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Bulletin



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QUESTIONS? COMMENTS? Contact us at bulletin@acr.org.

Digital edition and archives of past issues are available at ACR.ORG/BULLETIN.



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



Surprise Billing Implementation Update

As the healthcare system recovers from the pandemic, now is not the time to punish physician providers and empower insurers who have registered record profits.

As we have come to know, balance billing, also called surprise billing, is the practice of healthcare providers invoicing a patient for the difference between the total cost of services being charged and the amount that insurance might pay. Surprise bills typically arise in two situations: emergencies (when patients typically have little or no say in where and from whom they receive care, e.g., facility is in-network but providers are not) and interactions with ancillary providers who are not in-network and whom the patient does not typically choose. In many cases, this occurs when insurance carrier networks are limited and the providing physician is out of network.

The No Surprises Act

Surprise billing was brought to the attention of federal legislators because of affordability concerns for many families. Two in three adults say they worry about unexpected medical bills.¹ Among privately insured patients, an estimated one in five emergency claims and one in six in-network hospitalizations include at least one out-of-network bill.² Balance billing on surprise medical bills can reach hundreds or even thousands of dollars. Notably, Medicare and Medicaid prohibit balance billing.

In the closing days of 2020, and after two years of extensive debate and compromise, Congress provided new protections for patients against surprise billing as part of omnibus legislation. All parties supported getting the patients out of the middle of disagreements between insurers and providers about appropriate payment amounts. The No Surprises Act (NSA) was signed by the president and went into effect Jan. 1, 2022.

Several states have already enacted similar legislation. State surprise medical bill laws are not preempted unless they prevent the application of federal law.

Payment Issues

Prior to the passage of the NSA, two general methods

were debated for how to reach a reasonable payment amount for surprise billing.

The final compromise negotiated in the NSA protects patients from being required to pay surprise bills and being in the middle of disputes when the billing provider and insurer disagree on an appropriate payment amount. In those cases, the provider and insurance plan have a 30-day period to negotiate a payment amount if the initial interim payment is not sufficient. After the initial 30-day period, the NSA's federal independent dispute resolution (IDR) system allows the billing provider and the insurance plan to access a dispute resolution process where the arbitrator "shall" consider multiple components before determining a final payment amount.³ The legislation made it clear that the plan-calculated Qualifying Payment Amount (QPA) was to be just one of those components considered.

Despite the lengthy Congressional negotiations regarding the IDR section of the NSA to ensure the arbitrator "shall" consider multiple factors when determining an appropriate out-of-network rate, the U.S. Departments of Labor, Treasury, and Health and Human Services included the following language in the published Interim Final Rules (IFR): The arbitrator "must begin with the presumption that the QPA is the appropriate out-of-network rate for the qualified IDR item or service under consideration. These interim final rules further provide that the certified IDR entity must select the offer closest to the QPA, unless the certified IDR entity determines that credible information submitted by either party clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate."⁴

Current State

Unfortunately, the regulatory agencies and the White House got this wrong. The determination of the QPA as the primary consideration is distinctly contrary to the final legislative intent and specifically to the final language of the NSA. As misinterpreted in the IFR, the regulation will empower insurers to drastically cut reimbursement (and thus the median in-network rate), narrow medical networks, and restrict patient access. Reduction in access can result in longer wait times, delays in care, and delays in diagnosis — particularly in underserved and rural areas. Another critical consequence will be increases in out-of-pocket costs for patients when they are most vulnerable.

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For more ACR resources on surprise billing, visit acr.org/surprise-billing.



Comforting Sounds by Evocal, 2020. Photography by 13 Photography

Promoting Diversity, Equity, and Inclusion Through Art



After noticing that many of his hospital's community health centers seemed uninviting, Daniel B. Chonde, MD, PhD, a radiology resident at Massachusetts General Hospital, conceived the idea to display artwork in the centers that reflect the communities they serve. Chonde founded the People's heART project on the idea that these thoughtfully curated art installations could promote greater inclusivity and health equity.

"We want to use art to help community members feel more connected to our facilities," he says. "Research shows that when patients feel represented, they are more likely to engage more fully in their care, leading to better outcomes."

Read the *Imaging 3.0*® case study at bit.ly/ArtInclusion.

New Approaches in Breast Imaging



Register today for the 2022 SBI/ACR Breast Imaging Symposium, taking place May 16–19, 2022, in Savannah, Georgia. The meeting will offer more than 60 live sessions across all breast imaging modalities, access to ePoster abstracts, and the chance to connect with vendors in the extensive exhibit hall. For those who can't make it to Savannah for the in-person meeting, the hybrid format provides the option to attend virtually.

To learn more and register, visit eventscribe.net/2022/SBIACR2022.

IN MEMORIAM:

Michael J. Pentecost, MD, FACR



Michael J. Pentecost, MD, FACR, who served on the ACR BOC from 1997 to 2003, passed away on Sept. 20, 2021. Pentecost graduated from Staunton Military Academy in Virginia in 1967 and received his undergraduate and medical degrees from Tulane University. He moved to Los Angeles to do his internship, residency, and a fellowship in IR

at the University of Southern California (USC) School of Medicine. For the next 12 years, he worked in Los Angeles, first in private practice before turning to academic medicine as a professor of radiology at Keck School of Medicine of USC. He founded the Southern California IR Society while at USC. In 1992, he accepted a position as chief of IR and vice chair of radiology at the University of Pennsylvania. He left in 1996 to become chair of radiology at Georgetown University School of Medicine. In 2005, he became director of Mid-Atlantic Permanente Medical Group's radiology department. He concluded his career serving as associate chief medical officer at Magellan Health/National Imaging from 2008 to 2018.

Pentecost was co-editor of the radiology text *Abrams' Angiography: Interventional Radiology* and authored numerous articles in medical journals throughout his academic career. To read more about his life and work, visit bit.ly/Pentecost_ACR.

Applications Open for Three New RLI Leadership Awards

For ten years, the Radiology Leadership Institute® (RLI) has been putting business and leadership skills within reach of radiologists leading change at all levels. In observance of its 10th anniversary, the RLI has opened applications for three new leadership awards:

- The RLI Emerging Leader Award in support of residents and fellows who will be leading radiology into the future
- The RLI Impact in Leadership Award in recognition of those who are using leadership and business skills to make an impact in their practice or department
- The RLI Leadership Luminary Award in honor of those who have paved the way with a lifetime of leadership achievements

To see if you are eligible or to nominate a colleague, visit acr.org/RLIawards. Applications open Feb. 1 and the deadline for submissions is Feb. 28. Winners will be announced at ACR 2022 in Washington, D.C., in April.



“If AI continues to grow at the current rate, four years from now, there will be thousands of algorithms to select from. We need more transparency, clear product labeling, deeper tracking, and a simple reporting process for those who have algorithms on-site.”

— KEITH J. DREYER, DO, PHD, FACR,
ACR DATA SCIENCE INSTITUTE®
CHIEF SCIENCE OFFICER AND
CHIEF DATA SCIENCE OFFICER



CPI Releases New Module in Breast Imaging

The ACR Continuous Professional Improvement™ (CPI) Breast Imaging Module 2021 contains all new case material assembled and reviewed by breast imaging experts. Earn 8 SA-CME and test your knowledge with 52 self-assessment questions featuring:

- Case topics relevant to community and academic settings, ranging from commonly encountered breast imaging entities to emerging state-of-the-art imaging techniques and procedures
- Practical questions regarding ACR Appropriateness Criteria®, Practice Parameters and Technical Standards, and BI-RADS® lexicon to keep you up-to-date and highlight best practices
- Detailed explanations reviewing common and rare diagnoses with related patient management
- Relevant literature references for each topic providing opportunities for further self-study.

Choose the print or online format. Either format includes a complimentary digital download (e-book) — the perfect on-the-go reference. Print supplies are limited, so order today at acr.org/cpi.

IMAGING 3.0: Streamlining Clinical Decision Support

Radiologists at University of Virginia Health (UVA) implemented an AI tool for clinical decision support (CDS) that translates free-text imaging orders into those with structured indications. The tool helps ordering providers select appropriate structured indications and allows them to share specific clinical questions and unique patient narratives. Ordering providers preferred the AI guidance to traditional methods of structured indication selection, improving CDS usage and compliance rates.

