The RLI Summit only happens once a year. Don’t miss this chance to learn from radiology thought leaders and Babson business school experts.

SAVE THE DATE
Join us for the annual RLI Summit, Sept. 29–Oct. 1, 2023, to learn, network and find new inspiration for your leadership journey.

New Venue | Same Great Content
The 2023 RLI Summit will be held at a new venue — the Boston Seaport Hotel, located just minutes from Logan Airport on the historic waterfront.

Although the venue has changed, this year’s program will deliver the same compelling leadership training and networking opportunities you’ve come to expect from the RLI Summit.

acr.org/RLIsummit

THE SEAPORT HOTEL
Authentic New England feel on the historic waterfront. Restaurants, parks and museums within walking distance.
No Bullying
Although it often goes unreported, bullying within the specialty can lead to poor effects on radiologists’ mental health and performance — and can affect the delivery of quality patient care.

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On Our Members’ Minds

You’ve spoken and we are listening. Our latest survey shows you’re looking toward the future while coping with the challenges of today.

The College’s Centennial celebration at the 2023 ACR Annual Meeting last month provided a wealth of information and opportunities to exchange ideas with members from every walk of the field. Ahead of the event, with the goal of uncovering what our members think the future of radiology may hold, our ACR Centennial Committee worked in tandem with ACR staff to develop and disseminate two short surveys. The responses were thoughtful and enlightening — providing us invaluable insight into how the specialty may evolve in the coming years.

The surveys posed a variety of questions around healthcare policy, AI, quality and safety, physician wellness, physician shortages, COVID-19 and more. One survey focused on practicing physicians and the other on medical students. There were close to 200 respondents combined — though the vast majority were practicing radiologists — sharing their concerns, lessons learned and what excites them about radiology and its constantly evolving landscape.

Among practicing radiologists, most agree that the COVID-19 pandemic significantly altered working environment dynamics and changed communication patterns between themselves and referring physicians. About half think COVID-19 changed referrers’ ordering patterns and accelerated changes to technology. It was interesting to see the data support what we’ve all been feeling.

The survey showed there is near-unanimous agreement on the importance of health policy and economics as radiology moves forward. Our members are also highly interested in AI and machine learning, watching it very closely, along with the commoditization of the specialty. Survey respondents believe quality and safety policies present the most opportunities for positive change while commoditization is seen as the biggest threat — especially as we see venture capitalists buying more and more radiology practices.

The survey identified burnout within radiology as a major concern, with the majority of respondents worried about wellness within their own practice group or department. However, fewer expressed personal concern. Among the potential causes of burnout listed in the survey, physician and staff shortages were most commonly cited. We all seem to be feeling the pinch of doing more with less.

The survey identified reimbursement and practice creep, or encroachment, as areas of concern now and into the future. In contrast, AI and machine learning will catalyze some of the most exciting changes in radiology over the next five to 15 years, respondents say. These are two topics that seem to come up in sessions and discussions no matter where we go these days.

There was a wide range of responses to the question, What advice would you offer your former self? Maintaining a better work-life balance and slowing down was a popular answer. Other responses included getting involved sooner with local and national medical societies, being more of a self-advocate with management, remembering that there are patients behind the images, making more time for direct patient contact and never assuming it is too late to change work environments if you are unhappy. Most respondents, however, say radiology was a great medical path and that they plan to stay in their current work setting. That is good news.

The makeup of our membership was a consideration when the Centennial Committee was garnering information. A combined 57% of respondents work at an independent private practice or academic practice. Radiologists working at a hospital or within a hospital system account for 14% of respondents. Most of the physicians surveyed have been in practice for at least 10 years, and 14% identified as retired. Nearly 90% of respondents reported living in an urban or suburban area of the country, with only 10% living and working in rural areas. Most practicing physician respondents were male and an average age of 55 years old. For medical students, respondents were also mostly male, with an average age of 30.

It should be noted that a very small percentage of medical students responded to their survey. As a result, we have little data about what may guide their future career paths. Based on the answers of those who chose to participate, most are likely to pursue radiology as a career.

As we continue to celebrate the College’s 100-year anniversary, we rely on members to inform us about what the future of radiology means to them and how current events may impact outcomes. Most interesting will be seeing how factors we haven’t even thought of today will impact our specialty in the future.

Feedback from these surveys has given us a unique snapshot of what members expect from our College. We hear you and will continue listening so that we may serve you and our collective patients with the high level of care and commitment you exemplify.
ACR Representatives Head to GO2 for Lung Cancer Voices Summit

ACR Director for the Commission on Patient- and Family-Centered Care (PFCC) Tiffany Gowen, MHA, and ACR Project Manager Beverlee Carlisle, PMP, attended the GO2 for Lung Cancer Voices Summit March 19–21 in Washington, D.C., on behalf of the PFCC Commission and the ACR Lung Cancer Screening 2.0 Steering Committee. The premise of the summit was to secure a requested $60 million in research funding for the Lung Cancer Research Program (LCRP), the only dedicated program of its type for early detection and treatment for members of the military and the public who have a higher risk for lung cancer (learn more at cdmrp.health.mil/lcrp).

Patients shared their stories related to lung cancer with congressional leaders on Capitol Hill, including Sen. Tim Kaine (D-Va.), Sen. Mark Warner (D-Va.) and Rep. Jennifer Wexton (D-Va.). ACR PFCC staff explained the importance of early detection and the need for continued outreach, research and education in the lung cancer community.

The ACR encourages practices around the country to participate in Lung Cancer Screening Day on Saturday, Nov. 11, 2023, to continue to spread screening awareness.

Learn more about the ACR’s LCS resources at bit.ly/LCS_Resources.

ACR Achieves Highest CME Accreditation Status

The ACR was reviewed by the ACCME® and was awarded Accreditation with Commendation for providing continuing medical education (CME) for physicians, a status that will be in effect for six years. This is the highest accreditation status and longest accreditation term offered by the ACCME.

