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ACR® AMERICAN COLLEGE OF RADIOLOGY

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

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

Jacqueline A. Bello, MD, FACR

The Power of Listening

Jay R. Parikh, MD, FACR
Member, ACR Well-Being Committee

Guest Columnist

Understanding what radiologists are seeking from their practice leaders can help prevent burnout that leads to turnover.

Radiology practices are struggling to retain adequate radiologist staffing to cover their clinical duties. A study by the Harvey L. Neiman Health Policy Institute® (HPI) showed that between 2014 and 2018, approximately 40% of radiologists went through job separation.[1] Radiologists may leave practices for multiple reasons, including shifting radiology positions, retirement, termination and transitioning to a career outside of radiology.[2]

The annual workforce surveys conducted by the ACR Commission on Human Resources in 2018 and 2019 both demonstrated a wide-open job market.[3,4] Following the Great Resignation that spun off of COVID-19, the number of job postings at the ACR Career Center have further increased to record levels. Radiologists are a practice's most important and valuable asset. Without them, the practice can't thrive. The AMA estimates that the cost to replace a physician in a practice is around $1 million.[5]

So, what can leaders do? One critical leadership skill some leaders overlook is listening.[6]

First, leaders need to meet with their radiologists individually to hear what interests them most. Previous research suggests that physicians who spend at least 20% of their time doing what they enjoy most experience less burnout.[7] Radiologist burnout has been associated with intention to leave.[8] By supportively channeling resources to help radiologists focus on their career growth, organizations are more likely to retain their physicians. For instance, practices can create leadership opportunities for radiologists who are interested in management.

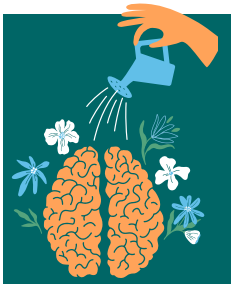
Second, leaders need to offer a safe space to genuinely hear their radiologists' concerns regarding the practice. Individual radiologists on the front lines as local leaders may offer practical solutions to operational issues such as workflow, staffing and ergonomics. Innovative solutions then can be brought forward into the practice that can help the organization grow and move forward. For example, an individual radiologist may be aware of an AI solution that can help streamline local radiology worklists that ultimately may be scaled to benefit the whole enterprise. By listening, leaders are afforded unique opportunities to leverage empathy and emotional intelligence to improve the practice's operations.

Third, and perhaps most important, the long-term benefit of repeated listening by leaders is trust and loyalty among their radiologists. By being open, sincere and transparent, leaders can engage in conversations that lead to a long-term dialogue, which in turn can initiate effective change.

This month's cover story on wellness within the profession offers insight on how radiologists can fend off burnout at their practices. It also includes observations and best practices that can help leaders solidify relations with their radiologists and retain their most valuable resource: people. B

ENDNOTES

1. Santavicca S, Hughes DR, Fleishon HB, et al. Radiologist-Practice Separation: Recent Trends and Characteristics. *J Am Coll Radiol*. 2021;18(4):580–589.
2. Parikh JR, Bluth EI. Career Alternatives for Radiologists Beyond Clinical Practice. *J Am Coll Radiol*. 2016;13(6):738–742.
3. Bender CE, Bansal S, Wolfman D, Parikh JR. 2018 ACR Commission on Human Resources Workforce Survey. *J Am Coll Radiol*. 2019;16(4 Pt A):508–512.
4. Bender CE, Bansal S, Wolfman D, Parikh JR. 2019 ACR Commission on Human Resources Workforce Survey. *J Am Coll Radiol*. 2020;17(5):673–675.
5. Berg S. How much physician burnout is costing your organization. American Medical Association. bit.ly/AMA-physician-burnout. Published 2018, updated October 11, 2018. Accessed Nov. 17, 2022.
6. Parikh JR, Bender CE. How Radiology Leaders Can Address Burnout. *J Am Coll Radiol*. 2021;18(5):679–684.
7. Shanafelt TD, West CP, Sloan JA, et al. Career fit and burnout among academic faculty. *Arch Intern Med*. 2009;169(10):990–995.
8. Higgins M, Nguyen MT, Kosowsky T, et al. Burnout, Professional Fulfillment, Intention to Leave, and Sleep-Related Impairment Among Faculty Radiologists in the United States: An Epidemiologic Study. *J Am Coll Radiol*. 2021;18(9):1359–1364.



BE WELL WITH THE ACR

Each month, the ACR will feature an activity or initiative 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.

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ACR Examines 2023 CMS Provisions for Final Rule on HOPPS and ASC

CMS has released the calendar year 2023 Medicare Hospital Outpatient Prospective Payment System (HOPPS) and Ambulatory Surgical Center (ASC) Final Rule. The ACR has created an initial review of provisions within the HOPPS Final Rule that may impact radiology or radiation oncology.

Notable changes include a 3.8% increase to the conversion factor (the number of dollars assigned to a relative value unit), bringing it to $85.585 for 2023. There are no structural changes to the seven imaging ambulatory payment classifications (APCs), but the payment rates are modified. CMS also modified the proposal to establish Healthcare Common Procedure Coding System (HCPCS) C-codes for software-as-a-service (SaaS) procedures, and instead will recognize SaaS CPT® add-on codes and will pay separately for them.

The ACR is reviewing the Final Rule and will release a detailed summary in the coming weeks.

Read the 2023 HOPPS ASC Final Rule-related documents:

- ACR CY 2023 HOPPS Final Rule Summary (bit.ly/HOPPS_Final_Rule)
- CMS Fact Sheet (bit.ly/HOPPS-fact-sheet)

If you have any questions, email Kimberly Greck, ACR economic policy analyst, at kgreck@acr.org, or Christina Berry, ACR team lead for economic policy, at cberry@acr.org.

ACR Releases Initial Review on Final Rule for 2023 Medicare Physician Fee Schedule

On Nov. 1, CMS released the calendar year 2023 Medicare Physician Fee Schedule (MPFS) Final Rule. CMS estimates a 2% decrease overall for radiology, while IR would have an aggregate decrease of 3%, nuclear medicine a 2% decrease, and radiation oncology and radiation therapy centers a 1% decrease. These reductions are less than those in the proposed rule due to CMS correcting an error in the calculation of the malpractice relative value units.

The ACR will release a detailed summary of its review of the MPFS Final Rule in the coming weeks.

Read the following 2023 MPFS Final Rule-related documents:

- ACR CY2023 MPFS Final Rule Summary (bit.ly/MPFS_FRS)
- CMS Press Release (bit.ly/MPFS-press-release)
- CMS Fact Sheet (bit.ly/MPFS-fact-sheet)

Read the full Final Rule at bit.ly/MPFS-final-rule-2023. If you have any questions, email Katie Keysor, ACR senior director of economic policy, at kkeysor@acr.org.

ACR Seeking Member Input on Surprise Billing Independent Dispute Resolution Experience

The ACR continues to assess the effect of the implementation of the No Surprises Act on its members while continuing its participation in litigation about the act. The ACR received information that indicates there are problems with access to the independent dispute resolution (IDR) process. The College is also aware there is a significant backlog of IDR claims that has led to delays.

To determine how widespread access and delay issues are, and how much of an impact they are having on ACR members, the College asks anyone in a practice who has used or has tried to use the IDR process to share information about the experience.

To provide input, contact Katie Keysor, ACR senior director of economic policy, at kkeysor@acr.org.

Read the feature article on the No Surprises Act in the December 2022 ACR *Bulletin* at bit.ly/no-surprises-article.

Register for the 2023 ACR Medical Student Symposium

Join the ACR Medical Student Subcommittee on Saturday, Jan. 28, 2023, noon to 5 p.m. ET, for the ACR 2023 Medical Student Symposium, a one-day virtual experience organized by medical students.

Throughout the day, attendees will explore the rapidly evolving field of radiology and hear from a diverse group of speakers on topics including diagnostic and IR, the role of radiologists in promoting health equity and the logistics of matching into radiology.

"Our goal for the symposium is to show medical students the breadth and variety within the field of radiology through conversations with a diverse group of speakers," says Christina Shehata, a third-year medical student at Northwestern University Feinberg School of Medicine who is serving as co-lead of the event. "We want people to know about the vital role radiologists play in patient care, whether they decide to go into radiology or a different field."

Visit bit.ly/MedStudentSymposium2023 to register.

