?

ER: The NHPI grants program is launching in October with the release of our first request for applications. By the summer of 2022, we intend to issue two more requests for applications. Grant objectives will be key issues for health policy and reimbursement, such as AI and other emerging technology, radiology value in the context of emerging payment and population health models, and practice advancements that improve equity, efficiency, or outcomes.

We will also introduce a NHPI fellowship in partnership with our research center at Northwell Health. This fellowship will provide training in clinical effectiveness research for radiology residents to contribute to research in this field throughout their careers. **B**

Interviews by Nichole Gay,
NHPI business and media manager

How to Apply to FCRI

The FCRI Grant Program is designed for unique, one-time investments in the most compelling and innovative research ideas that ultimately lead to advancement of the practice of radiology. Projects are typically pilot or seed grant-type ventures that test a new idea or help support a new direction of clinical research in radiology. These grants generally 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. Successful proposed projects require collaboration with the ACR and overall project sustainability.

Applicants must be current ACR members in good standing. Individuals or groups may submit proposals, and applications must have support from the chair of an ACR Research Committee. The ACR will announce a request for applications to the FCRI Grant Program this fall, along with communications containing application requirements and timelines.

For more information, contact ACR staff at research@acr.org.



"The NHPI has been at the nexus of research that has provided mission-critical data for the College's advocacy arm to drive policy change. I consider myself privileged to participate and contribute."

— JOSHUA A. HIRSCH, MD, FACR,
NHPI AFFILIATE SENIOR RESEARCH FELLOW



The Harvey L. Neiman Health Policy Institute® (NHPI) 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. NHPI research provides a foundation for evidence-based imaging policy to improve patient care and bolster efficient, effective use of healthcare resources. Learn more at neimanhpi.org.



Exceeding Expectations

The ACR's Population Health Management Committee is helping radiologists improve patient health while contributing to downstream savings.

The goal of population health management (PHM) is to proactively keep a patient population as healthy as possible, minimizing the need for expensive interventions such as ED visits, hospitalizations, imaging tests, and procedures. To accomplish this, PHM requires healthcare providers to develop new skill sets and infrastructures for delivering care more efficiently — and in a more highly coordinated manner. As this new approach to healthcare delivery develops, the field of radiology is uniquely positioned to play a crucial role.

To better understand what PHM is and where radiology fits within the wider conversation, the continuum of PHM can be divided into three major portions: surveillance/prevention, acute care, and chronic disease management. The surveillance and prevention aspects of PHM can include interventions such as cancer screening, the use of AI tools, or predictive analytics to anticipate medical issues before they progress to an acute stage. This approach involves stratifying risk between discreet patient populations and mitigating that risk in a proactive manner.

For instance, in the near future, patients at risk for heart disease could benefit from predictive analytics that guide which patients would benefit from having a coronary CT and, in turn, who should seek guidance from their PCP. In conjunction with

clinical interventions, management solutions could shore up missed care opportunities and other gaps in a patient's care by identifying and mitigating social determinants of health.

Even with the most robust surveillance and preventative initiatives aimed at keeping patients healthy, there will be instances in which their condition will progress to acute care status. This is traditionally where radiology plays a central role in healthcare, and radiologists can optimize their involvement in patient care by adhering to Choosing Wisely® guidelines, clinical decision support, Imaging 3.0® case studies, and following best practices when it comes to inpatient care coordination.

Finally, despite our best efforts, acute health issues can become chronic health problems. In this case, patients in a PHM framework are further subdivided into populations that follow appropriate chronic disease-management care pathways. PHM tools used to optimize care for this group include follow-up programs, oncology interventions, and remediating findings that predispose patients to chronic diseases such as fatty liver and metabolic syndrome.

Although the above three-part framework presupposes scenarios in which radiologists are deeply embedded in care coordination, in the current climate, radiologists often find themselves on the periphery when it comes to direct patient care. As such, contributing to continuity of care often presents a challenge. Some specialties, however, can take advantage of opportunities to consistently engage directly with patients and manage their care. Screening for breast cancer, virtual colonoscopy, and lung cancer screening are just three instances where radiologists play a central role in coordinated patient care, and other subspecialties can learn from these examples. Instead of simply sitting in a dark room reading images, radiologists should find ways to become involved in managing patients to make themselves indispensable to quality care.