"Achieving the highest level of CME accreditation is a testament to the medical community and our members that the ACR is dedicated to providing radiologists with the best possible CME opportunities to promote quality improvement," says ACR CEO William T. Thorwarth Jr., MD, FACR.

The ACR was awarded this designation because the ACCME recognized the achievements of the College to progress inter-professional collaborative practice, address public health priorities, initiate behavioral change, show leadership, leverage educational technology and show the importance of healthcare education.

Read the full story at bit.ly/ACR_ACCME.

Pricing Update Takes Effect July 1

The College is set to continue to improve and modernize its ACR accreditation value and customer experience by strengthening security, usability and efficiency. The result of these upgrades will be a pricing update on July 1, the first fee change in a decade.

The ACR continues to stay ahead of the evolving security landscape as the College works to get its Health Information Trust Alliance certification, making sure to protect its sensitive data with a more secure login process with multi-factor authentication. Fees are expected to increase by about 9% for all modalities except mammography and radiation oncology. Breast MRI accreditation will become a module under the larger MRI accreditation program, lowering the costs to sites.

Read the full article at bit.ly/ACR_Strengthens.

4 State Societies Receive 2023 ACRA SOP Grants

Four state radiological societies have been awarded 2023 grants from the ACR Association® (ACRA®) Scope of Practice (SOP) Fund. Societies receiving funds are New Jersey, Oklahoma, Pennsylvania and Texas.

The SOP fund was established in 2021 by the ACRA to safeguard patients and patient access to radiologist expertise by fighting state and federal non-physician SOP expansion legislation. Non-physician provider groups continually seek expanded authority by introducing legislation that would, for example, reduce radiologist oversight and enable direct billing. So far in 2023, the ACR has tracked non-physician scope-of-practice expansion legislation in 38 states.

For information about applying for an ACRA SOP grant, visit bit.ly/Scope-of-Practice.

For questions, email Eugenia Brandt, ACR senior government affairs director, at ebrandt@acr.org, or Dillon Harp, ACR senior state government relations specialist, at dharp@acr.org.
Leadership training is an essential component of professional development for radiologists of all levels.

KURT A. SCHOPPE, MD

RLI Power Hour Webinar Series

The Radiology Leadership Institute® (RLI) Power Hour Webinar Series continues with the topic of “Wellness in the Workplace.” A panel of experts talking about their projects aimed at reducing physical burnout will include Cheri L. Canon, MD, FACR; Ivan M. DeQuesada II, MD; Carolynn M. DeBenedectis, MD; and Gloria L. Hwang, MD. During this free webinar taking place from 7–8:15 p.m. EDT on Tuesday, June 27, panelists will share their experiences, lessons learned, signs to watch for within your team and proactive tools to use to achieve and maintain a mentally healthy staff.

Visit acr.org/powerhour to register.

Introducing Genitourinary Tract Module

A new self-assessment module from the ACR Continuous Professional Improvement (CPI) program allows you to assess your genitourinary imaging knowledge and earn eight CME. The module features over 170 multimodality high-resolution imaging examples including CT, MRI, US and radiography.

This CPI module also features:
• Case topics relevant to community and academic settings and for all levels of expertise, ranging from commonly encountered genitourinary imaging entities to emerging state-of-the-art imaging techniques and procedures.
• Entities involving the urinary tract, adrenals, prostate and female pelvis.
• Practical questions discussing the nuances of PI-RADS®, O-RADS™ US, O-RADS MRI and Bosniak classification v2019 to keep you updated on the latest guidelines and best practices.
• Discussion of cutting-edge issues in genitourinary imaging.
• Choice of print or online format. Each format includes a complimentary digital download version — the perfect on-the-go reference.

Print supplies are limited, so order your copy today at bit.ly/CPI_Module.

Still Time to Join the New RLI Bootcamp

For anyone interested in honing the skills it takes to successfully run a radiology department, the new virtual ACR Radiology Leadership Institute® (RLI) Learning to Lead Bootcamp is open for registration. The program is designed for leaders at every career stage, providing resources, tips and strategies to build skills needed to overcome common challenges. The bootcamp takes place from 6–8:15 p.m. on June 22.

Participants will:
• Gain confidence in their ability to build trust and earn respect among their fellow leaders.
• Learn how to balance clinical and administrative duties.
• Effectively interpret and advise based on financial reports.
• Develop a strategic plan to support leadership.
• Explore many other leadership topics.

Visit bit.ly/RLI_Bootcamp to learn more and to register.

Landmark Paper on Incidental Findings

The ACR and the American College of Emergency Physicians (ACEP) have unveiled new landmark recommendations to aid health systems, physicians and other clinicians in improving patient outcomes by addressing actionable incidental findings (AIFs) in emergency department (ED) imaging.

The recommendations were published in a white paper in the JACR® titled “Best Practices in the Communication and Management of Actionable Incidental Findings in Emergency Department Imaging.”

Over 150 million ED visits were recorded in the U.S. in 2019, and radiologic imaging was used in more than half of them. AIFs are defined as masses or lesions detected by an imaging examination performed for something else. “Strong communication and collaboration between clinicians when addressing actionable incidental findings is key to providing optimal patient care and preventing adverse outcomes,” says ACR CEO William T. Thorwarth Jr., MD, FACR. “The recommendations created by ACR and ACEP highlight a multispecialty effort between radiology and emergency medicine that aims to improve the reporting and communication of AIFs, which will ultimately benefit the patient.”

Read the full white paper at bit.ly/AIF-white-paper.

ENDNOTE:
FROM THE CHAIR OF THE COMMISSION ON ECONOMICS

Gregory N. Nicola, MD, FACR

SOS: Save Our Screening

A provision that helps patients receive lifesaving preventive care without co-pays is in jeopardy following a Texas judge’s ruling, which is being appealed.

