BUILDING ON POPULATION HEALTH MANAGEMENT
RLI Summit
2022

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Join us Sept. 9–11 to connect, share, and find new inspiration for your leadership journey, including how to:

• Spark Leader Self-Awareness
• Build Collaborative Teams
• Advance Relational Leadership
• Develop High-Quality Connections

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Sept. 9–11, 2022
Babson College
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Looking Back, Looking Ahead

While the pandemic dominated the ACR’s agenda over the last two years, it nonetheless provided the College with a unique growth opportunity.

At ACR 2022 this month, I will be handing over the BOC gavel to Jacqueline A. Bello, MD, FACR. It is appropriate to reflect back on my term at this time.

The majority of my two years as chair of the BOC was dominated by the COVID-19 pandemic — certainly not what I expected the College to focus on during my term, but it nonetheless provided us with a unique growth opportunity.

COVID-19 has changed many things, including the ACR. At first, we were concerned about the College’s financial viability. This focus quickly passed after it became clear that our members continued to support the organization. At the same time, we moved quickly to deliver COVID-19 recommendations and guidelines to our patients and our members. We also lobbied for pertinent legislation that delivered federal financial support to our members for their practices and departments. We quickly learned how to adapt and reimagine the College. Our meetings became either completely virtual or hybrid in format. Going forward, we will facilitate having more inclusive and representative meetings, including hybrid formats. Like many other organizations, we learned how to operate with our employees working from home.

Moving forward, this flexibility allows us to recruit from a larger workforce. The pandemic allowed us to rethink how we can support our employees’ work-life balance — a major step forward in addressing burnout.

Like many of my predecessors, a constant issue that came up during my term was crisis management — particularly with government relations. With the leadership and guidance of Cynthia Moran, executive vice president of government relations, economics, and health policy, the ACR has one of the most respected and credible government relations teams on Capitol Hill — not only in radiology but in all of medicine. By convening a coalition of more than 100 professional organizations, we were able to hold off the drastic reductions that were slated for radiology that would threaten patients’ access to imaging care. The fact that we were able to influence the legislative agendas despite the myriad distractions at the end of both 2020 and 2021 is truly a remarkable group effort.

Looking forward, we have begun the process of operationalizing our Strategic Plan, thanks to the efforts of Pam Mechler, MS, CAE, vice president of strategic planning and business excellence, and Strategic Planning Committee Co-Chairs Alexander M. Norbash, MD, MS, FACR, and Frank J. Lexa, MD, MBA, FACR. Three strategic initiatives have been identified:

- The first is communication. The priority is to revamp our efforts to find opportunities to be more effective, relevant, and bidirectional with our members.
- The second is volunteerism. We have to maximize opportunities for our members, especially our early-career members, to contribute their expertise to the committees and commissions of the College.
- The third is AI, including data science education. The ACR recognizes the organization’s need to be front and center as AI becomes part of our profession. The ACR Data Science Institute® continues to be one of the most prolific and important endeavors for AI in medicine.

One upcoming initiative for the College will be its rebranding, which will be informed by our work on the Strategic Plan. The way in which we present the College to our members, patients, and others is critical to how we identify ourselves and project our impact. Hence, we will be revisiting the rebranding effort at our next BOC meeting under the guidance of William T. Herrington, MD, FACR, chair of the Commission on Membership and Communications.

The ACR has had many significant accomplishments over the last two years, including the reimagination of the College, a focus on population health management (see page 10), the launch of the Radiology Health Equity Coalition, the American Institute for Radiologic Pathology™ becoming a managed department of the ACR and being renamed the ACR Institute for Radiologic Pathology, and multiple policy decisions, meetings with chapters, and partnerships with other societies. The College has also had its fair share of controversy. The Medicare Access to Radiology Care Act of 2021, the role of non-physician radiology providers, and scope of practice remain topics of debate for the membership and Council.

These past two years have provided me with a unique...
Upholding Requirements for Authorized User Criteria

The leaders of the U.S. Nuclear Regulatory Commission (NRC) voted against a controversial plan to reduce the stringency of authorized user (AU) criteria, which would enable non-experts to serve as AUs on NRC and agreement state licenses for unsealed diagnostic and therapeutic radiopharmaceuticals. The ACR and other medical stakeholders opposed the plan, reiterating that AUs must have adequate training in radiation and its safe use to safely perform their responsibilities.

For more information on the decision, visit bit.ly/NRC_Decision or contact the ACR’s Government Affairs Director Michael Peters at mpeters@acr.org.

Charles D. Williams, MD, FACP, Receives Lifetime Achievement Award

Charles D. Williams, MD, FACP, a retired diagnostic radiologist with Radiology Associates of Tallahassee, received a lifetime achievement award from the Florida House of Representatives on Jan. 24. The award was presented by Florida House Majority Leader Rep. Michael Grant. Williams is a former member of the ACR BOC, former vice president of the College, and an ACR Gold Medalist. He previously received a career achievement award from the governor of Georgia as well as a career achievement award from his hometown of Moultrie, Georgia.

Read more at bit.ly/DrWilliams_Award.

New CMS Guidelines to Move Forward Lung Cancer Screening

New CMS recommendations to lower lung cancer screening (LCS) initial age and smoking history requirements can make these exams the most effective cancer screening tests in history. In addition to lowering the initial screening age from 55 to 50, and smoking history requirements from 30 pack years to 20 pack years, CMS expanded coverage to thousands of independent diagnostic testing facilities nationwide and retained a requirement that providers use Lung-RADS® structured reporting.

“Expanded LCS access can help doctors hit back against the nation’s leading cancer killer and ease lung cancer outcomes disparities — particularly among women, Black men, and those in rural areas,” says Debra S. Dyer, MD, FACR, chair of the ACR LCS Steering Committee. “Screening providers, particularly those starting new programs, should seek accreditation, use Lung-RADS, take part in the LCS Registry, and leverage educational offerings to maximize screening’s lifesaving benefit. Providers must act on this opportunity.”

The ACR, the GO2 Foundation for Lung Cancer, and the Society of Thoracic Surgeons will work with CMS, medical providers, and those seeking care to implement and update screening recommendations.


ACR Strategic Plan: Empowering the Radiologist of the Future

A bold new ACR Strategic Plan will increase member value, improve radiologic care, and strengthen healthcare. The plan, “Empowering the Radiologist of the Future,” consists of twelve interconnected and interdependent strategic objectives, organized across four organizational perspectives, that will focus and drive ACR activities in coming years. When fully implemented, the plan will support improved health equity, quality, delivery, and outcomes.

According to ACR BOC Chair Howard B. Fleishon, MD, MMM, FACR, “The Strategic Plan — developed by, with, and for members — makes ACR decision-making more inclusive, transparent, and effective as it positions members, their practices, and the ACR for future success.”

Read the new Strategic Plan at acr.org/strategic-plan.
The advocacy the ACR performs is exponentially more effective when radiologists are directly engaged. There are many ways to get involved, whether it be participating in site visits, going to town halls, attending fundraising events, or writing letters to your Congressperson.

