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RADPAC, the American College of Radiology Association (ACRA) bipartisan political action committee (PAC), is celebrating its crystal anniversary this year. It hardly seems that 15 years have passed since the formation of radiology’s PAC. Of course, RADPAC was not the first physician political action committee. More than 50 years ago, the AMA’s PAC (AMPAC) became the first non–labor union PAC. As Ardis D. Hoven, MD, then chair of the AMA Board of Trustees, pointed out in 2011, physicians have long been engaged in the American political process, beginning with the five physicians who signed the Declaration of Independence in 1776.

PACs exist to promote and facilitate the education of policy-makers. Although RADPAC is not the largest medical PAC, it is close. Of the more than 120 registered health care PACs, RADPAC continues to rank in the top three for funds raised and contributed and recently ranked 12th out of the more than 4,300 PACs registered with the Federal Election Commission in funds raised. In each of the last three years, RADPAC raised more than $1.3 million in contributions from just over 3,000 individual radiologists. However, the number of contributors is just barely 10 percent of the entire ACRA membership.

RADPAC has been a pioneer in strategically using these contributions. In addition to direct contributions to campaigns to attend Washington, D.C. fundraising events for both democrats and republicans, RADPAC also helps sponsor and coordinate fundraisers throughout the country so that individual radiologists can be more engaged in political activity and directly participate in the education of federal politicians at a more personal and local level.

A more sophisticated way to support candidates is through so-called independent expenditures. While federal rules limit the amount of money a PAC can contribute directly to a candidate, the same rules allow PACs to spend an unlimited amount of money to purchase ads and other materials to support candidates as long as there is no coordination with the candidates, their offices, or their campaign staff. These expenditures allow PACs to make a bold statement on behalf of individual candidates. In the current election cycle, RADPAC is making a number of bipartisan independent expenditures for candidates with a strong connection to radiology.

Health care is a complex subject, and the need to educate members of Congress about health care issues continues. More than 40 percent of the current Congress is new since 2010, and more than 50 new members are expected after this November’s election. The next five to ten years in health care will likely be the most important in our lifetime, as the Affordable Care Act is implemented. For better or worse, Congress and politics will shape our future. Physicians and physician organizations need to make the politicians aware of our issues. The ACR’s government relations team does an outstanding job educating members of Congress about important issues on our behalf. For instance, 41 members of the U.S. Senate recently signed a letter urging Medicare to follow the lead of the U.S. Preventive Services Task Force and provide coverage for lung cancer screening using low-dose computed tomography.

The traditional gift on a 15th anniversary is crystal. As an avid college football fan, when I think about crystal, all I see is the crystal football, which is awarded each year to college football’s national champions. Well, for the last 15 years, RADPAC has been radiology’s champion. It has been a privilege for me to serve as RADPAC’s chair for the last two years, and I thank you all for that opportunity. The ACRA’s RADPAC team is dedicated to our specialty, and these professionals have made RADPAC an important facet of the politics of health care reform. Additionally, I am grateful to the ACRA member volunteers who make up the RADPAC Board and the RADPAC Advisory Council. They are also working diligently on your behalf.

The importance of RADPAC is crystal clear. RADPAC’s first 15 years have been stellar. I am excited about the opportunities physicians will have over the next ten years to be involved in shaping their futures. I’m eager to know what RADPAC’s silver anniversary story will be. For more information, visit www.RADPAC.org.
MRI HELPS PREDICT THE FUTURE

Brain imaging can be used to predict future cognitive abilities, meaning that developmental brain disorders could be detected in childhood, according to a study in the *Journal of Neuroscience*. The study examined 62 children between the ages of 6 and 20 who underwent a series of cognitive tests, including measures of working memory. As the children completed the tests, researchers performed MRI scans. The results were used to predict the children’s future working memory. Two years later, the participants completed the same tests while undergoing an MRI.

Researchers found that MRIs could predict to a degree the speed of cognitive development in the two years between the tests — future memory capacity and memory could be inferred from the first test by looking at how much activity went on in areas such as the thalamus. “Until now, neuroimaging has just given us pictures of behavior we already knew about,” said Torkel Klingberg, MD, PhD, one of the researchers. “Now this is telling us we can use the MR scanner for something novel.” For more information, visit http://bit.ly/MRIPredictor.