> **I could not be prouder of our profession and our professionals for the central role we play in the healthcare journey, preserving patient and population health with equal emphasis on the care that truly makes a difference.**
>
> JACQUELINE A. BELLO, MD, FACR,
> CHAIR OF THE ACR BOC

Membership Year in Review

Your ACR membership dues were hard at work in 2022, allowing the organization to bring you programs, podcasts, professional development and legislative results. Here are some of the highlights from the ACR this year:

- ACR advocacy efforts saved radiologists a projected $1.2 billion or more through 2023 by preventing Medicare physician payment cuts.
- Through ACR advocacy initiatives, the Medicare conversion factor rate for physicians increased by 3% for calendar year 2022 and 4% statutory pay-as-you-go Medicare reductions were averted until 2023.
- The ACR Education Center reopened for in-person mini-fellowships.
- The ACR provided more than 100 CME credits at no additional cost through Case in Point®, *JACR*® and timely webinars. ACR dues have not been increased for more than seven years.
- The College continued its participation in the Radiology Health Equity Coalition, comprised of 10 radiologic societies and backed by more than 770 pledges to promote health equity in radiology.
- The RADVOCACY Podcast launched, adding to the ACR's growing library of podcasts covering everything from elevating your leadership potential to providing quality patient care.

To continue your radiology journey and ensure access to quality programs, renew your membership for 2023 today at acr.org/renew.

Get Involved in PIER

The 2023 ACR PIER (Pipeline Initiative for the Enrichment of Radiology) Internship application just closed for all first-year medical students. The virtual internship will begin in June 2023 and conclude after the National Medical Association meeting in July. Students participate in lectures over the course of the summer covering diagnostic radiology, IR, radiation oncology, non-interpretive skills and more. The program, which included 27 students in 2022, is always in need of preceptors, faculty members and other volunteers.

To get involved as a volunteer, email PIER@acr.org.

NEWS FROM RLI

Start Off Your New Year Like a Leader

Are you feeling lost in the spreadsheets, data, politics and relationships it takes to navigate today's healthcare system? Start your new year with confidence by attending the ACR Radiology Leadership Institute® (RLI) Maximize Your Influence and Impact course, beginning Jan. 19, 2023.

In this 12-week virtual program, you'll learn how to create the right organizational structure to align radiology and hospital operations; how to effectively lead a team with diverse perspectives and backgrounds; and how to understand hospital finances and spell them to develop improvement strategies.

The course includes three modules to maximize your influence and impact:

- Navigating the Hospital Boardroom
- Stewarding the Department
- Influencing Change at the Hospital Level

Register today at bit.ly/RLI_MYII.

Leading from the Heart

In a new Radiology Leadership Institute® (RLI) podcast episode, host Geoffrey D. Rubin, MD, MBA, FACR, talks with Charles D. Williams, MD, FACR, FAAP, past president of Radiology Associates of Tallahassee, Fla., and a member of the practice for 48 years. A pediatric radiologist by training, Williams has been active in supporting the Florida Radiological Society and the ACR for many years, earning gold medals from both organizations.

As detailed in his two books, *Simpler Times: Tales of a Southern Boy* and *More Simpler Times*, Williams' family and community played an enormously important role in his ability to move from tenant farmer to physician. Those books, along with his contribution to *Chicken Soup for the Country Soul*, were fundraisers for the We Care Program, which provides medical care for low-income patients and is sponsored by the Capital Medical Society Foundation in Tallahassee.

Listen to the full podcast at bit.ly/RLI_Ep_50.

Gregory N. Nicola, MD, FACR

Lessons From the RUC

Participating in the RUC can help ACR members become more effective leaders by honing skills such as communication and advocacy.

For almost a decade, members of the ACR Commission on Economics have represented the ACR and the American Society of Neuroradiology (ASNR) at the AMA/Specialty Society RVS Update Committee, commonly known as the RUC. The RUC is comprised of a panel of physicians and other healthcare providers who debate the value of physician services and make recommendations to Medicare on how much to reimburse for medical procedures (relative value units or RVUs). The process is steeped in technical jargon and painful detail. Like a board meeting, RUC panel meetings involve members listening to presentations by specialty societies, asking questions and debating before deciding on the RVUs. By participating in the RUC, we have benefited from the lessons we've learned about communication and effective advocacy, which have helped us become more effective leaders.

Prepare Well

Preparation is key when you need to communicate complicated topics to an unfamiliar audience. Preparation facilitates brevity. It is tempting to drone on about a procedure you are the expert on and enjoy, but you run the risk of losing the audience. Your message should be focused on what the audience needs to hear to make a decision. Moreover, when you are well-prepared, you can succinctly answer questions you have anticipated. Conciseness projects confidence, preserves your audience's focus and respects people's time.

Preparation also helps you preserve your mental bandwidth. If you know your topic well, it allows you to "read" the audience to understand how your message is being received. Does the audience understand or need more detail? Does the room appear hostile or receptive to your message? Adjust your presentation appropriately. Perhaps shorten your presentation if you detect a friendly room with fewer questions. Or if your audience is hostile, work hard to close gaps by providing details the audience may need to hear based on the questions people are asking.

Be Succinct

The adage "Loose lips sink ships" holds true here. You likely know more about your topic than anyone else in he room. However, being a know-it-all does not help you persuade an audience. Other people in the room may share your viewpoint and could sway the group's opinion more effectively than you could, especially if you are considered to be on the "outside." By reading the room, you can detect when you have support from others and allow them to speak up before you answer every question.

Verbosity is also your enemy. If your answers are filled with unnecessary details, an inattentive audience member may only catch pieces of your argument. In the absence of the context of your argument, people process these pieces with their own understanding, history or biases. This can lead to misunderstanding or even distrust — and a lost opportunity to persuade.

The ultimate use of the "Less is more" philosophy for persuasion is the use of silence. Never underestimate how effective silence can be in a conversation. This may take the form of a long pause after being asked a question you are wary of, allowing another person to interject with another question. The use of prolonged silence can make an emphatic point. For example, sometimes a detailed question is designed to bait you into a long-winded response when questioners are looking for ammunition to attack your argument. Don't give it to them. If they have formulated their question as a binary question, answer "Yes" or "No" and then stay silent. You disarmed their attack and, without being seen as the aggressor, made it difficult for them to continue probing.

Don't Panic

Things won't always go your way. Maintaining your composure keeps the audience in a calm state and avoids escalating the environment to a hostile one. In the end, "being right" or "winning" never compels an audience. The respect you garner from your colleagues will serve you far better over time.

Effective communication to advocate for something is an art and an important skill in leadership. These lessons may seem cliché when read abstractly. Personal growth in this area requires intentional practice and self-reflection rather than just studying. For example, reading everything about the history of basketball, the rules of the game and the tactics of great coaches doesn't make you a player. The same is true for many of us in our roles as physician leaders. You could know all about radiology, the physics of imaging and the rules for reimbursement, but until you've internalized the wisdom from many difficult wins and losses, you can't really play the game. We share these lessons with you so you can feel more comfortable getting out there and playing your heart out. B

Guest Columnists

Kurt A. Schoppe, MD

ACR CSC Member and ACR Radiology Alternate RUC Representative

Melissa M. Chen, MD

ACR CSC Member and ASNR RUC Primary Advisor

REPOSITIONING YOUR ROLE

Dread going to work? Improve your daily life – and well-being – by working with your leaders to create the job you want.

NEXT >>

You won't know until you ask.

Such a simple and rational concept, but the frightening part might not be asking but managing what comes after. There's the worry of being labeled "a complainer." And when the question is related to your livelihood — asking for a change in your schedule, environment, or even your duties — it can feel like a lot is riding on the whole exchange. Your trepidation might even be enough to prevent you from asking the question. But your well-being is worth it.

One radiologist experiencing burnout was extremely unhappy in her position, so she did what many do: She started looking for a new job. When she was ready to resign, her manager asked what it would take to make her stay. "For me, tackling burnout was identifying the answer to the question, 'What does it take to make me happy?'" she says. She wanted to make changes to her daily duties and to her role, so she put together a proposal. "My chair was willing to try something different," she says.

Factoring in the cost for practices to recruit and train new staff, plus the time and effort for employees to find, apply for and interview for new jobs, it's logical to approach your leaders with your feedback before you jump ship — and equally important for them to want it. "That would be my message," says the radiologist, who preferred to remain anonymous. "Talk to your boss before you start looking. Maybe for burnout it's a matter of asking, 'What does "better" look like for me?' Is it more flexibility? Is it something I could change if I make the right request?"

In some cases, the issue is a fundamental mismatch with the job. "Sometimes the problem is something you can't change, like the hospital system asking me to read 200 RVUs a day," she says. "In that case, what are my options?" Either way, naming the items on your wish list is a helpful exercise in clarifying the problem and identifying solutions, whether they lie in transforming your current role or seeking a position elsewhere.