“What we’ve seen is that this new AI-based approach is the preferred mechanism for choosing structured indications,” says Cree M. Gaskin, MD, professor of radiology and orthopedic surgery and associate chief medical information officer at UVA Health, who led the implementation and evaluation of the AI-based tool. “Referring physicians appreciate the opportunity to communicate with free text in their orders, and we continue to see successful results with our evolving clinical decision support system.”

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

O-RADS for Ultrasound: Webinar Series

In this on-demand webinar series, earn CME and learn how to use an algorithmic approach for adnexal lesion categorization, view cases illustrating lexicon terminology and risk of malignancy categorization, and get answers to frequently asked questions about the Ovarian-Adnexal Reporting & Data System (O-RADS™).

Access the O-RADS webinar series at bit.ly/ORADS-webinar.



Register for RLI’s Power Hour Webinar Series

The Radiology Leadership Institute® (RLI) Power Hour Webinar Series is a selection of bi-monthly webinars that aims to provide radiologists at all career stages with valuable insights on a host of prescient leadership and healthcare topics. Chaired by Jennifer E. Nathan, MD, and Robert S. Pyatt Jr., MD, FACR, each 60-minute webinar will provide expert analysis on topics ranging from crisis management to future trends — all supported by data and practical tools that participants can use to promote better team workflow and improved service quality. Upcoming topics include “International Outreach” on Feb. 23 from 7–8 p.m. ET, and “Pandemic Impact on the Workforce” on March 30 from 7–8 p.m. ET. Register for the upcoming webinars at acr.org/powerhour. The RLI also records these webinars and posts them at acr.org/Power-HourRecord.

ACRA Announces Scope of Practice Fund Recipients

Four state radiological societies have been awarded grants from the ACR Association® (ACRA) Scope of Practice (SOP) Fund. Societies receiving initial funds are Kansas, New York, Pennsylvania, and Wisconsin.

The SOP fund was established in 2021 by the ACRA to safeguard patient access to radiologist expertise by fighting state and federal non-physician SOP expansion legislation. Non-physician provider groups continually seek expanded authority by introducing legislation that would, for example, reduce radiologist oversight and enable direct billing.

“Our state radiological societies continue to be on the front lines of dangerous SOP expansion efforts that would threaten patient safety and erode access to high-quality radiological care,” says Howard B. Fleishon, MD, MMM, FACR, chair of the ACR BOC. “The ACRA is committed to helping these state radiological societies as they work to educate lawmakers about the importance of radiologists and radiologist-led teams, and the SOP fund is one tool that can assist with their efforts.”

For more information about the fund and ACR scope of practice activities, visit acr.org/scope-of-practice.

2022 Membership Renewal Notice

Have you renewed your membership for 2022? The grace period to renew ends on March 31, 2022. Please take note of this new date to ensure you don't lose access to your CME activities and benefits, registries, members-only toolkits, and publications. If you plan to retire this year, are being deployed to active duty with the U.S. military, or have questions about this change, please contact membership@acr.org. To renew now, visit acr.org/renew.

Thank you in advance for renewing your 2022 membership if you have already renewed.

ACR Research Commission Chair Named RSNA Outstanding Researcher



Pamela K. Woodard, MD, PhD, FACR, a leading researcher in cardiothoracic imaging, was named Outstanding Researcher at RSNA 2021 in Chicago. 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 NIH recharge facilities, including the PET and MRI research facilities and the cyclotron facility.

"Dr. Woodard is truly an outstanding researcher," said RSNA President Mary C. Mahoney, MD, FACR. "She is respected not only for her enormous success in funded research, but her generous mentoring of so many of our future leaders in imaging research."

Woodard also serves as director of the Center for Clinical Imaging Research, head of cardiac MR/CT, and director of the radiology research resident track and program director of the NIH-funded T32 TOP-TIER clinician-scientist training program in translational imaging research. She has nearly 200 peer-reviewed manuscripts and several patents, and she has served as a charter member on NIH study sections, including clinical and integrative cardiovascular sciences and medical imaging, and chair of the NIH study section on imaging-guided interventions and surgery. She has received numerous awards for her work, including being named an Academy of Radiology and Biomedical Imaging Research Distinguished Investigator.

[Read more at bit.ly/RSNA2021_Woodard](http://bit.ly/RSNA2021_Woodard).

"Many of us who work in healthcare have witnessed firsthand the devastating impact of the barriers to care faced by medically underserved communities in the United States, and these inequities compel us to act."

— JINEL A. SCOTT, MD, MBA, ACR GENERAL RADIOLOGY IMPROVEMENT DATABASE COMMITTEE MEMBER AND RSNA MEMBER REPRESENTATIVE TO THE RADIOLOGY HEALTH EQUITY COALITION

NEWS FROM THE JACR



Call for Papers: Private Practice in Radiology

The pace of change in current practice environments can feel daunting, and the *JACR* is looking for ideas and insights from those on the front lines to help address issues facing busy radiologists. The *JACR* is accepting proposals for original content related to the strengths, challenges, and opportunities in private practice radiology today.

Articles should be concise reports of how a particular issue is impacting the practice of radiology or the lives of radiologists in private practice. Successful submissions should seek to answer a previously unanswered question through a quality improvement project, case study, or a synthesis of the current literature (when available).

[Submit your proposal at jacr.org](http://jacr.org).

Are You the Next Hillman Fellow?

Applications for the 2022 Bruce J. Hillman, MD, Fellowship in Scholarly Publishing are now open. The fellowship provides a concentrated experience in medical editing, journalism, and publishing for an interested and qualified staff radiologist. The fellowship supports talented physicians in pursuing an aspect of medical journalism as a part of their careers.

The selected fellow may visit ACR headquarters in Reston, Va., gaining hands-on experience editing and publishing the *JACR* with the *JACR* editor-in-chief and *JACR* staff. The fellow will also travel to New York City to spend time with the *JACR*'s publisher, Elsevier. Travel will be scheduled around the fellow's availability and will be subject to change based on the status of the pandemic. The fellowship also includes an ongoing project with the journal, a one-year appointment to the editorial board, and an invitation to the editorial retreat. The ACR and Elsevier will reimburse travel expenses, accommodations, and living expenses incurred during the fellowship period.

[Learn more and apply before Feb. 28 at acr.org/Hillman-Fellowship](http://acr.org/Hillman-Fellowship).





Ryan K. Lee, MD, MBA,

Co-Chair of the ACR Commission on Patient- and Family-Centered Care's Population Health Committee and American Society of Neuroradiology Alternate Advisor to the RUC

Guest Columnist

Thinking Beyond FFS

Radiologists are central to care coordination, which opens opportunities for us to participate in alternative reimbursement models.

The healthcare reimbursement model in the United States has seen both gradual and abrupt changes over the years. We have come a long way from the original Medicare tenet of allowing for “usual, customary, and reasonable charges.” Though the healthcare economic landscape today is different from 1965, when Medicare was born, the model for value-based care surprisingly can be traced back as far as 1973, when the Healthcare Maintenance Organization (HMO) Act was passed — ultimately paving the way for the modern structure of Medicare Advantage Plans. The government has made an explicit push away from traditional fee-for-service (FFS), with the development of numerous alternative reimbursement models. These models are designed to move the reimbursement system away from being volume-based (i.e., FFS) toward being value-based.

The Merit-Based Incentive Payment System (MIPS), essentially a modified FFS model, can be considered one of the gradual changes that CMS has implemented as an in-between step toward its goal of a complete value-based system. MIPS has elements of a value-based model, including rewarding physicians for quality care; however, these rewards are small, especially considering the administrative lift required — which is an incentive to move toward an alternative payment model (APM). At the other end of the spectrum are the advanced APMs, which dispense with FFS in favor of full-on, two-sided risk that incorporates extensive rewards for high-quality care and corresponding severe penalties for poor-quality care. In between MIPS and these advanced APMs are numerous other models which, compared to MIPS, have progressively more value-based elements.

With this clear movement away from a traditional FFS environment, many specialties have progressively increased their involvement with these quality-based models. Radiologists, however, are for the most part still working in a predominantly FFS environment. It is true these newer value-based models are inherently designed more for patient-facing physicians, and this is one reason radiologists have been slower to adopt value-based models. However, as value-based models continue to grow in prominence, it is essential that

radiologists engage more in these models — particularly as disincentives for operating in a purely FFS environment continue to grow. As these models appear to favor the more patient-facing specialties, how can radiologists engage in them?