SAVVY STOCK TRADERS GET BIOLOGICAL WARNING SIGNS

Want to be stock market savvy? Listen to your brain. Researchers at Caltech and Virginia Tech Carilion Research Institute used MRI technology to look at the brain activity and behavior of people trading in simulated markets created by the researchers. When participants noticed that the price of a stock far exceeded the actual value, a warning signal formed in the participants’ brains that caused some to be anxious enough to sell their stock. Those participants who received the signal sold their stocks early and earned the most money. The researchers hypothesize that the insular cortex (also known as the insula) might be what causes the warning signal; the area has been linked to risk aversion in earlier studies. In the high earners, insular cortex activity increased shortly before they sold their stocks. In low earners, insular cortex activity decreased. To learn more, visit http://bit.ly/RiskMRI.

ACR 2015: JAMES H. THRALL, MD, FACR, TO GIVE MORETON LECTURE

James H. Thrall, MD, FACR, ACR Gold Medalist and Leadership Luminary, will give the Moreton Lecture at ACR 2015, entitled, “Imaging in the Era of Precision Medicine.” This year’s lecture will explore the basics of precision medicine, what it means for the entirety of the specialty, and how you can apply it within your practice. Well known for his tenure as the chair of the ACR Board of Chancellors, among many other prominent positions, Thrall is one of the leading radiology visionaries. Attendees will not want to miss this insightful lecture. For more information, visit www.acr.org/Annual-Meeting.
BREAST BIOPSY PAYMENTS GET A BOOST

Last year’s Hospital Outpatient Prospective Payment System (HOPPS) rule created a series of disappointments for radiologists — among them were drastic cuts to the payments for stereotactic, ultrasound, and MRI-guided vacuum-assisted breast biopsy. However, with a new year come new rules, and hopefully some good news for radiologists. In 2014, CMS has released a proposed rule for the 2015 HOPPS that will bring a 51 percent increase in payments for breast biopsy procedures. “This is good news — after years of bad. We’re glad CMS is correcting the bundled codes so that these breast biopsy procedures will be paid decently,” said Pam Kassing, senior economics and health policy advisor at the ACR, in an interview with Aunt Minnie. While there is much to hope for, the rules are still only a proposal. CMS will post its final ruling on Nov. 1, 2014. For more information, visit http://bit.ly/HOPPS15.

WHO WILL YOU NOMINATE?

It’s time to submit your candidates for next year’s elected and selected positions. Among the open elected positions are president and vice-president of the College; four positions on the BOC, three of which are held by incumbents eligible to run for a second term; four positions on the Council Steering Committee; three positions on the College Nominating Committee (CNC); and two members-in-training representatives to the Intersociety Conference (ISC). Additionally, the CNC will select a private-practice representative to the 2015 and 2016 ISC meetings.

Any ACR member may submit recommendations to the CNC for elected or selected positions in care of the ACR Governance Office on or before December 15, 2014. Detailed information is available at http://bit.ly/NominationsACR or through the ACR Governance Office. All information can be sent to Kathy Bentley or Katie Kuhn via email (cnc@acr.org) or to the ACR headquarters at 1891 Preston White Drive, Reston, VA 20191.

ACR CAREER CENTER HELPS WITH TRANSITIONS

The ACR Career Center is the premier electronic recruitment resource for the radiology profession. With over 4,400 active resumes and the most competitive prices in the industry, employers have access to a robust listing of highly qualified physicians. Post your jobs and search resumes by locations, career levels, and specialties. Save 10% on your next job posting by using the code: BULLETIN2014

Job seekers, whether you are looking for your first job out of training or you’re ready to take your career in a new direction, the ACR Career Center is your resource for connecting with great job opportunities. ACR members have free access to hundreds of the best jobs in the United States and around the world. Post your resume to be recruited by some of the most highly sought-after employers in the industry.

TIPS FOR YOUR TOOLKIT

Although reactions to contrast material are rare, not knowing how to respond in those situations could have dire consequences. Are you prepared?