Rocking the Boat

Changing just a portion of your day to include work you're passionate about can lift your mood. According to the Mayo Clinic, spending at least 20% of your time in meaningful work can have a protective effect against burnout.[1,2] "I try to hit 80–90%," says Priscilla J. Slanetz, MD, MPH, FACR, who is surprised at the statistic's seemingly low percentage. "You want to be sure you're spending at least some of your time doing things you're passionate about. But I would aim higher than 20%."

Slanetz, a member of the ACR Well-Being Committee, became the acting section chief of breast imaging at Boston Medical Center in March 2022 and knows what it's like to want to tweak a position to improve well-being and work-life balance. "Early on in my career, I didn't speak up quite as much as I did later on," she recalls. "But when I had three kids under age five and was regularly getting home at 10 p.m., I went to my chair and said, 'This is not working.'" Slanetz proposed switching to part-time academic work, but leadership wasn't open to that change at the time. "They told me, 'This is the job. You figure out how to make it work.' When I resigned six months later, they were surprised." A year later, she adds, they started offering part-time academic positions.

As for the evolution of such decision-making, "some people come to the same conclusion at different rates," says Delphine M. Lui, MD, associate medical imaging director at Winchester Hospital Breast Care Center in Winchester, Mass. "I've seen it happen. A few people offer a suggestion, and it takes a while for others to realize that things need to change." For example, a few members of her practice group suggested adding another radiologist to their team to better balance an overwhelming workload in recent years, but the idea wasn't a slam-dunk initially. "It wasn't really that easy," Lui says. "We only just recently agreed to move forward."

Lui believes the ability to come forward and ask for changes gets easier as you begin to understand your value. "Early in my career, I didn't speak up," she says. "After 23 years, I believe in myself. I've paid my dues and am comfortable expressing my opinions. Things change when you're confident about your position in the group. When you know you're valuable, then you feel like you have a little leverage."

> "Things change when you're confident about your position in the group. When you know you're valuable, then you feel like you have a little leverage."
>
> DELPHINE M. LUI, MD

Considering Group and Leadership Culture

Leverage and confidence mean nothing, however, if you're faced with leadership or a culture that emphasizes the status quo. It's important to ask yourself, "Is this an environment in which change is possible?"

Demonstrating a positive, open culture — one that values change — starts with communication, Slanetz says. "It varies for every group, but honestly the most effective way to gain respect is to be on the floor doing some of the work," she says. "That is how you build relationships with your peers, and they become comfortable coming to you with feedback. You can really learn so much just by listening."

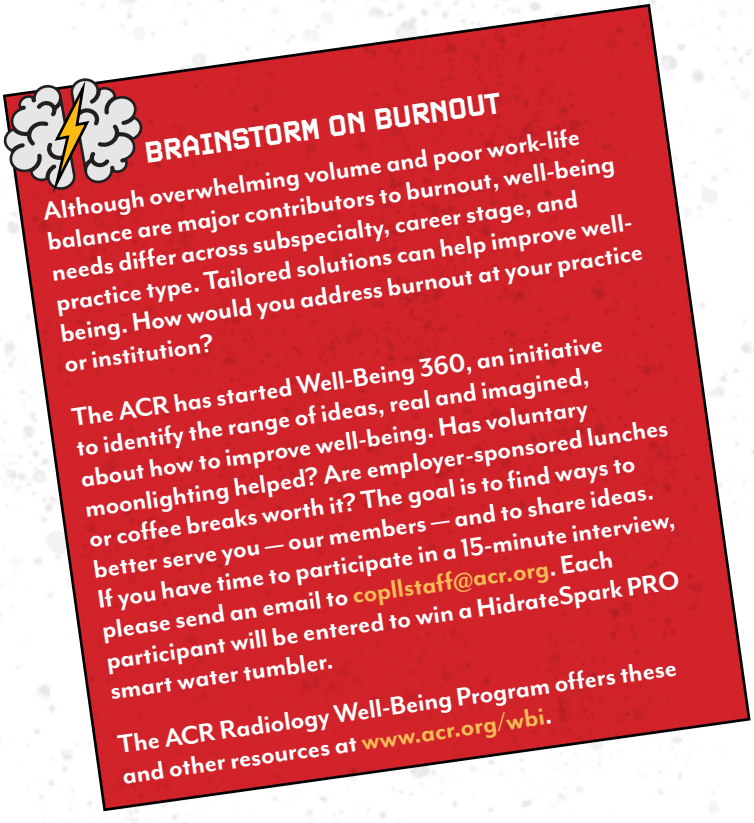
Changes are sometimes inevitable and driven by workforce retention, regardless of culture. ACR Well-Being Committee Member Dianne L. Johnson, MD, a diagnostic radiologist with RadPartners in Jacksonville, Fla., wasn't surprised her leadership wanted to tackle major scheduling concerns in her seven-person team, but she was somewhat amazed by their approach. "They made breast imaging its own section," Johnson says. "No more weekends, nights, holidays. They said, 'Here's your own schedule — you figure out among yourselves how you're going to cover the work with the people you have.' It went from a system that was highly competitive between partners for days off, which was incredibly stressful, to an intensely collaborative approach."

CONTINUED >>

Now she and her fellow breast imagers manage the schedule, which previously was created by non-mammographers, and they've created some flexible shifts, allowing radiologists to select work they can do whenever they want. "We created some screening mammography rotations, so you can read after work, on the weekend, it doesn't matter," Johnson says. "But it gives you the chance to go to the dentist or attend an event at your child's school." The latter was especially important to Johnson: "After the pandemic, I really looked at what was important to me, and I was no longer willing to miss those things."

Residents and fellows may have a slightly easier time approaching leadership, primarily because of structured feedback processes. Otto G. Schoeck, MD, chief radiology resident at Einstein Hospital in Philadelphia, explains that at the end of each academic year, the radiology residents come together to grade each attending on areas like education, communication and professionalism. The anonymous feedback also includes suggestions for improvements. "This is a true example of one suggestion," Schoeck says. "Our resident bathroom needed updating. The next year they changed it. The chair really pays attention to the end-of-year suggestions, and they put money into those problems."

Outside of the annual feedback process, Schoeck sometimes relies on his mentors to address concerns, including those related to burnout. "We feel like that's a safe place," he says. "You go to your mentor, who can anonymize and articulate problems in a way that is more effective, and then the mentor will approach the chair if needed. My mentor will speak on my behalf if I don't feel comfortable. That's just inherent to a power dynamic, and residents may get nervous and worry about perceptions that they're complaining."



Avoiding Appearing as a "Complainer"

To eschew the complainer label, "be thoughtful, and come in with an ally, if possible," Lui says. "You must be organized in what you want to say. Practice it, because you don't want to sound like you're complaining. Better even, there's often an ally — someone in the group who sees what you see the same way, so you can come to leadership and say, 'We've been talking,' which can give it more weight. If it's about you and your job, then consider how to make it work for the group before you make your proposal."

Of course, one of the additional worries is that whatever you want to change might be taken personally by leadership. "My experience has been when you do go to a manager or someone in a position of power, they seem to think it's a poor reflection on them," Schoeck says. "It takes someone with experience to understand that you're not critiquing them. We've all kind of faced that. The comfort level comes from the top down — a sense of, 'You can come and talk with me and we won't be upset.'"

Every workplace is different, and the key is in decoding the dynamics where you are. "You need to understand who the players are and the culture," Slanetz says. "The leader of a practice or department sets the tone. In some places, you can't even bring up any issue because you're dubbed a complainer. It's nothing to do with you. You're bringing up an important point and have a constructive solution, but the leader doesn't want to hear it."

Finding the Right Fit

Given the current environment, with the shortage of radiologists and the numerous practices and departments wanting to hire, it seems like a no-brainer for leadership to be open to working with its members, particularly in ways that support well-being. "People are shuffling to higher-paying jobs or jobs with better vacation time or access to more committee time," Schoeck says. "So now more than ever, I feel like the power is with the person who is applying. There are so many jobs out there, you have to give people what they want to maintain the workforce."

What people usually want is a job that aligns as much as possible with their own priorities, which is no small feat. "I don't think you'll ever get to 100% alignment," Slanetz says. "But many times, people don't take the time to say what's not working. What can I change to make it more aligned with my priorities? You have the power to try to do that, to give yourself a more satisfying career. Some leaders or cultures will not allow you to get to that point, and you need to be willing to look elsewhere. It's a loss for them.