Radiologists must think creatively and outside the box. For example, CDS promotes appropriateness of ordering studies and is a reproducible and transparent method of vetting imaging orders, which obviates the need for radiology benefit managers. Partnering with payors to use CDS instead of radiology benefit managers can improve patient care and save costs. Creating an arrangement of shared savings with payors using CDS can be a source of value generation for all parties.

Taking advantage of AI in opportunistic imaging to direct patient care on studies already performed is another way in which radiology can add value in keeping patients healthy. This decreases downstream costs by reducing acute ER and inpatient visits, which decreases expenses in a fixed reimbursement environment. In addition, this can have implications for a network's quality scores, which also impact reimbursement.

Speaking of quality measures, radiologists can take leadership roles in many quality metrics. For example, breast and colorectal cancer screening rates are quality metrics used in both MIPS and accountable care organizations, such as the Medicare Shared Savings Program. Many radiology departments today lead these screening efforts in their networks, and we should all follow these models ([learn more at bit.ly/Rad_PHM](https://bit.ly/Rad_PHM)). Another area in which radiologists can lead is in the management of incidental findings. Being leaders means we should take ownership when these types of initiatives fare poorly and result in penalties, but it also means we should be eligible for bonuses when these screening rates grow.

Value-based reimbursement models really form the basis of population health. Although there are various definitions of population health, it ultimately revolves around improving a defined population's health through deliberate coordinated care that is supported by appropriate reimbursement models. Radiologists are central to this care coordination — think of how diagnostic imaging affects almost all patients in one way or another. This central role of radiology opens opportunities for us to participate in alternative reimbursement models. In fact, the ACR will be forming a Payment Reform Workgroup to further explore these different models. I challenge you to also consider ways in which you can generate additional value for your patients besides the traditional FFS model. **B**

ACR Reimagined

The highest level of patient care and the continued success of the specialty depend upon on the College's adaptability and educational offerings.

Throughout the challenges the COVID-19 pandemic has presented, the ACR has been resolute in adapting to the quickly changing radiology landscape. As evidenced by the work of many groups within the College, such as the Commission on Publications and Lifelong Learning (CoPLL), the Commission on Quality and Safety (Q&S), the Commission on Patient- and Family-Centered Care (PFCC), and the Commission on Informatics, among others, the ACR has been reimagining its role for members and the specialty at large.

"During the winter of 2020, when another surge of the coronavirus was upon us, I proposed a challenge to the Board and staff to reimagine the College," says ACR BOC Chair Howard B. Fleishon, MD, MMM, FACR. "As complexity increases, the imperative to reimagine grows stronger — and ACR operational innovation is happening at a faster pace with greater engagement from more commissions."

Non-profits exist to have impact. "So, an initial step is to clearly determine our focus," Fleishon says. "For the ACR, concentrating on impact goes beyond our environmental surveillance and strategic planning process. It relies on candid, data-driven discussions about how current individual commissions and programs will deliver impact in a new environment."

Pivoting and Learning

"The CoPLL has reimaged the ACR's resources to better equip our members to engage with their patients," says Elizabeth Bleu, senior director of the ACR's department of publications and lifelong learning. To counter the COVID-19 restrictions on in-person gatherings, for example, the Commission reinvented two leading and unique educational programs: the ACR Institute for Radiologic Pathology™ (AIRP) and the ACR Education Center.

"We have changed delivery models within the ACR Education Center from entirely in-person to virtual and hybrid models," Bleu notes. These virtual and hybrid models will continue beyond the pandemic as an improved offering to participants, she says. The AIRP has undergone a similar transformation.

"With a robust web presence, and multiple new offerings that launched in January, the ACR has implemented an effective campaign to attract medical students and their institutions to participate in educational programs," Bleu says (see more at [acr.org/Member-Resources/Medical-Student](https://www.acr.org/Member-Resources/Medical-Student)). In addition, the ACR 2022 Medical Student Symposium in January built upon the success of past events to provide insight into the field of radiology and to encourage students to consider radiology as a career path.

“Although the past two years have been trying for all of us, our team has embraced Dr. Fleishon’s challenge to reimagine the ACR,” says Lori A. Deitte, MD, FACP, chair of the CoPLL. “We are committed to designing meaningful professional development resources and experiences for the membership, including members-in-training and medical students. We want to be inclusive of all career stages and types of practice.”

“The pandemic provided a critical inflection point for us — we had to build off of our established trajectory to chart a new future path to serve members and patients in this new environment.”

—Mythreyi B. Chatfield, PhD

The College has also turned its attention to improving our longstanding in-training exams for residency programs — a reinvention via the transitioning of the DXIT™ and TXIT™ programs into ACR’s internal platform. By surveying training program directors and coordinators, the ACR discovered that robust security measures, virtual proctoring, national benchmarking among programs and within each program, and the psychometric precision of exams are highly valued.

In keeping with the commitment to serve members-in-training and their residency programs, the ACR is now offering residents the option for remote, virtual, in-training testing for DXIT and TXIT. The in-training exams offer residents and program directors an opportunity to evaluate their training progress and identify areas for improvement relative to peers at the same level of training. These assessments provide secure and accurate evaluations and offer residents opportunities for maximizing testing preparation for their upcoming Board exams.

Quality and Safety

“The pandemic provided a critical inflection point for us — we had to build off of our established trajectory to chart a future path to serve members and patients in this new environment,” says Mythreyi B. Chatfield, PhD, executive vice president of ACR Q&S. “The ACR, in general, was already forward-looking and set up for remote work and continued services when the pandemic began. This positioned us to move quickly on the new features our members needed when the pandemic began.”

Even before the pandemic, the ACR Q&S

department was able to virtually support practices in accreditation and registry participation. “We had already created an electronic platform for content development for guidelines, and a seamless workflow and services,” she says. When the pandemic hit, the Q&S team was ready to support members with fully electronic uploads of images for accreditation and a fully electronic data upload process for registries.

“Then we added a number of other services,”

Chatfield says, including:

- Virtual surveys at facilities where they could not be done in-person. These initially began as a temporary measure but will continue in some capacity post-COVID-19.
- A sharper shift to virtual meetings and reserving in-person gatherings for occasions that generate the most value.
- Adding fields to registries to capture COVID-19-related information and running virtual improvement courses to train facilities in structured improvement.

“As a result of this reimagining, we found that virtual surveys for renewals, where appropriate, can reduce disruptions to patient care without compromising facility quality and safety,” Chatfield says. “We will continue to offer these services where possible. The reduction in travel time to support surveys leaves more room to focus on resources to help facilities improve and provide better care” (learn more at bit.ly/Remote_Recognition).

The ACR Q&S department’s future plans include the expanded use of virtual platforms for meetings to help younger members/junior members who may not be able to get time away from practice for travel — or who have young children at home. “We are also looking for opportunities to capture member input into more of our programs (such as improved field reviews and comment periods),” Chatfield says.

The College also aims to use quality registries beyond their originally intended purpose to track practice patterns. The registries can be used to assess population impacts more nimbly, such as looking at the effects of COVID-19 delays on cancer rates and outcomes. “We want to use our footprint in the Q&S space to coordinate with research registries to set up more innovative and robust work going forward,” Chatfield says.

Registries and Residents

“Many successes throughout the pandemic that fall under the College’s reimagining strategy have come in the form of research and collaboration,” says Durga Gandhi, vice president of the ACR’s IT operations and technology solutions. The ACR Center for Research and Innovation™ (CRI) has been assembling the COVID-19 Imaging Research Registry (CIRR) — an effort of the ACR CRI and the ACR Data Science Institute®, in collaboration with the ACR and the Society of Thoracic Radiology (learn more at acr.org/CIRR).



Reimagining the ACR

Listen to an ACR *Bulletin* podcast episode at acr.org/bulletin, during which BOC Chair Howard Fleishon, MD, MMM, FACP, discusses reimagining several of the ACR’s focus areas during the COVID-19 era and beyond.

The CIRR is a primary step to advancing the understanding, prevention, and treatment of COVID-19. It is a cross-disciplinary initiative with collaborations extending beyond radiology to engage other clinical experts and diagnostic modalities, including clinical medicine, genetics, biomarker discovery, laboratory sciences, and others. Participating sites contribute demographic information, clinical data on signs and symptoms, imaging exams, laboratory test data, and outcomes for U.S. patients tested for COVID-19. The registry is designed to link to other existing COVID-19 registries and datasets, with use and development of common data elements.

