

Bulletin



Beyond Data

Jan. 13–15 | Orlando, FL

2023 ACR-RBMA Practice Leaders Forum

Today's radiology leaders must be ready to adapt at a moment's notice. At the **2023 ACR-RBMA Practice Leadership Forum**, you'll gain critical insights to boost your strategic resilience.

Whether you're only a few years into practice or a seasoned practice leader, there's something here for everyone, including:

- Dealing with the great resignation.
- Recruiting and engaging your team in the era of remote/hybrid work.
- Building a successful and sustainable private practice.
- Navigating today's economic challenges.
- Mitigating medical errors with AI.
- Planning for mergers and acquisitions.
- And much more.

In January, we'll gather in person for three days of learning, collaboration and friendship.

See you there!

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to rebound from
the great resignation
and other stressors**

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Beyond Data

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Open for Detection

The ACR and its partners are asking screening centers nationwide to open their doors on Saturday, Nov. 12, to grant individuals access to lung cancer screening.

We have all witnessed firsthand the success of detecting lung cancer early. With early detection, patients are often eligible for curative resection, providing significant improvement in both morbidity and mortality when compared to what occurs with a late-stage diagnosis. Still, challenges remain in enrollment and return visits for lung cancer screening (LCS).

The President's Cancer Panel has charged associations, screening centers, and community health advocates with communicating and promoting LCS. The panel monitors the activities of the National Cancer Program and reports to President Joe Biden on barriers to reducing cancer.

To answer the call, the ACR and its partners are asking screening centers nationwide to open their doors on Saturday, Nov. 12, to grant individuals access to LCS without having to take a day off work if they are unable to be screened during the week — thereby increasing the accessibility of screening overall. It will provide one extra day of screening that could save lives.

We've partnered with the American Cancer Society and the GO₂ Foundation for Lung Cancer on this outreach. We have also forwarded an overview of this initiative to the communications lead for First Lady Jill Biden, EdD, recognizing her passion for cancer education and prevention.

This is the introductory year for the initiative, but we envision that it will become an annual event on the second Saturday of each November. In addition to marketing and informational materials, the ACR will provide an “engage your local media” toolkit every year to create a buzz in mid-to-late October. By promoting this day, facilities will be extending screening opportunities to those who may be unaware of this lifesaving, preventative screening option — actively increasing awareness of screening within their communities.

Anyone can sign up — facilities that are already open for screening or those that want to open their doors on this day specifically. We expect that patient advocates will support the purpose of this day and spread the word of its importance. Everyone has a role in doing so. The next life saved could be someone near and dear to you. Simply

put, early detection saves lives. It is our hope that this national day will be approved so that it will be noted on calendars each November moving forward.

Lifesaving LCS has a low rate of adoption of only about 20% among eligible patients compared to mammography and colorectal cancer screening, which both have adoption rates of about 80%. This disparity is, in part, due to a lack of awareness by referring providers and patients.^{1,2} Access to LCS has been particularly challenging for rural and historically marginalized groups, who are more likely to live more than 30 minutes away from a designated LCS center, be underinsured, and/or have lower health literacy levels.^{3,4,5}

However, inadequate access to care and low utilization rates for LCS present an opportunity for patient advocates, medical professionals, cancer centers, health systems, payers, industry, and community health organizations to work together to reduce healthcare disparities and enhance accessibility to lifesaving LCS.

Additionally, the ACR's Lung Cancer Screening Registry (LCSR) can help clinicians monitor and demonstrate the quality of CT LCS in their practices through periodic feedback reports that include peer and registry benchmarks. Because screening is performed on an asymptomatic population, there is added responsibility for the medical community to ensure that risks and benefits are adequately measured and monitored.

Please consider joining the ACR, the National Lung Cancer Roundtable, and the Radiology Health Equity Coalition to promote National LCS Day on Saturday, Nov. 12, 2022. In the spirit of Thanksgiving this month, I thank you in advance for your support of this initiative. **B**

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



Spread the Word About LCS Day



You can spread the word to encourage your screening center and

other facilities to open their doors on Saturday, Nov. 12, 2022. To join the effort

and receive complementary marketing and instructional materials, visit bit.ly/LCS_Day. If you have questions, please submit them at bit.ly/LCS_Questions and a team member from the ACR or the National Lung Cancer Roundtable will be in touch to help you make a noticeable difference on LCS.



Take the ACR's Radiology Job Market Survey

The ACR is looking to gather valuable insight into the evolving radiology job market through the 2022 ACR Career Benchmark Survey. The survey will capture data related to compensation, benefits, quality of life, job selection trends, and career fulfillment.

The anonymous results will support a new interactive data dashboard for ACR members. In the dashboard, you will be able to view and filter the data by location, subspecialty, and demographic information. From there, members can refer to this data when making offers as an employer or negotiating as a job seeker. This dashboard will be published to the ACR Career Center in January 2023.

Complete the survey at acr.org/RadiologyJobMarket.
Questions? Email CareerCenter@acr.org.

Increasing Awareness of Abbreviated Breast MRI Could Improve Access

Despite being shown to play a vital role in cancer detection, surgical planning, and assessing treatment responses, breast MRIs have been underutilized in some regions due to limited resources and high price tags. New research published in *Radiology* touched on these barriers by conducting a comparative analysis between full and abbreviated breast MRI protocols. The research found that the abbreviated method could decrease the associated costs of the exam while also expanding access in lower-resource areas.

While the notion is promising, bringing abbreviated protocols to fruition in underserved areas remains a challenge, according to a first-person take from providers at a clinical practice in Bogotá, Colombia. “The results of abbreviated MRI in breast cancer could be transformed into initiatives that can eventually be included in our clinical practice, with better yields and superior clinical outcomes. Unfortunately, poor infrastructure and health policies do not encourage the use of these diagnostic methods, especially for screening,” José David Cardona Ortigón, MD, and his colleagues explained.

Read the full *Radiology* article at bit.ly/ABRV_Breast_MRI and the first-person perspective take at bit.ly/Screening_MRI.



The ACR's members provide an important voice to the efforts of the Colleges. According to ACR CEO William T. Thorwarth Jr., MD, FACR, “As my advocate voice at critical venues such as CMS, the CPT® Editorial Panel, and the AMA Resource-Based Relative Value System Update Committee (RUC) to ensure appropriate coding and reimbursement, I have always viewed my ACR dues as providing profession insurance.”

Renew your 2023 dues today at acr.org/renew.

IN MEMORIAM:

Gadson J. Tarleton Jr., MD, FACR



Gadson J. (Jack) Tarleton Jr., MD, FACR, passed away at the age of 102 on Sept. 3, 2022. Tarleton is credited with educating and mentoring thousands of medical students and colleagues, demonstrating the impact he had on the field of radiology during his tenure.

Tarleton served as chair of the department of radiology at Meharry Medical College in Nashville, Tenn., 1949–1977, where he initiated a radiology residency program, and he later served at Alvin C. York Veterans' Administration Medical Center. He was actively involved in many professional organizations and societies, including the National Medical Association and the ACR, becoming a fellow of the ACR in 1974. Tarleton also served as an examiner for the ABR. In addition to his many volunteer roles with professional societies, Tarleton was named a Knight of Saint Gregory by Pope Paul VI in March 1971.

Read more about his impact on radiology at bit.ly/Legend_Looks_Back and at bit.ly/Tarleton_Obituary.

ACR Changes CT and MRI Accreditation Contrast Media Supervision Requirements

The ACR CT and MRI Accreditation Committees have announced that a radiologist will now provide direct or general supervision of intravenous (IV) contrast material administration and ensure compliance with guidance provided in the ACR Manual on Contrast Media.

In line with the ACR-SPR Practice Parameter for the Use of IV Contrast Media, the requirements recognize a range of responsible providers trained in managing an acute hypersensitivity reaction under general supervision of a radiologist. The following may provide direct supervision of IV contrast administration under the general supervision of a radiologist:

1. Non-radiologist physicians (MD/DO)
2. Advanced practice providers (nurse practitioner, physician assistant)
3. Registered nurses following a symptom- and sign-driven treatment algorithm

The provider of direct supervision must be immediately available to furnish assistance and direction throughout the performance of the procedure. This does not mean the supervising provider or radiologist must be present in the room where and when the procedure is performed.

Read more at bit.ly/Contrast_Media.

“Continuing education helps radiologists maintain, develop, and increase the knowledge and skills critical to providing high-quality patient care.”