"It's about finding the right environment. Someone else will embrace you and allow you to thrive. People need to thrive." B

By Raina Keefer, contributing writer, ACR Press

ENDNOTES

1. Shanafelt TD, Noseworthy JH. Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout. *Mayo Clin Proc*. 2017;92(1):129–146.
2. Shanafelt TD, West CP, Sloan JA, Novotny PJ, Poland GA, Menaker R, Rummans TA, Dyrbye LN. Career fit and burnout among academic faculty. *Arch Intern Med*. 2009;169(10):990–995.

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Who's Responsible (and Liable) When AI is Used in Healthcare?

With AI-based devices, physicians can increase diagnostic accuracy and efficiency, as well as improve treatment regimens. But as the technology continues to mature, so does the risk landscape.

As the world grows fonder of self-driving cars, manufacturing robots, smart assistants, social media monitoring software and many other AI-enabled products and services, it's not surprising that AI-based devices are swiftly making their way into the healthcare industry. Several hundred AI/ML-enabled medical devices have received regulatory approval since 1997 via 510(k) clearance, a granted De Novo request or Premarket Approval.[1,2,3] More than 70% of these are in the field of radiology. More detailed information regarding FDA-cleared AI medical products is now available from a number of available resources, including the ACR Data Science Institute's AI Central.[4]

Integrating AI-based devices into medical practice has the potential to increase diagnostic accuracy and increase efficiency in treating and diagnosing patients by allowing physicians to focus on diagnoses and procedures that require greater skill and judgment. It also has the potential to improve treatment regimens. However, as the number of these devices and applications grows, the number of questions and concerns pertaining to misdiagnosis, privacy breaches, bias, cost and reimbursement is also increasing.

Potential for Patient Harm

Although fully autonomous AI diagnostic software is already a reality, such as the IDx-DR software for the diagnosis of diabetic retinopathy, at present all AI-based medical devices and software for diagnostic radiology are used as screening or confirmatory tools, rather than as replacements for a trained healthcare provider. As such, it is not surprising that, according to a recent study by Aneja et al., both the general public and the majority of physicians still believe the physician should be held responsible when an error occurs (66.0% vs. 57.3%; P= .020).[5] Physicians are also more likely than the public to believe that vendors (43.8% vs. 32.9%; P= .004) and healthcare organizations (29.2% vs. 22.6%; P= .05) should also be liable.

Someday, the AI solutions we use will be able to integrate more data at faster speeds than a human and provide even more sophisticated decision support to us, the expert physicians. That raises unanswered questions about what happens in situations where the human expert disagrees with the automaton on a finding such as presence or absence of intracranial hemorrhage, and how those situations are perceived or potentially adjudicated. Will physicians be liable for disagreeing with or disregarding the output of a medical AI? Alternatively, if the AI is used for independent decision-making at any step in the care pathway and produces an output that harms a patient, will responsibility shift in any material way from the supervising physician to the AI developers or the medical device company?

For now, since no diagnostic radiology models are cleared for autonomous use in the U.S., the responsibility remains with the radiologist. However, if autonomously functioning AI solutions are developed and cleared for clinical use, AI vendors and developers will have to shoulder more risk when the model fails to detect significant disease or initiates unnecessary treatment.

Protected Health Information

In order to train and test AI-based devices, developers require access to large amounts of patient data. Data de-identification refers to the process of removing all information that could reasonably be used to identify the patient, and it is the basis of sharing data while preserving privacy.

> **As we navigate the uncharted territory of AI creation and implementation in the healthcare industry, it is imperative to adopt a culture of transparency.**

In the U.S., the Health Insurance Portability and Accountability Act of 1996 Privacy Rule (HIPAA) governs de-identification of patient data.[6] However, recent work has shown that elements of patients' identity, such as race, can be predicted from the de-identified data.[7,8] Furthermore, models that allow for data re-identification have raised concern and emphasized the need to act from a legal and regulatory perspective, beyond the de-identification release-and-forget model.[9] It is important to bear in mind that the rules pertaining to data sharing and privacy are complex, and HIPAA violations can result in significant financial penalties, criminal sanctions and civil litigation.

Culture of Transparency

As we navigate the uncharted territory of AI creation and implementation in the healthcare industry, it is imperative to adopt a culture of transparency. From an end-user perspective, transparency includes both explainability — so radiologists can understand how the model reached its conclusion — and details of how models were trained and validated, including numbers of institutions, scanner types and patient demographics.

The ACR Data Science Institute® (DSI) has been an advocate for increasing transparency in AI with the FDA and participated

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Increasing Mammography Access

At Massachusetts General Hospital, the Pink Card program allows same-day referrals for mammography screening. It has been especially helpful for underserved populations.

For many patients, mammography screening can mean the difference between life and death. Studies show it can reduce mortality rates by nearly 20% for all age groups.[1] Unfortunately, not all patients have easy access to screening.

Patients who face racial, ethnic and economic disparities often experience barriers to screening mammography, which can result in catastrophic consequences.[2] For example, patients of color are 72% more likely to develop invasive breast cancer before age 50, partly because of limited access to screening.[3] Recognizing this, the ACR and the Society of Breast Imaging have updated their breast cancer screening guidelines to increase awareness of the need to screen patients from underserved populations.[4]

"We have to think about the patient journey — the steps patients have to take to access healthcare and all of the obstacles they might encounter."

GARY X. WANG, MD, PHD

Radiologists, RTs and administrators at Massachusetts General Hospital (MGH) are doing more than taking notice — they're taking action to help patients access screening mammography. In 2015, MGH's breast imaging team led the development and implementation of the Pink Card program, an initiative that allows eligible patients to receive mammography screening on the same day as their primary care appointments.[5]

Gary X. Wang, MD, PhD, a breast radiologist and the community health and equity officer for MGH Radiology, studied the outcomes of this program. He and his co-investigators found that during the program's first two years at the suburban Mass General Imaging center in Waltham, nearly 20% of all patients from participating primary care providers who received screening did so through this program. Many of these patients were from local underserved populations.

"I wondered if, instead, we could reframe our thinking to make it easier for patients to access our care."

CONSTANCE D. LEHMAN, MD, PHD, FACR

Identifying Barriers

When Constance D. Lehman, MD, PhD, FACR, joined MGH as chief of breast imaging services in 2015, she knew one of her first priorities was to develop more effective pathways to patient care, especially for underserved populations. "Sometimes, due to our healthcare system complexities and our emphasis on technology, we lose sight of our patients' unique challenges," she says. "For example, we might describe patients who are not engaged as 'non-compliant,' putting the responsibility on them to take advantage of services. I wondered if, instead, we could reframe our thinking to make it easier for patients to access our care."

Lehman, who is also a professor of radiology at Harvard Medical School and founder of the breast imaging research center at MGH, began discussing these ideas with radiology colleagues, including Tejas S. Mehta, MD, MPH, FACR, FSBI, who served as co-director of the Linsey Breast Center at Beth Israel Deaconess Medical Center (BIDMC) at the time. Mehta, now an associate professor of radiology and director of diversity, equity, inclusion and population health in radiology at the University of Massachusetts Memorial Medical Center, envisioned a same-day walk-in mammography screening service at BIDMC.

Mehta described a "pink slip" program that enabled women to walk into the on-site breast imaging center after primary care visits and receive mammograms. After just one year of this program, BIDMC increased mammography screening compliance in this targeted population from 72% to 81%. As a result, numerous cancers were discovered early enough to treat. One patient offered, "If I had not gotten my mammogram the same day as my doctor's visit, we would not have found my breast cancer. I would not have come back just for a mammogram on another day as I have too many other responsibilities."

Inspired by this success, Lehman began to consider ways to implement something similar at MGH. She brought the idea to the MGH Radiology leadership team, which included Wang, and all were immediately on board.

"We have to think about the patient journey — the steps patients have to take to access healthcare and all of the obstacles they might encounter," Wang says. "Those from lower

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socioeconomic strata may be more likely to work hourly jobs, have more competing priorities, have difficulty accessing transportation, or lack childcare resources. This is in contrast to patients from higher-advantaged populations, who typically have more resources to overcome those barriers. A program like this is a critical way to decrease patient burden and prevent women from falling through cracks in the healthcare system."

Implementing the Program

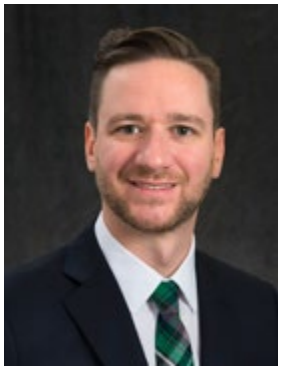
To determine how to best implement the program, Lehman reached out to the MGH practice development team, which oversees the radiology group's non-clinical strategic goals and works closely with referring providers, schedulers, and RTs."My team has personal relationships with 4,000 of our ordering physicians and schedulers," says Phil Jones, director of radiology practice development and innovation. "Our group is the radiology department's conduit to the community."