RYAN K. LEE, MD, MBA, CO-CHAIR OF THE ACR COMMISSION ON PATIENT- AND FAMILY-CENTERED CARE’S POPULATION HEALTH MANAGEMENT COMMITTEE

ACR CAREER CENTER:
Top Five Procedure Skills Employers Are Seeking

In a recent survey of employers who have current job openings on the ACR Career Center, the procedure skillsets that are most sought after are thoracentesis, paracentesis, lumbar puncture, breast biopsy, and thyroid fine needle aspiration.

By asking employers to identify specific skillsets needed, the ACR Career Center will showcase the procedure skillsets in an effort to help job seekers find positions that align best with their body of knowledge.

Additionally, the College will share the results of this survey with training program directors to support their education efforts. This will allow the programs to ensure their residents and fellows are among the most qualified hiring candidates.

Visit jobs.acr.org/jobs to view the more than 1,400 jobs at the ACR Career Center.

Attention RFS Members:
The ACR AC Committee Wants You

Residents and fellows who are interested in evidence-based guidelines and want to learn how the ACR develops its Appropriateness Criteria® (AC) will want to attend the on-demand webinar “Introduction to ACR AC.” The AC are guidelines to help referring physicians and other healthcare providers make the appropriate decisions for imaging and treatment of certain conditions.

At this webinar, residents and fellows will learn about what the AC is and why it is important to the practice of medicine, what each participant’s role in the AC development process involves, and the process for creating evidence-based guidelines.

After this webinar, the AC Committee hopes that you will consider being a part of the Committee.

Register for the webinar at bit.ly/ACRAC_Webinar.

Neiman Institute Names Inaugural Research Fellow

Emily Avery, an aspiring diagnostic radiologist and third-year medical student at Yale School of Medicine, has been selected as the first-ever Harvey L. Neiman Health Policy Institute® research fellow. Her research project will focus on the impact of arterial collateral flow on the cost-effectiveness of endovascular thrombectomy in acute stroke.

Read more about the inaugural fellowship at neimanhpi.org.

ACR CAREER CENTER:
Top Five Procedure Skills Employers Are Seeking

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Required | Preferred
Register for the 2022 SBI/ACR Breast Imaging Hybrid Symposium

The 2022 SBI/ACR Breast Imaging Hybrid Symposium will take place May 16–19 in Savannah, Georgia. Registrants will have the opportunity to attend either virtually or in person. All attendees will have access to more than 60 live sessions across all breast imaging modalities. In addition, Society of Breast Imaging members will have the ability to view recorded symposium sessions for a year following the event.

Visit bit.ly/SBIACR2022 to secure your spot.

ACR Supports the Resident Education Deferred Interest Act

The ACR recently joined other physician organizations to voice support for the Resident Education Deferred Interest (REDI) Act, introduced by Sens. Jacky Rosen (D-NV) and John Boozman (R-AR). The REDI Act would pause principal loan repayment and student loan interest accrual for medical and dental students during their residencies and internships. It would save medical and dental residents thousands of dollars in interest and reduce a significant financial burden for radiology residents who typically pursue at least one fellowship and are often unable to begin repaying student debt immediately.

Relieving the burden of those considerations will help address the physician shortage by encouraging students to pursue careers in medicine by making financial burdens generated during their education easier to manage, aid in leveling the playing field between disparate practice settings, and ultimately improve patient access to quality care.

For more information, contact Rebecca Spangler, ACR Senior Government Affairs Director, at rspanger@acr.org.

A CR Research Commission Chair Awarded Fellowship From AAAS

In January, the American Association for the Advancement of Science (AAAS) named Pamela K. Woodard, MD, PhD, FACR, as one of eight Washington University faculty fellows. Woodard, who serves as chair of the ACR Commission on Research, is the Hugh Monroe Wilson professor of radiology and professor of biomedical engineering at Washington University in St. Louis, where she is also the senior vice chair and division director of radiology research facilities. In this role, she provides administrative oversight to the directors of the department’s ten National Institutes of Health recharge facilities, including the PET and MRI research facilities and the cyclotron facility.

Read more about Woodard’s work at bit.ly/AAAS_Fellows.

Implementation and Uptake of Rural LCS

Given the higher rates of tobacco use along with increased mortality specific to lung cancer in rural settings, low-dose CT (LDCT) screening could be particularly beneficial to such populations. However, patients in these areas face increased barriers to screening initiation and adherence, from limited radiology facilities and increased geographical distance, to lower income and education levels.

In collaboration with community leaders and stakeholders, researchers developed and implemented a community-based screening program, including telephone-based navigation and tobacco cessation counseling support, serving 18 north Texas counties.

The researchers collected data on LDCT referrals, orders, and completion. And after one year of operation, it was found that 107 medical providers referred 570 patients for lung cancer screening, of which 86% were eligible for LDCT. Common reasons for this were due to age and insufficient tobacco history.

Read the full study in the JACR® at bit.ly/JACR_CT.

Register for the 2022 Data Science Institute Summit

The 2022 ACR Data Science Institute® Summit will take place Wednesday, June 8, 2022, in Kissimmee, Florida, along with the Society for Imaging Informatics in Medicine’s annual meeting. Registrants will have the opportunity to attend either virtually or in person. This year’s theme will be Using AI in Clinical Practice: A Practical Guide for Radiologists. In addition, attendees will have the ability to view recorded sessions following the event.


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An ACR Advocate in Action

Getting a bill introduced at the state legislative level and having it enacted is not an easy feat, but Ezequiel “Zeke” Silva III, MD, FACR, FSIR, FBRMA, RCC, immediate past chair of the ACR Commission on Economics, was instrumental in doing that in 2021 in Texas. Representing both the Texas Radiological Society and the Texas Medical Association, Silva led the charge in advocating for House Bill 3459, which established a continuous prior authorization exemption for physicians who earn a 90% approval rate on prior authorization requests for a given service over a period of six months. Known as the “gold card” legislation, this bill passed in September 2021, and Silva is now focused on its implementation.

While every state legislature is different, there are a few key strategies that Silva learned that could be beneficial in other states when thinking about introducing legislation:

- Identify a pressing and relevant issue to both patients and physicians.
- Gather reliable data.
- Build coalitions with other medical specialties, medical organizations, and impacted individuals. This is essential when speaking to legislators and their staff and testifying at legislative committee hearings.
- If possible, find a physician legislator to be the primary sponsor.
- Become familiar with how the legislation, if enacted, will be implemented.

The ACR supports advocacy efforts at the state and federal levels. For more information, contact Dillon Harp, ACR’s senior state government relations specialist, at dharp@acr.org, or visit bit.ly/AdvocateInAction.