Research shows that cost-sharing, even in small amounts, reduces the likelihood that people will use preventive services. As a result, the Affordable Care Act (ACA) contains a provision that mandates group health plans and health insurer coverage of certain essential health benefits and preventive services without cost-sharing by patients. The ACA’s list of preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) includes several radiology exams, like breast, lung and colon cancer screenings, that have received a rating of “A” or “B” from the USPSTF.

However, this widely popular provision is in jeopardy. A federal judge for the U.S. District Court for the Northern District of Texas ruled on March 30 that the ACA provision requiring health plans to cover care and treatments recommended by the USPSTF is unconstitutional. According to Judge Reed O’Conner, this provision of the ACA violates the U.S. Constitution’s appointments clause since members of the USPSTF are not Senate-confirmed. Instead, the 16 members of the USPSTF, who are primarily physicians and scientists, are chosen by U.S. Department of Health and Human Services leaders.

The decision builds upon a prior ruling from September in which O’Conner concluded that coverage of an HIV prevention treatment violated the Religious Freedom Restoration Act and, separately, that the USPSTF was unconstitutional. At that time, O’Connor requested supplemental briefings addressing whether the government should be entirely blocked from requiring health plans to cover services identified by the USPSTF, or whether the decision should apply only to the plaintiff in this case.

The latest ruling, which went into effect immediately, now applies nationwide. However, most insurance plans run on the calendar year, so preventive services are expected to be covered through the end of the enrollment year.

As a result of this ruling, health plans are no longer required to cover any of the recommendations for preventive services made by USPSTF since 2010, when the ACA was first signed into law.

Recommendations made by USPSTF prior to 2010, including screening mammography, will not be affected. However, private insurers could rescind coverage of CT colonography and lung cancer screening CT. Insurers may now choose to charge a co-pay for preventive services or cover only select services, which would tragically erase recent progress in improving access to screening for these high-mortality diseases.

In 2016, USPSTF designated CT colonography as a recommended screening test for colorectal cancer starting at age 50 and continuing until age 75. In May of 2021, USPSTF expanded the age range recommended for colon cancer screening to patients ages 45 to 49, granting millions more Americans private insurance coverage for this vital screening test. This coverage provided hope on the heels of American Cancer Society data showing that the proportion of colorectal cancer occurring in people under age 55 doubled between 1995 and 2019.

While we continue to advocate for Medicare coverage of CT colonography, mandated private payer coverage was a huge step in the right direction. Simply, this coverage saves lives.

In March 2014, the USPSTF recommended annual lung cancer screening in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. The USPSTF expanded the eligible age range to 45 to 80 and reduced the pack-year requirement to 20 in March 2021. Early detection of lung cancer through screening has been shown to reduce mortality by 20%. Providing insurance coverage for lung cancer screening CT saves lives. Yet, lung cancer screening rates remain abysmally low with 5.8% of eligible patients receiving the recommended screening nationwide.

We can make every effort to improve our screening tools, provide education on their benefits and build programs that navigate patients through the system. But without coverage, our patients will never have access to these lifesaving services in the first place.

Following the March 30 decision, the U.S. Department of Justice quickly filed an appeal. Multiple physician groups and patient advocacy groups, including the ACR, voiced concern and expressed support for the appeals process. The federal government is also expected to pursue a stay of the ruling, which would prevent it from going into effect during the appeals process.

The ACR will continue to advocate for access to evidence-based screening services, especially for our most vulnerable patients with the lowest ability to pay out-of-pocket health expenses.

ENDNOTES available in the digital edition at acr.org/bulletin
Bullying in the workplace occurs in every sector of industry. The healthcare landscape, including radiology, is not exempt from a problem that can have devastating effects for talented physicians who feel they have nowhere to turn. Unprofessional behavior that amounts to bullying is often difficult to identify, prevent and stop — and who does it, what they do and why they do it may surprise you.

Bullying behavior may involve abuse, humiliation, intimidation or insults. Victims are often on the receiving end of this behavior repeatedly, at the cost of great distress that may impact education or insults. Victims are often on the receiving end of this and why they do it may surprise you.

Unprofessional behavior that amounts to bullying is often difficult for talented physicians who feel they have nowhere to turn. “I have seen some examples of bullying that I have seen, and sometimes unfortunately experienced in a previous academic workplace and other radiology settings such as national societies, encompass a great many things. There may be a denial of privileges, like the amount of time allocated to academic pursuits. Some radiologists with qualifications equal to their colleagues may be prohibited from performing the same tasks they are trained and able to do.”

Undesirable shifts or duties are sometimes given only to certain staff. Denying or delaying promotions for an extended period with insufficient explanation or justification can also qualify as bullying.

Other examples include repeatedly declining to put someone forwarded for a leadership position or preventing certain radiologists from sitting on orchastrating committees. Radiologists with extensive experience are asked to complete other tasks that traditionally are not part of their job. “These assignments may be regarded as demeaning and could make staff feel small,” she says.

Women, people of color, trainees, residents and younger radiologists tend to be the most frequent targets for bullying. Kelly says. Trainees need a degree to qualify as doctors, and residents need someone at a higher level to sign off on their certificate, for example. “If someone in a position of power can affect whether someone gets that degree or certificate. Younger radiologists who are not familiar with the working group may feel support or allies or like more seasoned colleagues. They may have no one to champion for them,” Kelly says.

The consequences of bullying should not be taken lightly. “If your health and performance are compromised as a result of bullying, there can be a direct impact on the quality of patient care you deliver,” Meltzer says. “It is nearly impossible to undo these things,” Meltzer says. “We have seen terrible outcomes from this type of bullying in education among younger people, and physicians are just as at risk. “If your health and performance are compromised as a result of bullying, there can be a direct impact on the quality of patient care you deliver,” Meltzer says. “It is nearly impossible to undo these things,” Meltzer says. “We have seen terrible outcomes from this type of bullying in education among younger people, and physicians are just as at risk.