The radiology and practice development teams quickly realized that a key to making the pilot work was communicating with referring providers and developing materials for the program. The materials included a pink business card that referring providers can present to any patient due for a screening mammogram. The card provides the on-site mammography clinic's name, phone number and website, with the message, "Get your mammogram — it's time."

Once patients receive a card, they can take it to the screening mammography center without an appointment and receive the exam within 30 minutes of arrival. The Pink Cards are available in both English and Spanish. Lehman says a key to the program's success lies in considering the patient's individual needs. "Designing a program that is tailored to a patient's specific circumstances, meeting patient needs in a healthcare facility in which they already feel comfortable, and taking time to accommodate their individual schedules makes all the difference," she says.

With communications materials in hand, the practice development team reached out to schedulers at Mass General Imaging, a community-based outpatient facility located in the Boston suburbs. Beverly Pizzi, a breast imaging technical manager there, was immediately on board. Having lost her best friend to breast cancer, Pizzi knows how valuable early screening can be. Though she knew it would require scheduling adjustments, such as creating additional time slots to accommodate walk-ins, she wanted to help support the initiative.

Pizzi accompanied practice development team members as they visited Mass General Imaging's referring providers in primary care practice. Similar to BIDMC, these referring providers are all located in the same building as Mass General Imaging, making a same-day referral program easily accessible. The team gave presentations that discussed the program's desired outcomes, provided sample scripts for engaging with patients, and alleviated concerns about deliverability. "Referring providers ultimately loved the concept," Jones says. "It offered them another pathway to achieve population health goals. There is really no extra burden on them. The challenge was to make sure that services could accommodate patients."



"It works because it forces everyone to think about the barriers for our patients."

PHIL JONES

Gathering Results

To track patient flow, the practice development team included a unique code on each referring physician's Pink Cards. Pizzi maintained a spreadsheet with information that tracked the referrer as well as whether this was a first-time screening mammography visit, or if the last screening had been greater than one, two or three years prior.

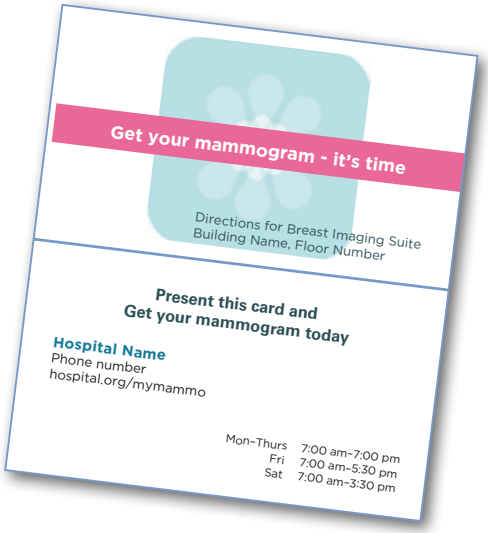
From Nov. 1, 2016, to Dec. 31, 2018, 733 women participated in the Pink Card program at Mass General Imaging, representing nearly 20% of all patients who underwent screening mammography at this location. Pink Card users were more likely to represent underserved racial and ethnic demographics, accomplishing many of the program's goals. In addition, approximately 70% of women who used the Pink Card program were not up to date on their screening mammography.[5]

Patient responses to the pilot program have been overwhelmingly positive. One patient raved about it in a feedback survey: "I was able to get my mammogram THE SAME DAY I spoke to my doctor about it. That was FANTASTIC: No return visits or figuring out when I could get back again. Thank you for this new option!!!!"

Jones attributes the program's success to teamwork and patient-centered innovation. "It works because it forces everyone to think about the barriers for our patients," he says. "The Pink Card program allowed us to reframe our services based on the needs of patients — maybe we are serving the mother of three who is prioritizing her children over her own healthcare. If we can accommodate that mother while she has a few minutes, it makes a lasting impact." B

By Chelsea Krieg, freelance writer, ACR Press

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



Focusing on Practice Excellence

Operational improvement, lung cancer detection, population health, point-of-care ultrasound and patient follow-up were among the discussion topics at the 2022 ACR Quality and Safety Conference.

Inspired by a jam-packed agenda and an in-person audience for the first time since 2019, the 2022 ACR Quality and Safety Conference explored some of the hottest trends and topics in radiology and quality improvement. The Oct. 20–22 event in Washington, D.C., drew about 180 in-person attendees and 70 people virtually, and it featured a keynote, educational sessions, an award ceremony and preconference workshops. Here are some of the highlights:

Operational Improvement

During a welcome session on "High-Value Operational Improvement Strategies," keynote speaker Pamela T. Johnson, MD, FACR, vice chair of quality and safety at Johns Hopkins Medicine's department of radiology, provided context on why provider-led strategy around the value of care is so important to improving clinical effectiveness and reducing healthcare costs. Her keynote was titled "Harmonizing the Drivers of Value-Based Care Transformation: Professionalism, Provider-Led Performance Improvement, Payers and Policy Makers."

Johnson, who also serves as vice president of care transformation and a professor of radiology and radiological science at Johns Hopkins, said the quality of radiology interpretations needs to be monitored to find opportunities to reduce misdiagnoses — in turn, improving patient outcomes while reducing costs, she said. For example, she shared evidence that radiology interpretations can contribute to overdiagnosis of pulmonary and genitourinary infection, which in turn drives overuse of antibiotics. Twenty percent of hospitalized patients who receive antibiotics have an adverse reaction, which may prolong hospitalization or result in a post-discharge emergency department visit or readmission.[1]

Communication with clinicians results in better radiology quality, and she cited a service she created at Johns Hopkins Medicine to help clinicians easily contact radiology specialists. In closing, Johnson spoke about the radiologist's role in patient outcomes and experience: "It's a tremendous opportunity for us, as diagnostic radiology is the beginning of the patient journey, and we can drive better care longitudinally by measuring the quality, demonstrating the quality and improving the quality of what we're doing."

LCS and Population Health

The ACR's efforts in early lung cancer detection and population health took the spotlight during a session led by Ella A. Kazerooni, MD, MS, FACR, chair of the College's Lung-RADS® Committee and Lung Cancer Screening Registry (LCSR). "It is reassuring to have a session on LCS and population health — considering lung cancer is the number one cause of cancer deaths in the country," Kazerooni said. "A few things we've learned through the 1.2 million screens in the Registry compared to the national population include who is being screened more than we thought and who is not being screened enough."[2]

For instance, she said, more women, individuals over age 65 and current smokers are coming forward for screening. Individuals eligible for LCS are disproportionately low-income, uninsured and on Medicaid.[3]

Kazerooni talked about early lung cancer detection programs, citing the National Lung Cancer Roundtable's LungPLAN™ model, which is free. It is evidence-based, using ACR LCSR data, and customer-focused for clinicians, navigators and administrators. She mentioned the revenue that can be gained by participating in the program. LungPLAN resources and more information are available at nlcrt.org/lungplan-overview.

"It's a tremendous opportunity for us, as diagnostic radiology is the beginning of the patient journey, and we can drive better care longitudinally by measuring the quality, demonstrating the quality and improving the quality of what we're doing."

PAMELA T. JOHNSON, MD, FACR

"We really can make a difference in lung cancer survivors," she told the audience. "And thanks to the ACR for its tremendous activity in this realm. The depth of knowledge the ACR has is unparalleled." She also encouraged attendees to visit screenyourlungs.org to watch an important public awareness video on LCS.

Kazerooni introduced Liora Sahar, PhD, GISP, senior director of data science with the American Cancer Society, to talk about population health and how geospatial mapping can be used to identify diverse populations at risk for lung cancer, allowing the medical community to help close the gaps in screening. For example, there's a difference in access to LCS among eligible adults living in rural versus urban communities. Some patients have to drive 40 miles or more for screening, she said.

The session also included a presentation by Shawn D. Teague, MD, FACR, chair of the ACR's LCSR Education/Quality Improvement (QI) Subcommittee and associate professor with National Jewish Health/University of Colorado, who spoke about using ACR LCSR data for performance improvement. The LCSR, Teague

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explained, is one of six QI registries that comprise the National Radiology Data Registry (NRDR®), with the goal of helping clinicians monitor and demonstrate the quality of LCS CT in their practices through regular reports, including peer benchmarks.