By employing image-based screening and other technologies to enhance the health of discreet patient populations, radiologists can meet and exceed strategic health system needs. Further, by working with payers and health systems, radiologists can leverage their expertise to participate in alternative payment models and risk-sharing arrangements. By partnering with the ACR, members also have the opportunity to help develop quality metrics that can lead to tighter care integration. Ultimately, our field should aim to be recognized by referring clinicians, the healthcare enterprise, and patients, as providing high-quality and cost-effective care. **B**

By Syed F. Zaidi, MD, MBA, chair of the PHM Committee of the ACR Commission on Patient- and Family-Centered Care and associate chief medical officer of integrations with Radiology Partners, and Ryan K. Lee, MD, MBA, co-chair of the ACR's PHM Committee and chair of the department of radiology at Einstein Healthcare in Philadelphia

To learn more about how radiology can position itself to help health systems realize downstream savings by improving patient health, watch a recent PHM Committee webinar at acr.org/screening-webinar featuring Cecelia C. Brewington, MD, FACP; Lauren P. Golding, MD; Debra S. Dyer, MD, FACP; Ryan K. Lee, MD, MBA; and Syed F. Zaidi, MD, MBA. During the webinar, the panelists dive deeper into how radiology's central role in patient screening is one of the key foundations of successful PHM.

Bringing Peer Learning to Accreditation

A new pathway for ACR-accredited facilities to meet the Physician Quality Assurance Program requirement has been approved — and an upcoming webinar will explain the minimum requirements.

Peer learning is a group activity in which expert professionals review one another's work, actively give and receive feedback in a constructive manner, teach and learn from one another, and mutually commit to improving performance as individuals, as a team, and as a system. As an alternative approach to traditional score-based peer review, peer learning has gained significant traction in radiology practice, however until now there was no formal recognition of peer learning by the ACR as an alternative approach to meeting the Physician Quality Assurance Program requirement of accredited facilities. Authors of a recent *JACR*[®] article on the topic asserted that "accrediting organizations should formally recognize peer learning as an acceptable form of peer review and specify minimum criteria for peer-learning programs."¹ In an answer to this call, "This summer, through the work of the newly convened Peer Learning Committee, the ACR has approved a second pathway that accredited facilities can now use to meet the Physician Quality Assurance Program requirement — and that is through the development of a peer learning program," says Shlomit A. Goldberg-Stein, MD, co-chair of the New York State Radiological Society Quality and Safety Committee, and member of the ACR Peer Learning Committee, who led the accreditation effort. "This is really big news."

To help programs understand the minimum requirements for the new peer learning pathway and support the transition to peer learning, Goldberg-Stein and Mara M. Kunst, MD, neuroradiology section head at Lahey Hospital and Medical Center, will be co-chairing an upcoming ACR webinar. The *Bulletin* recently spoke with Goldberg-Stein to discuss the new pathway.

How did the pathway get created?

All practice sites that initially apply for or renew ACR accreditation have a requirement to actively participate in a Physician Quality Assurance Program. Until now, there was really only one pathway for an accredited facility to meet that program requirement — and that was a physician score-based peer review. Since its introduction nearly 20 years ago, score-based peer review has not actually been shown to have a meaningful impact on radiologists' performance or to be a valid measurement instrument of radiologists' performance. So, in the last handful of years, a new paradigm has emerged, peer learning, which has become very

popular as an alternative approach to score-based peer review.

How does the peer learning pathway differ from traditional score-based peer review?

The goal of peer learning is really for participants to teach and to learn from each other. It's a commitment to actively give and receive feedback in a constructive manner, and to establish a just culture environment in which non-punitive learning can take place.

One of the requirements of the peer learning pathway is a written policy that includes a statement of a commitment to sequester peer learning activity content from any individual practitioners' performance evaluation. The goal of peer learning is not performance evaluation, and it really shouldn't be a part of it at all. That's a critical component of peer learning: to allow for an open, non-punitive learning environment. If you are committed as an organization to sequestering all peer learning content from any sort of performance evaluation, then your culture is appropriately set up for peer learning.

What does an accredited facility need to know to utilize a peer learning program?

There are two minimum requirements: One is that there should be a written policy, and the other is that there should be annual documentation. Details about what comes under these umbrellas can be ascertained through participation in the webinar (see sidebar).