In addition, the ACR has brought together the full power of CRI and ACR Informatics™ resources to launch the innovative ACR National Clinical Imaging Research Registry™ (ANCIRR). The ANCIRR collects images and clinical data from multiple practice settings — enabling researchers to address complex scientific questions and produce results applicable across various care settings, geographic locations, and populations. “As ANCIRR was established, we came up with ways in which facilities can use their data for multiple purposes to support local improvement, as well as research,” Gandhi says.

In addition, the ACR, the RSNA, and the American Association of Physicists in Medicine formed a research consortium last year to develop the Medical Imaging and Data Resource Center (MIDRC), funded through the National Institute for Biomedical Imaging and Bioengineering. The open-source database will house medical images from thousands of COVID-19 patients. CIRR is contributing clinical and imaging data to MIDRC. The resource represents the country’s largest medical imaging associations, and its data platform provides a critical tool for doctors and scientists to better understand COVID-19.

“ACR Informatics is also utilizing tools such as Okta, Office 365 (Teams), conflict of interest and legal systems (Agiloft), and other cloud-based tools to allow staff and volunteers to engage with us from anywhere in the world,” Gandhi says. All of the tools utilized, and reimaged, represent the ACR’s continued focus on patient care, she says.

Patients and Families

“The PFCC Commission has always recognized the disproportionate impact social determinants of health have had on the populations of patients we care for,” says Arun Krishnaraj, MD, MPH, chair of the ACR’s PFCC Commission. “To this end, our first population health webinar focused on this topic with concrete advice from our participants on how members could address these disparities in their local communities.”

COVID-19 has had a profound impact on the morale of both caregivers and the patients they serve, Krishnaraj says. “From a PFCC perspective, we have always strived to improve the patient experience and understanding of radiological services by developing

and deploying resources which facilitate better communication with our patients,” he says. “Whether it be our comprehensive Spanish language content on [RadiologyInfo.org](https://www.aacr.org/radiologyinfo), our development of ACR Appropriateness Criteria® summary animations, or a guide on setting up a Patient and Family Advisory Council at your institution, the PFCC is striving to empower members with the tools they need to deliver on the promise of patient-centered care.”

“The PFCC is currently developing the PFCC hub page to improve the user experience,” says Brett W. Hansen, MA, CAE, director of operations with ACR Press. “The idea is to improve the user experience, while getting more exposure for the myriad resources that PFCC provides.” As part of that exercise, the PFCC toolkit content on [acr.org](https://www.aacr.org) has been streamlined, updated, and made more user-friendly.

Also, under the purview of the PFCC Commission, the Patient Education Committee has headed up an initiative to collect artwork from patients and radiologists to display at the ACR annual meeting. This initiative debuted at ACR 2021 and will continue at ACR 2022 to better humanize the individuals who create the radiology experience. The new Patient Engagement Committee, as well as the Quality Experience Committee, have named patients and patient advocates as co-chairs. “This is a first for the College,” Hansen says, “and demonstrates a reimaged commitment to include patient perspectives to achieve and improve radiology excellence.”

“The organization’s overall success will depend on its investing in leading-edge infrastructure so that the ACR can modernize its processes and services,” Fleishon says. “Reimagining an organization is hard. It necessitates thinking outside the box and frequently outside our status quo comfort zone. This process represents an opportunity to be introspective about who we are, to better focus on our mission, and to reinvent better ways to serve our members and patients.” **B**

By Chad Hudnall, senior writer, ACR Press

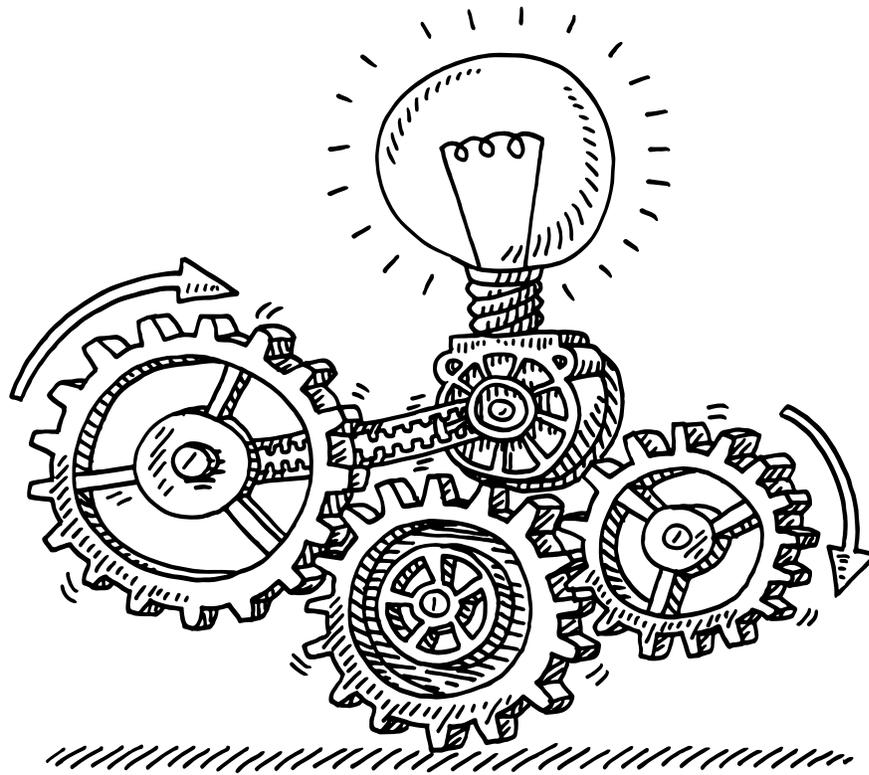
Taking Action on Scope of Practice

The American College of Radiology Association® (ACRA) last year 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.

“Proper supervision and interpretation of imaging exams by highly trained radiologist physicians is critical to the accurate diagnosis and treatment of disease, injury, and illness,” ACR BOC Chair Howard B. Fleishon, MD, MMM, FACR, says. “The ACR works with our state chapters to advocate at the legislative, regulatory, and administrative levels for clear, sensible definition of scope for allied health professionals.”

To protect patient access to safe, high-quality care, the ACR has tracked and acted on hundreds of bills nationwide for the past two years — including those regarding SOP. To learn more, visit [acr.org/scope-of-practice](https://www.aacr.org/scope-of-practice).





An Abbreviated Process

A new ACR workgroup is aiming to improve the way the Practice Parameters and Technical Standards are approved.

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 goal is to save time with a more efficient process to create space to discuss substantive issues affecting ACR members. The resolution stated, “After completion of the field review process, ACR-only PP&TS would be reviewed by the BOC and CSC. If there was unanimous support from the BOC and CSC, the parameter or standard would be officially adopted. If one member of the BOC or CSC dissented, the approval process would proceed normally with consideration and voting by the ACR Council.”

The resolution was referred to the CSC, with instruction to report back to the Council at ACR 2022. Interpreting the will of the Council, the Reference Committee responsible for Resolution 1 stated that there was support for improving the PP&TS process, but a different method was needed.

Council Speaker Amy L. Kotsenas, MD, FACR, 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. As the workgroup began, it immediately became clear that ACR-only PP&TS accounted for a small

minority of the total. In formulating a new methodology, with meaningful time savings, the workgroup expanded the scope to include all PP&TS.

The Background

The workgroup’s review noted historically low participation during the many opportunities to voice opinions about proposed PP&TS language before the annual meeting. The PP&TS process is time-consuming, particularly for the writing and comment reconciliation committees. In addition, major changes to PP&TS language can lead to frustration when first brought up at the annual meeting. Changes incorporated late in the PP&TS process may have unintended consequences that are not immediately apparent.

Lengthy debates also affect the Council. Not infrequently, the Council may get into a “wordsmithing” discussion, with multiple motions and discussion periods. This may lead to “parliamentary fatigue” — the desire to just finish the session, which may lead to poor decision making. Later resolutions may not get as much discussion as earlier resolutions, even though these may be very important resolutions to the ACR membership.