ANCIENT CANCER PATIENT DISCOVERED

Cancer is relatively absent from archaeological records compared to other diseases, leading many to believe that it is mainly attributable to modern lifestyles. But a new study suggests otherwise. British researchers have found what they believe is the world’s oldest example of a human being with metastatic cancer — a 3,000-year-old skeleton found in a tomb in Sudan. Using X-rays and a scanning electron microscope, the archaeologists were able to get clear imaging of the lesions, which showed widespread tumors across the upper body. “Insights gained from archaeological human remains like these can really help us to understand the evolution and history of modern diseases,” said Michaela Binder, a Durham PhD student who led the research and excavated and examined the skeleton. To read more, visit http://bit.ly/CancerBones.

GOOD NEWS FOR CANCER PATIENTS

The American Cancer Society released its 2014 Cancer Treatment and Survivorship Facts and Figures report in June. It found that although the number of Americans with a history of cancer is growing (due to the number of individuals living longer), so is the number of cancer survivors. Check out some of the current statistics for the U.S.

- There are nearly 14.5 million cancer survivors alive in the U.S. today.
- 46% of today’s survivors are 70 years or older. This means that more cancer survivors are living longer and that older individuals are increasingly surviving.
- By 2024, the American Cancer Society estimates that the number of cancer survivors will increase to almost 19 million.
- This is a steady increase from the 13.7 million survivors in 2013.
- The report also includes helpful information for patients, as well as detailed information about specific cancers and treatments. To see the report, visit http://bit.ly/CancerSurvivorship.

NEW AIRP™ COURSE AVAILABLE

The AIRP recently unveiled a new course, AIRP Radiation Oncology, which will take place February 2–5, 2015. The course will evaluate and interpret diagnostic imaging with respect to oncologic pathology and will cover all imaging modalities as well as a broad range of diseases. “A good understanding of the pathologic correlates of disease is an essential part of radiation oncology training and practice. We are happy that the resources of the AIRP have been utilized to develop a syllabus that will focus on topics of special interest to radiation oncology residents and practicing physicians,” says Seth A. Rosenthal, MD, FACR, chair of the Commission on Radiation Oncology. For more information, visit http://bit.ly/AIRPRO.
**SEEN AND HEARD**
Check out these intriguing links from around the Web.

- What Would an EMR on Twitter Look Like?
- Stop Hunting for Zebras in Texas: End the Diagnostic Culture of Rule-Out
- Teaching the New Interns About Imaging Appropriateness

**THE SPARK**
Kick off discussion with these notes and quotes from the field.

> "The trouble with quality is not just that it is nebulous in definition and protean in scope. It can mean whatever you want it to mean on a Friday. It is that it comprises elements that are inherently contradictory."
> — Saurabh Jha, MD, in "Who is the Better Radiologist?"

> "It is time we have a national conversation about 'what' we pay for in health care, not just 'who' pays for it."
> — Sherry Reynolds (@Cascadia), patient-centered design advocate

> "We need to transition from a world where health care is provided in person from 9-5 to one where it is accessible to meet individualized needs and is more seamlessly interwoven into a patient’s day."
> — Brad Stulberg, in "Five Things Health Care Can Learn from Running a Marathon."

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**CALENDAR**

**OCTOBER**

- **10–12** Body and Pelvic MR, ACR Education Center, Reston, Va.
- **17–18** ACR-RBMA Annual Forum, Seattle, Wash.
- **28** Data Registries Forum, Reston, Va.
- **29–30** ACR Imaging Informatics Summit, Washington, D.C.

**NOVEMBER**

- **4–5** Breast MR with Guided Biopsy, ACR Education Center, Reston, Va.
- **20–22** Breast Imaging Boot Camp with Tomosynthesis, ACR Education Center, Reston, Va.
- **22–24** Emergency Imaging for the General Radiologist, ACR Education Center, Reston, Va.

**DECEMBER**

- **5–7** Coronary CT Angiography, ACR Education Center, Reston, Va.
- **11–13** Neuroradiology of the Head and Neck, ACR Education Center, Reston, Va.
- **15–17** Advanced PET/CT, ACR Education Center, Reston, Va.

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SCAN THE QR CODE TO SEE THE MOST RECENT VERSION OF THE ACR MEETING AND COURSE CALENDAR.
Happy 4th to You Too, CMS

THE RECENTLY RELEASED PROPOSED RULES CONTAIN BOTH GOOD NEWS AND BAD NEWS FOR RADIOLOGISTS.