Engage With #RadHealthEquity

Radiology is one piece of the larger healthcare system, but radiologists’ presence makes a huge impression on several factors that impact patients, such as representation of providers and access to equitable care. This is why the Radiology Health Equity Coalition is so important. Pledge to join the community advancing health equity in radiology. Submit and share resources to help your colleagues achieve equity in their practice.

Please visit radhealthequity.org and engage with #RadHealthEquity on social media to learn more about how you can advance equity in radiology.

I would like to see a healthcare system where inclusivity is commonplace, where Black patients have the benefit of the doubt without being labeled, and a verity that the Black community could trust.

JADE ANDERSON, MD, AMA SECTION COUNCIL ON RADIOLOGY MEMBER REPRESENTATIVE TO THE RADIOLoGY HEALTH EQUITY COALITION

IMAGING 3.0: Promoting a Sustainable Future

Recognizing that hospitals account for up to 8% of carbon emissions in the U.S., radiologists formed a group called Radiologists for a Sustainable Future. The group is dedicated to making healthcare more environmentally sustainable and improving population health. In a new Q&A case study, one of the group’s founders, Julia Schoen, MD, MS, discusses how radiologists can reduce their environmental footprint and promote sustainability.


ACR Urges Increased Residency Slots for Radiology

In comments submitted Feb. 22, the ACR urged CMS to consider increasing radiology residency slots when allocating 1,000 new Medicare-funded positions authorized in the Consolidated Appropriations Act of 2021. In December, CMS included provisions that relate to hospital payment for graduate medical education (GME) costs in its federal fiscal year 2022 Inpatient Prospective Payment System final rule.

The Appropriations Act makes available the new GME positions beginning in 2023. CMS specified that no more than 200 slots will be granted per fiscal year and priority for those slots will be determined using four statutorily specified categories.

For more information, contact Kimberly Greck, ACR’s economic policy analyst, at kgreck@acr.org.
Get Involved With the CAC Network

If you find that Medicare coverage policies seem too restrictive or are not current with practice patterns, consider joining the ACR Contractor Advisory Committee Network.

Ever heard of a Local Coverage Determination (LCD)? An LCD is a determination by a Medicare Administrative Contractor (MAC) regarding whether a contractor covers a particular item or service. We encourage each state chapter president to appoint Contractor Advisory Committee (CAC) representatives and alternates in diagnostic radiology, radiation oncology, interventional radiology, and nuclear medicine to participate in the development of LCD policies and to review existing policies. These representatives might also seek clarification and suggest updates as clinical practice evolves. In addition, CAC Network members provide valuable feedback to their chapters and the ACR on problems at the local level and disseminate information back to their chapters on updates to Medicare policies.

Prior to 2019, each MAC held meetings three times a year with primary care and specialty representatives of the CAC to start its review of draft LCDs. Before the LCDs were finalized, the CAC members made suggestions for revision based on scientific data and published literature. However, in 2019, Congress passed the 21st Century Cures Act aimed at improving the process of LCD development and decreasing regional variation in policies. The restructured CAC meetings are now open to the public. CAC members serve in an advisory capacity as representatives of their constituency to review the quality of the evidence used in the development of an LCD. MACs can host CAC meetings in several ways (in-person, telephone, video, webinar). MACs determine how frequently these meetings occur based on the appropriateness and volume of LCDs requiring CAC input. MACs have the option of hosting CAC meetings prior to the posting of a proposed LCD to assist in the upfront analysis of the evidence or after the publication of the proposed LCD. MACs now also have the option of organizing meetings with CAC members of multiple jurisdictions convening at one time. In addition to physicians, other healthcare professionals (e.g., nurses, social workers, epidemiologists) can participate in the CAC. The CAC must also include Medicare beneficiary representation.

What is the difference between National Coverage Determination (NCD) and LCD policies? Medicare coverage is limited to items and services that are “reasonable and necessary” for the diagnosis or treatment of an illness or injury. NCDs are made through an evidence-based process with opportunities for public participation. In some cases, CMS research is supplemented by an outside technology assessment and/or consultation with the Medicare Evidence Development and Coverage Advisory Committee to provide comments regarding specific clinical and scientific issues in an open and public forum (although CMS makes the final decision on coverage issues). NCDs are binding on all Medicare contractors, quality improvement organizations, health maintenance organizations, competitive medical plans, and healthcare prepayment plans.

In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors based on an LCD. It turns out that 90% of Medicare policies are established at the local level, providing contractors with tremendous authority over payment policy in each state. However, the ACR CAC Network is concerned about recent changes in the LCD development process — particularly with the lack of transparency and consistency, the lack of compulsory CAC meetings in states/jurisdictions, and the removal of CAC member input into proposed LCDs prior to final policy release. Recently, the ACR joined other specialty organizations to send a letter to CMS to share our concerns and make recommendations to improve the LCD development process. Regardless of what CMS decides to do, members of the ACR CAC Network continue to play a critical role in the LCD development process and other proposed policy changes.

Laeton J. Pang, MD, FACR, ACR Radiation Oncology CAC Network Chair
Sammy Chu, MD, FACR, ACR Radiology CAC Network Chair

JOINING THE CAC NETWORK

If you are a young physician and have an interest in health policy or reimbursement of imaging care in the future, we invite you to join our national effort! The CAC Network helps ensure that physicians are appropriately reimbursed for services provided to Medicare patients. Hence, becoming a member of the CAC Network is essential to the process. For more information or to get involved, contact Alicia Blakey, ACR’s principal economic policy analyst, at ablakey@acr.org.
BUILDING ON
Population health management (PHM) can be confusing at times, with many different definitions put forth in the literature. Upon closer inspection, the differences in the various descriptions really reflect differences in emphasis in the components of population health. The American Hospital Association definition might serve as a useful starting point: Population health is “the process of improving clinical health outcomes of a defined group of individuals through improved care coordination and patient engagement supported by appropriate financial and care models.” Radiologists are central to care coordination, which opens opportunities to participate and lead in alternative reimbursement models.

An important element of population health bears being called out explicitly. Patients in a population — whether defined as within a healthcare network, insurance plan, or geographic area — may have varying degrees of access to healthcare. A central aim of population health is to identify the social determinants of health that contribute to these access issues and to formulate action plans. Improving access to care contributes to the goal of promoting proactive care to all patients in a given population.

The following Imaging 3.0® case studies demonstrate leadership opportunities for radiologists committed to improving access to care through PHM.
Addressing a Care Gap
Breast cancer is the most common cancer affecting women in the U.S. While mammography screenings are proven to reduce breast cancer mortality rates, many women forgo the annual exams.2

Recognizing that early detection and enrollment into disease management programs is one of the hallmarks of PHM, one South Carolina health system took action. Working with radiologists, referring physicians, and scheduling staff, the population health team at Bon Secours St. Francis Health System, a market of Bon Secours Mercy Health, launched Save a Life, a campaign to increase access to mammography screening for women in the Greenville, South Carolina, area. Radiology schedulers reached out to patients directly to schedule screening exams, the radiologists added additional hours to accommodate more screening appointments, and the health system deployed a mobile mammography unit to increase access to screening.