DANIEL KAROLYI, MD, PHD

Be Well With the ACR

Each month, the ACR will feature an activity or initiative that you can use in your daily life to support your well-being. Participants can win prizes for sharing their activities with friends and colleagues on social media. Be sure to follow [#BeWellWithACR](#) and [@RadiologyACR](#) on Twitter to be the first to hear about the monthly wellness challenge. Share a photo or video of yourself completing the activity and be sure to include [#BeWellWithACR](#) in your post. The ACR will randomly select a winner.



Register: 2023 ACR-RBMA Practice Leadership Forum

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- Navigating today's economic challenges
- Mitigating medical errors with AI
- Planning for mergers and acquisitions

Register for three days of learning, collaboration, and friendship by visiting acr.org/PLF.

NEWS FROM THE JACR



FREE WEBINAR:

Practice Quality Improvement with the JACR

A new resource from the *JACR*® sets learners on a path to choose, plan, and launch an impactful Practice Quality Improvement (PQI) project — and it's free for ACR members. Quality experts will explain useful models, share example projects, and answer frequently asked questions to help participants get started on their first project or level up their current PQI game. Attendees will also be eligible to earn CME.

Access the on-demand webinar at bit.ly/JACR_PQI.



JACR: IRs Needed in Small and Rural Areas

The work of interventional radiologists can make all the difference in rural areas, where residents typically have little to no access to specialized health-care. A new report from a joint task force of the ACR and the Society of Interventional Radiology (SIR) addresses solutions.

“Interventional radiologists play a key role in improving patient health outcomes and creating healthier communities,” says Alan H. Matsumoto, MD, FACR, FSIR, vice chair of the ACR BOC.

“The recommendations outlined in this paper will help practices attract IR talent and expand IR services where they are often needed the most, eliminating IR deserts and improving patients' access to the care they need,” adds SIR President Parag J. Patel, MD, FSIR.

The joint task force focused on improving training opportunities, creating templates to help radiology practices and hospitals in small and rural communities, and developing financial models to recruit and retain interventional radiologists.

Read the full report online in the *JACR*® at bit.ly/3MfCpYU.

Connecting Quality, Performance, and Outcomes

Interventional radiologists are pushing to standardize the way their specialty collects and stores information about healthcare processes, organizational structure, use of resources, outcomes of their work, and patient satisfaction.

As interventional radiologists continue to strive for quality in patient care, clinical data registries measuring performance and patient-centered outcomes play a vital role. Registries focus on improving quality, patient satisfaction, and efficient resource allocation by providing timely feedback on optimal patient care.

Data registries align with evolving healthcare reimbursement models, which prioritize health outcomes, patient satisfaction, and cost effectiveness. A variety of reimbursement models currently exist to help meet these priorities, including shared saving programs, capitated models, episodic bundled payments, and modified fee-for-service (FFS) payments tied to quality standards.

These all have a common theme of rewarding health teams that save money and meet quality standards. These models incentivize providers to hold down costs by improving clinical outcomes, reducing waste by tracking utilization, and standardizing clinical care, as well as rewarding patient satisfaction. Healthcare teams that are successful in meeting these objectives are rewarded by receiving incentive payments on top of FFS payments. In the more advanced payment models, healthcare teams share in financial risk, facing potential monetary penalties for wasteful or expensive care that leads to less-than-optimal patient outcomes and patient satisfaction.

CMS and commercial payers collect many types of data required for evaluating healthcare teams in these payment models. Data includes healthcare processes, organizational structure, resource utilization, patient outcomes, and patient satisfaction. Many options exist for collection of data; however, registries have numerous advantages, including timely feedback reports to clinical users. Registries also include benchmarking capabilities locally, regionally, and nationally. Registries can integrate into EHR systems, allowing for easy data extraction.

Another advantage of data registries is the potential

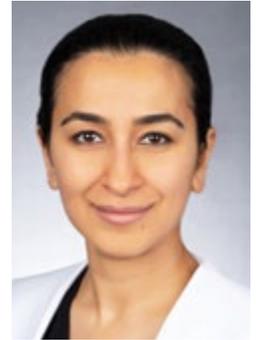
for an increased pool of measures specific to a specialty available for submission into the Quality category of the Merit-Based Incentive Payment System, if the registry is approved by CMS as a Qualified Clinical Data Registry. This advantage is particularly meaningful to both diagnostic and interventional radiologists. The ACR's National Radiology Data Registry® includes many measures applicable to interventional radiologists such as:

- Prevention of central venous catheter-related bloodstream infections
- Rate of endovascular aneurysm repair (EVAR) of small or moderate non-ruptured abdominal aortic aneurysms (AAA) without major complications (discharged to home post-operative day 2)
- Rate of carotid artery stenting (CAS) for asymptomatic patients without major complications (discharged to home post-operative day 2)
- Clinical outcome post-endovascular stroke treatment
- Door-to-puncture time for endovascular stroke treatment
- Varicose vein treatment with saphenous ablation: outcome survey
- Appropriate assessment of retrievable inferior vena cava filters for removal
- Uterine artery embolization technique: documentation of angiographic endpoints and interrogation of ovarian arteries

The Society of Interventional Radiology (SIR) has recently launched its own registry named VIRTEX ([read more on page 9](#)). This initiative promises to take registry reporting to the next level by standardizing reporting and making quality data tracking and extraction easy for IR procedures. VIRTEX collects patient demographics, medical comorbidities, technical details of the procedure, intra-procedure complications, labs, and patient-reported outcomes.

The registry has also been designed to collect data from follow-up outcomes and from future procedures to ensure longitudinal follow-up and position the SIR to be able to collect quality information for future quality payment programs.

As the registry matures, the data collected will have a powerful impact on proving the benefits of the minimally invasive techniques championed and perfected by interventional radiologists. Tracking patient outcomes and resource use may hold substantial influence when

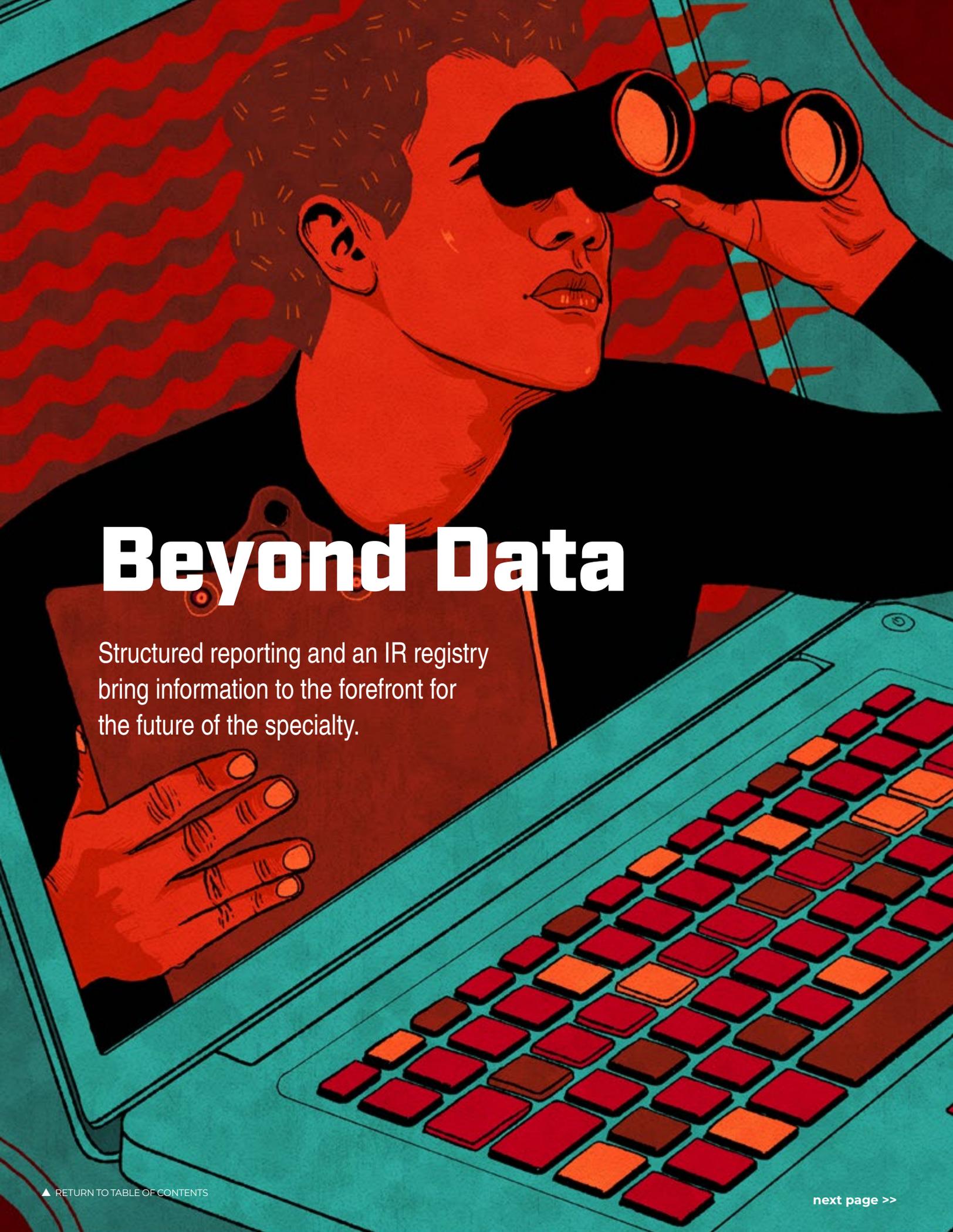


Nadia Khan, MD

Chair of the Economics Committee on Interventional and Cardiovascular Radiology

Guest Columnist

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Beyond Data

Structured reporting and an IR registry bring information to the forefront for the future of the specialty.