Teague pointed out that while CMS no longer requires participation in the LCSR for reimbursement, participation in the Registry continues to grow. "We are adding new measures to the Registry, including new reports that help participants understand their performance and how it compares to that of their peers," he said. Benefits of participation include guidance to gain the most from your LCSR reports, 20 CME credits for completing a plan/do/study/act (PDSA) project, and a QI project that can count toward ABR Maintenance of Certification.

Point-of-Care Ultrasound

A preconference session on point-of-care ultrasound (POCUS) focused on how certain organizations develop POCUS programs. Moderated by Alexander J. Towbin, MD, associate chief of clinical operations and radiology informatics and a pediatric radiologist at Cincinnati Children's Medical Center, the session included presentations from numerous organizations on how they built their POCUS programs. Sonya Echols, PhD, RT, and David Evans, MD, represented Virginia Commonwealth University Health Systems. David L. Waldman, MD, PhD, FACR, represented the University of Rochester Medical Center, and Jeannie K. Kwon, MD, represented the University of Texas Southwestern Children's Medical Center. The doctors weighed in on factors that helped them build their POCUS programs, such as developing a business plan or framework, forming a POCUS committee and workforce, enlisting an effective vendor and working together to form a workflow with other practices within the organization.

Patient Follow-Up

In a session on "Follow-Up Recommendations," moderator Ben C. Wandtke, MD, MS, MMM, vice chair of quality and safety at University of Rochester Medical Center, set the stage for organizations to share their best practices in not only identifying incidental findings and making sure patients get proper care, but also implementing a follow-up tracking system.

Woojin Kim, MD, a radiologist at the Palo Alto Veterans Affairs Hospital and the chief medical officer at Equium Intelligence, stressed the importance of making a proper plan for follow-up recommendations. Kim highlighted the need for analyzing multiple methods to find the most effective way to track and implement follow-up exams. Regan City, PA-C, CPHQ, a healthcare quality and performance improvement specialist with Radiology Partners, discussed a pilot study she was involved in to help her organization develop a long-term tracking plan. Key factors, she said, are to consider the workload involved to ensure everyone is properly prepared and to interview radiologists to be sure everyone is on the same page.

Neville Irani, MD, an associate professor in the radiology department at the University of Kansas Health System and founder of the Healthcare Quality Improvement Platform, focused on developing relationships with patients to make sure they come back for follow-up exams. Christopher Moore, MD, an emergency physician and professor at Yale School of Medicine, capped off the presentations by focusing on how to analyze data found through follow-up tracking. Moore talked about looking at disparity factors and how everything was communicated to determine opportunities for improvement.

"We really can make a difference in lung cancer survivors, and thanks to the ACR for its tremendous activity in this realm. The depth of knowledge the ACR has is unparalleled."

ELLA A. KAZEROONI, MD, MS, FACR

Quality Improvement

A breakout session titled "Participating in a National Quality Improvement Learning Collaborative" featured seven panelists who gave the audience ideas on improving their practices. Moderators David B. Larson, MD, MBA, FACR, chair of the ACR Commission on Quality and Safety and vice chair for education and clinical operations at Stanford University, and Kandice Garcia Tomkins, MS, RN, quality improvement manager in the radiology department at Stanford Health Care, explained that a learning network is an organizational structure to facilitate meaningful improvement. The session moved to presentations by practices and organizations that have participated in the ACR Learning Network, which has created four cohorts comprised of four to six healthcare sites each that work together to solve the same problem (bit.ly/ACR-learning-network). Representatives from Hudson Valley Radiologists, P.C., talked about how they learned through the program to slow down and work more methodically so they can break down the image/data part by part, and to value all opinions in working to find the best way to improve patient care. Solis Mammography used the program to learn the differences between its definition of quality and the ACR's definition, using that information to continue its success plan.

2023 Event

Planning is already in the works for the 2023 ACR Annual Conference on Quality and Safety. As the ACR marks its 100th anniversary, the next meeting of the minds will help radiologists continue to keep up with the most pressing issues in quality and safety. B

By Alexander Utano, editorial assistant, and Chad E. Hudnall, senior writer, ACR Press

ENDNOTES

1. Tamma PD, Avdic E, Li DX, Dzintars K, Cosgrove SE. Association of Adverse Events With Antibiotic Use in Hospitalized Patients. *JAMA Intern Med.* 2017;177(9):1308–1315. bit.ly/JAMA_OI.
2. American Cancer Society, Key Statistics for Lung Cancer, bit.ly/ACS-lung-cancer. Accessed 11-21-2022.
3. Silvestri GA, Goldman L, Burleson J, Gould M, Kazerooni EA, Mazzone PJ, Rivera MP, Doria-Rose VP, Rosenthal LS, Simanowith M, Smith RA, Tanner NT, Fedewa S. Characteristics of persons screened for lung cancer in the United States: A cohort study. *Ann Intern Med.* 2022; 175(11):1501–1505.

Early pioneers in medicine and radiology paved the way for today's ACR.

Stamp issued by the Republic of Transkei in South Africa in 1984 recognizes Wilhelm Röntgen, who discovered the X-ray.

The Council is Born

The development of the ACR Council has been a source of pride for the College, representing a governance structure that survives the test of time while also evolving to meet changing needs in the radiology profession.

The ACR Council has come a long way since the start of the College back in 1923. Originally, the ACR was governed by a small BOC, which guided the College's efforts. As the College grew, the BOC began exploring ways to change the organization's structure. The Commission on Constitution and Bylaws, led by Ross Golden, MD, presented a new College structure in 1939, which led to an amendment added in 1941 for the appointment of councilors across the country.[1] A total of 34 councilors formally met for the first time in 1955. The following year, the councilors were invited to a joint session with the BOC.

The first iteration of today's Council came about in the 1960s, when the group consisted of representatives from state and local societies who attended the ACR Annual Meeting. The representatives began taking an interest in the business side of the College and eventually gained independence from the BOC. In the early 1960s, George Cooper Jr., MD, pitched the idea of transforming the Council into a delegate assembly that would create policy rather than act as an advisory group to the BOC.[2] A committee was created to study how to charter both state and local societies to become ACR chapters. In 1963, the BOC decided to approve charters for state chapters and for the Council to act as a delegate assembly of the ACR.

It wasn't an easy transition, with chapters required to coalesce existing state and local societies to a singular group due to new bylaws from the BOC to ensure fair representation. This especially held true for states like New York and California, where state societies had to work with their local counterparts within the state's major cities to combine interests. As the Council developed over time, the BOC began to understand how valuable councilors were to the organization. This would lead to the councilors becoming either selected or elected, depending on the chapter's preferred method.

The Power of Voting

With the delegate model in place, the next major shift occurred in the 1990s with updates to the process for elected contested and uncontested leadership positions. The Council Steering Committee (CSC) became the representative voice of the ACR membership, facilitating and developing College policy while providing oversight of Council activities.

"The CSC is made up of councilors, as well as the Council speaker and vice speaker, who run the Annual Meeting as the chair and vice chair of that committee," says William T. Herrington, MD, FACR, chair of the ACR Commission on Membership and Communications. "They cannot be councilors themselves. They are the moderators of the Council but have no vote."

According to Herrington, there was a feeling that only an insular group got to participate in top leadership. There were plenty of elections for ACR positions, but many of them included only one candidate. The Council decided some changes needed to be made. Because councilors originally were appointed, the pool of candidates was limited to the networks of the BOC. Moving to open elections broadened the slate of candidates and brought new perspectives to the Council. When the new system debuted

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Members of the 2022–2023 ACR Council Steering Committee, photographed in 2022, include back row, left to right: Join Y. Luh, MD, FACR; Daniel G. Gridley, MD, FACR; K. Elizabeth Hawk, MD, MS, PhD; Gaurang V. Shah, MD, FACR; Derrick Siebert, MD; Rachel Gerson, MD; Kurt A. Schoppe, MD; Andrew K. Moriarity, MD; Juan C. Batlle, MD, MBA; and Ashley Prosper, MD.

Pictured front row, left to right: Daniel A. Rodgers, MD; Melissa M. Chen, MD; Elizabeth A. Ignacio, MD, FACR; Timothy A. Crummy, MD, MHA, FACR, Vice Speaker; Amy L. Kotsenas, MD, FACR, Speaker; Kristin K. Porter, MD, PhD; and Matthew J. Brady, MD, FACR.

Not pictured: Max R. Amurao, PhD, MBA; Ivan M. DeQuesada II, MD; Yasha Gupta, MD; Nolan J. Kagetsu, MD, FACR; and Natasha Monga, MD.

in 1999, the ACR saw an increased number of open elections for BOC and CSC seats that were becoming vacant.