When saw the tweet from @CMSGov on July 4, I couldn’t resist an eye roll. “Happy #July4th!” it said.

Happy for you, CMS staff, I thought. Not so happy for those of us whose inboxes started buzzing at 5 p.m. on July 3 with news that the proposed rules for 2015 had been issued. Emails and texts flew back and forth as we combed through the more than 1,200 combined pages of the Physician Fee Schedule and HOPPS Fee Schedule to see what changes were being proposed for our specialty. Thanks to our speed-reading staff and a laser focus, we were able to digest both reports and publish summaries for members on the website almost as fast as Joey Chestnut gobbled down 61 hotdogs to win his eighth straight Nathan’s Hotdog Eating Championship. Access these summaries at http://bit.ly/2015summaries.

So will the proposed rules give you as much indigestion as the hot dogs gave the “Mustard Belt King”? All levity aside, these proposed rules contained fewer challenges than we have seen previously, but we still found many areas of concern.

Once again CMS did not extend the multiple procedure payment reduction to all imaging, which is a positive. But CMS has not yet complied with the legislative mandate that it publish its data and rationale for imposing the reduction in the first place. We sent a letter to CMS on June 17, 2014, requesting that it provide this data with all due haste.

The issue of changing the practice expense inputs in the payment formula from film to digital comprises the largest across-the-board potential cut. If CMS, as described in the proposed rule, removes all the inputs associated with a film environment and replaces them with a desktop computer, we would see significant reductions. Anyone who has installed or replaced a PACS system knows that this is simply ludicrous, and the Commission on Economics has had extensive communications with CMS to address this.

Once again, several of the services we provide were identified as fast growing, high expenditure, and targeted for future review. The review process has been riddled with flawed methodology, especially around the recognition of the amount of time rooms are in use. Since CMS continues to turn a deaf ear to our logic, we regard these future reviews with trepidation.

CMS has also decided it is time to retire the digital mammography G codes. In the short term, CMS proposes to pay the existing mammography CPT codes at the G code rates (150 percent of the analog rate).

That’s good news, but CMS also wants to review those payment rates to see if they remain accurate. I don’t have to tell this audience how important it is to ensure our patients’ access to this life-saving service, so expect us to make a strong case to CMS that the current reimbursement should not drop.

And what is going on with tomosynthesis? You all know that CPT codes were created for tomosynthesis earlier this year by the CPT Editorial Panel. The new codes will be effective on January 1, 2015. Recommended RVU values for the codes were sent from the Relative Value Scale Update Committee to CMS. The values remain confidential until CMS finalizes them with the publication of the Final Rule, which comes out at the end of October. So the answer is, we don’t know yet. An FAQ was issued by CMS last November, strongly opposed by the ACR, stating that tomosynthesis is an integral part of the mammography service. This remains in effect until we learn what values are assigned for tomosynthesis and, very importantly, whether CMS will pay for the service. It’s important to remember that having a code and an RVU value is not a guarantee of coverage; just look at screening CT colonography.

On a bright note, we saw an egregious error corrected for the payment of the technical component of the new bundled breast biopsy codes in the hospital outpatient environment. This will result in a 51 percent increase in these payments. Unfortunately, this does not address the drastic reductions in the professional component payments. Our team has appealed the assigned value to CMS. We will know their decision upon publication of the 2015 Medicare Physician Fee Schedule Final Rule.

CMS walked away from a previous proposal to equalize payments across all sites of service after criticism from across the stakeholder spectrum. This topic remains of interest to CMS, so we will continue to monitor it. CMS is also interested in the impact of hospitals acquiring independent practices, on overall costs and out-of-pocket costs to beneficiaries. As we know, this has been an active trend in our specialty. In January, CMS plans to start gathering data on this trend using a modifier on the claim form.

In addition, CMS is asking for information on how, where, and why second interpretations are provided for imaging studies. It is looking into whether a change in payment policy might have a positive impact in reducing unnecessary repeat studies. I know this is a topic of great interest to all of us, and we would welcome your perspective. As always, you can reach me at gmcginty@acr.org.

No matter what challenge we are faced with, your dedicated economics team will be working diligently to ensure that the reimbursements you receive for the valuable services you provide to your patients are fair and allow you to innovate and maintain the level of quality for which you strive.