The Proposal

The workgroup focused on phases of the PP&TS approval process that would increase efficiency, while maintaining or increasing individual members’ ability to influence each PP&TS. To achieve maximum gain, the workgroup’s proposal applies to all PP&TS, including those sponsored by multiple societies. In an effort to

gain input from the larger ACR membership, the ACR hosted a virtual town hall on Dec. 9, 2021. Members of the workgroup communicated the plan and invited comments from those in attendance. Additionally, an ACR Engage discussion thread is dedicated to the proposal and the PP&TS process. 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. Below are the main points in the proposal:

All PP&TS would be released for public comment simultaneously with one common deadline. Currently, PP&TS are released for public comment in three to four groups, each with a separate deadline. This change will result in less confusion over the timing of public comment and may lead to greater participation. During the town hall, we heard several attendees request the public comment period be long enough to allow members time to read and comment on all PP&TS relevant to them.

The workgroup proposes a virtual meeting to discuss the PP&TS, three to four weeks in advance of the ACR annual meeting. This proposed meeting would function similarly to the reference committee open hearings that typically occur at the annual meeting. A PP&TS Reference Committee would hear testimony from ACR members and entertain changes to the wording of individual PP&TS.

Following the virtual PP&TS meeting, the Reference Committee would create a final draft version of the PP&TS for distribution to the Council before the ACR annual meeting. At the annual meeting, approval of the PP&TS final draft versions would be presented to the Council as a consent agenda item. Any persistent concerns may be resolved by extraction of the PP&TS in question by ACR Councilors after a motion, second, discussion, and simple majority vote by the Council. The unextracted PP&TS would be passed by the Council after a simple majority vote on the consent agenda.

The extracted PP&TS may be debated during the annual meeting at the discretion of the Speaker, Vice Speaker, and the Council. Debate should be limited to minor corrections or

Phases Not Altered by the Proposal

While the process refresh would update the way PP&TS are created, many of the current steps would be retained.

Initial Phase

The PP&TS are formed by the writing committee.

Reconciliation

The public comments are reconciled by CSC members, the writing committee, and the ACR membership.

Review

The PP&TS are reviewed by the BOC and CSC after the reconciliation phase.

Finalization

The PP&TS are finalized by ACR staff in preparation for the Council meeting.

Dissemination

The final draft is disseminated to collaborating societies at the PP&TS meeting in advance of the ACR annual meeting so that they may provide feedback. Their acknowledgment and comments may prove useful to the Council in their decision to approve or extract proposed PP&TS.

PP&TS deemed vitally important. Routine, lengthy PP&TS debate should occur earlier in the approval process. The PP&TS that are not passed during the annual meeting would be submitted for approval at the following annual meeting. Until a new version is passed, pre-existing PP&TS would revert to the previous version. There would not be a PP&TS for new parameters and standards if there was no previous version.

The workgroup's proposal states that the remainder of the PP&TS process would continue to operate as it currently does (see sidebar).

The Comments

The proposal gives members multiple opportunities to voice their opinion on proposed wording. At the annual meeting, ACR Councilors may move to extract PP&TS from the consent agenda. The discussion of each individual PP&TS is permitted and encouraged, but the venue for discussion would be changed from the annual meeting to the dedicated virtual PP&TS meeting.

During the town hall, several members agreed with the proposal but mentioned a trial period may be useful. The workgroup agrees that by gradually phasing in this process — perhaps initially putting half the PP&TS through the new method and half through the traditional process — we may best demonstrate the efficiency gains.

While the members of this workgroup evaluated potential pitfalls, it is nearly impossible to foresee every issue that may arise. We ask members to keep an open mind as we all work toward improving the PP&TS process. If we find, after an honest trial period, this is not the best solution, we will have learned a lot about what works and what doesn't. While we hope this proposal exceeds everyone's expectations, our goal is to find the best possible solution. **B**

By Derrick R. Siebert, MD, chair of the CSC Workgroup on Resolution 1

Send Us Your Input

We welcome feedback to make the PP&TS process the best we can.

Please contact the following members of the workgroup at csc@acr.org

to provide your comments:

Derrick R. Siebert, MD, chair of the CSC Workgroup on Resolution 1

Eve D. Clark, MD

Juan C. Batlle, MD, MBA

David R. Larson, MD, MBA

Neel Madan, MD

Mary (Mimi) S. Newell, MD, FACR

Suzanne L. Palmer, MD, FACR

Daniel A. Rodgers, MD

William F. Sensakovic, PhD

David Kurth, ACR senior director of clinical guidelines

Mythreyi B. Chatfield, PhD, ACR executive vice president for quality and safety

Opening Up Opportunities

Radiologists can use public health informatics and direct community engagement to expand care access in underserved communities.



Farouk Dako, MD, MPH

As the COVID-19 pandemic has made clear, quality medical care is unevenly distributed throughout the United States. The Centers for Disease Control and Prevention notes, “People from some racial and ethnic minority groups face multiple barriers to accessing healthcare. Issues such as lack of insurance, transportation, childcare, or ability to take time off of work can make it hard to go to the doctor.”¹ Cultural differences and language barriers can also play a role, contributing to a situation where care may vary widely from one Zip code to another.

Although not traditionally thought of as a frontline specialty, radiologists have an opportunity to close these care gaps. Farouk Dako, MD, MPH, assistant professor of radiology in the cardiothoracic imaging division of the Perelman School of Medicine at the University of Pennsylvania, is on a mission to do just that. Dako sees both real-time and predictive analytics as two key tools in radiology’s arsenal when confronting healthcare disparities.² By using such tools, in combination with straightforward human interactions in underserved communities, radiologists can combine imaging diagnoses with historical and real-time data to produce helpful predictions through the use of AI algorithms — and pave the way for an enhanced quality of life for patients. During a recent interview with the *Bulletin*, Dako spoke about the importance of harnessing data to survey and triage patient populations and connect them with needed care.

What are data analytics and predictive analytics and how do they relate to radiology?

Data analytics is simply the process of analyzing data to obtain useful information and to guide decisions. All radiologists analyze imaging data but there’s also a lot we can do with the non-imaging data we accumulate. For instance, practices often determine their staffing levels based on imaging type and volume.

But there are applications for data analysis beyond just staffing. For instance, by putting this data into a structured format we can detect patterns that give us a fuller picture of the circumstances confronting either an individual patient or a patient population. This gets us into the territory of healthcare disparities; we can look at how different types of imaging modalities are used by different racial or ethnic groups, for example, and determine if there are inequities in utilization.

In contrast to descriptive analytics, predictive analytics involves looking at the same kind of data to predict future unknowns. On the health system level, it’s within the scope of predictive analytics to say something like, “Based on a given pattern we’re seeing on Thursdays, we

anticipate 20% more cases than we think one radiologist should safely read. We can then create interventions to improve patient safety.”

On a population level, we can similarly combine imaging and non-imaging data to predict health outcomes. For example, there are lung cancer risk prediction models for nodules identified on CT combining imaging features with non-imaging data typically in the EHR. There is ongoing research into AI-based risk prediction models that, for example, can use chest X-rays to predict future cardiovascular risk.

Taking these techniques to the next level, we could combine this imaging with non-imaging data to identify high-risk patients and intervene to improve their chances at living a healthy life.

Underserved areas that encounter challenges in accessing AI will be at a disadvantage compared to those areas that can more readily and effectively access it.



For more information about how imaging surveillance and predictive analytics can contribute to the health of distinct patient populations, watch a webinar produced by the PHM Committee of ACR’s Patient- and Family-Centered Care Commission at acr.org/PHM.

Do you think that AI could have negative repercussions in low-resource communities?

Underserved areas that encounter challenges in accessing AI will be at a disadvantage compared to those areas that can more readily and effectively access it. But apart from that, even in places that use AI, it can become a problem if they don't have enough clinical supervision to ensure that the technology is being used for the correct indications. We're only beginning to uncover these kinds of issues as we do more research and ask forward-thinking questions about the future of AI. Because of this, we need to be vigilant as we try to introduce it into different clinical scenarios.

And this technological disparity might one day exist not just within the United States, but internationally as well between wealthier and poorer countries. I'm from Nigeria, and I consult with Nigerian radiologists as part of my global health work as a program director with RAD-AID International. Consequently, I hear these radiologists' concerns. One major question they have is this: If AI comes to Nigeria, who's going to own it?

There aren't policies in place right now in Nigeria to ensure that the appropriate people will control AI in the clinical setting. The concern is that because of a trend where capable physicians often leave the country to pursue a life somewhere else, individuals with inadequate medical training will begin to fill that void. This could inadvertently result in worse health outcomes for patients than in places where more stringent protocols are in place.

Missed care opportunities are often the result of suboptimal social determinants of health. Can employing predictive analytics help resolve these barriers to quality care?