Getting ready for work, you quietly move around the house, following your routine. You're on autopilot, steps so practiced that your brain has checked out, perhaps working on other information in the background. And then it hits. A hypothesis — an idea for scheduling, a better way to route patients, a research paper, a question. You've amassed data from education and practice and are passively making connections to answer questions or address problems you didn't even know you had.

In the above example, it seems as if data are always present, waiting for a calm moment to bring to our attention possible quests for new adventures. However, conscious data-gathering and processing outside of our minds, particularly in healthcare, require a small amount of upfront work to be so connective. But according to Neil J. Halin, DO, FSIR, FAOCR, chief of cardiovascular-IR at Tufts Medical Center, the future of IR depends on it.

PARTICIPATING IN THE REGISTRY

Halin serves as co-chair of the Standardized Reports Committee at the Society of Interventional Radiology (SIR). His committee has been tasked with developing structured reports to both improve the reporting process and also facilitate registry use and data extraction. "It is critical to understand how structured reports serve as a way to get information into a registry and then to comprehend how important registries are for our own survival, economically and as a profession," says Halin. "Every other major profession we deal with has some form of registry, and participation is required. And they're way ahead of us in having data so they can write the papers that need to be written and can go to the regulatory agencies and insurance companies with actual performance data."

SIR Standardized Reports Committee Co-Chair Mark G. Kleedehn, MD, assistant professor in the department of radiology at the University of Wisconsin School of Medicine and Public Health, and more than a dozen IRs and specialists on the committee have been essential to the development of SIR's latest structured reports (freely available at bit.ly/SIR_SR). These structured reports are the keys to the treasure chest of data that is VIRTEX, the IR registry SIR launched in 2020.

"I believe that structured reports and registry participation are truly how we as radiologists and interventional radiologists grow and defend our own existence," says Halin. "It's always better to go to the government or insurers with data. It also helps with industry, who are interested in collaborating with us on devices, so we need to have data."

Like many registries, VIRTEX also allows participants to compare their data to that of similar practices, with the goal of improving quality, the primary reason to participate in registries, according to ACR CEO William T. Thorwarth Jr., MD, FACR. "For example, for inferior vena cava filters, you can look at how often those are being retrieved, and if your retrieval percentage is substantially lower than similar facilities then maybe you should look at what your process is to call those patients back," Thorwarth says.

CATCHING UP TO OTHER SPECIALTIES

More than 20,000 papers on PubMed are related to structured reporting in radiology, with the greatest number of papers on the topic published between 2019 and 2020. The number is not surprising. Data-gathering has flourished since the mid-1990s, skyrocketing with the allure of "Big Data" and its seemingly limitless applications. However, structured reporting in IR, as a way to input and extract such data, has lagged behind that of other radiology subspecialties.

"We're behind other fields in data that support the effectiveness and value of many of our procedures," says Katharine L. Krol, MD, FSIR, FACR, immediate past chair of the SIR Foundation. "We take it for granted that the procedures we've done for 50 years are valuable because we know they help people, but we don't have a lot of data to demonstrate the value to patients and hospitals."

For other medical specialties in which registry participation is required for payment, hospitals and practices must invest in making it easy to submit data elements for procedures and patients, such as through structured reports. "IR covers such a wide breadth of disease processes and body parts, and every practice is different," notes Krol. "For these reasons and because hospitals don't always recognize the value of IR to the hospital and patients, they are mostly unwilling to underwrite or voluntarily participate in registries to the same extent as other specialties."

"I BELIEVE THAT STRUCTURED REPORTS AND REGISTRY PARTICIPATION ARE TRULY HOW WE AS RADIOLOGISTS AND INTERVENTIONAL RADIOLOGISTS GROW AND DEFEND OUR OWN EXISTENCE."

NEIL J. HALIN, DO, FSIR, FAOCR

DEFINING THE VALUE OF IR

"Any specialty can do procedures, and there's a lot of overlap between IR and other specialties," says Kleedehn. "Part of proving your value is that you can do these things better than other specialties can. You have to offer great clinical service as well; it's not just about the procedural care. The VIRTEX registry includes procedural data but also can add lots of clinical follow-up. We've integrated clinic note-related data elements as well. The EHR will directly be able to send info via the structured reports into the VIRTEX registry, and things like lab values, pathologic results, etc., can be directly sent to the registry, so it's not just looking at the procedural component. It's much more holistic and clinically oriented."

To round out the key areas of data collected across the continuum of care, VIRTEX also includes the patient perspective with a patient-reported outcomes component. Patients will be able to directly provide feedback on their quality of life, health, and function, which will enable VIRTEX to track and improve outcomes and well-being longitudinally.

As a specialty, IR often struggles with some procedures being categorized as off-label or not medically necessary. "We are hoping to be able to use registry data to support the efficacy of our procedures and proper reimbursement," says

Stephanie L. Dybul, MBA, RT(R)(VI), CIRCC, a key member of the SIR Standardized Reports Committee.

Although seasoned radiologists will recall a time when data wasn't required to receive payment for procedures and services, as IR and medicine have matured, data are essential. "So the way to ensure we have the data on the breadth of what IR does is through a registry," says Krol. "And how to do that in a way that's inexpensive and that every IR could participate in is using structured reports because they don't require staff on the ground at every hospital to manually pull that data."

USING THE NEW REPORTS

SIR's Version 3.1 structured reports have evolved from initial efforts more than 10 years ago, and an impressive array of opinions — and language recommendations — have helped make the reports friendlier for those who prefer their own way of dictating. "We've tried to open up the scope of this project to bring in more input, going to other groups within the ACR and the SIR to get their input," says Halin. "We consulted with pediatric interventionalists, peripheral vascular specialists, the ACR's LI-RADS® group, and others, which has been very beneficial. Based on input from the pediatric group, for example, we were able to eliminate a lot of unnecessary language and streamline things."

To understand how these structured reports are unique, it's helpful to view early structured reports as templates that help radiologists know how and what to dictate in an interventional case. The new SIR reports go beyond a basic framework, with named data elements and a data structure that specifically allow for automated extraction of data elements to a registry. The non-registry elements can be changed for personal preference or facility use.

In developing the reports, the committee considered the normal workflow an interventional radiologist might use when reading a case. "You have to look at the image, process it, come up with something to say, say it. Then the system must accept it, it must accurately transcribe it, you have to edit it, and the clinician has to read it and understand it," says Halin. "That's a lot of steps. It's important that the conveyance of information be as streamlined and as accurate as possible because there are too many steps and opportunities for error."

Those radiologists who struggle to depart from their narrative style shouldn't panic. The reports

include a free-text block "so that the inner Hemingways can wax poetic," jokes Halin. "You can say whatever you want in that block because the registry isn't looking at that information."

PLANNING FOR THE IMPLEMENTATION

Jeremy Durack, MD, FSIR, began the structured reporting and registry initiatives at SIR and has followed the development of the latest report versions and, like many "new" things, understands that adapting to change can be difficult. "I'm extremely proud of the way the project has evolved," says Durack. "The challenge now is to gain more uptake on the part of clinicians and practices. There's a real task to convince practices of the value of standardized reports when they've used their own custom reports for many years. But research and quality efforts can really be propelled with broader adoption."

Although it takes effort to integrate the reports into the transcription system (reports are available in .rtf and XML PowerScribe formats), they can be customized for an institution or an individual provider or even for each patient. "At first it seems daunting, but the learning curve is very quick," says Kleedehn. "If you don't take the time to get used to the reports, you won't be very happy with them. Use them for at least a couple of weeks before you make any judgment."