Since the team permanently adopted the program in March of 2018, following a successful pilot, the number of mammograms Bon Secours St. Francis Health System has performed has risen significantly. The campaign led to a 39% increase of monthly mammogram orders year over year, contributing to the health system’s 256 positive breast cancer diagnoses in 2018.

“This approach is like a spider web,” Tami Johnson, director of business development at Bon Secours St. Francis, says. “It starts in the center with one focus and then stretches outward to cover other areas. If you know your part and your area of influence, consider how you can use it to make a positive impact on patient care.”

Read the full case study at acr.org/Save-a-Life.

Connecting With Patients
During imaging exams, RTs often provide directions about how patients should position themselves to ensure the best image acquisition and quality. But when language is a barrier, providing optimal patient care can be difficult. While in-person translators and telephone-based translation services can help, connecting with those services can sometimes slow down care.

That’s why radiologists at Massachusetts General Hospital (MGH) have leveraged AI to develop a translation tool to enhance care and improve health equity among non-English-speaking patients. MGH radiologists created RadTranslate™, a web app that currently delivers imaging instructions in Spanish, Mandarin, and Portuguese — the three most-common languages after English among MGH patients. The web-based tool delivers common imaging exam instructions, such as “hold your breath,” at the push of a button. Since MGH deployed the tool, preliminary data shows that exam times are more predictable for standard chest X-rays while enhancing the patient experience.

“As large academic medical centers with the means and resources, if we can use technology to help reduce health disparities, then it’s our obligation to do it,” Marc D. Succi, MD, emergency radiologist at MGH who led development of RadTranslate, says. “Everyone deserves a high level of care, and this tool can help us deliver that level of care to all of our patients.”

Read the full case study at acr.org/Translated-Care.
“While you can assign responsibility for improving the patient experience to administration staff, you won’t be as successful if you don’t have a physician champion who can ensure that the patient remains at the center of the entire care process. The culture starts at the top and works its way down.”

— NINA S. VINCOFF, MD

Improving Care

After engaging patients who are living with physical limitations, a New York radiology practice adapted processes to improve the patient experience and expand health equity. Lisa Panzica, MHA, has lived with the neurodegenerative disorder spinal muscular atrophy since she was a child. Unable to walk and reliant on a wheelchair, Panzica has come to expect daily obstacles and persists to overcome them.

It was when she was denied a screening mammogram due to her disability that Panzica was truly stunned. Still, she managed to turn her disappointment into action — partnering with the radiology team to improve care for patients living with physical limitations. Based on Panzica’s feedback about gauging patients’ challenges and concerns ahead of time, the radiology team at Northwell Health added a question to their digital intake form that asks patients about their limitations and needs. The team then proactively responds to patients’ concerns and provides enough support for every patient to have the same access to care.

“Leadership in this arena really has to start with the radiologists,” Nina S. Vincoff, MD, chief of breast imaging and radiology vice chair for patient experience at Northwell, says. “While you can assign responsibility for improving the patient experience to administration staff, you won’t be as successful if you don’t have a physician champion who can ensure that the patient remains at the center of the entire care process. The culture starts at the top and works its way down.”

“Always put yourself in the shoes of the patient and be proactive — not only addressing expressed needs, but unexpressed needs, too,” Panzica says. “That’s how to raise the bar in healthcare.”

Read the full case study at bit.ly/ImprovingCare_I3.

By Chad Hudnall, senior content specialist, ACR Press, with input from 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

ENDNOTES


Striking a Balance

Two radiologists share how they maintain balance in a two-physician relationship.

Many couples work in the same industry. From marketing to politics, a shared passion for something can further cement a couple’s bond. The same goes for physicians, but it’s trickier than your typical profession—particularly at a time when hospitals and healthcare systems have been strained, leaving healthcare workers overwhelmed and burned out.

The Bulletin spoke with Melissa M. Chen, MD, assistant professor of radiology at MD Anderson Cancer Center and member of the ACR CSC, and her husband Stephen R. Chen, MD, associate professor in the department of IR at MD Anderson, about thriving together with two demanding jobs and the shared responsibility of raising a family.

How did you meet each other?

MC: I was in business first and then I transitioned into medicine after working on Wall Street for a couple of years. I met my husband when I moved back home to San Antonio, Texas, to save money while I was doing my post-baccalaureate work for premed. I met him at church, and it just so happened at the time that he was a lieutenant colonel with the U.S. Air Force and a radiology resident at San Antonio Uniformed Services Health Education Consortium. I explored radiology as a specialty because Stephen was a radiologist. It may not have been something that I would’ve otherwise explored because you’re not commonly exposed to radiology as a medical student. It was Stephen who said to me, “I think you would enjoy radiology.”

With both of you practicing in the same profession, what have you learned from each other?

SC: We have different specializations within the same profession. I often ask Melissa to review head and neck imaging findings before my biopsies and after therapeutic procedures. She asks me to review possible aneurysms, vascular malformations, and post-procedural artifacts. Melissa is very efficient and task-oriented at work and some of these habits have rubbed off on me over the years.

MC: There are a lot of synergies as well as differences in our personalities. Stephen likes to try new technology. He’s not afraid to troubleshoot things, especially when it comes to radiology. He is someone who takes things apart and digs in deeper and gets very focused in a problem, whereas I try to think about how to get something done most efficiently.

Do you encounter differences in how people ask each of you about your family life?

MC: I think there’s definitely differences in people’s expectations. It’s easier for me if I say, “My kid is sick, and I have to stay home from work.” But if my husband said that, he would probably be looked at a little bit differently, so there’s a kind of reverse discrimination.

There’s also this expectation that I’m inherently taking care of a lot of the kids’ stuff versus Stephen. I encountered this when I was looking for positions and found that sometimes there’s the assumption that I may be trying to balance a family and so I’m not as interested in my career because I am female. I remember when I was in medical school someone asked me, “Oh, now that you’re marrying a doctor you don’t have to go to medical school anymore, right?” It was an assumption that one physician in the family was good enough. I think assumptions like this have pushed me to overcompensate to show that I’m committed to the work that I do, which sometimes can lead to me overworking a bit.

How do you two find a way to balance your work and family?

SC: We both try to stay actively involved in assisting the kids with schoolwork and their extracurricular activities. We take turns driving them to dance classes and piano lessons. We also like to exercise and go running together on the weekends. The routine helps keep some balance between work and family life.

MC: Stephen’s work hours are longer than mine, so it’s sometimes tough trying to coordinate schedules with the kids. We have a common calendar to keep track of commitments. We have a nanny because there’s no other way for me to get everyone to where they need to go. And then if there’s something I need Stephen’s help on, it has to be planned ahead of time. If I know that I’m going to be out of town attending a conference, or if I need his help to do something with the kids, he’ll block it off on his calendar. And we just trade off. There are certain tasks he knows that are his job and there are certain tasks that are my job.