Ultimately, we want peer learning to be something that's both meaningful and attainable — and we have designed the minimum accreditation requirements to achieve that aim. The requirement is essentially to design your program and set a policy with metrics befitting your program. Certainly, there are going to be programs that are going to go well beyond the minimum requirements — but the policy for the peer learning program was written so that peer learning can be meaningful, and not too burdensome for practices of all types to undertake.

What will the ACR webinar cover?

The upcoming webinar is designed to help programs and facilities understand how peer learning can meet the requirements for ACR accreditation — and answer the multitude of secondary questions that emerge from there. It's been a long time coming, and it is great news for radiology practices who have already been doing peer learning or have been thinking about doing peer learning but weren't quite sure how it would meet the ACR's accreditation requirements, The Joint Commission's requirements, or the requirements of other accrediting bodies. We now have a formalized pathway with defined criteria, approved by the ACR and CMS, and this webinar is the rollout of these new minimum ACR requirements for the peer learning pathway, as well as an opportunity to learn how those requirements can be met. **B**

Interview by Cary Coryell,
publications specialist, ACR Press

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

Register for the ACR Peer Learning Physician Quality Assurance Pathway for Accreditation webinar on Sept. 14 at 3 PM ET at acr.org/PhysicianQAPath-Webinar1. A recording of the webinar presentation with a live Q & A will be made available on Sept. 17 at acr.org/PhysicianQAPath-Webinar2.

Stamp of Approval

Navigate the accreditation process with tips, tricks, and a timeline from an accreditation professional.

Accreditation is a powerful tool for distinguishing high-quality imaging programs from those that have not met the rigorous review requirements. For non-hospital-based imaging facilities billing under the Medicare Physician Fee Schedule, accreditation can also be a requirement. But accreditation is so much more than a mandate, says Patricia B. Wilson, director of accreditation at Asheville Radiology Associates in North Carolina. “Accreditation is an opportunity to be reviewed by your peers and ensure you’re working to the highest standard. It also shows patients and providers that quality of care is important to you,” she says.

Asheville Radiology, which provides services to hospitals, clinics, and imaging centers throughout Western North Carolina, began its accreditation journey with the ACR in 1989. It started with mammography, and now, the team accredits every modality except for radiation oncology with the College. Wilson says that working with the ACR is an important component of their process. “The ACR is a college of our peers. We can expect the highest standards of review from them,” she says. “They are a partner in helping us provide quality patient services.”

Despite the benefits of accreditation, some programs may find the costs and effort required to complete the process daunting, Wilson notes. “There’s also a big fear of the unknown. Accreditation involves so many requirements that you may not expect. Practices may be afraid of making errors,” she adds.

To help ease some of that fear, Wilson, an accreditation veteran, shares her tried-and-true process that has served her and her practice well throughout the years. **B**

By Jenny Jones, publications manager, ACR Press

INFOGRAPHIC BY SUE IRISH

A Timeline for Accreditation Success

1

START EARLY



Start the accreditation process a year before accreditation expires. The ACR sends a renewal notice eight months before accreditation expiration. Accreditation can be completed only after a practice submits an accreditation application and the ACR accepts it. Note that mammography exams must be dated after the ACR acceptance date.

PROTIP!

Manage your time by creating a list of each modality's accreditation expiration date.

2

COMPILE RESOURCES

PROTIP!

The ACR provides an accreditation checklist for each modality. Access the checklists, modules, and other resources at acraccredit.org



Assemble an accreditation manual to keep everyone on track and ensure you have everything you need for each accreditation submission. The manual should include imaging requirements, data sheet instructions, a list that matches each radiologist with their modality, ACR contact information, and helpful tips about study submission. It should also include the ACR-provided checklist for each modality.

3

HOLD A KICKOFF MEETING



Send invitations to lead technologists and facility directors. In the meeting, discuss key information — such as due dates — identify the lead interpreting radiologist for each modality, and share the accreditation manual. Be sure that all scanning technologists meet the certification requirements for each modality. For example, a vascular US submission requires that at least one technologist has the appropriate vascular certification (RVT, RT(VS), or RVS).

PROTIP!

Have attendees use the “Reply All” feature from your initial email forward so that no one misses key information.

6 ENTER DATA AND UPLOAD IMAGES



Enter the required information and data into the ACR accreditation database.