Yes, predictive analytics can help minimize missed care opportunities. But one of the

"I've also found that going out into the community over time and building trust is key to welcoming folks into the healthcare system."

major hurdles to doing so can involve getting access to the relevant data. This is key, because to be able to understand which barriers to care exist so that we can surmount them, we have to gather data that indicates when patients are being scheduled, who's not showing up, where they live, what their patient satisfaction survey results are, and so on. We need to have patient representatives involved in understanding the problems and designing solutions to ensure a patient-centered approach.

To convince gatekeepers that radiologists should have access to this kind of data, we have to go beyond simply stating that shoring up missed care opportunities is the right thing to do. We have to speak the C-suite's language and demonstrate the financial cost of missed care opportunities. We can take the lead to show executive leadership the revenue that's to be gained by keeping a CT scanner running at optimal levels by highlighting the number of patients showing up for their appointments.

What are some practical steps a radiology practice can take to improve the health outcomes of underserved communities?

One thing I've realized by going out into the community is that misunderstandings exist. For instance, some folks think that imaging care will cost too much. Others may just not know how to engage with the healthcare system. And it's not just community members who feel this way. I'm a physician, and I engaged with the healthcare system as an adult patient for the first time recently when I got my job as an attending and I got my insurance card. I

didn't know what to do next. If this wasn't clear to me, then how are non-physicians supposed to know where to begin? It's a real challenge, especially if you're experiencing other social or economic challenges that take precedent over seeking healthcare. Going out into the community over time and building trust is key to welcoming folks into the healthcare system. Many people probably have preconceived notions about why you're in their community in the first place, so it's important to let them know why you care about their health. A big part of success is just showing up, and that's something all radiologists can do. Most importantly, we should talk to community leaders to figure out why people aren't using the healthcare system the way we think they should. Ultimately, we may realize that the system isn't working for them and we can begin to think about alternate approaches. **B**

Interview by Chris Hobson, senior communications manager, Imaging 3.0®

ENDNOTES

1. Health Equity Considerations and Racial and Ethnic Minority Groups. Centers for Disease Control and Prevention. Nov. 30, 2021.
2. Philips.com. Predictive analytics in healthcare: three real-world examples. June 12, 2020.



Listen to an ACR *Bulletin* podcast at acr.org/bulletin to learn how Farouk Dako, MD, MPH, and his team achieved success with the vaccine rollout in Philadelphia.

The Gold Standard

The ACR Accreditation program is raising the bar for radiology and radiation oncology practices to achieve a higher level of consistent imaging quality.



Margaret M. Szabunio, MD, FACR, FAWR

The overarching goal of the ACR Accreditation program is to ensure consistency in radiological practice by adhering to established industry standards for every modality — a goal that Margaret M. Szabunio, MD, FACR, FAWR, chair of the ACR Committee on Accreditation Chairs in the Commission on Quality and Safety and chair of the ACR Committee on Mammography Accreditation, takes very seriously. In a recent interview with the *Bulletin*, Szabunio — who is professor of radiology, surgery, and biomedical engineering at the University of Kentucky, as well as division chief of women's radiology and program director of the Women's Radiology Fellowship at UK HealthCare — shared the ACR Accreditation program's commitment to improving quality and safety.

Why is the ACR Accreditation program considered the gold standard for quality and safety?

With more than three decades of experience, ACR Accreditation is the oldest and most experienced radiological imaging and radiation oncology accreditation body. By displaying the gold seals of ACR Accreditation, facilities can demonstrate to their patients, payers, and referring providers that they are committed to providing the safest and best quality care possible. We are a gold standard because we are raising the bar for radiology and radiation oncology practices to achieve a higher level of consistent imaging quality. The ACR Accreditation review program includes physicians, physicists, and technology experts in radiology and radiation oncology. What we're trying to do is to make sure that we, as representatives of the ACR, are all looking at images and scoring examinations in the same way. To do that, we require education for the reviewers to reduce subjectivity and to make the assessments as objective as possible. So, we all can be proud of giving out an ACR Certificate of Accreditation — meaning that we all believe in and follow the same standards.

Tell us about the ACR Accreditation program's commitment to improving quality and safety.

The ACR offers accreditation programs in CT, MRI, breast MRI, nuclear medicine, and PET as mandated under the Medicare Improvements for Patients and Providers Act (MIPPA), as well as for modalities mandated under the Mammography Quality Standards

Act (MQSA). We aim to ensure we have reproducibility of what we do and continually strive to reduce medical errors, one of the leading causes of death in the U.S. With the ACR Accreditation program, we want to make sure that we, as physicians, are meeting certain standards and also that the images we produce in our institutions are complying with established standards. The ultimate beneficiaries of ACR Accreditation's rigorous standards are our patients.

What initiatives are currently underway to update and strengthen the ACR Accreditation program?

The ACR Accreditation program is constantly evolving to help facilities keep up with the latest quality and safety guidelines and to deliver the best care possible. Prior to the pandemic, the ACR would perform on-site surveys to validate compliance with regulations and safety standards. Those visits have been one of our best tools to communicate with facilities and personnel and allow them to ask questions. We have enabled the Radiation Oncology Accreditation and Diagnostic Imaging Center of Excellence™ programs to perform virtual site visits to ensure continuous operation of these important programs. In addition, the FDA has allowed virtual site visits under limited circumstances for mammography facilities. The ACR will soon release an updated accreditation database with many enhancements. We are also participating in the ACR Learning Network, which seeks to improve diagnostic excellence in imaging with a focus on cancer diagnosis. Four initial improvement collaboratives are supported by a standard process



To receive quarterly updates on ACR activities and issues related to quality and safety in radiology, sign up at bit.ly/Inside_QS.

for improvement. What we learn from those collaborations will inform the ACR Accreditation program going forward.

What are some steps that radiologists should take now to improve their quality and safety?

The ACR has many quality improvement programs such as Image Gently® and Image Wisely®. We should all participate in those programs and I encourage all radiologists to “take the pledge” to Image Wisely and get resources and information on radiation safety in adult medical imaging. Image Gently is working to increase awareness of the opportunities to promote radiation protection when imaging children.

I would also encourage all centers to become a designated Center of Excellence, such as the Breast Imaging Center of Excellence, Diagnostic Imaging Center of Excellence, ACR Designated Lung Cancer

Screening Center, and ACR Prostate Cancer MRI Center. If all practices strive to become a designated Center of Excellence in these domains, it will help to ensure proper imaging and the best possible interpretation of images, because all the radiologists and RTs will be doing everything they need to do to stay not only at their current level of knowledge, but to raise the bar.

Finally, I am very passionate about the education of residents and fellows, our next generation of radiologists, and we want them to be more successful than we are. It is important for all of us not to lose sight of this perspective: that we are not just looking at images or interpreting images or doing biopsies. There’s a human being behind the images — a person with feelings and fears — and I’ve always tried to teach my residents and fellows how important it is to remember that. **B**

Interview by Linda Sowers, freelance writer, ACR Press

“The overarching goal of the ACR Accreditation program is to ensure consistency in radiological practice by adhering to established industry standards for every modality.”

COMING SOON: ACREDIT PLUS

The ACR Accreditation team will soon unveil an updated accreditation database called ACRedit Plus, with a user-friendly interface and enhanced features. ACRedit Plus will be available for all modalities (except radiation oncology) and includes several new features such as:

Dashboard: A user-friendly dashboard that allows you to see all modalities up for renewal, as well as pending activities for your accreditation process. In addition, the menu navigates you straight to the task you need to accomplish.

Mammography: Facilities with digital breast tomosynthesis (DBT) units will no longer have to apply as two separate units for Full-Field Digital and DBT. Instead, these units will apply as a single unit with modules. Facilities under this scenario will see an FDA-approved fee decrease over the current model, as well as benefit from the more streamlined process.

Breast MRI: The Breast MRI Accreditation Program will become a module under the MRI Accreditation Program. Facilities that are currently accredited for Breast MRI will apply under the MRI

Accreditation Program at the time of renewal. This will result in lower fees, as well as the benefit of the more streamlined process.

Nuclear Medicine and PET: Participants in the Nuclear Medicine and PET Accreditation program will see a change in the structure of their invoices. Currently, the invoice reflects a facility fee, along with separate module-based fees per unit. In the new system, the facility fee will become part of the first unit fee and will not be displayed as a separate facility fee line item.

Prostate Cancer Designation: A new ACR Prostate Cancer MRI Center Designation will be available to distinguish your site as a provider of safe, effective diagnostic care for prostate cancer patients.