ASKING AND ANSWERING QUESTIONS

Big Data, such as the information provided by registries, offers new ways to answer questions, including "How well am I doing my job?" In radiology and IR, both asking and answering this question is critical to patient care, quality and safety, and reimbursement — the trifecta of needs for any physician. Without the information that comes from the registry, that question and others may remain unanswered, and the specialty will suffer.

"I really see registry participation as a must-do," says Krol. "If we don't have people participate, IR is at significant risk in the future because I don't think the payment and coverage will be where we want it to be, we will not be able to attract candidates to the specialty, and it will limit patient access."

It can be difficult to understand the big picture promised by Halin and Kleedehn, but any temporary discomfort of adaptation can give way to improved efficiency. "I can dictate a report so much faster now," says Halin. "I hope people out there will see this and see it's a good idea. Any one of us on the committee or in SIR support staff ([available at virtex@sirweb.org](mailto:virtex@sirweb.org)) would be happy to provide support on how to make the reports work for someone, how to make them their own. Once people adopt them, there's very little downside." **B**

By Raina Keefer, contributing writer, ACR Press

"I REALLY SEE REGISTRY PARTICIPATION AS A MUST-DO. IF WE DON'T HAVE PEOPLE PARTICIPATE, IR IS AT SIGNIFICANT RISK IN THE FUTURE..."

KATHARINE L. KROL, MD, FSIR, FACR

Delving Into Data Breaches

ACR members should conduct a data security audit to stay out of legal trouble.

A famous commercial memorably closed with “American Express — don’t leave home without it.” That pitch resonates in the cybersecurity space. Why? Patient data are vital to so many individuals, including ACR members. Yet, it has left the digital “home” of too many healthcare stakeholders in 2022. Reports of patient data breaches dominate health news.

Radiology has confronted this challenge, with some practices and related organizations enduring breaches and addressing their legal and reputational impact.¹ In this column, we focus on a recent court ruling in a class-action case against a radiology group and radiology services company that involved a breach of patient data. We will analyze the case’s implications for members and their practices. A main takeaway is to safeguard your patients’ data and prepare for potential government inquiries and private lawsuits.

The case involves Northeast Radiology PC and Alliance HealthCare Services in federal court in New York state.² Northeast is a radiology practice with locations in New York state and Connecticut. Alliance is an outpatient imaging company that owns and operates more than 80 radiology and oncology centers throughout the United States. Northeast and Alliance formed a partnership in which Northeast’s New York and Connecticut offices joined Alliance’s radiology division and now function as Alliance fixed-site locations.³

An independent cybersecurity analysis in 2019 identified “major flaws” in Northeast’s and Alliance’s PACS that allowed “unauthorized access to more than 1.2 million patients’ medical records.”⁴ The researchers analyzed 2,300 PACS, including those of Northeast and Alliance.⁵ This supposed gap involved “at least 61 million X-rays, CT scans, MRIs, and/or other imaging studies that contained extremely sensitive electronic protected health information (e-PHI) — such as medical test results, diagnoses, and procedure descriptions — in addition to patients’ names, Social Security numbers, dates of birth, and addresses.”⁶

The researchers subsequently informed journalists of their work. A January 2020 article regarding the data breach named Northeast and Alliance and described their deficient security features, including a lack of security encryption or passwords, that apparently exposed the 1.2 million records on the Internet. These reports apparently motivated an earlier class-action lawsuit against Northeast Radiology in February 2020 in New York federal court. They eventually agreed to dismiss their lawsuit after Northeast contested their allegations.⁷

In March 2020, Northeast and Alliance notified patients about a significant data breach that had occurred over a period of at least nine months. The companies disclosed they had investigated the breach and determined that unauthorized individuals had accessed at least 29 patients’ information. But Northeast and Alliance could not pinpoint how many of the “[o]ther patients’ information ... also available on the [PACS] was compromised.”⁸

Government agencies entered the picture because Northeast and Alliance alerted the New York and Connecticut Offices of the Attorney General. The attorneys general from both states then investigated the breach.

Based on these developments, two individuals who had imaging at Northeast between 2016 and 2019 brought a class-action lawsuit against Northeast and Alliance in July 2021. These plaintiffs alleged that the defendants negligently failed to protect their data and the data of other individuals who had obtained imaging services from the defendants. Notably, the plaintiffs claimed that the cyber researchers had advised Northeast and Alliance of their discoveries, but the defendants had disregarded the findings. The allegedly deficient PACS posed an “ongoing imminent risk of identity theft and fraud because, unlike a credit card, there is no way to cancel e-PHI.”⁹ The plaintiffs asserted that had they realized that defendants failed to use adequate security measures, they would have gone elsewhere to receive imaging.¹⁰ However, the plaintiffs alleged no misuse of patient data.

The trial court granted a motion from Northeast and Alliance to dismiss in May 2022. The court ruled that the plaintiffs failed to prove they had standing, or the right to lodge a complaint. A claim of an injury can win only if plaintiffs establish that they actually were harmed by a defendant’s action. The court relied on a 2021 U.S. Supreme Court decision which held that one must prove that “exposure to the risk of future harm itself causes a separate concrete harm.”¹¹ Here, the plaintiffs failed to show that third parties actually misused or attempted to misuse their health data.¹²

The court further determined that plaintiffs offered no evidence the data breach was “a targeted attempt to perpetuate identity theft.”¹³ Consequently, it held that the risk of actual harm was too remote. The plaintiffs initially appealed the ruling but withdrew their appeal in August 2022.

ACR members might believe this case means data breach lawsuits generally will lose. Not necessarily. The radiology practice and its radiologists prevailed. But they still suffered a data breach, incurred legal fees, and lost time. Additionally, the lawsuit may well raise questions in the minds of current and future patients about the integrity of their data at the radiology practice.

You may be required to report data breaches at your practice to federal and/or state authorities. That may lead to a HIPAA and/or a state investigation under privacy and data security laws. The HIPAA regulators — the Office for Civil Rights — could impose significant fines and force your practice to take remedial actions.

As troubling, class actions have emerged as another threat to members and their practices. Several law firms have sought to capitalize on data breaches by advertising for clients.¹⁴

How to act? Retain qualified counsel and IT professionals. Conduct a data security audit to learn where strengths and vulnerabilities exist. You can tailor it to your practice. Reasonable steps will help you stay ahead of the legal curve — and out of the courtroom. **B**

By Bill Shields, JD, LL.M., CAE, general counsel, and Tom Hoffman, JD, CAE, vice president, ACR Legal

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

Be a Part of the Next Decade of Leadership



As the RLI closes out its 10-year anniversary celebration, the team looks to the future.

The ACR is a longtime advocate for the impact that radiology leadership skills can have on the delivery and advancement of high-quality healthcare. Since its inception in 2012, the Radiology Leadership Institute® (RLI) has embodied that value proposition — teaching radiologists the business and management skills to successfully navigate a shifting healthcare environment.

Over the course of this series commemorating the RLI’s 10-year anniversary, the *Bulletin* looked back at the history of the RLI, the topics and skills that are critical to advancing the careers of future radiology leaders, and how its world-class faculty designs the RLI courses to keep pace with changing times. In the final installment of this four-part series, the *Bulletin* connected with ACR staff and RLI leaders and faculty who are forging the path to the next decade of radiology leadership.

Building a Culture of Leadership

In 2022, the RLI celebrated a decade of educating strong radiology leaders. At the same time, the team guiding the RLI recognized that the challenges facing today’s radiologists have never been greater. “To help the specialty navigate an increasingly complex practice environment, we convened a series of ‘listening

sessions’ comprising radiologists at all career stages and practice environments to gain insights to guide our strategic vision and the programs that will help radiologists succeed into the next decade and beyond,” says RLI Chief Medical Officer Frank J. Lexa, MD, MBA, FACR.

Coupled with the ACR Strategic Plan ([available at acr.org/strategic-plan](https://www.acr.org/strategic-plan)), the input from radiologists gathered in the sessions helped the RLI team formulate a “manifesto” for the future — a set of four pillars expressing shared values and beliefs that will guide decisions about developing next-generation leadership programs to help members tackle the challenges ahead:

- Pillar 1:** Leadership is for everyone.
- Pillar 2:** Leadership education should begin early and be a lifelong endeavor.
- Pillar 3:** Non-interpretive training and volunteerism should be highly valued across all practice environments.
- Pillar 4:** A foundational set of leadership skills is imperative.