There is the issue of diminished patient care and the reputation of the radiology group or practice when word gets out about workplace bullying,” Kelly says. It is also costly and time-consuming to replace a radiologist who abruptly leaves because of bullying. “You may be losing a talented radiologist with valuable skills,” she points out.

Today it’s important to keep in mind that not all bullying happens in person. “Outside of the workplace, one thing we don’t talk enough about is cyberbullying,” Meltzer says. “In social media around radiology, we see anonymous Twitter handles, for instance, used to engage another through demeaning posts. “Malicious responses to someone’s tweets can be especially painful for victims because they don’t know who is making the belittling statements. “It is nearly impossible to undo these things,” Meltzer says. “We have seen terrible outcomes from this type of bullying in education among younger people, and physicians are just as at risk.

“Those in positions of power need to set the tone for professionalism, inclusion and flattening the hierarchy. As leaders, we should strive to create a welcoming and less formal environment. Ultimately, that will better serve our patients.”

Carolyn C. Meltzer, MD, FACR

Causes Differ

Tracey H. O’Connell, MD, a musculoskeletal radiologist who left private practice five years ago and now does teleradiology, says she coaches physicians, including radiologists, who are being gaslighted and bullied. Gaslighting is a form of psychological manipulation that involves abusers seeking to control other individuals by making them question their own judgment and intuition.

“Bullying is more often — behavior or actions that people can see from the outside,” O’Connell says. “For instance, most people in a meeting can witness bullying behavior and recognize that something isn’t right. Gaslighting is more subtle, but still
have established protocol to allow those who feel bullied or_gaslighting or防火 is done subconsciously as a response to feeling ‘not enough’ — not smart enough, not fast enough, not skilled enough. Ironically, shame is often what causes bullying and gaslighting, and shame is especially difficult to address. O’Connell says, “When someone needs to feel more secure, they bully or gaslight. They feel threatened and want to maintain their position in the hierarchy.” She explains, “They may be afraid of anyone who is in a position of power over them.” O’Connell says, “Medical students may be afraid of residents and everyone above them. Residents may be afraid of fellows and attendings, and those people above the chair, and the chair afraid of the administration. This vertical power structure limits an individual’s ability to speak out about what’s OK and what’s not.”

The competition never ends in radiology, with partners competing with each other for RVUs, number of cases read and perceived dedication — or competing for referrals with another radiology group in town. Sometimes it all takes, for example, someone commenting offhandedly to others, “I hope this person doesn’t come in late tonight, because they were late yesterday.” Then others in the group may say, “Oh yeah, I noticed that, too.” They are often late. “Little comments like this can put that person in the crosshairs,” O’Connell says. A similar result may happen if someone tells residents they aren’t going to pass boards. Another common way gaslighting shows up in radiology is through differences of opinion. A different interpretation is not always a “mistake” because it’s possible to have many interpretations of the same study, particularly when reading MRIs, O’Connell says. “The same case, however, can have many different interpretations during a disagreement.”

People can work in bad situations for a long time, until they can’t anymore,” O’Connell says. “You can sacrifice your well-being for decades, until it becomes unsustainable. I’ve seen very qualified people giving up years of rewarding radiology in a psychologically unsafe environment where no one is speaking up or offering support. Some radiologists, when they have had enough, realize they don’t need to tolerate bullying — that they can go to work somewhere where they are valued and can have relationships with colleagues based in mutual trust.”

One type of bullying can take the form of spreading rumors and planting seeds of doubt. Trainers and early-career radiologists are vulnerable to anyone trying to undermine their expertise. Often bullying or gaslighting is done subconsciously as a response to feeling ‘not enough’ — not smart enough, not fast enough, not skilled enough. Ironically, shame is often what causes bullying and gaslighting, and shame is especially difficult to address. O’Connell says, “When someone needs to feel more secure, they bully or gaslight. They feel threatened and want to maintain their position in the hierarchy,” she explains. “They may be afraid of anyone who is in a position of power over them.” O’Connell says, “Medical students may be afraid of residents and everyone above them. Residents may be afraid of fellows and attendings, and those people above the chair, and the chair afraid of the administration. This vertical power structure limits an individual’s ability to speak out about what’s OK and what’s not.”

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Speaking Validates

When radiologists experience bullying, they have to decide how to handle the situation — and that brings up a whole new set of stressors. “Raising concerns in isolation will not always be the best approach because of potential adverse reactions,” Melzer says.

Training and education are fundamental to stopping bullying. “We don’t hold the assumption that bullying and gaslighting are things that only happen in the military. He and everyone else in the department was single with no children. I felt like he was trying to make me feel stupid and insignificant — if ‘looking back, in reality those trains applied to him. Practicing with a teleradiology group part-time from home has been great for balancing more commitments, but when it was really, really, really stressful, this all started because a fellow resident had had enough as well and she introduced me to the practice. I thought I would try it in another residency colleague. We all understand how things should run. Bullying is not a part of our work.
What have been the biggest challenges in this experiment? Has anything surprised you during the preparation?

The biggest challenge has been the process of launching an experiment into space. This is not unique to our experiment, but universal for all space-relevant endeavors. The playing field was significantly changed by the advent of private commercial space entities, and the field will continue to evolve. I think the most surprising thing is the positive exception this project has received so far. In particular, I would like to thank the radiology department at USC, which has been extremely supportive — especially the chair at the time, Robert K.W. Ryu, MD, and my team of co-residents and collaborators. This project wouldn’t have been possible without all of them. I hope that means there are more radiologists who believe improving space radiology is a worthy goal and are willing to help make it a reality. Overcoming the challenges of patient care in space will require a community and not just one person, group or institution.

How will this endeavor benefit patient care on Earth?

As necessity is a driver of invention, the limitation of resources in space will likely result in X-ray-based medical technologies that consume less power and, consequently, use lower levels of ionizing radiation. This would likely reduce the carbon footprint of radiology equipment and reduce patient exposure to ionizing radiation. In addition, I am sure there will be other unintended benefits. One of the reasons I personally enjoy research is because of the joy the hurdles of finding a research question or discovery — and, as a physician, figuring out how it might be used to help my patients. I hope that will be the case for space radiology as well.