Schedule a meeting with your IT team to upload the images to the ACR accreditation database.

PRO TIP!
Meet with your IT team via videoconferencing and give everything a final review before submitting.

7 TIME TO SUBMIT



5 REVIEW IMAGES



Conduct a preliminary review to look for common errors, such as mislabeled images, and then send collected images to at least two radiologists for review.

PRO TIP!

Although the ACR requires that only the lead supervising physician review the images, two radiologists can ensure that all questions and concerns are covered before submission.

4 COLLECT YOUR EXAMS



Review ACR's accreditation modules to determine which exams to submit for each modality. Communicate the exam requirements to the scanning technologists and share necessary forms. Have the facility supply required images within a month of the kickoff meeting. Send reminders if images are not received in time. The goal is to have all of the exams approved by the time of the ACR renewal notice.

PRO TIP!

Ask the facility staff to write the patient's last name and medical record number on the data sheet so that you can confirm that you have received the correct images.

8 SHARE FINAL REPORTS



Circulate final ACR accreditation reports with everyone involved in the accreditation process, including the program director,

supervising radiologists, and specializing radiologists. The information contained within the reports can help the team prepare for future accreditations.

PRO TIP!

Ask the team to review the reports to identify quality improvement opportunities.



REMEMBER ...

- ❖ A consistent, standardized method for accreditation — whether you're completing one accreditation or 50 — makes the process quick and efficient.
- ❖ Embrace the accreditation process. As with most things, it gets easier each time as you learn and build knowledge along the way.
- ❖ Reach out to the ACR for help. The accreditation team is available to help and wants you to succeed. Contact the team at acr.org/accreditationsupport.

Creating More Inclusive Breast Cancer Screening Guidelines

Delaying the age for women to start breast cancer screening will result in unnecessary loss of life and will disproportionately disadvantage minority women.



Annual mammography screening starting at age 40 yields the greatest breast cancer mortality reduction, diagnosis at earlier stage, better surgical options, and more effective chemotherapy.

Breast cancer remains the most common non-skin cancer, the second leading cause of cancer deaths, and the leading cause of premature death in American women.¹ Breast cancer currently accounts for 30% of all new invasive cancer diagnoses in women. In 2021, there are expected to be 333,490 new invasive and *in situ* cases and 44,130 breast cancer deaths nationwide.² Well-defined breast cancer screening guidance is critical for all women and especially for underserved and underrepresented populations. Mammography screening can prevent thousands of unnecessary deaths each year.

Minority women are 72% more likely to be diagnosed with breast cancer before age 50, are 58% more likely to be diagnosed with advanced stage disease prior to age 50, and are 127% more likely to die of breast cancer before age 50, compared to white women.³ Females transitioning to male who do not undergo mastectomies maintain their previous risk for breast cancer, and these individuals are less likely to have routine screenings, which further increases their risk. Males transitioning to female are at increased risk for breast cancer compared to other males, due to hormone use.⁴

These demographic differences are why I want to share the new expanded and inclusive guidelines, developed by the ACR and the Society of Breast Imaging (SBI). The new guidelines state that annual screening is to start at age 40 in transfeminine (male-to-female) individuals who have used hormones for five years or more, and for transmasculine (female-to-male) individuals who have not had mastectomy. The ACR and the SBI continue to recommend that individuals at average breast cancer risk begin screening at age 40, but have a risk assessment at age 30 to see if screening prior to age 40 is needed. The societies also

recommend that individuals continue screening past age 74, unless severe comorbidities limit life expectancy.⁴

Individuals have a choice of whether and how often to be screened for breast cancer. Annual mammography screening starting at age 40 yields the greatest breast cancer mortality reduction, diagnosis at earlier stage, better surgical options, and more effective chemotherapy. These benefits should be considered along with the possibility of recall for additional imaging and benign biopsy and the less tangible risks of anxiety and overdiagnosis.⁴ Delaying screening until age 45 or 50 will result in an unnecessary loss of life due to breast cancer and will disproportionately disadvantage minority individuals. **B**

By Debra L. Monticciolo, MD, FACR, ACR past president and vice chair of the department of radiology and section chief of breast imaging at Baylor Scott & White Medical Center-Temple

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Read the new guidelines published in the *JACR*® at jacr.org. For more information about the proven effectiveness of regular mammography screening to reduce breast cancer deaths, visit RadiologyInfo.org, MammographySavesLives.org, and EndTheConfusion.org.