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Reuniting and Reconnecting

Council business remains a significant priority at ACR 2022 and for the first time in two years, attendees will gather in person in Washington, D.C.

To say that we’re excited to see each other in person in April, for the first time since ACR 2019, is an understatement. One of the best parts of the ACR annual meeting is the chance to catch up and connect with colleagues in the ACR community.

ACR Council business will be a significant priority from April 24–26 at the Washington Hilton. In this month’s column, we’ll give you a preview of the Council activities, educational programming, and networking opportunities that you can expect at ACR 2022, whether you plan to join us in person or virtually.

Participating in Council Business

While virtual participation is possible for the ACR 2022 meeting, in-person attendance is required to receive Council credentials to vote in ACR elections and on Council business. However, off-site attendees will be able to participate in the Reference Committee Open Hearings and question and answer sessions that accompany the Economics Forum and Moreton Lecture. Participants will be able to raise their hand, just like they would in person, to provide testimony at the open hearings, or ask questions following programming during the Council meeting. Here is a snapshot of some of the policy resolutions and bylaws amendments that we’ll be discussing at ACR 2022:

- **PRACTICE PARAMETERS AND TECHNICAL STANDARDS**
  At ACR 2021, the Council reviewed Resolution 1, “ACR Practice Parameters and Technical Standards (PP&TS) Refresh,” which proposed an abbreviated process for approval of the PP&TS. The resolution was referred to the CSC, with instructions to report back to the Council at ACR 2022. We formed a CSC Workgroup on Resolution 1, comprised of councilors and ACR members who have experience with the PP&TS process, along with ACR staff. Our ultimate goal is to devise an easily understood, logical, and inclusive method that does not significantly increase the time commitment of the PP&TS process on members or staff and, importantly, frees up time to debate more substantive issues on the Council floor.

- **PAID FAMILY AND MEDICAL LEAVE**
  In the past, we’ve passed some resolutions related to this issue. This resolution focuses on the paid component. It’s asking practices to “strive” to find a way to provide paid leave for the radiologists who work in their practices to take time off to see to their own health or to help with caring for their families.

- **RADIOLOGY LEADERSHIP INSTITUTE® ANNIVERSARY**
  Navigating an increasingly complex practice environment requires an additional skillset that goes beyond traditional clinical training. The ACR recognized this need more than a decade ago, and in 2012 launched the Radiology Leadership Institute®. We will have an honorary resolution to celebrate the RLI marking a decade of educating strong leaders.

- **ACR FELLOWSHIP WAIVERS**
  There are instances when members are unable to come to the ACR annual meeting to receive their fellowship, either due to serious illness or significant life events. A proposed bylaws amendment outlines the process by which the ACR Fellowship Committee would authorize the Executive Committee of the BOC to approve waiver recommendations from the ACR Committee on Fellowship Credentials in order to grant waivers allowing fellowship to be bestowed on an individual outside of the Convocation.

Educational Sessions

On Sunday, April 24, there are a variety of sessions that attendees can participate in, in person or virtually. Leadership for the RFS and YPS have developed programming especially for their peers, and the Committee on Chapters will host the Chapter Leaders Workshop to provide relevant and timely information for chapter management. Five separate sessions will also be offered, four of which will provide an opportunity to earn CME. Topics will include “Building an Advocacy Culture in Your State,” “Building a Sustained Culture of Wellness from Top Down or Bottom Up,” “Succeeding in an Uncertain Future: Insights and Lessons from the Radiology Leadership Institute®,” “Radiation Oncology Advocacy,” and “A Cybersecurity Primer for Practicing Radiologists.”

Reconnecting With Colleagues

The networking portion of this annual meeting is so important, and there will be several opportunities for members to catch up with those they haven’t seen in the past two years. On Sunday, candidates in the 2022 ACR elections will be available for a meet and greet. Later that afternoon, the 2022 New Fellows, Honorary Fellows, and Gold Medalists will be recognized, with the Convocation streamed virtually for all attendees, family, and friends. The President’s Reception on Sunday evening and the RLI 10th Anniversary Reception on Monday evening are open to all attendees. As much as we would have loved to also reconnect with our colleagues on Capitol Hill, due to numerous and onerous Congressionally-mandated safety protocols in place, we had to

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Rural Outreach

How can radiologists work to improve access to imaging services in rural America?

About 20% of Americans live in rural areas, where many face unique challenges when accessing healthcare, such as lack of primary care doctors and specialists, lack of transportation, and long drives to doctor's offices. In rural areas, one in five people are served by a federally qualified health center (FQHC), which are community-based healthcare providers that receive funds from the U.S. Health Resources and Services Administration to provide care to underserved patients on a sliding scale.

The Bulletin recently spoke with Robert S. Pyatt Jr., MD, FACR, chair of the ACR Commission on General, Small, Emergency and/or Rural Practice (GSER), which represents approximately 55% of the ACR’s members. Pyatt, who previously served as president of medical staff at WellSpan Chambersburg Hospital in Pennsylvania and CEO of the private practice Chambersburg Imaging Associates, has been working with nearby Keystone Health Center, an FQHC, with the goal of improving access to radiology services.

How did WellSpan and Keystone Health begin working together?

Michael J. Colli, MD, Keystone’s chief medical officer, said the ACR was the first medical specialty society to reach out to them to understand the issues related to access to imaging services. WellSpan had a conference call in the fall of 2021 with Keystone leaders, during which Dr. Colli and his colleagues pointed out that the patient has to be able to get to their primary care physician (PCP) so that they can determine what kind of imaging they need. If the person can’t get to their PCP, then there won’t be any imaging order.

What are some of the other barriers to diagnostic imaging in rural areas?

Our practice has been here for 40 years, and we serve a population of about 175,000 people in this region. A large number of them are migrant and seasonal workers, many of whom wait until they arrive here to receive their medical care, which would include lab work, diagnostic screening studies, medical visits, and so forth. There are also a lot of translation and bilingual services we need to provide, including in radiology. Transportation is a common health equity shortfall. If you live in an urban area, there might be public transportation and other ways to get to various health facilities. But in the more rural areas, there are fewer options or even no options when it comes to public transportation.

What are the next steps?

The ACR GSER Commission will continue discussions with Keystone to understand where our missions overlap and how we can support this community-based hospital. Then on a larger scale with the GSER Commission, we want to look at access to care nationwide. We have a Rural Practice Critical Access Hospital Committee as part of the GSER Commission. This is something we’re going to put on their agenda so that whether you’re in a rural practice in Texas, South Dakota, or Kansas, how can we support improving health equity, access to imaging services, and education about imaging services?

At the state chapter level, we’ve talked about developing report cards that can help state chapters measure their health equity efforts — and developing templates that state chapters can use to initiate contact with community health organizations. We’re in our very early phase on all of this, so I think there'll be more accomplishments and insight as we go ahead.

Radiology health equity awareness and efforts can have a significant positive impact on everyone in the community.

What opportunities do you see for the ACR GSER to make inroads in terms of access to care issues?