I encourage you to follow me on Twitter @DrGMcGinty. //
RADIOLIGISTS SOMETIMES HOLD THE KEY TO DIAGNOOSING INTER-PARTNER VIOLENCE, BUT ARE THEY WATCHING FOR THE SIGNS?
Do a search in PubMed for "domestic violence," and you will discover over 40,000 results. Add "radiology," and the numbers drop to 836. Now eliminate the articles dealing with child and elder abuse from that search — meaning you are searching only for information on inter-partner violence — and the numbers go down to just 19.

Inter-partner violence, particularly violence against women, is at epidemic proportions, affecting about one third of women worldwide.¹ And it isn't just a problem in underdeveloped countries. One in four women and one in seven men in the United States have experienced severe physical abuse by an intimate partner.²

There is a surprising disparity between the rate at which domestic violence occurs and the amount of medical imaging literature related to domestic violence. The dearth of literature on the topic could represent a low awareness of inter-partner violence among some radiologists.

It is important that radiologists consider domestic violence as a possible diagnosis as they work through their cases. Imaging findings can play a crucial part in uncovering cases of domestic abuse, and radiologists have the interpretation skills to find the more subtle symptoms.

Digging Deep

There are a variety of reasons inter-partner violence may not be at the forefront of a radiologist's mind. One reason may simply be the number of cases that come across a radiologist's desk. Timothy V. Myers, MD, chief medical officer for Direct Radiology, LLC, who frequently reads emergency department cases, notes that because radiologists have such large caseloads, domestic violence might slip their notice because the signs can be very subtle and take some digging. Such clues as older fractures, which would indicate that these injuries had occurred before, may take time to uncover. “Finding some of these signs is a lot like detective work. If you’re in a hurry, the subtle things are the first ones you start missing,” Myers says.

Another reason inter-partner violence is often overlooked relates to the taboo surrounding the topic. Domestic abuse remains a largely undiscussed, and perhaps misunderstood, subject. “A lot of people don’t realize that when adults are in these situations, it’s not any better than when the victims are children,” says Sonya Bhole, MD, a radiologist at Northwestern University who has published on the topic.³ Some individuals might believe that because the victims are adults, they should be able to seek their own

LOOKING AT THE LAW

Disclosing patient information such as the possibility of abuse may raise concerns about legal implications. Here is a quick run-down of HIPAA’s stance on domestic abuse. As always, however, check with legal counsel should you have any concerns.

- Under HIPAA, a radiologist can disclose to a referring physician the patient health information (PHI) of a patient who the radiologist suspects is the victim of domestic abuse.⁴
- HIPAA also allows radiologists to disclose PHI to government authorities who are authorized to receive reports of domestic violence. This comes with some stipulations, however. A radiologist may report if laws require such disclosure, if the patient agrees that the radiologist can disclose the information, or if the radiologist believes that disclosure must occur to prevent serious harm to the patient or other potential victims.
- Since most states have laws requiring physicians to disclose suspected domestic abuse to police or other specified authorities, HIPAA should not be an impediment for physicians in such situations. In fact, a physician’s failure to make such a report may actually be a crime. See Cal. Penal code §§ 11160-11163.2 (at http://bit.ly/DVLaw) for an example.
as punching. Gunderman also says one of the most important things is to pay attention to the patient history. Note the injuries and make sure they match up with the story the patient has given.

If something seems amiss, quickly call your referring physician. “You can’t just put it in the report and hedge it,” says Myers. “There is a likelihood that the ER doctor will misunderstand you, and the case will fall under the radar.” And don’t assume that your referring clinician has already suspected abuse. Both Bhole and Myers noted several times they called and the clinician had no suspicion at all.

When you’re speaking with your clinician, first try to get a more complete patient history. Sometimes, the patient may have a history of abuse that wasn’t put into the medical record, notes Bhole. Other times, suspicious indicators have easy explanations, such as sports injuries.

Radiologists who want to be more aware should also look to the principles of Imaging 3.0™. By being more patient-centered in their practice, radiologists may notice things that have been left out of medical histories, allowing them to pinpoint more discrepancies that arise.