How is the ACR helping you make connections and build strength in a way that is difficult to achieve alone?

“We have a duty to care for the people we serve, but this duty can become a colossal task if we are not also taking care of ourselves. It is refreshing to see the ACR discuss such complicated, yet drastically important topics such as health equity, healthcare access, racial disparity, physician burnout, and the concerns of young professionals regarding family planning and work-life balance. I am genuinely proud of the ACR and its actions toward achieving a positive culture in the field of radiology. It has showed me that with continued peer-to-peer education, we can better ourselves as individuals, as a collective, and as a society.”

Kieran Lacey, MD, radiology resident at
Memorial University of Newfoundland, Canada



“I believe that being part of a vibrant ACR social media family on Twitter has kept me connected to my colleagues and community, although we are separated due to continued physical distancing. I am grateful to the ACR for sharing information and providing education about well-being and COVID-19-related issues to keep us healthy and safe as we work together to support our communities during this ongoing pandemic.”

Ian A. Weissman, DO, FACP, chair of the ACR Commission on
Patient- and Family-Centered Care Outreach Committee



GAURANG V. SHAH, MD, FACP

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research and put together potential talking points for the bill and the scope of work of APRNs. We were able to argue against the bill on the basis of the difference in training, lack of radiological safety perspective, and likelihood of increased healthcare costs (backed by published research).

Our grassroots efforts were great and included a media campaign. A local newspaper covered our point of view. We pushed an email campaign — in which many radiologists participated — and many Michigan citizens emailed their state legislators. Nevertheless, the headwinds were strong, and the bill passed on the floor of the Senate. Without losing hope, we doubled our efforts on the House side.

The sands started to shift when the bill was presented in the House Health Policy Committee. With our strong opposition, the committee deleted the provision related to radiology services and we were pleased that the committee members shared our concerns about the quality of the patient care the residents of Michigan deserve. Still, we continued our efforts in the coalition with other specialty medical societies. In the end, the bill's one-year clock ran out and there could be no vote. We survived an existential crisis for our specialty by being vigilant, prepared, engaged, and committed. **B**

LORALIE D. MA, MD, MA, PHD, FACP

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is going on in other states and learn from successes and losses (see sidebar on page 9). On that website, you can track scope of practice bills under consideration in your state or others, find out how to support the ACR and state chapter efforts regarding such bills, and read about the ACR's efforts, in conjunction with other societies, against physician extender scope of practice expansion.

We are all in this together. Let's work to protect patient access to safe, high-quality, radiologist-led medical imaging care. **B**

EXCEPTIONALISM

continued from page 4

Radiology continues to be an incredible profession — providing societal value, professional satisfaction, and intellectual curiosity. Our specialty is witnessing the explosion of technology and science amidst the promise of our future.

As I speak with residents and fellows across the country, I congratulate them for choosing radiology as a specialty. Despite all the distractions, they are entering the specialty at an exciting time. Yes, there will continue to be challenges. In an earlier era, the introduction of Medicare was thought to be the end of radiology. But radiology survived — and even thrived. The specialty looks very different from the time when we had rolloscopes. The promise is that radiology will look very different even ten years from now. We will continue to innovate, adapt, and serve our patients.

Radiology is indeed exceptional. We are well-positioned for continued success. The ACR is a crucial organization in guiding the specialty. As we develop our new strategic plan, we will focus on maximizing our collective potential. I encourage all of our members and the broader radiology community to work together to realize our future — for our specialty and our patients. **B**

ENDNOTE

1. Bloom B. *Developing talent in young people*. Ballantine Books, 1985.

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ACR Bulletin (ISSN 2160-4754) is published monthly by the American College of Radiology, 1891 Preston White Drive, Reston, VA 20191-4326 or email to membership@acr.org.

From annual membership dues of \$900, \$12 is allocated to the *ACR Bulletin* annual subscription price. The subscription price for nonmembers is \$90. Periodical postage paid at Reston, Va., and additional mailing offices. POSTMASTER: Send address changes to *ACR Bulletin*, 1891 Preston White Drive, Reston, VA 20191-4326 or email to membership@acr.org. Copyright ©2021 by the American College of Radiology. Printed in the U.S.A.

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