I didn’t quite understand the access to care issues fully until I talked with Keystone. I think it would be a benefit for radiologists to start conversations with their local FQHC and learn what challenges their patients face in receiving imaging. We have an obligation to everyone in our community to help their health and well-being — not just the patients who show up. We need to find ways to help patients to get into the system. We need to be inclusive and think holistically about everybody in the community. It’s an aspect of professionalism that healthcare providers need to think about and act on.

Why should radiologists get involved in advancing health equity?

Radiology health equity awareness and efforts can have a significant positive impact on everyone in the community. In the smaller and rural practices, the radiologists may actually know many of the patients who are helped by their efforts. As part of the health system and medical staff, radiologists are part of a team caring for everyone in their service area. Radiologists should think globally about providing their imaging services, appropriately indicated, to all members of the population where they reside. By doing that well, they will prove their value to society and everyone in their service area and improve the outcomes of all members of society.

Interview by Melanie Padgett Powers, freelance writer, ACR Press

ENDNOTES
Uniting the Enterprise

The 2021 ACR Imaging Informatics Summit explored informatics initiatives beyond the radiology department and how to effectively lead change.

You have to navigate complex, evolving healthcare environments to maximize the impact of imaging informatics projects — that was the take-home point of the 2021 ACR Imaging Informatics Summit, which took place virtually in October 2021. The meeting featured innovative leaders in imaging informatics, including moderator Nabile M. Safdar, MD, MPH, vice chair of informatics at Emory University, who facilitated a timely discussion on the importance of establishing sustainable relationships with other departments.

Defining Governance

Namita S. Gandhi, MD, associate chief imaging informatics officer at Cleveland Clinic, led the enterprise imaging power hour with a thorough introduction to governance, highlighting the significance of a fluid approach that evolves to address each institution’s changing needs. “Governance is a process, not a project,” said Gandhi. “There is no one size that fits all.”

Building on concepts outlined in the “Technical Challenges of Enterprise Imaging: HIMSS-SIIM Collaborative” white paper (available at bit.ly/TCEI_paper), Gandhi outlined operational considerations (i.e., central versus distributive structure) and strategic items (i.e., local versus national growth strategies and patient engagement) key to developing an effective foundation for enterprise governance. Gandhi emphasized that, ultimately, effective governance requires strategic alignment across the enterprise. Institutions must design processes that mature over time, accommodating for increasing growth and autonomy at the enterprise level.

Effectively Managing Change

The conversation transitioned to leveraging established frameworks to drive innovation, as Melissa A. Davis, MD, MBA, chief quality officer at Emory University, presented on change management. Acknowledging that resistance to change is inherent to human nature, Davis referred to Kotter’s 8-Step Process for Leading Change to provide guidelines that may aid clinical champions in their efforts to garner support for new ideas.

“Being a change agent is always going to be an uphill battle,” said Davis. “Find people who resonate with your ideas and vision and start to test small changes. And when those changes are successful, message that success around your organization to build momentum in your vision.”

Staying Ahead of the Status Quo

Davis’ points were echoed by Christopher J. Roth, MD, vice chair of radiology, clinical informatics, and informatics technology at Duke University, who added that those proposing new initiatives should “convey that your missions will evolve… demands on your infrastructure will evolve… and at some point the infrastructure itself is going to evolve, and you are the right changemaker to make that happen.”

Roth drew on his own experiences as a former athlete on the University of Michigan football team to illustrate the importance of maintaining a unified team mission, understanding one’s teammates and stakeholders, and avoiding complacency to remain competitive as an agent of change.

“As iconic football coach Bill Parcells would say, we’re in ‘a competitive environment. To stay the same is to regress,’” cited Roth. “The hospitals and competitors around are improving, and you need to improve with them.”

“Being a change agent is always going to be an uphill battle.”

— MELISSA A. DAVIS, MD, MBA

Roth used practical examples, such as PACS deconstruction and adoption of early enterprise imaging platforms within the last decade, to demonstrate the notion that technology and solutions once thought to be an advantage become disadvantages as interoperability demands evolve within increasingly complex healthcare environments. However, adopting new technology to “relentlessly improve” can face several barriers, including hesitancy from clinician colleagues and hospital leadership. To overcome this hurdle, Roth underscored the importance of communicating the necessity of change in terms that are relevant to a designated stakeholder, such as focusing on workflow efficiency of a solution when addressing physicians and patient satisfaction or return on investment when proposing the same solution to administrators.

Keeping People Engaged

The panel concluded the session by providing actionable items to effectively lead enterprise-level change. For instance, Davis recommended approaching risk-averse settings with objective metrics that quantify the impact of a proposed solution, which necessitates having “good data infrastructure around the healthcare system so that you can pull out data as seamlessly as possible.”

Aligning with his previous sports metaphor, Roth provided a buzzer-beater response to Safdar’s question of effectively inspiring one’s team in an era when individual members are often separated across the enterprise, interacting virtually from remote locations. In addition to using a “team wall” of group photographs and mementos as one’s Zoom background, Roth emphasized a need to take advantage of every opportunity to “explain the why of what it is you’re doing. You should want people to be psyched to work where they work… to keep people engaged and really more productive.”

By Ali Tejani, MD, diagnostic radiology resident at the University of Texas Southwestern Medical Center
Technology’s Helping Hand

Radiology teams can integrate AI into their workflow to prioritize imaging studies with critical findings and improve patient care.

Facing a backlog of work during non-core working hours is nothing new to most radiologists. Particularly when working evening or overnight shifts, cases can pile up with no way of knowing which are the most critical. But now, radiologists can get assistance in the form of AI algorithms that, when combined with workflow orchestration software, can help triage cases, moving studies with potentially critical findings to the top of the worklist and improving patient care. At Lahey Hospital & Medical Center in Burlington, Massachusetts, Christoph Wald, MD, PhD, MBA, FACR, chair of Lahey’s radiology department and chair of the ACR Commission on Informatics, and his colleagues from the neuroimaging and emergency radiology departments led the way on deploying this type of findings-detection software to improve their workflow and, in general, alleviate the pressure on radiologists. During a recent interview with the Bulletin, Wald discussed the importance of integrating AI algorithms alongside workflow-orchestration software to help radiologists prioritize imaging findings and how, despite popular media narratives, AI isn’t poised to take radiologists’ jobs anytime soon.

How has a suite of AI algorithms coupled with new workflow orchestration software helped your group move images with critical findings to the top of the worklist?

The first set of FDA-cleared algorithms that we implemented focus on computer-aided triage (CADt). This iteration of technological support determined whether a finding was present or absent for the purpose of prioritizing work, so that radiologists could then triage the cases to be interpreted by likely urgency. It is important to emphasize that the CADt AI wasn’t FDA-cleared for making the primary and final diagnosis, and radiologists must take care to not use AI to automate making a diagnosis. That original approach has actually held up quite nicely during times of the week when there is a mismatch between studies to be read and radiologist capacity to interpret them. Specifically at nighttime when the ED is busy and we’ve got very few radiologists in the department, it becomes important to leverage this technology to help the radiologists direct their attention to the most urgent studies where a finding might be present.