Interview by Alexander Uran, editorial assistant, ACR Press


date with photography for the Keck School of Medicine at the University of Southern California Keck School of Medicine, preparing the radiology space payload has been a team effort. Pictured left to right, integrated IR/DR resident Matthew Hartman, MD; former USC radiology department chair Robert K.W. Ryu, MD; integrated IR/DR resident John Choi, MD; PhD, DO; resident Sall Ahmed, MD, and integrated IR/DR resident Matthew Hartman, MD; NKT; integrated IR/DR resident Max W. Raynor, DO, and DR resident Dave Weiant, MD.

Left: Ships' X-ray imaging residents. Reprints: P. Sugar, MD, Adam T. Miller, MD, and Matthew Hartman, MD, make adjustments to the experiment that will go to space.
Medicaid Reimbursement Is Not Keeping Pace With Medicare

New data from the Harvey L. Neiman Health Policy Institute® offers insight into the differences between reimbursement rates for the two programs — bringing to light striking variations.

While Medicare reimbursement rates are consistent nationally, differing only by a geographic cost index, Medicaid reimbursement rates are determined by each individual state and are based on one of three factors: 1) a percentage of the state or 3) a relative value scale. In general, Medicaid reimbursement rates tend to be much lower — usually equaling only about 78% of Medicare reimbursement. Further, the rates vary substantially across states and for specific procedures.

The lower reimbursement rate has contributed to reductions in provider participation in Medicaid, as reported by the Medicaid and CHIP Payment and Access Commission (MACPAC) in 2017. Specifically, 96% of providers said they were accepting new Medicaid patients, but only 74% were accepting new Medicare patients.

Among some specialty groups, only 70% were accepting new Medicaid patients. Lower provider participation in Medicaid means that having insurance does not equate to having equal access to care. Continued degradation of Medicaid reimbursement will further diminish the already limited access to care that low-income patients in the United States currently face.

Knowing the Numbers

Given the importance of imaging reimbursement deficiencies in ACR advocacy, the ACR Government Relations team collected the past 10 years of state-level Medicaid and Medicare reimbursement rates for 10 common procedures of varying complexity. The Harvey L. Neiman Health Policy Institute® analyzed these data and created heat maps, now available on NeimanHPI.org.

The analyses served to verify the dire situation. Many states are severely deficient in their Medicaid reimbursement rates for professional fees. This was seen even among states with the highest rates of Medicaid enrollment, which means more than 25% of the state population, including Alaska, California, New Mexico, Arizona, Louisiana, Kentucky, West Virginia, New York, Vermont and Washington, D.C. For instance, in Rhode Island, where 32% of the population uses Medicaid, the professional rates for Medicare are only about two-thirds (64%) of the Medicare rates, whereas Medicaid rates in Wyoming are almost double Medicare rates (194%) in a state with only 12% Medicaid enrollment.

A more complex procedure with higher reimbursement, CT of the abdomen and pelvis, showed similar variance. In 2022, the Medicare rate for this procedure in New York State (which has a 28% Medicaid enrollment) was 59% of Medicare’s rate, while Nebraska’s Medicaid program paid doctors 159% of the Medicare rate but had only about half the rate of Medicaid enrollment (15%).

Closing the Gap

For some procedures, the Medicaid-to-Medicare reimbursement gap seems to have grown wider over the last 10 years. In 2012, for instance, these rates were nearly equal for a single-view chest X-ray in Rhode Island, a ratio one-third higher than it would be in 2022 (0.64). For a more complex procedure, an esophagram with upper gastrointestinal imaging, states such as New York, Connecticut and Rhode Island are even seeing Medicaid professional reimbursement at less than half of what was paid by Medicare in 2022, while the same ratio for these states in 2012 was 0.54, 0.98 and 0.99, respectively.

In general, the majority of states are seeing shifts toward Medicaid-to-Medicare ratios of less than 1.00 for professional charges reimbursed for common imaging procedures, regardless of procedure complexity or cost.

Together, state and federal governments need to find a way to narrow the massive gap between Medicare and Medicaid reimbursement to improve access to care rather than just access to insurance. Although states do receive funding from the federal government to cover a majority of their Medicaid expenditures — and particularly so after the Medicaid expansion under the Affordable Care Act — Medicaid is ultimately a state-run program, and states determine reimbursement specific for services. Medicaid expansion has resulted in increases in access to care, including higher rates of early-stage cancer diagnoses, which have led to fewer premature deaths in the U.S.1 Hence, while Medicaid expansion has been helpful, its potential impact is limited by its relatively lower reimbursement that may hinder access to care and create disparities across the states. Although Medicaid often reimburses at a mere fraction of Medicare rates, it does provide a necessary lifeline for much of the U.S. population, allowing people to receive medical care when they otherwise would not be able to if Medicaid did not exist, even if the access to care it provides is more limited than for Medicare or commercially insured individuals. During the COVID-19 pandemic, for example, Medicaid served as a safety net for patients, when so many people who were laid off from their jobs lost their private or employer-sponsored health insurance and relied on Medicaid to access the care they needed. Medicaid enrollment rose 29% in the first 22 months of the pandemic, while employer-sponsored health insurance and other private plan enrollment dropped. It is time to level the playing field for providers who treat Medicaid patients and for patients who do not meet the eligibility criteria or cannot afford other healthcare coverage options. Not only will this ensure providers are being paid appropriately, but it will also facilitate access to preventive care, like cancer screening, for patients who so desperately need it.

ENDNOTES

1. By Casey E. Pelzl, senior economics and health services research analyst, Harvey L. Neiman Health Policy Institute®. Eugenia K. Brandt, Neil C. Davey, MD, FACP, Elizabeth Y. Rula, PhD, and Eric Christensen, PhD, contributed to this column. According to the numbers available online to provide objective data for advocacy. Please visit the Neiman Almanac at neimanhpi.org/heat-maps-2022.