“The RLI is committed to ensuring all radiologists are ‘future-state and leadership ready,’ and we believe that by focusing on these four areas, we will be able to accomplish that and deliver the most value in the coming decade,” says Anne Marie Pascoe, senior director of the RLI. “It’s essential that we not only help individual radiologists succeed, but that we give them tools to help their departments and practices succeed.”

So, what’s next for the RLI? There are four pillars that RLI leaders say will lead the program into the future.

Pillar 1: Leadership Is for Everyone

We believe it is critical for radiologists at all career levels, regardless of title, to have strong leadership skills.

Whether leading a department or practice or serving in a clinical role, these non-interpretative skills support the development of more effective teams, enable the creation of stronger relationships within and across practices and the health system, provide a structure for managing the inevitable changes radiologists face, provide mechanisms to facilitate better communication and deal with difficult situations/people, and provide a framework to understand the importance of strategic planning and ensure radiology is prepared to meet all future challenges.

All radiologists have a role to play in the future success of their practice/department and the specialty, and it will be important that the RLI continues to share this message and provide examples of the way radiologists are leading at all levels.

The future state of healthcare will impact every radiologist — whether you're in a leadership role or a practitioner in a reading room or interventional procedure suite. According to Richard Duzak Jr., MD, FACR, chair of the department of radiology at the University of Mississippi Medical Center, radiologists can no longer float along with the current; otherwise, they'll wind up on the rocks. "Chance favors the prepared mind," he says. "You might not have a title but, as a physician, you have to be a leader to be effective. Leadership training is what takes you from being a good radiologist to being a successful one."

As CEO of Triad Radiology Associates, Lauren P. Nicola, MD, feels strongly that radiologists shouldn't wait until they've practiced for decades to consider taking on leadership roles. "We try to get people involved in committee and leadership roles early on in their careers. We want the future of our practice to be driven by the people who will be there the longest. Having a voice is important, and anybody who wants to make their voice heard needs skills in communication, change management, setting goals and priorities, negotiation, and many other things that aren't taught in medical school and residency. That's where the RLI comes in."

Pillar 2: Leadership Education Should Begin Early and Be a Lifelong Endeavor

We believe leadership education should begin in medical school and be embedded as a component of every resident curriculum.

The RLI will work to continue to increase engagement with medical students and residents. It is never too early to start building a strong foundation and talking about the variety (and importance) of leadership opportunities that are available during medical school, residency, and throughout a radiologist's career. The RLI is committed to providing programs for residents and fellows and, in the coming years, will work to expand our reach further into residency programs.

The ACR is formalizing a process to create meaningful opportunities to engage medical students in the work of the College in alignment with the ACR Strategic Plan. The RLI is committed to

increasing its role in these medical student initiatives and developing future leaders.

When asked about the optimal time to start leadership training, Lexa says, "There's an old cliché that the best time to plant a tree was 20 years ago. If you want to be a good leader, the time to get training was yesterday. Everyone needs to take steps to be leadership ready. So, when the opportunity presents itself or the need arises in an organization, radiologists are prepared, and they can step in and be most effective."

As a member of the ACR BOC, Duzak serves as chair of the Commission on Leadership and Practice Development and, in that role, helps oversee the RLI. "It helps if you start early with leadership development — before you know you need the skills," he says. "A key goal of the RLI is to help teach the teachers so that this becomes self-sustaining within the culture. Empowering people can be quite contagious. The goal of a leader should be to build future leaders, not simply create followers. That's where the magic happens. People can take action and accomplish things on their own without lots of handholding — all because you've made it clear where the organization is headed."

Pillar 3: Non-Interpretive Training and Volunteerism Should Be Highly Valued Across All Practice Environments

We believe that the value of non-interpretive training and volunteerism should be understood and embraced by everyone in every practice or department.

The discussion around the value that radiologists add for their non-clinical work is well established, but it is important that radiologists understand the importance of volunteerism and the value it brings to a practice or department and to the specialty as a whole.

Enroll in the RLI

Now more than ever, strong radiology leaders are needed to provide crucial guidance to fellow physicians and patients. Learn more about how the RLI can help you become a stronger leader at [acr.org/RLI](https://www.acr.org/RLI).



"It's critical for practices and departments to invest in leadership skills and provide opportunities to a broad and diverse group so they can exercise their leadership muscles and build their strengths."

FRANK J. LEXA, MD, MBA, FACR

The RLI will work to help reshape the culture to encourage an increased level of support for those who want to serve in volunteer roles in their practices, their institutions, and professional organizations. We will highlight the short- and long-term value that volunteerism brings — personally, professionally, and to the specialty — so that it becomes embedded into the culture.

Today's RVU-driven culture is often the biggest roadblock to developing radiology's future leaders. Building a culture of leadership requires a shift in mindset and a deeper understanding that non-clinical training is highly valuable and should be supported for every team member.

"It's critical for practices and departments to invest in leadership skills and provide opportunities to a broad and diverse group so they can exercise their leadership muscles and build their strengths," says Lexa. "In that way, you're building a cadre of leaders versus having a small number of people making most of the key decisions. That's how to future-proof your practice or department."

Ryan K. Lee, MD, MBA, chair of radiology for the Einstein Healthcare Network and an RLI faculty member and co-chair of the RLI Resident Milestones program, notes that the ROI pressure is on for both private practice and academia alike. "The clinical work radiologists perform continues to grow, which in turn decreases time available for leadership development. It's left up to individual practices and departments to figure out how to cover non-clinical time when there aren't enough radiologists. Today's radiology leaders need to develop a plan that allows the organization to invest in leadership training. We absolutely need people to take care of patients, but we also need individuals to steer our practices in the right direction and help us evolve with the times."

Pillar 4: **A Foundational Set of Leadership Skills Is Imperative**

We believe that all radiologists, regardless of career stage and role, should have proficiency in a foundational set of leadership principles.

At every stage of their careers, radiologists can benefit from leadership training. It is important that radiologists understand strategy, finance, business planning, and other non-clinical topics. To succeed in academics or private practice, they need to know how to build strong teams, manage change, and overcome difficult work situations. The RLI can provide the keys for success at each step in the career path.

Radiologists who want to hold their own among the ever-shifting healthcare landscape must deepen their knowledge of business and leadership practices. While some physicians choose to pursue a business degree to gain leadership skills, the ACR aims to put that knowledge within reach of all radiologists — with programming that was designed by radiologists for radiologists.

"In the next decade," says Lexa, "we want to deliver leadership programs that have high impact and are useful to radiologists at all stages of their careers. Our goal is to help them be better leaders and to contribute to their practices and to the specialty. Another goal is for us to make foundational leadership training as accessible and affordable as we can and to ensure that training and education is compatible with the work and lifestyle of radiologists."

"Leadership training's the one thing that will make you

indispensable," Nicola says. "Being a good radiologist has many facets, but the one thing that's going to lead to job security and potential for advancement and satisfaction in what you do every day is leadership training and lifelong learning. That's where the RLI excels. These are the core things that will help you become a better radiologist and enhance the specialty. That's true for radiology and for medicine, in general. We need to get the leadership skills that will allow us to stand on par with the non-physician administrators who are in leadership roles. It's the only way we can ensure that patient care looks the way we think it should."

Paving the Way for the Future of Radiology

For the past 10 years, the RLI has helped more than 9,000 participants — ranging from residents to young professionals to seasoned leaders — fill critical gaps in their non-interpretive skills. Looking to the future, Pascoe says that the RLI aims to reach even more radiologists and notes that there are two keys to success in the next decade of radiology leadership: community and collaboration.

"When you have community, you have a shared mission that exemplifies the value of leadership. Everyone can find a place," Pascoe says. "Participants can come together in a safe space to share ideas, brainstorm solutions, gain perspective, and tackle challenges. The more people who are a part of the RLI, the stronger the community becomes and the more value it provides."

She adds, "Collaboration is the long pole in the tent when it comes to value-based care and contributing to population health. Prioritizing collaborations within the ACR and with medical schools, residency programs, other national societies, international partners, and other specialties is how we will continue to foster and grow the RLI community. More broadly, my hope is that we'll see more radiologists collaborating with other specialties and departments within their institutions and be seen as valued members of the patient care team for decades into the future." **B**



"The more people who are a part of the RLI, the stronger the community becomes and the more value it provides."

ANNE MARIE PASCOE

By Linda Sowers, freelance writer,
ACR Press

Leadership Is for Everyone

A new year is fast approaching. Hit the ground running with new leadership skills to advance your career and make an impact on your practice, the specialty, and your patients.

You don't need a title to be a radiology leader. Join the free RLI Power Hour webinar — Leadership Is for Everyone — Jan. 10, 2023, from 7 to 8 p.m. ET and be part of the next decade of radiology leadership. Register at acr.org/powerhour.