These algorithms were cleared for triage, but they accomplish this through carrying out a narrow diagnostic task. The radiologist essentially gains a “look over the shoulder.” There are certainly some instances where we as radiologists have not detected very subtle findings, for example a small peripheral segmental pulmonary embolus, which the software may detect. However, that doesn’t mean the algorithm is anywhere near ready to replace a radiologist.

And of course, sometimes it goes the other way, where we humans detect something that the software didn’t see. The software might flag something that it was not trained on, mistaking it for a real finding, and we determine that it’s an artifact. So, there’s a little bit of a back and forth where the radiologist always determines whether or not to include an AI’s finding in the report. We prefer not so much to compare radiologist performance to that of the AI, but rather compare the performance of the radiologist in collaboration with AI against the radiologist alone.

Media portrayals often show AI being poised to take radiologists’ jobs. Can you address this perception?

In our practice, we don’t see AI as a threat. On the contrary, it assists our radiologists in prioritizing their work more appropriately. We anticipate that the intensity of imaging utilization will only rise in the future as the so-called baby boomers age into the high-consumption years of medical care.

At the same time, there are extreme cost pressures. For example, CMS has continually decreased payments to radiologists in the recent past, and there seems to be no end in sight for this trend. Added to this is the fact that, in recent years, we haven’t really changed the rate at which we graduate radiology residents. The bottom line is that, most likely, radiologists will be asked to continue doing more work for less pay; consequently, using AI to lessen certain aspects of the work burden and make radiologists more efficient will be welcomed by radiology.

We must also not forget that AI is increasingly used to perform routine quantitative analyses on patient studies — brain thickness mapping and emphysema quantification being two examples — which we cannot easily perform ourselves during conventional image interpretation. Inclusion of the derived quantitative maps and outputs into the radiology report makes our work product more valuable to our clinical colleagues and patients.

Can you tell us about the process of teaming up with a vendor?

For the vast majority of radiology groups, including my own department, making our own AI is beyond the scope of what we do. We just don’t have the core competency in house. Clinical
In gearing up for this change, our department looked at best practices and noticed that the majority of stroke revascularization trials had incorporated a particular AI which claimed to be able to distinguish dead brain tissue from recoverable brain tissue. Since the technology also included a perfusion analysis and had been successfully included in multicenter trials, this solution seemed like a good candidate. Proof of its efficacy from the trials proved especially attractive to our referring clinician colleagues, so we certainly wanted to follow that precedent. Fortunately, our practice had established itself at our institution as the go-to division for undertaking such technological projects. We’d already laid the groundwork for being recognized as honest partners who would work well with the clinical team and address their needs. It’s important for the decision-makers in our institutions — whether that be the C-suite or others — to recognize radiologists in this role. The last thing you want is a clinical service other than radiology independently contracting for an AI installation without your knowledge.

**In our practice, we don’t see AI as a threat. On the contrary, it assists our radiologists in prioritizing their work more appropriately.**

Furthermore, anyone looking to work with a vendor in this space should find out what your IT security department is comfortable with implementing. Some can live entirely behind your institution’s firewall. Others employ a local server that sends de-identified information to the cloud for processing. And some vendors will give the customer a choice.

One way to make reviewing, trialing, and ultimately implementing more than one AI algorithm easier is by contracting with so-called platform companies or AI marketplaces. Contracting with a marketplace vendor provides a single platform where you can more or less turn on or off algorithms without having to write individual, complex contracts and stand up separate servers and solutions.

In 2018, your team asked for referring provider input when it came to deciding which algorithms would be incorporated into the workflow. Can you discuss why you brought referrers into that decision-making process?

Imaging departments should gain an understanding of what their clinical customers need and expect from them as radiologists. Right around the time we began exploring the use of AI, Lahey was transitioning to becoming a comprehensive stroke center. In gearing up for this change, our department looked at best

**What role do you see AI playing in radiology in the next 10 years, and how should radiologists be preparing for the future?**

Ignoring AI integration is probably not a good long-term strategy for radiologists. Rather, I think radiologists should seek out every opportunity where AI either enhances their work product or makes them more efficient — or both. I see it impacting the entire value chain of radiology, including how we manage our practices.

Radiology as the first truly digital specialty lends itself to AI applications. For instance, AI will most likely influence how we schedule patients, how we predict missed-care opportunities, and how we schedule our workforce to match imaging volume on a given day. In addition, clever software is being introduced that can make similar or better-quality images based on lower doses when it comes to CT or limited case-based sampling and MR. There are also exciting new developments when it comes to speeding up image acquisition in ways that were never possible before. We’re also seeing the emergence of opportunistic screening, where AI extracts features and information from imaging studies done for another reason. The purpose behind this is to make risk predictions for certain diseases in patients.

At the end of the day, the future of AI in radiology will involve unlocking more value from what we do. I think that the combination of radiologists plus AI is most likely to win the day in the long run.

*Interview by Chris Hobson, senior communications manager, ACR Press*
A Force for Good

A radiologist is addressing food insecurity and patient advocacy — one Tweet at a time.

In early 2020, more than 38.2 million people in the U.S. lived in food insecure households, indicating that they lacked reliable access to a sufficient quantity of affordable and nutritious food.¹ Hence, it was no surprise that when COVID-19 and its economic disruptions hit, already vulnerable populations found themselves in greater need.²

That’s why when Kemi Babagbemi, MD, heard about the online Healthcare Workers Versus Hunger contest on Twitter, she wanted to get involved. Babagbemi, who is vice chair for diversity, equity, and inclusion in the department of radiology at Weill Cornell Medicine and a member of the ACR Commission on Patient- and Family-Centered Care’s Outreach Committee, led a team of radiologists who competed in the 2021 online competition. The Bulletin caught up with Babagbemi to learn more about the contest and why food security is important for every healthcare worker to address.

What is Healthcare Workers Versus Hunger?

Healthcare Workers Versus Hunger is an annual, Twitter-based competition that raises money for food banks across the world. It was started in 2020 by Angela Weyand, MD, a pediatric hematologist oncologist at the University of Michigan Mott Children’s Hospital, and Tatiana Prowell, MD, associate professor of oncology in the Johns Hopkins Breast Cancer Program, to address food insecurity and help those impacted by hunger during the pandemic. Participants donate money to any food bank they choose and submit/tweet the receipt or proof of donation to the team captain. Teams are made of different healthcare specialties, and the team that donates the most amount of money wins.

Why did you decide to participate?

I’d been involved in raising money for vulnerable groups for quite a few years now, but this was the first time I’d organized it over social media. I had just started actively participating on Twitter as part of my job as vice chair for diversity, equity, and inclusion at Weill Cornell. It was at the height of the pandemic in 2020, and most people were doomscrolling — using social media feeds to read more and more bad news. I wanted to find a way to harness social media as a force for good. I came across Healthcare Workers Versus Hunger and noticed there weren’t any radiologists involved. I was too late to participate in the 2020 contest, but I made sure the second time around I’d be ready.