Starting a Conversation

Technologists can also play a key role in helping identify domestic violence, says Gunderman. “They’re the ones who see and interact with the patient. They can tell you if the patient was behaving in an odd fashion, or if there were physical signs such as bruising,” he notes. The best way to catch domestic violence when it comes across your caseload is to be aware and promote awareness among your colleagues, say both Bhole and Myers. Building awareness can be as simple as sharing your cases with your colleagues, adds Myers. Seeing examples in their own patient population may spark physicians’ interest and keep the issue on their minds as they go through their cases.

Another way to spread the word is to add to the current literature. “We need more case studies,” says Bhole. “If we as radiologists document inter-partner violence more, we can start conversations about domestic abuse in other places, such as residency curricula and at conferences, educating more radiologists and making them more aware.”

FACING THE FACTS

Domestic violence might be more common than you think. Take a look at some recent statistics:
- On average, 24 people per minute are victims of physical or sexual trauma by an intimate partner in the U.S. That’s more than 12 million women and men over the course of a year.
- 38 percent of all murders of women globally were reported as being committed by intimate partners.
- Health care providers correctly diagnose only 1 in 35 patients seeking medical care for problems related to inter-partner violence.

And as radiologists become more aware of domestic violence, they will be better prepared to work with their referring physicians to support their patients. "It's important that we find and diagnose these cases when we can," says Myers. "Victims of domestic abuse can come in one day with a broken arm and be dead several weeks later. Abuse escalates.

ENDNOTES
WHEN ADVERSE EVENTS OCCUR, INSTITUTIONS TURN TO ROOT CAUSE ANALYSIS TO PINPOINT WEAK AREAS AND IMPROVE PATIENT CARE.
Two patients with the same last name were on the same floor of a major hospital in Houston, Texas, both scheduled for procedures on the same day. Attendants wheeled the patients to their respective procedure areas in the hospital. That’s when hospital personnel realized something was amiss. The patients had been taken to the wrong areas — each about to receive the other’s procedure. Fortunately, the error was discovered before the procedures began, but the incident still raised significant concerns. How did such a mistake occur when the hospital had extensive safeguards in place to prevent such a mishap? And how could future incidents be prevented?

Milton J. Guiberteau, MD, FACR, professor of radiology at Baylor College of Medicine, in the Texas Medical Center, says that while the most convenient answer was that the transporters were to blame, that wasn’t necessarily the fundamental cause of the incident. To better understand how the mistake occurred, the hospital performed a root cause analysis (RCA) — a retrospective investigation to identify failures within an organization’s processes. “It’s human nature to immediately jump to an initial conclusion that is usually the most obvious cause,” Guiberteau says. “But many things must be evaluated before you can decide what the primary system error was.”

The hospital’s quality care team gathered representatives from every department involved in the care of the patients in question — including radiology — and two uninvolved staff members to provide objectivity as the group discussed and documented how the incident unfolded. They studied everything from the procedure orders to how the patients were identified for transport. At the conclusion, the team determined that the root cause was a breakdown in the process used for patient identification. “Patients must be identified not by the way they look, not by the room they’re in, not even by their names, but instead by their medical record identification numbers,” says Guiberteau, who participated in the RCA. “Those numbers need to be checked without exception during every interaction with a patient. We’ve been hammering that lesson in ever since.”

To Analyze or Not

RCA is used across industries to identify and resolve system failures. In health care, the Joint Commission requires that institutions conduct root cause analyses for all sentinel events — unexpected deaths or serious injuries to patients and incidents that put patients at significant risk of adverse outcomes. In radiology, sentinel events may include falls during a procedure, dose-related errors, procedural complications, and contrast extravasations. But radiologists can provide value to an RCA even when an event occurs outside of radiology, says Sumir S. Patel, MD, chief resident at Georgia Regents Medical Center. “We have an overarching perspective on the care that patients receive, and that helps in the RCA because we can piece together a timeline and details that may not be as evident to other clinicians,” Patel says.

While an RCA is required for any sentinel event, an institution may also conduct the analysis for less serious incidents. For instance, the radiology department at Georgia Regents Medical Center conducted an RCA to identify ways to streamline its
workflow for fluoroscopy-guided lumbar punctures. “We had an inefficient process that took a lot of time before, during, and after the procedure,” Patel says. “We wanted to determine what the bottlenecks were in that process and how to fix them.” Radiologists assumed that transport issues were bogging down the process, but through RCA they discovered several other contributing factors. “We addressed all of those issues to a certain degree, reducing the time it takes for lumbar punctures significantly more than if we had just addressed the transport problem,” Patel says.