Joe Hsu, MD, co-director for the coronary CTA course, is pictured at the ACR Education Center.

A Long-Awaited Return

In-person courses have resumed at the ACR Education Center, much to the excitement of the College and its members and just in time for the Center's 15th anniversary.

The COVID-19 pandemic affected the College's educational offerings in many ways, including putting a pause on in-person courses at the ACR Education Center in Reston, Va. But with the Education Center having reopened in its original location in September, in-person courses have resumed, and members of the College couldn't be happier.

"We have been anticipating and planning for the return to in-person courses at the ACR Education Center for over two years," says Lori Deitte, MD, FACR, chair of the ACR Commission on Publications and Lifelong Learning. "These courses provide an unparalleled, individualized, hands-on experience that simulates real-life image interpretation at the PACS workstation. We have received many testimonials on the value of this experience, and numerous questions asking when the Education Center will return to in-person courses. We are absolutely thrilled to reopen our doors and welcome our members back to this highly valued in-person learning experience."

It all started in 2007 for the ACR Education Center. Past ACR BOC Chair James H. Thrall, MD, FACR, credits two members with having a big impact in its formation. "Arl Van Moore Jr., MD, FACR, and former ACR CEO Harvey L. Neiman, MD, FACR, asked me to put together a little program statement," Thrall says. "At the same time, Dr. Neiman worked with the chief financial officer of the College to put together a financial plan for the Education Center. We took the program statement and the financial plan to the BOC, and Dr. Moore presented it. It was overwhelmingly supported. Then Dr. Moore and Dr. Neiman immediately assembled the technology and the people to make it happen." By 2008, the Education Center opened its doors at the ACR headquarters in Reston.

The Education Center presented a unique opportunity for radiologists to get hands-on experience in what they would be doing in their practices, while having room to grow from trial and error. "At that point in time, most people were getting their

education either through attending lectures or through reading papers," says Daniel Karolyi, MD, PhD, lead for the ACR Education Center Advisory Committee. "The Education Center was meant to be a real-world simulator of what actual practice is, knowing that most radiologists learn best by looking at cases, reviewing cases, and learning from their mistakes. It was meant to be a simulated environment where people could learn from those mistakes without causing any patient harm, and then take those new skills back to their practices."

The hands-on experience the Education Center provided couldn't be matched, so when the COVID-19 pandemic struck in the spring of 2020, the Education Center, just like every other business around the world, had to adapt. Deitte says the Commission on Publications and Lifelong Learning used this time to step back and analyze how the Education Center operated and how it could adapt to this new environment. When the world began to trend toward remote/virtual education, the Education Center started producing virtual micro-courses. Today those include pre-recorded lectures and faculty case review sessions as well as faculty case review sessions, and full DICOM cases that radiologists can take on their own time to earn CME and SAM credits.

While these micro-courses were a great alternative during the pandemic, the College knew they weren't a true substitute to in-person sessions. "In-person education is vitally important because there are members who enjoy the interaction of the in-person environment with high faculty-to-student ratios," says ACR CEO William T. Thorwarth Jr., MD, FACR. "They get the true simulator experience of the Education Center, which is unique and, quite

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ACR Education Center at a Glance

The ACR Education Center's offerings now include a blend of both in-person, hands-on learning through the Center's real-world simulation experiences and virtual micro-courses participants can take at their own pace.

PARTICIPANTS	COURSES
In-person: more than 15,000 since 2007	In-person: 16 developed since 2007
Virtual: more than 1,300 since 2020	Virtual: 21 developed since 2020

For more information, visit acr.org/EdCenter.



Improving LCS Adherence

The ACR's new education efforts aim to make a difference for patients when it comes to lung cancer screening.

The ACR Lung Cancer Screening Registry (LCSR) helps clinicians monitor and demonstrate the quality of lung cancer screenings (LCS) in their practices through detailed feedback reports that include peer and registry benchmarks. Because screening is performed on an asymptomatic population, there is an added responsibility for the medical community to ensure that risks and benefits are adequately measured and monitored. Contributing data to the LCSR not only helps clinicians improve their own quality of patient care, but also helps improve and refine LCS care for everyone at the national level.

The *Bulletin* recently spoke with Shawn D. Teague, MD, FACR, lead for the ACR's LCSR Quality Improvement (QI) Education Subcommittee and associate professor with National Jewish Health/University of Colorado about the LCSR's new QI initiative to help participating facilities use their LCSR reports to improve patient care. A Plan-Do-Study-Act (PDSA) process was developed that offers step-by-step guidance for conducting a QI initiative focused on three LCSR measures: achieving appropriate radiation dose, increasing adherence to annual screening, and improving smoking cessation rates (the latter two LCSR measures are new).

Why has the ACR been pursuing new LCSR QI opportunities?

Our work emphasizes the QI opportunity of the LCSR. It is important to understand the LCSR is not static — as ideas for

new LCSR measures and LCS program performance reports arise, the ACR staff and volunteers continue to expand the registry's scope and functionality. For example, the PDSA process we are working on includes a new reporting tool that enables you to review your LCSR performance data over a custom time period before and after implementing a QI project for one of the three PDSA-focused measures. By utilizing the reporting tool and the PDSA process, the best potential opportunities to improve performance for LCSR Corporate Accounts (available at bit.ly/NRDR_Act_Prof) can be identified. For example, a corporate account with multiple facilities can identify which facilities may benefit the most from implementing a QI project.

What is the intended impact on patients and benefits for participants?

Improving patient outcomes is the overarching goal of the program with a focus on smoking cessation and identifying lung cancer at the earliest possible stage. In addition, physicians can earn up to 20 CME by completing an LCSR PDSA project, and participation can count as a QI project for your ABR Part IV Maintenance of Certification credit.

How is new data helpful for sites looking to better serve patients through LCSR participation?

We are giving practices the data to help guide their effectiveness. For example, they can find out what percentage of patients are coming back for their annual LCS — and how each site compares to similar radiology sites around the country. It is a way to discover how well they are performing. We have also created

continued on page 22

A Look at Lung-RADS 2.0

Exploring questions around lung cancer screening leads to better patient outcomes.

“Lung-RADS has evolved to meet the needs of both patients and radiologists in providing lifesaving care. With Lung-RADS, we are able to more accurately detect, classify, and manage cancer in its earliest, most treatable stage,” says Jared D. Christensen, MD, MBA, director of the Duke University Lung Cancer Screening (LCS) Program, vice chair and associate professor of radiology at Duke University Medical Center, and chair of the ACR Lung CT Screening Reporting & Data System (Lung-RADS®) Committee.

Lung-RADS is a quality assurance tool designed to standardize LCS CT reporting and management recommendations, reduce confusion in LCS CT interpretations, and facilitate outcomes monitoring. A complete lexicon of LCS CT terms, classification, and follow-up guidance standardizes the language used in reports. The *Bulletin* recently caught up with Christensen about the latest updates to the Lung-RADS tool (available at acr.org/Lung-RADS).

What is the goal of Lung-RADS?

The ultimate goal of Lung-RADS is to identify findings that may represent lung cancer and provide appropriate and timely management guidance to reduce lung cancer mortality. Achieving this goal is a multifocal approach that involves engagement by patients, referring physicians, and radiologists.

How is lung cancer research tied to Lung-RADS?

The accuracy and overall benefit of Lung-RADS is directly tied to research. We encourage ACR members who have an interest in lung cancer to explore questions around screening and the impact on patient outcomes. It is all about data. For instance, the new criteria for atypical pulmonary cysts and juxtapleural nodules are predicated on available research. The strongest and most reliable recommendations come from evidence-based data. In the absence of such data, we rely upon expert consensus to inform best practices.

What is new with Lung-RADS 2.0?

Lung-RADS 2.0 makes some significant updates to our classification system. We have added new classification criteria for atypical pulmonary cysts. Up to 6% of all lung cancers have an associated cystic component, and cystic lesions were difficult to categorize in version 1.1. We have also expanded management criteria for juxtapleural nodules — version 1.1 applied only to perifissural nodules that met specific shape and size criteria. However, new research suggests we can apply similar criteria to all nodules along the pleural surface. There are several other updates that provide clarity to the system, including additional guidance for endobronchial

nodules, stepped management criteria for follow-up of suspicious nodules, and guidance on how to handle interval diagnostic CTs in screening. Finally, we plan to release a text and image-based Lung-RADS atlas that will illustrate how to apply Lung-RADS in clinical practice. Whenever we make changes, we strive to balance potentially increased complexity with the overall benefits of patient care. As a committee, we have attempted to keep things as simple as possible to facilitate adoption.