Around Thanksgiving of 2021, when the contest was announced, I noticed radiologists were still not signing up, so I made myself team captain, created a hashtag for our team (#RadsForFood), and started getting the word out to my colleagues on Twitter. I spent a lot of time tweeting information about food insecurity, and why initiatives such as Healthcare Workers Versus Hunger are important and encouraging people to donate. We ended up combining our radiology team with oncologists, hematologists, and a few other specialties, to form #MultiDFoodBoard, and by the end of the contest, we won second place. Our team alone raised over $110,000 to donate to food banks across the country. The contest raised over $400,000 in total for food banks in less than two weeks.

How can the radiology community get more involved in initiatives like this?

I encourage radiologists and all healthcare workers to learn about local food banks. Two of my other favorite organizations are No Kid Hungry and Feeding America. I also encourage radiologists to join me in participating in this year’s #HCWvsHunger contest on Twitter. Monetary donations to food banks go farther than donating food, as most food banks have ways to buy nutritious food wholesale or in bulk versus what you are able to buy at a store with the same amount of money.

Participating in initiatives such as this helps to raise radiology’s profile. At one point in December 2021, #HCWvsHunger was trending more than #Omicron. All across Twitter, users could look at the hashtag and see our specialty’s efforts to raise money for vulnerable populations.

Why is it important to get involved in addressing food insecurity?

I’d like to refer to a quote from the late Paul Farmer, MD, PhD, who said, “Only when we link our efforts to those of others committed to initiating virtuous social cycles can we expect a future in which medicine attains its noblest goals.”

I tell people I’m a people advocate rather than a patient advocate, because intervening before someone becomes my patient can help them better in the long run. I want to tackle immediate risk factors early on while larger forces work on the complex systemic issues. Food insecurity can have particularly long-term effects. Children who face prolonged food insecurity can experience developmental delays and have a risk of chronic illnesses such as asthma and anemia. In adults, food insecurity is linked with diabetes, hypertension, and other negative health outcomes.³ If we can do something for people now, why wait until they’re in our offices?

Interview by Meghan Edwards, freelance writer, ACR Press

ENDNOTES available on ACR.org/Bulletin
How do you avoid getting burned out?

“As a medical student, we are constantly in ‘preparation mode’ — preparing for the next exam, the next day on rotation, the next residency interview, etc. We can become so lost in this vicious cycle that we may not realize we are pushing ourselves past our limits. Going into medicine, I knew burnout was common and easily missed and/or ignored. Therefore, I made it a priority to do everything possible to avoid it happening to me. One thing I have maintained throughout these four years is making time for myself every single day. Regardless of what I have going on that day, I make sure that the last two hours before bedtime is time for me to wind down and do something I enjoy.”

Simone Raiter, fourth-year medical student at the Chicago Medical School at Rosalind Franklin University of Medicine and Science

“The specter of burnout is constantly lurking. Keeping it at bay requires a concerted effort between myself and my employer. Giving employees a degree of autonomy — whether it be choice of duties or flexibility in work schedule or work location — is one effective guard against burnout. While at work, I am fortunate that I am allowed to pursue projects that bring me joy and advance the missions of my hospital while avoiding endeavors which do not. I am fortunate that my department has a faculty development committee tasked with supporting its radiologists. Most recently, they completed a round of ‘stray interviews’ with all the faculty — a proactive step in preventing burnout and lowering turnover.”

David R. Pettersson, MD, associate professor of neuroradiology at Oregon Health and Science University, and editor-in-chief of ACR’s Case in Point®
opportunity to lead one of the most influential organizations in radiology. Serving as an ACR officer is the capstone of my career with the College. It has been remarkable experience working with very talented volunteer physicians and staff. Although we have lived through interesting times with the challenges of engaging with one another virtually, I very much look forward to future meetings where we can meet again in person.

This final Bulletin column would not be complete without a round of recognitions. First, I must thank Dr. Bello for being a superb vice chair and ACR CEO William T. Thorwarth Jr., MD, FACP, for his steadfast guidance and expertise. Jackie, Bill, and our new vice chair, Alan K. Matsumoto, MD, FACP, will do a phenomenal job in guiding the BOC and representing the organization.

The ACR staff is the best in the association business. Each staff member is committed to the success of the College and our members. Importantly, they recognize the value of contributing to the culture of the organization. I am grateful to the ACR executive vice presidents for their trust, partnerships, guidance, and commitment in moving this organization forward. I am grateful to Nicole Racadag and Lyndsee Cordes, the editors of the Bulletin, who have made these monthly columns the best they could be with the very raw material I delivered. Finally, I am grateful to Eileen LaGreca and Lisa Puertas for their tireless efforts in organizing my workload, keeping me on track, and making sure my schedule was up to date.

Looking forward, I hope to continue to serve the College. The ACR is an incredible organization and well-deserving of its respect and credibility throughout medicine. As physician volunteers, we are paying it forward for our future leaders, partners, and most of all, our patients. I am grateful to you, the membership, for allowing me the opportunity to serve.

**LOOKING BACK, LOOKING AHEAD**

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**NEWS FROM THE CSC**

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make the difficult decision to cancel an in-person Hill Day as part of ACR 2022. The College will aim to have a virtual Hill Day later in 2022 when our legislative priorities are most likely to be debated in Congress.

Finally, we urge you to plan your meeting time to be with us through the end of the Council session on Tuesday afternoon and attend the RADPAC gala on Tuesday evening. To accomplish all of the Council’s business, we need councilors to be present until all of the Council’s business is concluded. The Council is scheduled to meet until at least 5:00 p.m. on Tuesday.

By Amy L. Kotsenas, MD, FACP, Speaker, and Timothy A. Crummy, MD, FACP, Vice Speaker

**STRIKING A BALANCE**

*continued from page 14*

**What advice do you have for physicians who are trying to navigate work-life balance?**

**SC:** Neuro IR is a busy specialty, and Melissa helps me maintain work-life balance by reminding me to take vacation time and to spend time with family as much as possible on the weekends.

**MC:** You also have to ask yourself what aspects of your family life are most important for you to be present for. For me, it’s important for me to be there for my kids’ recitals or help them with their homework. So I figure out how I can be present with the family in those moments, and then decide what I can outsource. Be creative and try to figure out who can help you and fill in those gaps, and then prioritizing what is important in terms of the time that you do have together. It’s taken a while to get here. And you have to evolve and constantly evaluate what you can get rid of or do differently.

Interview by Alexander Utano, editorial assistant, ACR Press

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**Is a New Job in Your Future?**

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The American College of Radiology® is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. Review each course offering for specific CME and SAM accreditation details. For information about the accreditation of this program, please contact the ACR at info@acr.org.
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