Lung Cancer Screening Designation: An improved and streamlined application process for the ACR Lung Cancer Screening Center Designation will be available for both new and renewing applicants.

Learn more about **ACRedit Plus** at acraccreditation.org/Coming-Soon.

Beyond Borders

The ACR's Radiology Leadership Institute[®] and the International Society of Radiology partnered to provide a leadership course to resource-constrained areas beyond the U.S.

The ACR Strategic Plan Vision Statement aims for ACR members to be “universally acknowledged as leaders in the delivery and advancement of quality healthcare.” This means ensuring radiologists are essential and valued providers of patient care and that they participate in population health management. To become universally recognized, however, requires going beyond the borders of one's country, as well as fostering and collaborating with radiology organizations worldwide.

In pursuit of this goal, the Radiology Leadership Institute[®] (RLI) and the International Society of Radiology (ISR) partnered to create a leadership course, called “Being an Effective Leader: Core Principles for Success.” Frank J. Lexa, MD, MBA, FACR, chief medical officer of the RLI, says that a partnership with the ISR is critical to helping the College reach its international collaboration goals. “The ISR has a long history of doing great things in education and in the international community,” says Lexa. “The RLI and the ACR have a history of teaching leadership skills, so this was a great chance to combine our skills and do this together.”

A Beautiful Friendship

The pilot program for this project was a virtual course targeted at radiologists in Sub-Saharan Africa; the majority of participants were located in Zambia. Zambia faces substantial healthcare challenges, including an HIV crisis, high rates of pre-term birth, a high infant mortality rate, and increasing trauma and non-communicable diseases. Although the country's doctors are dedicated to serving their patients, there are only 13 radiologists in the entire country (nine in the public sector and four in the private sector). Three public MRI machines exist in the country.¹

Geraldine B. McGinty, MD, MBA, FACR, education chair for the ISR and past president of the ACR, says it was easy to pitch the idea to both parties. “We're well-resourced in terms of being able to develop programs like Image Gently[®], the RLI, or the Practice Parameters and Technical Standards,” says McGinty. “And while we are careful stewards of the College's resources, we also want to share these tools with other countries who are not as well-resourced. It speaks so much to the ACR membership as a community of excellence that we want to be generous with that excellence.”

Beyond resource-sharing, international partnerships such as the ACR-ISR help raise the profile of radiology, McGinty notes, particularly when you already have resources like the RLI. “Investing in imaging infrastructure poses a huge benefit to society,” she says. “Resource-constrained countries obviously have to choose carefully where they invest, so by supporting other radiologists in their journeys as leaders, we're helping them speak to the value of imaging and creating a more influential voice for the specialty overall.”

Lexa agrees. “Ever since the COVID-19 pandemic, we've realized how much smaller the world is,” he says. “Many of the problems we face as radiologists are not unique to the United States, and we were able to discuss big issues of leadership that transcend national boundaries and culture. You can't get that perspective without stepping out of the reading room and participating in a much larger community.”

Local Champions

The course would not have been possible if Lexa and McGinty had not connected with Veronica Sichizya, MB, CHB, FC Rad Diag(SA), consultant radiologist at University Teaching Hospital-Adult in Lusaka, Zambia. University Teaching Hospital is the largest hospital and main referral health institution in Zambia. Sichizya, who is a leader in the community, convinced eight out of nine radiologists in Zambia, as well as several South African radiologists and trainees, to attend the course. She also organized a way for the attendees to receive continual professional development credits by the Health Professions Council of Zambia, the equivalent of CME.

Although McGinty and the other RLI faculty members, Harprit Bedi, MD, and Ryan K. Lee, MD, MBA, had developed and taught leadership courses before, both in-person and virtually, they wanted to take a different approach to this one. “We wanted to make sure we were very thoughtful of our programming to ensure we correctly addressed issues that they were facing and to understand the hierarchical structure in their community,” says Bedi. Sichizya organized a focus group of attendees so that faculty could understand the unique challenges each radiologist experienced, as well as an understanding of the basic medical system, infrastructure, and governance of the medical community in sub-Saharan Africa.

The course consisted of three virtual learning modules: “Leading Yourself,” “Leading Teams,” and “Leading Change.” After attendees viewed the pre-recorded modules, the RLI convened a live workshop, where faculty discussed each module. Then, faculty presented two case studies and led discussions around them. Bedi, who taught “Leading Yourself,” says that he focused on well-being and how that contributes to being a better leader overall in his module. “The Zambian radiologists work so hard and so long, I wanted to impart the importance of giving yourself time for sleep and connection with family and community,” he says.

Benefits for All

Sichizya reports that the course was well-received by all attendees. “I learned so much,” she says. “Initially, some of us thought, ‘What can you do with a one-day course?’ But now we've found ourselves referencing things we learned that one day. Leadership is an ongoing learning experience, but the course really helped give us the tools to use as effective leaders and continue learning.”

Bedi comments the faculty learned just as much as the attendees. “The loyalty, dedication, and purpose of these physicians was inspiring,” he says. “In the United States, our sense of purpose tends to get lost during the day-to-day. But it really reminded

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Advocating for Access

The ACR's interest in collaborating with sister organizations drives its participation in the Commission on Cancer's activities.

The ACR was one of the six organizations that founded the American Joint Committee on Cancer (AJCC) in 1959, along with the American College of Surgeons (ACoS), the College of American Pathologists (CAP), the American College of Physicians (ACP), the American Cancer Society (ACS), and the National Cancer Institute (NCI). The long standing commitment between the AJCC and the ACoS Commission on Cancer (CoC), and the ACR's direct interest in collaborating with sister organizations, drive the ACR's participation in CoC activities.

A Longstanding Commitment to Care

The ACR's own medical imaging accreditation efforts date to 1987, when ACR radiologists and medical physicists on the ACR's Breast Task Force developed the Mammography Accreditation Program to address documented concerns about inadequate quality mammography in the U.S. Since then, the ACR has accredited more than 39,000 facilities across the full spectrum of diagnostic and therapeutic radiologic modalities.

"The longstanding commitment of the ACR to the development of quality standards in radiologic practice and their application through the accreditation process dovetails perfectly with the efforts of the CoC's accreditation programs," says Alan C. Hartford, MD, PhD, FACR, president-elect of the ACR Council of Affiliated Regional Radiation Oncology Societies. "Quality metrics for diagnostic imaging and radiation therapy must be fundamental to the CoC's development of quality standards in cancer diagnosis and treatment. Given its longstanding traditions within the CoC and its many years of organizational experience, the ACR's quality standards and accreditation activities are a natural bedrock for the CoC's efforts in quality assessment and improvement."

According to Alda L. Tam, MD, a member of the ACR Commission on Interventional and Cardiovascular Imaging, IRs interface with patients at multiple time points during their cancer journey: acquiring tissue through biopsy for diagnosis, offering personalized procedural care and therapy for tumor control, and providing symptomatic relief at the end of the life. "Frequently, IRs are able to offer minimally invasive image-guided treatment options to cancer patients who otherwise would not be operative candidates," says Tam. "As the incoming ACR representative to the CoC, I'm excited to share this perspective as an additional dimension of radiology's commitment to and delivery of high-quality cancer care."

An Advocate for Screening

Mounting evidence suggests that COVID-19 will be an endemic virus that will continue to shape healthcare delivery for the foreseeable future. In this context, cancer care has suffered, especially for underserved and underrepresented populations. Studies from

the U.S. and Europe have shown that cancer screening dropped dramatically during the pandemic, which may worsen preexisting disparities.¹

In March 2021, the U.S. Preventive Services Task Force (USPSTF) updated its lung cancer screening guidelines to widen screening eligibility for individuals 50 to 80 years of age and who have a 20 pack-year or more smoking history (either currently or have quit in the last 15 years). This update is projected to double the number of individuals eligible for screening and to help reach Black patients who have a higher risk of lung cancer at a younger age and with a lower smoking history.² "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," says Ella A. Kazerooni, MD, MS, FACR, chair of the ACR Lung-RADS Committee and Lung Cancer Screening Registry®.