Jared D. Christensen, MD, MBA

We believe the updates in Lung-RADS 2.0 help accomplish that objective. Simply put, low-dose CT screening saves lives by reducing lung cancer mortality.

Why are these updates important?

Much like with other image-based systems or tools, Lung-RADS provides a standardized way to communicate and report findings with evidence-based management recommendations. Although most nodules are benign, we want to capture suspicious nodules that could represent lung cancer and facilitate early treatment. We believe the updates in Lung-RADS 2.0 help accomplish that objective. Simply put, low-dose CT screening saves lives by reducing lung cancer mortality.

What are the secrets to your success?

The ACR Lung-RADS Committee is very diverse — representing diversity in experience and in practice, with both community and academic programs represented, as well as in gender, race, and ethnicity. Over the past three years, the committee has grown along these parameters to bring to the table the most robust expertise and perspectives around LCS. Such diversity results in better outcomes.

What should ACR members take away from this?

I would love all ACR members to recognize that the Lung-RADS system has been developed to benefit patients — it saves lives. For radiologists, it helps us provide better and more timely care. I would also stress that while CMS no longer requires reporting to the National LCS Registry, the ACR strongly encourages programs to continue registry participation — because data from the registry help inform future Lung-RADS updates. We need radiologist engagement to ensure continued progress in LCS. **B**

Interview by Chad Hudnall, senior writer, ACR Press

Proving the Value of Imaging

Celebrating 10 years of research, the Harvey L. Neiman Health Policy Institute® continues to shape health policy through the radiology profession.



“We involve a wide range of stakeholders to ensure that we understand what radiologists and policymakers are concerned about, so we can build our research agenda to directly address those issues.”

ELIZABETH Y. RULA, PHD

Before the ACR established the Harvey L. Neiman Health Policy Institute® (HPI) in 2012, practice leaders and policymakers had to make decisions about imaging services without knowing how changes would affect individual patients or overall healthcare systems. To connect these dots, the HPI has spent the last decade producing research to help practitioners and policymakers make informed decisions that facilitate access to effective radiologic care, improve patient outcomes, and promote efficiency in the healthcare system.

“At the HPI, our goal is to objectively measure the value radiology is adding to the overall healthcare system, and ensure all patients have access to imaging for screening, diagnosis, and minimally invasive procedures,” says Elizabeth Y. Rula, PhD, executive director of the HPI since 2020. “Our research is a foundation to the future strategy of radiology, paving the way for access and reimbursement that will improve patient care.”

Through collaborative research, self-service data tools, academic training, and other outreach, the HPI provides credible resources to guide imaging practices and policies forward as healthcare rapidly evolves. In part two of a three-part series celebrating the HPI’s 10 years of research and excellence, the *Bulletin* dives into the HPI’s external-facing work and how it impacts the radiology community, keeps policymakers and other stakeholders informed with evidence, and ensures the HPI is positioned for the future.

Shaping Future Policies

Researchers at the HPI work closely with radiologists, lawmakers, academic and economic leaders, and other stakeholders to set strategic research priorities relevant to the changing times. The team has worked with more than 92 unique authors in over 35 institutions. These studies are regularly published in peer-reviewed journals, typically 30 per year, which are picked up by the press, expanding the HPI’s impact far beyond the ACR.

“All of our research is collaborative,” Rula says. “We involve a wide range of stakeholders

to ensure that we understand what radiologists and policymakers are concerned about, so we can build our research agenda to directly address those issues.”

Generally, the HPI pursues five research themes: payment models, imaging value propositions, practice advancement, workforce development, and health equity. In addition to these pillars, the HPI examines pressing issues like the CT contrast shortage and reduced mammography screening utilization due to COVID-19-related shutdowns, offering mitigation strategies to help radiology practices adapt to current and coming challenges.^{1,2}

“We’re able to quickly respond to emerging issues to ensure that radiology can be well-positioned to add value in these new healthcare paradigms,” Rula says. “We balance these urgent needs with our proactive research agenda to address the big issues up the road.”

Assessing Healthcare Costs

To access additional expertise and ensure objectivity, the HPI established academic research centers like the Health Economics and Analytics Lab (HEAL) at the Georgia Institute of Technology’s School of Economics, and the Policy Research and IMaging Effectiveness (PRIME) Center inside the Institute of Health System Science at the Feinstein Institutes for Medical Research at Northwell Health. These research partners support the HPI’s mission to generate evidence-based imaging recommendations to inform health policy and improve population health.

“The focus of the PRIME Center is to demonstrate the value of imaging by assessing the health benefits and costs associated with radiology services,” says Pina C. Sanelli, MD, MPH, FACR, director of the NHPI PRIME Center since it opened in 2018. “We study new imaging technology and perform cost-effectiveness analyses to show how much it would cost to improve health outcomes.”

For example, the PRIME Center assessed the costs, benefits, and trade-offs between comprehensive and stepwise imaging for acute stroke patients.³ The research revealed that comprehensive imaging strategies yield better health outcomes, and comprehensive CT provides the most cost-effective approach.

“The research we generate provides the evidence that shapes the guidelines and

recommendations for how we practice medicine, and that drives policy decisions,” Sanelli says. “The cost of care becomes incredibly important when changing policies, so part of our mission is to help policymakers understand the costs while focusing on improving patient outcomes.”

Leveraging National Data

Conducting objective research is only part of the HPI’s legacy. The other piece is translating and sharing these insights through scientific articles as well as robust online data tools — like the Neiman Almanac (available at neimanhpi.org/almanac) which aggregates years of information from various sources and provides more than 100 data series within the tool.

“For years, there was a lack of reliable national data about imaging economics and radiology utilization,” says Shawn Farley, director of public affairs for the ACR. “That information didn’t exist — or if it did, it was hard to find. The HPI has been a godsend because it makes it easy to get accurate information to providers, reporters, and the public. We can link directly to the data, so it’s easily consumable by people who are not researchers or doctors.”

The HPI has access to national Medicare and private payer data dating back to 2004. “This allows us to see trends over time, understand the impact of policy change, and project what’s coming in the future,” Rula says. “Having these huge data sets allows us to not only answer questions at the national level, but also to drill down and understand factors influencing health locally at the community level.”

Committed to continually enhancing these data assets, the HPI is acquiring claims datasets from Medicaid and the Children’s Health Insurance Program (CHIP) that will contain 100% of beneficiary claims from 2018 and 2019. “This data will generate new insights to drive policy decisions for these often-underserved populations and help us understand the impact of state Medicaid policies,” Rula says. “It’s very exciting.”

Funding Future Research

To foster novel research from future radiology leaders, the HPI also facilitates the Neiman Institute Grants Program. Two grants are awarded annually to radiology research topics that align with the institute’s mission, focusing on areas like AI and emerging technology, emerging payment and population health models, and practice advancements. The current grant application cycle closes on Nov. 8 (learn more at neimanhpi.org/grants-fellowships).

Last year, the HPI also established a

fellowship through the PRIME Center with the goal of training young radiologists interested in health services and policy research. What makes the fellowship unique, Sanelli says, is that it combines these research disciplines into a single experience, supported by mentorship.

“It’s important to foster the research interest and skills of early-career radiologists. Through this fellowship, we hope to build a pipeline of researchers who will continue to contribute to the mission of the HPI,” says Sanelli, who oversees the program. “The fellow learns how to demonstrate the value of imaging technology and understand its impact, providing evidence that will inform health policy and radiology practice.”

Creating a Legacy

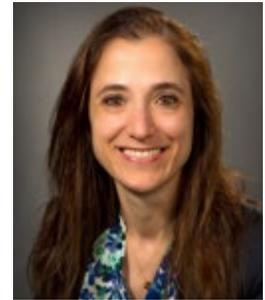
Just 10 years since its formation, the HPI is already advancing the role of imaging in the health system. As an ACR board member once told Rula, “The HPI is a crown jewel of the ACR,” because it adds value to the profession far beyond the reading room.

Rather than looking back at the last 10 years of accomplishments, the HPI’s leaders and partners are looking to the future as they equip stakeholders with the research to move medicine forward.

“The Neiman Institute importantly raises awareness of imaging evidence to a variety of stakeholders who influence the future of healthcare delivery, including the policymakers who are making the recommendations and the radiologists and healthcare leaders who are implementing the recommendations,” Sanelli says. “This is important in ensuring that future imaging policies actually benefit patients.” **B**

By Brooke Bilyj, freelance writer, ACR Press

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



“It’s important to foster the research interest and skills of early-career radiologists. Through this fellowship, we hope to build a pipeline of researchers who will continue to contribute to the mission of the HPI.”