2. This heat map demonstrates the ratio of Medicaid-to-Medicare charges for professional services rendered, covering a range for reimbursement, for a single-view chest X-ray in each state in 2022. Ratios below 1 indicate lower rates of Medicaid reimbursement as compared to Medicare for that state in 2022. Ratios above 1 indicate higher Medicaid reimbursement rates as compared to Medicare for that state in 2022.

3. The Harvey L. Neiman Health Policy Institute® has made the map presented here and other state-level interactive maps available online to provide objective data for advocacy. Please visit the Neiman Almanac at neimanhpi.org/heat-maps-2022.
With his passion for quality improvement, David B. Larson, MD, MBA, FACR, who serves as chair of the ACR Commission on Quality and Safety, shares the origins of the ACR Learning Network, its purpose and what participants can expect from the program. Larson is a professor of radiology at Stanford University, where he also serves as the senior vice chair for education and clinical operations in the radiology department. He is the associate chief quality officer for improvement for Stanford Health Care and physician co-leader of the Stanford Medicine Center for Improvement. He is also the founder of the Realizing Improvement through Team Empowerment (RITE) program, co-founder of the Clinical Effectiveness Leadership Training program and founder of the Advanced Course for Improvement Science, all at Stanford.

What is the ACR Learning Network?

It’s a program that is designed to help local teams make improvements in specific patient care areas by growing skill sets in problem-solving and enabling sharing of ideas between organizations.

The ACR Learning Network is made up of separate improvement collaboratives, each of which uses this same general approach to address different challenges.

The idea of the ACR Learning Network was an outgrowth of my work in developing a number of improvement training and project-support programs at Stanford, which were built on my experience at Cincinnati Children’s Hospital. The quality improvement (QI) training portion of the Learning Network, ImPower, was patterned after the RITE program at Stanford, which was initially supported by an RSNA Research and Education grant.

We recognize that joining the Learning Network requires a real investment. But we are confident it is just that — not a cost, but rather a worthwhile investment into the individuals in your organization and the organization as a whole. It’s the kind of investment that turns on its head the conventional wisdom that greater costs more. Once the investment is made, we are convinced it easily pays for itself in financial and other ways. For example, we find that when participating sites develop a program for organizational development, such as a coaching model to support their frontline staff, those staff members feel supported and tend to stay at their organizations. This becomes a powerful recruiting and retention tool that positions your organization favorably and also decreases problems associated with high turnover. In other words, it requires a bit of a leap of faith to get started. But once you do it, we’ve found that participants consistently say, “Yes, it was a lot of work. Yes, it was humbling. And yes, it was hard. Would I do it again? Absolutely.”

This is a big project. How and why do you do it and still have a full-time job (or two)?

I think my motives are the same as anyone else who volunteers for the ACR and other radiology societies — for the love of the profession we have inherited and the desire to meaningfully contribute by helping to make it better.

I don’t think we should underestimate our ability in radiology to impact the entire medical field for the better. In fact, the Gordon and Betty Moore Foundation has told us they view this as a showcase model for learning networks in general. If we do it right, our efforts can not only improve care but can also improve healthcare more broadly. And this is just one of many examples of how radiology leads the field in important ways.

With that type of opportunity, you make time — especially given the wonderful staff and colleagues we have throughout the ACR. The opportunity to work with such amazing people to create something that can be self-sustaining for decades to come is incredibly rewarding. Come join us and build it together — and have a lot of fun on the way.

ACR Learning Network Physician Director David B. Larson, MD, MBA, FACR, discusses tackling some of radiology’s toughest challenges.

Can an institution solve these kinds of challenges on its own?

In theory, any organization could make these types of improvements without help from a program like the Learning Network, but in reality, we find that rare is the chance for a variety of reasons. These types of improvement initiatives are much more likely to be successful in a structured program like this one.

ACR Learning Network — 15 years of learning.

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Q&S
Making an Impact in Leadership and lift communities.

Meet two recipients of an annual award recognizing radiologists for noteworthy contributions that improve organizations and lift communities.

In 2022, the Radiology Leadership Institute® (RLI) celebrated 10 years of delivering leadership and professional development training to radiologists at all career stages. Each year, the RLI recognizes the work and achievements of current leaders and provides scholarship opportunities for new leaders through its RLI Leadership Awards and Scholarship program (learn more at bit.ly/ACR_RLI). One of those honors is the RLI Impact in Leadership Award (read more at bit.ly/Impact_LeadershipAward), which recognizes individuals whose participation in an RLI course or program was integral to the successful completion of a specific project or initiative at their practice or institution.

The 2022 Impact in Leadership recipients were Andrew K. Moriarity, MD, vice president of clinical operations and quality chair at Advanced Radiology Services (ARS), and Vivek Masson, MD, system chair of radiology at CarePoint Health. Here are their stories of leadership initiatives and impact.

#### Optimizing the Organizational Structure

At ARS, Moriarity faced the challenge of integrating two disparate reading environments, where 200 radiologists were reading more than 2 million exams each year. Over the course of a year, he led a project to merge the practice’s largest hospital partner into the ARS teleradiology platform, creating a cohesive reading solution. As a result, the practice was able to achieve its goals of enhancing patient care, standardizing systems and improving overall clinical operations.

“The beginning was, we were effectively operating in two parallel environments, with limited ability for radiologists in one area to assist others,” Moriarity says. “Creating a cohesive reading workflow not only helped us optimize case distribution, but we were also able to expand the reach and impact of our subspecialists, while improving overall scheduling flexibility and radiologist work-life balance.”

As chair of the Clinical Leadership Committee, Moriarity was tasked with coordinating this project while working with radiology practice section chiefs, the distributed radiology information technology department, the clinical decision support analytics team and hospital partners. According to Moriarity, participating in the RLI Maximize Your Influence and Impact Course (learn more at bit.ly/RLL_Maximize) provided the crucial foundational leadership knowledge and the skills to lead this project to fruition.