It is also well-known that Black patients fare worse in multiple phases of the colorectal cancer continuum — they are less likely to be screened with colonoscopy, are more likely to present with late-disease stages, and have lower five-year rates of survival following a diagnosis, despite adjustments for disease stage at presentation.³ That's why the new USPSTF recommendation for adults ages 45–49 means that millions more Americans will receive private insurance coverage for this vital screening.⁴

Finally, new evidence continues to support annual breast cancer screening starting at age 40, with closer attention given to minority women in underserved populations.⁵ According to Stamatia V. Destounis, MD, FACR, chief of the ACR Commission on Breast Imaging, "Mounting data and more inclusive screening recommendations should remove any thought that regular screening is controversial." **B**

By Nicole B. Racadag, MSJ, managing editor,
ACR Bulletin

ENDNOTES

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ACS Commission on Cancer Celebrates 100 Years

The Commission on Cancer (CoC) has launched a year-long campaign to celebrate its 100-year anniversary. Established by the American College of Surgeons in 1922, the CoC is a consortium of professional organizations dedicated to establishing standards to ensure quality, multidisciplinary, and comprehensive cancer care. To learn more, visit facs.org/quality-programs/cancer/coc.

Expanding AI Opportunities

Federated learning allows for multiple facilities to participate in model training while data remain local to each facility and secure behind their firewalls.

AI has the potential to aid radiologists in numerous ways, evidenced in part by the extensive list of radiologist-defined AI use cases compiled by the ACR Data Science Institute°. Despite this huge potential, there are challenges facing the development of clinically useful AI models.

Many of the challenges stem from the fact that imaging data features vary from facility to facility. This occurs for various reasons. While some are well understood, such as variability in equipment manufacturers or patient populations, many are hard to interpret. We do know that AI models trained on data from a single facility are biased toward that facility's population and do not generalize well across facilities. In practice, this means that AI models trained on data from Facility A can perform poorly when tested on data from Facility B. Ultimately, this slows the radiology community in developing clinically useful models that minimize bias and health inequity.

One way to get around this issue is to acquire training data in a central location from a diverse array of source facilities. Unfortunately, due to the sensitive nature of medical imaging data, this is often not a viable option. That is where federated learning (FL) can help. It offers a solution where multiple facilities participate in model training, while data remain local to each facility and secure behind their firewalls (see sidebar).

Tackling the Data Sharing Problem

FL is a method of collaborative AI model training that does not require data sharing. During FL, AI models, not data, are shared among participating facilities and a coordinating server. Facilities train models locally before passing them to a coordinating server, which then aggregates multiple facility-trained local models into a single AI model. In this way, FL allows model training across a distributed network of facilities.

Prepare for an AI-Enabled Future

By early 2022, AI-LAB™ users will be able to get started using the technology to benefit from federated learning (FL) in developing AI models. Registration is now open for practices that would like to participate in FL via AI-LAB. Facilities that sign up to participate will then install ACR Connect (or access a secure instance in the cloud) to participate in the first FL session. Prior to participation, facilities will be required to create a relevant dataset using ACR Connect Data Manager. Register your site today by visiting the AI-LAB home page at ailab.acr.org/Account/Home and clicking learn more in the “Federated Learning” section.

AI models created through FL are generally more robust and able to be generalized across facilities than single-facility-trained models because training data derives from more diverse sources and patient populations. The performance of final AI models produced with FL often reach levels of performance similar to models trained on data collected in a central location.

Recently, the ACR participated in an FL initiative that produced a breast-density classification model, which performed better on a test dataset consisting of data from all participating facilities than any of the single-facility-trained local models produced in the study.

Offering Analysis Tools

ACR Connect° is free ACR-developed software, which can be installed on premises. It offers various medical imaging analysis tools and makes them readily accessible through a series of applications. ACR Connect applications make it possible to participate in cross-site research initiatives and create curated local datasets, without the need for data to leave a site's protective firewalls.

The AI-LAB™ app in ACR Connect provides even non-technical users with the ability to create or evaluate AI models through an easily navigated graphical interface. Since AI-LAB's focus is on both educating the radiology community about AI and providing a tool to help radiologists develop robust AI models, AI-LAB offers a simple interface and various background materials to bring radiologists up to speed about AI. This includes videos explaining important AI concepts and content throughout the application. As a result, AI-LAB users without any technical expertise can participate in AI development and validation and the radiology community can build expertise in developing clinically useful models.

Producing Better AI Models

AI-LAB is introducing new FL capabilities. At the conceptual level, the process of FL is fairly straightforward with AI-LAB via ACR Connect. To begin, an ACR central server passes a base model, which was developed previously to perform the same or similar task but found to have non-ideal performance, to the ACR Connect instance at each participating facility. At each facility, the base model is then trained on a local dataset prepared by the site, which is used to create a new site-specific model.

New models from each site will be passed back to the ACR central server for aggregation. The process of aggregation will create a single AI model that will be used as the base model in the next round of training. When repeated over many rounds, this process will produce a final AI model that performs well at all participating facilities. On the ACR side, a custom AI-LAB implementation will leverage NVIDIA FLARE™, which enables multi-party orchestration, training, model sharing, and model aggregation.

For a more detailed look at how ACR Connect clinical integration services work, visit acr.org/clinical-integration. **B**

By Kendall Schmidt, PhD, data scientist with the ACR

How do you incorporate peer review into your busy schedule?

“We all recognize the value of peer review as an effective means of performance improvement, but finding the time to actually do it is increasingly a challenge. Developing the habit of including a tiny dose of peer review on a regular basis is the best means of getting the benefits of continuous feedback while ensuring it does not become an overwhelming task.”

Lars J. Grimm, MD, MHS, associate professor of Radiology at Duke University School of Medicine



“Reviewing a lot has helped me become more efficient. I use a template document to standardize my review process. The bottom line is that I make time for reviewing because I simply enjoy reading about the work others have done. I am honored to be given the opportunity to provide the authors with feedback that may increase the value of what they have submitted.”

Nadja Kadom, MD, director of radiology quality and radiology research at Children’s Healthcare of Atlanta and associate professor at Emory University



SURPRISE BILLING

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We are already seeing the consequences of the IFR. At least one insurer has sent notices to reduce payment schedules, trim its network, and limit imaging access for patients.⁵

Despite the ACR's comments regarding the IFR, there has been no satisfactory response. With the impending implementation of the NSA, the ACR chose to take decisive action to protect our members and patients. Along with the American College of Emergency Physicians and the American Society of Anesthesiologists, the ACR filed a lawsuit to block the inaccurate parts of the regulatory mandate. Importantly, the lawsuit does not challenge those parts of the legislation that protect patients during out-of-network payment disputes. While the AMA and American Hospital Association have also filed suit, independent action by our three societies was the best recourse.

We are all still recovering from the COVID-19 pandemic. Now is not the time to punish physician providers and empower insurers who have registered record profits. Medical imaging is not driving medical costs. In fact, the trend in recent years has shown decreasing costs. Instead, health insurers' net incomes and profit margins have grown every year since 2015. Insurers pocketed record profits in 2020 — even as their costs dropped.⁶ Most importantly, insurance premiums continue to rise, along with insurance company revenue.⁷

We are physicians and trusted providers for our patients. We will continue to stand for securing equitable access to vital medical imaging for our patients. We want to thank the entire community of radiology and, most importantly, our patients for their continued support as we fight for patient protections in the NSA. **B**

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

BEYOND BORDERS

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me why we are here as physicians.” Bedi also learned how the different cultural contexts and hierarchical structures in sub-Saharan Africa could affect Western leadership techniques. For example, he says, “The idea of ‘managing up’ is very much a Western thing and doesn't work the same way there, especially for junior positions. We had to figure out how that might work within their cultural boundaries.”

Lee who taught the “Leading Change” module agrees. “The interactive nature of the sessions allowed us to learn about the issues they face which in many instances are very different from what we experience here,” Lee says. “However, we also found many similar issues demonstrating that despite differences in our practices, we also have much in common.”

“Being an Effective Leader” won't just end in Zambia. After presenting the results of the pilot program to the ISR Executive Committee, planning is underway for additional workshops in 2022. The faculty also plan on following up with the sub-Saharan African radiologists and continue learning from one another. They're also working on how to reproduce the course for different areas in Africa, as well as to other continents. McGinty says, “We're definitely thinking about different economies worldwide and how we might offer this in other languages. It's important that we don't stop here — there's a whole world out there.” **B**

By Meghan Edwards, freelance writer, ACR Press

ENDNOTE

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With programming for radiologists who are leading change at all levels, the RLI can help you advance your career and master the challenges ahead. Explore all of the leadership training opportunities on the RLI website at acr.org/RLI.

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