Institutions determine whether non-sentinel events warrant an RCA and who should be involved in the analysis. “The threshold for performing a root cause analysis is set both at the regulatory level by the Joint Commission as well as at the institutional level, which might require all adverse events and even some near misses to undergo such a process,” says Jonathan B. Kruskal, MD, PhD, professor of radiology at Harvard Medical School and chair of the department of radiology at Beth Israel Deaconess Medical Center. Kruskal says that every trainee in his department must participate in an RCA during residency. The exercise helps trainees identify factors that can lead to adverse events so that they can address those issues before such an event occurs.

The RCA Way

Once an institution or department decides to perform an RCA, it follows prescribed guidelines for conducting the analysis: identify the adverse event, gather data through interviews with everyone involved in the event, analyze and prioritize possible causes, identify the root causes, generate solutions, and devise methods for disseminating the results and implementing corrective measures.\(^1\) James V. Rawson, MD, FACS, chair of radiology and imaging and chief of radiologic services at Georgia Regents Medical Center, notes that the goal of an RCA is to identify system lapses rather than to place blame on individuals. “A peer review or a morbidity and mortality conference might focus more on the role an individual played in an outcome, but a root cause analysis looks for system flaws,” he says.

For a successful RCA, an institution must establish an atmosphere that allows people to talk about the event without fear of ridicule. “Everyone must be assured that their thoughts are being taken seriously and that they can speak without being judged or blamed,” Guiberteau says. Rawson uses an analogy from the automobile industry to explain the purpose of an RCA. In the past, when automobiles could be started while in reverse, many people accidentally struck their children in their driveways. While the obvious conclusion was that the drivers were to blame for the accidents, the root cause was that automobiles could be started in reverse, Rawson explains. Once carmakers eliminated that ability, those accidents decreased dramatically. “Using such an analogy at the beginning of an RCA illustrates that we are looking for flaws in the workflow and process that allowed us to make the mistake,” Rawson says.

The success of an RCA is also dependent on the information gathered during the interviews. “The value of an RCA is being able to look at the incident as a combined-care team to identify potential system flaws and how to improve them,” Rawson says. “So one of the biggest pitfalls of an RCA is not getting all of the stakeholders in the room at the same time.” Guiberteau says he has learned a lot about operations in other hospital departments by participating in root cause analyses. “I’ve been around a long time, but I had never before got down to that level of understanding of what my nonradiology colleagues do in their corners of the hospital and the complexities that they deal with,” he explains. “The experience is rewarding.”

The Benefit of Change

Perhaps the most important step in an RCA is the follow-through. Once the root causes have been identified and solutions developed, corrective measures must be implemented. In the case at Texas Medical Center, each department offered recommendations to the quality care team for improving patient identification. Then, transfer documents were introduced to remind staff that continuity of identification is critical, and follow-up meetings were held at three and six months to gauge the effectiveness of solutions. In more complex cases with multiple root causes, it may take longer to realize results.

While conducting an RCA takes time and effort, the benefits for institutions and patients are significant. Through the analysis, institutions can eliminate inefficiencies in processes they use every day, which gives physicians more time for patient care. RCA also helps resolve issues that lead to adverse patient outcomes, reducing the likelihood of future incidents. “Performing root cause analyses and implementing change raises the overall quality and, therefore, the value of our services to all of our customers,” Kruskal says.

Furthermore, RCA is a powerful tool for meeting the objectives of ACR’s Imaging 3.0™ initiative. It advances the role of radiologists by bringing radiologists and personnel from other departments together to solve challenges and improve patient care. “Being an active player in the root cause analysis can get your face out there,” Patel says. “It gets you out of the dark reading room and really helps show your referring physicians that you are there, you are part of the patients’ care, and you’re there to help provide the highest quality of care possible.”

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ENDNOTE

The Board of Chancellors (BOC)

What is the Board of Chancellors? The Board of Chancellors is the executive body of the ACR. It includes a maximum of 34 chancellors and is presided over by the chair.

What does it do? The BOC meets to discuss strategic issues, guide the College’s finances, oversee the activities and programs of the College, and implement policies determined by the ACR Council.