Among the successes, Moriarity’s project:

- Created the right organizational structure to navigate change in radiology and hospital operations. The team mapped out the practice volume across 14 different hospitals, according to detailed historical data, and used a robust capacity analysis tool to optimize scheduling on a per-hour basis, which guarantees patient exams to the right radiologist faster.
- Addressed team challenges by aligning members with diverse perspectives and backgrounds around performance goals. The project tackled “turf” concerns and created equity across different jobs, which was vital to program implementation and success.
- Focused on enhancing work-life balance. Optimizing subspecialty workload distribution for on-site staff and increasing in-home workweek deployment by 100% resulted in enhanced job satisfaction and greater ability to recruit new staff, especially for second and third shifts.
- Recognized the critical relationship between radiology and clinical operations to improve outpatient turnaround times (TAT). By combining a robust remote reading solution and optimizing clinical staffing, the practice was able to improve outpatient TATs by more than 35% within just three weeks.
- Used basic financial statements and financial analysis to assess financial health and develop improvement strategies. While improving patient care and clinical operations were key goals of the project, the team paid specific attention to how changes would improve operational finances while also supporting radiologists’ well-being.
- Improved standardization of protocols and reporting templates. As a result of the project, protocol standardization increased from 54% to 80.2% and technologist history standardization increased 10 times.

“The RLI is a great resource to supplement the clinical training we get as radiologists.”

**ANDREW K. MORIARTY, MD**

“Throughout the project, I was able to draw on lessons learned from the many hands-on discussions and real-world case examples,” Moriarity said. “The course highlighted how to build effective teams, manage change and develop operational efficiencies, as well as underscored the importance of both formal and informal communication in building relationships and enhancing the success of major initiatives.”

#### Serving the Underserved

Integration of disparate imaging providers is a focus at CarePoint Health, which serves a busy network of safety-net hospitals and outpatient centers in northern New Jersey and is located in one of the most populous and ethnically diverse counties in the greater New York area. In his role as system chair of radiology, Masson integrated previously separate radiology divisions and hospitals into one combined service line, allowing for increased subspecialized care for the local community.

In 2022, the Radiology Leadership Institute® (RLI) celebrated its next decade of achievements and contributions have made a lasting impact on the field. As the Radiology Leadership Institute Institute® (RLI) enters its next decade of leadership training, it will continue to recognize those radiologists whose achievements and contributions have made a lasting impact on the field. Visit the RLI website for more information on all current RLI Impact in Leadership Award recipients.

The RLI has empowered me to make a positive impact in my local community that I hope will lead to bigger and more impactful initiatives in the future.

**VIVEK MASSON, MD**

One example of Masson’s efforts to enhance patient care in this underserved community was the development of a Woman’s Health Pavilion in 2022, which aimed to address access-to-care issues for local communities.

“Over the past few years, I have worked hard to address access to care and systemic bias issues in our local system and community at large,” Masson says. “A significant aspect of the woman’s center is offering affordable care to populations who would otherwise be unjustly deprived of access. Beyond that, we’re providing state-of-the-art technology, top-quality facilities and exceptional care for underserved communities — we didn’t sacrifice anything. Quite the opposite.”

**RECOGNIZING REMARKABLE RADIOLOGISTS**

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The ACR is celebrating a major milestone this year: a century of leadership, integrity, quality and innovation. Our 100th anniversary gives us an opportunity to recognize and celebrate the world-changing achievements and contributions of our members.

In August 2022, the ACR Centennial Steering Committee, in concert with the ACR Environmental Intelligence team, sent out a brief survey asking members for their thoughts on what the future of radiology might look like and how current events might impact those outcomes.

The Future: What we’re watching

<table>
<thead>
<tr>
<th>Future Factor</th>
<th>Threat (%)</th>
<th>Opportunity (%)</th>
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</thead>
<tbody>
<tr>
<td>Health policy and economics</td>
<td>97%</td>
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<td>Government and policy changes</td>
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<td></td>
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<tr>
<td>Use of genetics</td>
<td>62%</td>
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</tbody>
</table>

The Future: What we’re most excited about in the next 5 to 15 years

Al, machine learning and new technology

Burnout: Where we’re worried about it

While the majority of respondents are concerned about burnout in general, respondents are significantly more concerned about burnout across the radiology profession and in their workplaces. They are least concerned about suffering from personal burnout themselves.

Burnout: What’s causing it

Respondents pointed to physician and staff shortages as the top areas of concern related to burnout.

Lingering Effects of the COVID-19 Pandemic

Nearly 7 out of 10 respondents agree the pandemic has modified communication patterns between radiologists/referring clinicians, significantly more than has:

- Accelerated changes in technology
- Impacted referring physician ordering patterns

About the Survey | The ACR Centennial Steering Committee worked with ACR staff to conduct a survey between Aug. 4 and Aug. 19, 2022. A total of 190 radiologists responded.
How do you foster patient- and family-centered care in your organization?

“As breast imagers, we are intimately involved in a patient’s breast journey from conducting preventive care with screening mammograms, and addressing concerns with diagnostic imaging, to helping a patient with a breast cancer diagnosis and surveillance afterward. We have an incredible opportunity to involve the patient and selected family members in their care and decision-making along each step. Viewing the mammogram alongside the patient is a great way to provide education on breast density and supplemental screening options. In our ambulatory center, every patient is offered a patient liaison to address any needs, allowing a consistent point of contact. Promoting shared decision-making empowers patients to be their own advocates, which not only contributes to the best patient experience and outcomes but also leads to greater job satisfaction for the healthcare team.”