PINA C. SANELLI, MD, MPH, FACR



HPI HARVEY L. NEIMAN
HEALTH POLICY INSTITUTE®
Studies in Health Care and Economics

HPI Celebrates 10 Years of Excellence

In 2012, the ACR and the late Harvey L. Neiman, MD, FACR, made a bold move to impact the national health policy debate by forming the Harvey L. Neiman Health Policy Institute® (HPI).

To celebrate a decade of accomplishments and progress, the *Bulletin* is looking back at the highlights the HPI has provided these past 10 years. To learn more about the HPI and how it is having an impact, visit neimanhpi.org

Mentoring Military Members



LTC (Ret.) Peter Van Geertruyden, MD, FACR



Jennifer E. Nathan, MD

A new ACR program will guide active-duty military radiologists in the transition to civilian practice.

Transitioning from the military ranks to the civilian workforce can be challenging, especially for those who have experienced overseas deployments, combat tours, time away from family, and multiple household moves. To help redress these sacrifices, the Military Radiology Committee supporting the ACR Commission on General Small, Emergency and/or Rural Practice has launched a new Military Radiology Mentorship Program, which will pair an active-duty military radiologist with a prior-service military radiologist to aid in the transition to civilian practice. The ultimate goal of this mentorship program is to guide the mentee with both short-term and long-term career aspirations.

“Military radiologists usually exit military service as astute seasoned radiologists with

leadership experience and a strong work ethic,” says Col. Robert A. Jesinger, MD, FACR, radiology consultant to the U.S. Air Force Surgeon General. “Having a mentor provide advice on private-sector radiology opportunities and challenges can assist military radiologists in decision-making.”

Jesinger is one of the leaders kickstarting this new ACR program, supporting the work of Jennifer E. Nathan, MD, and LTC (Ret.) Peter Van Geertruyden, MD, FACR, co-chairs of the Military Radiology Committee. To participate in the mentorship program, a military radiologist mentee submits a questionnaire to identify a potential prior or retired radiologist mentor match. The questionnaire will include topics such as geographic area of interest, specialty type, and work setting. The goal of the program is to guide ACR military members on their pathway to civilian employment. **B**

By Julie Huxsoll, ACR member services supervisor

To begin your military mentorship journey, contact military@acr.org or visit acr.org/military.

Supporting Veterans Affairs

Radiologists and radiation oncologists who work with the Veterans Health Administration can now consult the ACR website for information and are invited to join the ACR Veterans Affairs Committee.

A centralized source of resources has been published to the ACR website in support of and focused on radiologists and radiation oncologists who serve in the Veterans Health Administration.

Members who are employed by the Department of Veterans Affairs are encouraged to review ACR.org/VeteransAffairs to identify programs that

support ACR members who provide healthcare services for U.S. veterans.

As chair of the ACR Veterans Affairs Committee, Ian A. Weissman, DO, FACR, joins committee members in sharing updates on recent initiatives. “We are confident that this powerful website resource developed through the ACR will empower VA radiologists and radiation oncologists,” he says. “We welcome VA physicians to serve on the ACR Veterans Affairs Committee, where we are exchanging knowledge with VA and non-VA physicians across the nation, sharing resources and developing projects with the goal of providing the best care for our patients.” **B**

To learn more about VA membership and education discounts, visit acr.org/VeteransAffairs or contact VeteransAffairs@acr.org.



“We are confident that this powerful website resource developed through the ACR will empower VA radiologists and radiation oncologists.”

IAN A. WEISSMAN, DO, FACR

What are some of your key takeaways from the 2022 ACR Richard L. Morin, PhD, Fellowship?



“The Morin Fellowship is currently the most publicly available path for junior medical physicists to start working with the ACR Commission on Medical Physics. Serving as a Richard L. Morin Fellow has given me numerous opportunities to better understand advocacy, the socioeconomic aspects of the radiology and medical physics community, and regulatory considerations in clinical practice parameters. Also, ACR 2022 provided me with a unique window to observe a reconciliation discussion during the Medical Physics Caucus and learn more about ongoing advocacy efforts.”

Shengwen (Sean) Deng, PhD, medical physics resident at University Hospitals Cleveland Medical Center



“As a medical physicist in training, my understanding of the clinical impact the ACR has in radiation oncology was limited to accreditation standards. Thanks to the opportunity provided by the Richard L. Morin, PhD, Fellowship, I can comprehend the immense impact that the ACR has in the development of policies and clinical standards used in radiation therapy daily. As a Morin Fellow, I was able to witness ACR governance and advocacy efforts at ACR 2022. During that time, I enjoyed one-to-one interactions with members of the ACR Commission on Medical Physics that have helped me define long-term career goals that align with the mission of the College. I have come to realize that it is not only necessary to provide clinical guidelines, but to encourage all practicing members to strive for a higher quality of care and communicate it effectively.”

Ana Dieguez, MS, medical physics resident at Oregon Health and Science University in Portland

IMPROVING LCS ADHERENCE

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educational resources and suggested tactics to support LCS sites in improving performance on each of the three measures. We have seen participation continue to increase in the LCSR and know people are finding value in it, but we want to continue to develop new value-added features.

What is the LCSR QI Education Subcommittee working on around adherence to annual screening?

The adherence to annual screening measure identifies the percentage of patients enrolled in an LCS program who adhere to the recommendation of a yearly routine screening CT. These patients may not have anything concerning detected from prior scan results; however, published research documents the importance of an annual screening for eligible patients to detect lung cancer at an early stage — similar to patients who are recommended to have an annual routine screening mammogram. Prior to this project, the measure and performance data were not available.

What role does CMS play in changes to the LCSR?

CMS no longer requires reporting to the LCSR's database for reimbursement. However, we believe there is continued added value to participating in the LCSR. By participating, you have access to added benefits including quality measures and educational material to help improve your program's performance.

What is the value of the PDSA process?

The LCSR's QI initiatives help facilities collate and review their LCSR data and provide step-by-step guidance for conducting a QI initiative using a PDSA process. The PDSA worksheet is a useful tool for developing a plan, observing and learning from the initial results, and determining what modifications should be made. Modeled after the Institute for Healthcare Improvement's "Methods and Tools for Breakthrough Improvement" (the PDSA worksheet used by hundreds of healthcare organizations), the LCSR PDSA worksheet is tailored specifically for the LCSR performance improvement initiative.

What is the future of the LCSR QI initiative's work?

We are giving participants in the LCSR a new way to review important quality indicators and providing a process to improve performance by giving them custom reporting tools, templates, and how-to educational material to improve quality toward achieving program excellence.

To get started, read the Knowledge Base article "LCSR — PDSA Performance Improvement Overview" in the NRDR Support portal at bit.ly/NRDR_Portal. The radiation dose project is currently available, and the adherence project will be available by the end of the year. **B**

Interview by Chad E. Hudnall, senior writer, ACR Press

ECONOMICS

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negotiating payments and attracting patients as the world evolves toward data analytics and cost transparency. The registry aims to become a CMS-approved registry during future iterations.

A data registry is a useful method of collecting appropriate clinical data to generate actionable information to improve quality and outcomes. As IR continues to provide patient-centric and cost-effective care, it is imperative for our specialty to participate in data registries as part of our commitment to quality, safety, and improved disease outcomes. This will require further support from CMS and other regulatory bodies to steward additional measures related to diseases that interventional radiologists diagnose and manage. **B**

ACR EDUCATION CENTER

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frankly, unmatched around the world. It's a kind of limited didactic course, combined with extensive case-based learning, which is what radiologists do every day. Allowing them to learn with experts helping to guide them is just a truly unique experience that we've missed for several years."

With the acute days of the pandemic seemingly in the rear-view mirror, the Education Center is back up and running, with exciting plans. The Commission has reviewed surveys regarding the Center and continues to look for ways to augment its offerings.

"We are excited about the future of the Education Center," Deitte says. "We have access to state-of-the-art technology to further enhance the learning experience. In addition to returning to in-person courses, we plan to continue to offer micro-courses and extended access to the case material. We are committed to listening to our members and adapting to their needs."

The Education Center provides a lot of opportunities for radiologists, and the College can't wait to have full classrooms again, Thorwarth says. "We certainly hope everybody will take advantage of the Education Center. Whether you have attended previous courses or not, this is a great new opportunity to advance your knowledge and confidence, thus improving the care you're able to provide to patients." **B**

By Alexander Utano, editorial assistant, ACR Press

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