The Council Today

Today, the ACR Council is made up of roughly 380 councilors from all 54 chapters, 24 subspecialty societies, governmental bodies (such as the U.S. Department of Veterans Affairs, military branches and U.S. Public Health Service), the RFS and the YPS. The Council is charged with setting policy for the organization, as well as considering Practice Parameters and Technical Standards and bylaws amendments.

ACR Council Speaker Amy L. Kotsenas, MD, FACR, has seen the Council change in many ways. "One of the most important changes that has rapidly increased representation of young people in the Council is giving the state chapters the ability to have an extra alternate councilor position that is dedicated to a young physician," she says. Another area of change has been in practice type among Council members. "The Council was previously dominated by independent private practice radiologists, and they still have a very strong voice there," she says. "But we're seeing more representation from hybrid private practices and academic practices. We're seeing some of the big national corporate practices. We're seeing a lot of teleradiology, which was controversial around the time that I started. Now there are a lot of people who practice that way — and who are represented in the Council."

The Changing Times

Even today, the ACR Council is still evolving and adapting to new challenges. A significant moment for the Council came in the spring of 2020, when the COVID-19 pandemic brought the world to a temporary stop. With the ACR 2020 meeting approaching, Kotsenas knew the Council had to move quickly.

"We had about six weeks to go from what we had been planning to be a fully in-person meeting to one that was 100% virtual," she says. "Certain elements of the Annual Meeting are specified in our bylaws. We have to conduct elections, we have to have the Reference Committee open hearings to discuss policy, and then we have to approve those Reference Committee reports and essentially vote on what becomes policy of the ACR. And we had to find a way to do all of that virtually." The team worked quickly to set up a virtual meeting when many were still getting comfortable with the idea of meeting over Zoom. When the date arrived, the Council was ready and the ACR's first virtual Annual Meeting was a success, as was the second virtual meeting in 2021. In 2022, the meeting returned to Washington, D.C., with a unique hybrid format combining in-person participation with remote access via Zoom. The 2023 meeting is expected to be similar.

In the Council's next era, Kotsenas predicts great things: "Diversity is only going to increase, and that's important. It helps keep our organization fresh. It helps to make sure we're considering new, innovative ideas. Overall, the future is bright for the ACR and for the Council. We'll continue to have a lot of dynamic conversations." B

By Alexander Utano, editorial assistant, ACR Press

ENDNOTES

1. del Regato JA. *The American College of Radiology: Fiftieth Anniversary.* 1973;107(1):113.
2. Linton OW. *The American College of Radiology: The First 75 Years.* Reston, VA: American College of Radiology; 1997.

Empowering Patients

When it comes to imaging, patients often experience fear or apprehension. To help them better understand what to expect, the ACR has released several animated videos to guide them.

The ACR has long strived to assist referring physicians in educating patients about imaging. The idea is that patients will be more likely to have appropriate imaging if they know exactly what they are getting into and why it helps. To facilitate this, the ACR Commission on Patient- and Family-Centered Care (PFCC) has created a series of short videos (available at bit.ly/PFCC_PFA) to help educate patients about imaging tests. The *Bulletin* caught up with Nina S. Vincoff, MD, co-chair of the PFCC Patient Engagement Committee, to learn more about the animated video project and what she hopes it will accomplish.

What inspired the video series?

The PFCC Patient Engagement Committee is creating these short animations to answer common questions patients typically have about imaging. The goal is for patients to watch the animations for information and be able to participate in shared decision-making with their physicians. So far, we have about a dozen videos either finished or in production. We released two in October to coincide with Breast Cancer Awareness Month — one on breast cancer screening tests and what the differences are and who is appropriate for each, and another on whether patients should continue to have breast cancer screening if they're pregnant or breastfeeding. We also released two in November to coincide with Lung Cancer Awareness Month.

Are the videos meant to prompt physicians to dig deeper into the ACR Appropriateness Criteria® summaries?

Our target audience for these videos is the patient, and we're trying to serve two purposes. The first is just standalone content. You can watch these videos that are approximately one minute in length — consistent with the way many people seek information today and short enough to be posted on a variety of social media platforms. Second, the videos are available for viewing and sharing

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from the *JACR*® YouTube page, and links to the relevant patient-friendly summary and the full ACR Appropriateness Criteria® (AC) document can be found in the YouTube caption for each video. That summary has more information than we could contain in a one-minute video. Nearly 100 patient-friendly summaries have been published by the *JACR* and are available at acr.org.

Were patients involved in the development of the series?

The video scripts were written by the radiologist members of the PFCC Patient Engagement Committee, but the source content for the videos comes from the ACR AC patient-friendly summaries, which are authored by patients. The patient-friendly summaries are written by the ACR AC Patient Engagement Subcommittee, which I also chair. On that committee, layperson authors, who are recruited and supported by Andrea Borondy-Kitts, MS, MPH, work together with radiologist technical authors to create evidence-based lay-language summaries of the ACR AC.

What's your vision for the future of the video series?

Right now, the first goal is to 1) make more videos and 2) coordinate them with awareness months. When we first started talking about the videos, we had all this content and asked, "Which ones do we want to turn into videos?" We started looking at awareness months on the calendar and we said, "When might patients be looking for content?" We thought they might be looking for content at a time that's getting a lot of play in the media. So, we created an editorial calendar tied to awareness months. So far, we have released videos to coincide with Breast Cancer and Lung Cancer Awareness Months and will continue to release more timed content over the course of the year.

The next step is to use social media to promote the videos. The step after that is to partner with patient advocacy groups to take these messages into their communities. Another thing we really need to start thinking about is how we can make these videos available to radiology practices and, even more important, to referring physicians. If our goal is to help patients to partner with their physicians in a more effective way for shared decision-making, we should be providing these resources to our referring doctors so they can share them with their patients.

Linda Sample, BCPA, CPXP, co-chair of the Patient Engagement Committee, and I encourage ACR members to keep an eye out for new videos and consider sharing this great new resource with your referring providers and patients. B

Interview by Chris Hobson, senior communications manager, and Alexander Utano, editorial assistant, ACR Press

HELPING PATIENTS UNDERSTAND LUNG SCREENING

Two new animated videos will help patients understand whether they are eligible for lung cancer screening and how they can participate in shared decision-making with their physician. Aligned with the patient-friendly summaries of the ACR Appropriateness Criteria®, these videos answer questions about whether screening is right for the patient and how to calculate smoking history.

The ACR Commission on Patient- and Family-Centered Care and the *JACR*® have developed a series of animated videos to help patients better understand their imaging. Access the videos at bit.ly/PFCC_Animations.

The FACR Application: Trends and Transparency

The high rate of approved candidates for the FACR designation indicates that members are applying at the appropriate stages of their careers. Candidates are seeking mentorship from chapter fellowship chairs and reviewing the FACR nomination criteria before applying.

Each January, the application opens for ACR members to apply to become a Fellow of the ACR, an honor that comes with an FACR designation in their credentials. Early-career members often wonder what criteria are needed to be met to achieve an FACR designation. The following descriptions will review the best time to apply for the FACR, based on your current achievements when compared to the nomination criteria, and provide clarity around the application process.

Eligibility 101

To start, an FACR applicant must have been an ACR member for a minimum of 10 post-training years. That minimum is cumulative and permits two or more periods of membership with lapses between them. Next, the application must reflect achievements by membership-year group according to the FACR nomination criteria (available at ACR.org/FACR) and include at least two letters of endorsement from current ACR Fellows.

The Importance of Mentoring

Through support from ACR chapter leaders, members can be guided to enhance their careers and contribute to radiology beyond the scope of employment. These mentors (chapter presidents, fellowship chairs, etc.), as well as current ACR Fellows, may recommend available leadership positions to strengthen an FACR application. The likelihood of being approved to become an ACR Fellow increases when current achievements are in sync with the nomination criteria.

Approved Yet Deferred?

If an FACR application is approved, the member is invited to the next convocation ceremony at the ACR Annual Meeting to receive the FACR award. If the application is approved yet deferred, the member is invited to a postdated convocation once the membership years and achievements are in line with the FACR nomination criteria. Most often, these members applied marginally ahead of the nomination criteria requirements. With additional experience in continued achievements, the member does not receive a rejection and is not required to submit a new FACR application later once positioned within that nomination criteria year group.