Sonya Bhole, MD, director and physician lead of ambulatory breast radiology and assistant professor of radiology, Northwestern University, Feinberg School of Medicine, and member of the ACR Commission on Patient- and Family-Centered Care’s Outreach Committee

“We have really been working on our scheduling process. We have developed a self-scheduling process through Epic MyChart for many types of imaging exams — mammograms, most CTs and we are now adding MRI and dual X-ray absorptiometry (DEXA) scans. Patients can schedule as soon as the order is placed by their provider. We’ve also made it easier for provider offices to schedule imaging exams directly into our software while the patient is checking out so patients have an appointment before they leave. These shifts have resulted in a lower wait time and abandonment rate at our call center. No more waiting on endless hold!”

Jennifer A. Harvey, MD, FACP, chair of imaging sciences and professor at the University of Rochester, and member of the ACR Commission on Patient- and Family-Centered Care’s Outreach Committee
simply, this center has saved lives by providing one-stop screening, diagnosing and treatment for women who have breast cancer, as well as a host of other gynecological malignancies and diseases.”

Masson says the RLI has been instrumental in his efforts to lead radiologists across three hospitals and build a unified platform and system for the health system. “When I entered my position 10 years ago, I had little knowledge or formal training in radiology leadership. The RLI became my primary source for this knowledge. The ability to learn and be shaped by world-class leaders who are giants in the healthcare field was instrumental in my success, particularly in building new the Woman’s Health Pavilion.

Masson’s lessons learned from various RLI courses include:

- **The need to develop strong relationships with the medical staff and administration.**
  This seminar laid the foundation for Masson’s project. Getting buy-in from all parties involved was instrumental in selling his vision, and truly building a connection with the president of the medical staff as well as the system CEO was crucial to the success of the program.

- **The importance of understanding finances.**
  Masson gained a solid foundation to understand the business side of radiology, where he could sit down with relevant stakeholders from the finance and business development teams and speak their language with confidence so everyone was aligned to the same goal for the Woman’s Health Pavilion: being self-sufficient and sustainable, while providing additional downstream sources of revenue.

- **The critical opportunity to think outside the box.**
  The involvement of political and public health teams allowed Masson to advocate for the project on a grassroots, community-health level and engage local officials — including the mayor, council members and state lawmakers — who would become vested stakeholders in the importance of the project and who helped overcome legislative and financial hurdles.

“Without the RLI, I would not have had the tools to be able to lead my radiology team for the past decade,” Masson says. “The skills learned from the RLI and ACR have been by far the most important part of my transformation into a practice and system leader. If not for the RLI, this project, which will help save the lives of thousands of underserved people in northern New Jersey, would not have happened. The RLI has empowered me to make a positive impact in my local community that I hope will lead to bigger and more impactful initiatives in the future.

“For radiologists at every level, it’s more important than ever to develop leadership skills,” Masson adds. “With the advent of AI, our workflows are going to change. And those people who can lead reorganization of processes and navigate management changes will be the ones who come out ahead. My advice: Keep building your leadership skills and it will pay off in the end. The RLI is an incredible organization, and the people behind it are extraordinary. We’re fortunate to have their wisdom and the ability to network with one another and bounce ideas off other people who are solving the same challenges we have. That’s a remarkable advantage.”

Read more about Masson’s award-winning Impact in Leadership project at bit.ly/Masson_Project.

By Linda Sowers, freelance writer, ACR Press

2023 RLI SUMMIT | NEW VENUE

The 2023 RLI Summit will be held Sept. 29-Oct. 1, 2023, at the Boston Seaport Hotel, just minutes from Logan Airport. Located in the Seaport District, one of Boston’s most exciting neighborhoods, the award-winning Seaport Hotel offers an authentic New England feel on the historic waterfront with dozens of restaurants, parks and museums within walking distance.

Although the venue has changed, this year’s program will have the same compelling content and networking opportunities you’ve come to expect from the RLI Summit. As always, we’ll have our renowned Bobson faculty covering topics important to your journey as a leader, including strategy, finance and negotiations. Radiology experts will share case studies designed to help you apply what you learn.

The 2023 RLI Awards recipients will be honored during the RLI Summit Awards Dinner being held on Friday, Sept. 29. You won’t want to miss it!

The RLI Summit happens only once a year. Don’t miss this!
Get the Skills You Need to Improve Your Diagnostic Accuracy with AIRP® Categorical Courses.

**Neuroradiology**
Aug. 7–10, 2023 | Virtual

**Pediatric Radiology**
Aug. 16–18, 2023 | Virtual

**Musculoskeletal Imaging**
Sept. 18–21, 2023 | In person

**Breast Imaging**
Sept. 22–23, 2023 | In person

**Abdominal Imaging**
Oct. 16–20, 2023 | Virtual

**Thoracic & Cardiovascular**
March 28–April 3, 2024 | In person & Live stream

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For information about the accreditation of this program, please contact the ACR at info@acr.org.

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Empowering Better.
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He adds, “Every radiologist needs the skills the RLI teaches to be successful. Our practice subscribes to the RLI philosophy that leadership is for everyone, and we believe every radiologist should be an excellent clinician but also bring an additional expertise to the practice. The RLI provides a forum to explore your own personal interests and see how you can bring added value, maximize your own contributions and develop those gifts to give back in service to others.”

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He adds, “Every radiologist needs the skills the RLI teaches to be successful. Our practice subscribes to the RLI philosophy that leadership is for everyone, and we believe every radiologist should be an excellent clinician but also bring an additional expertise to the practice. The RLI provides a forum to explore your own personal interests and see how you can bring added value, maximize your own contributions and develop those gifts to give back in service to others.”

Read more about Moriarity’s award-winning Impact in Leadership project at bit.ly/Moriarity_Project.

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ACR Bulletin (ISSN 2160-4754) is published monthly by American College of Radiology, 1892 Preston White Dr., Reston, VA 20191.
From annual membership dues of $900, $12 is allocated to the ACR Bulletin annual subscription price. The subscription price for nonmembers is $90. Periodical postage paid at Reston, Va., and additional mailing offices. POSTMASTER: Send address changes to ACR Bulletin, 1892 Preston White Drive, Reston, VA 20191-4326 or email to membership@acr.org.
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