Across each of the five membership year groups within the nomination criteria rubric, from 10 to 11 years up to 20-plus years, a five-year average shows about 14% of all candidates are deferred. On average, the majority of deferred candidates applied one year group ahead of current achievements, such as applying within the national domain among 12-14 year candidates with 13 years of membership while having regional achievements which

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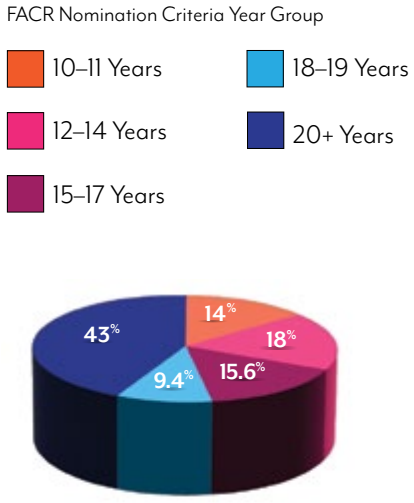
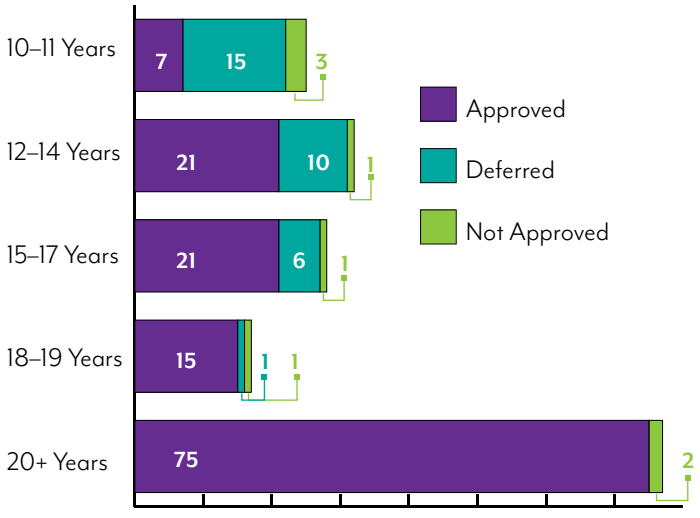
2022 Application Quantities



2022 Application Results



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What led you to apply for the ACR's E. Stephen Amis Jr., MD, Fellowship in Quality and Safety?

"Radiology faces higher volumes and more staffing shortages than ever before. Burnout can be insidious, creeping into the psyche and causing the individual to turn inward. This frame of mind makes us more prone to mistakes, particularly when the work is complex. A primary goal, then, is to develop and adhere to practice standards to minimize unnecessary variation. As I near the end of residency at Wake Forest, this has been a major interest for me."

C. Michael Hood Jr., MD, radiology resident, Wake Forest Baptist Medical Center

"My desire has always been to provide the highest quality of care for all patients I encounter, but I learned early on that it went beyond any individual physician and that system factors were essential for accomplishing sustained improvement. This led to my search for opportunities, additional training and exposure in quality improvement to augment my clinical training curriculum for a more wholesome approach to patient care."

Temilola Akinola, MD, MBBS, MPH, radiology resident, Lahey Hospital and Medical Center

"I have always been curious and interested in learning about how AI will be integrated into our radiology workflow and how it will both improve and challenge our radiology specialty long-term to optimize efficiency and patient care. The E. Stephen Amis Jr., MD, Fellowship in Quality and Safety will provide me with an invaluable opportunity to learn about the various quality and safety issues affecting radiologists."

Jung H. Yun, MD, integrated diagnostic/IR resident, Einstein Medical Center Philadelphia

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in the FDA's Virtual Public Workshop on AI Transparency in October 2021. The FDA's Digital Health Center of Excellence is part of the planned evolution of the Digital Health Program in the Center for Devices and Radiological Health.[10] Its main goal is to empower stakeholders to advance healthcare by fostering responsible and high-quality digital health innovation.

To ensure AI tools can be efficiently implemented into daily workflow and have the potential to improve the quality and efficiency of patient care, the ACR DSI has assembled subspecialty panels to review and publish structured-use cases. Use cases empower AI developers to produce models that are clinically relevant, ethical and effective and are published freely with common data elements that allow pathways for workflow integration.

It's crucial that developers, physicians and professional organizations work together to safely integrate these AI-based devices into the clinical workflow. Where relevant, patients should be counseled on the risks and benefits pertaining to the use of AI-based devices so they can make informed decisions. Liability for use of AI will likely evolve over time as the sophistication of the AI models evolves. As radiologists, we will undoubtedly find ourselves at the forefront of the penetration of AI into medicine, and although this will bring challenges and uncertainties, it will also present us with the opportunity to shape this new and exciting reality. B

By Irene Dixe de Oliveira Santo, MD, integrated interventional and diagnostic radiology resident, Yale School of Medicine, and Tessa Sundaram Cook, MD, PhD, associate professor in the department of radiology, Perelman School of Medicine, University of Pennsylvania

ENDNOTES

1. U.S. Food & Drug Administration, 510(k) Clearances, bit.ly/FDA-501k-Clearances. Accessed 11-11-2022.
2. U.S. Food & Drug Administration, De Novo Classification Request, bit.ly/FDA-De-Novo. Accessed 11-11-2022.
3. U.S. Food & Drug Administration, Premarket Approval, bit.ly/FDA-premarket-approval. Accessed 11-11-2022.
4. ACR Data Science Institute® AI Central, aicentral.acrdsi.org.
5. Khullar D, Casalino LP, Qian Y, Lu Y, Chang E, Aneja S. Public vs. physician views of liability for artificial intelligence in health care. *J Am Med Inform Assoc.* 2021;28(7):1574–1577.
6. Centers for Disease Control and Prevention, Health Insurance Portability and Accountability Act of 1996 (HIPAA), bit.ly/HIPAA-Act. Accessed 11-11-2022.
7. Gichoya JW, Banerjee I, Bhimireddy AR, Burns JL, Celi LA, Chen, LC. AI recognition of patient race in medical imaging: a modelling study. *Lancet Digit Health*. 2022;4(6): e406–414.
8. Adleberg J, Wardeh A, Doo FX, Marinelli B, Cook TS, Mendelson DS, Kagen A. Predicting Patient Demographics from Chest Radiographs With Deep Learning. *J Am Coll Radiol*. 2022;19(10):1151–1161.
9. Rocher L, Hendrickx JM, de Montjoye YA, Estimating the success of re-identifications in incomplete datasets using generative models. *Nat Commun*. July 23, 2019.
10. U.S. Food & Drug Administration, Digital Health Center of Excellence, bit.ly/FDA-dhce. Accessed 11-11-2022.

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are reflected in the 15-17 year group. Deferred candidates annually attest to continue similar achievements until participating in a postdated convocation. During the convocation, all Fellows are inducted equally without any designation of having been previously deferred.

The Timing of an Application Submission

The bar to achieve this professional goal is based upon years of ACR membership. Examples of ideal timing would be a 13-year member with nationally recognized achievements or an 18-year member with state-level achievements.

The high bar for the group with 10 to 11 years of membership requires international or major national achievements. Candidates with 12 to 14 years of membership experience must demonstrate an application reflecting national achievements.

Snapshot of 2022 Application Results

Most FACR candidates are applying at the correct stage of their careers, which contributes to a high approval rate. In 2022, there were 179 submitted FACR applications. With 139 approved and 32 deferred, 18% of the total candidates were deferred for continued achievements, according to the nomination criteria, with most deferred candidates being early-career members. This high acceptance rate and low deferred percentage demonstrate that members are applying at the right stages of their extraordinary careers for this highly distinguished membership award.

Next Steps

You are encouraged to reach out for mentor support to guide the optimal timeliness for submitting your future FACR application. Begin networking with current ACR Fellows at chapter and ACR meetings for mentor opportunities. Chapter leadership, the Committee on Fellowship Credentials and FACR staff are ready to support your FACR professional pursuits. B

By Julie Huxsoll, MS, ACR member services supervisor

APPLY FOR FACR

The FACR application cycle begins each January with submission deadlines varying by chapter. Visit ACR.org/FACR for the application, eligibility requirements and the FACR nomination criteria. For questions, contact FACR@acr.org.

CONTACT US
To contact a member of the *ACR Bulletin* staff, email bulletin@acr.org.

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Register at: **acr.org/PLF**

2022 Chapter Recognition Awards

Tell us about your 2022 accomplishments by participating in the ACR® Chapter Recognition Awards Program.

Apply for recognition in the following categories:

- Government Relations
- Meetings & Education
- Membership
- Quality & Safety

- Apply in all four categories and be automatically considered for the Overall Excellence Award.
- Earn additional points by submitting up to five Share a Successful Practice forms.

ACR™ CHAPTER RECOGNITION

Visit **acr.org/ChapterRecognitionAwards** for application requirements.
The deadline to submit is **Jan. 15, 2023**.