Commissions, Committees, and Task Forces

Who makes up these groups? Each commission is chaired by a member of the BOC and made up of ACR members typically with specific experience in the area. Commissions are further divided into committees and subcommittees. Task forces are formed at the discretion of the chair of the BOC.

What do they do? Commissions, committees, and task forces are established to carry out policy initiatives and oversee activities and programs.
With so many initiatives going on at once, the College needs a well-defined, streamlined structure that is well representative of its diverse constituency. But who does what, how do the different parts of the ACR fit together, and how are you represented in this structure?

The ACR Council

What is the ACR Council? The council includes 343 representatives from chapters, branches of the military, government agencies, qualified subspecialty societies, the Resident and Fellow Section, and the Young and Early Career Physician Section.

What does it do? The council debates and approves ACR policy resolutions, bylaws resolutions, and practice parameters and technical standards.

The BOC may submit resolutions to the council.

Policy decisions from the council are sent to the BOC.

GOVERNANCE IN ACTION

At ACR 2015, members will have a front-row seat as the business of the College unfolds. The Governance Pathway will guide attendees through the meeting, including reports from ACR leadership, ACR elections, the consideration of resolutions, and lively discussion and debate providing critical insight into areas affecting medicine and radiology.

Many physicians, including radiologists, pursue formal business degrees to enhance their strategic thinking and leadership skills. Currently, more than 1,700 radiologists are participating in the Radiology Leadership Institute® (RLI), which prepares imaging professionals to advance their career and shape the specialty’s future — especially considering the many pressures on the U.S. health care system today. (Visit www.radiologyleaders.org to learn about the RLI.)

Alexander S. Misono, MD, MBA, radiology resident at Massachusetts General Hospital in Boston and a former management consultant, believes, “In any field or industry where things are likely to change and there’s tumult, confusion, or uncertainty about the future, it’s good to be equipped to handle that situation. Coming at [those changes] from a business angle can often provide valuable insights.” Here are several tips gleaned from corporate case studies to help you avoid pitfalls and ensure the specialty’s longevity.

Prioritize Quality

It’s the ACR motto: “Quality is our image.” And examples from the business world only further confirm the importance of quality. Recently in the JACR®, Anand M. Prabhakar, MD, cardiovascular radiologist at Massachusetts General Hospital in Boston, highlighted the links between challenges to interventional radiology (IR) and Starbucks, a company whose “invincibility was challenged,” during the 2007 economic crisis. Briefly, customers laughed at the idea of paying $4 for a cup of coffee. Now, Starbucks is one of the largest coffee chains in the world. What did the company do right? Prabhakar says that when Howard Schultz, the founder of Starbucks, was...
brought back in 2008 as CEO to turn
the company around, he made quality
a high priority. He focused on training
employees to make the perfect espresso
manually rather than relying solely on the
automated espresso machinery intended
to maximize efficiency. Schultz also
purchased individually brewed, unique
blends and redesigned the storefront
setup, thus improving the customer
experience. Switching gears, from coffee
to patient care, interventional radiol-
ogy faces similar challenges, including
commoditization — with numerous
non-IR clinicians performing procedures.
Prabhakar and his coauthors suggest
becoming more visible to patients,
volunteering objective quality data, and
ensuring the appropriate utilization of
services to demonstrate value.

Keep Innovating

Some of the most successful companies
are those that know how to innovate.
The same goes for such successful and
innovative leaders as Steve Jobs, late CEO
of Apple, or Bill Gates, former CEO of
Microsoft. These companies are constantly
creating new products and evolving to
meet customer demands.

However, not all companies have
applied this policy of innovation victori-
ously. Geraldine B. McGinty, MD, MBA,
FACR, chair of the ACR Commission on
Economics, believes a lack of innovation
caus ed one well-known organization —
Kodak — to go under. “They were such
a great American company,” McGinty
says, “but they didn’t really adapt. They
didn’t find a way to be a part of the future
of imaging in a successful way.” A recent
article in the New England Journal of Med-
icine discussed Kodak’s surprising 2012
bankruptcy: ”Kodak was late to recognize
that it was not in the film and camera
business: it was in the imaging business.
With the advent of digital imaging, Kodak
was outpaced by other companies that
could better meet our consumers’ needs.”

McGinty believes the same challenges ap-
ply to radiology. “We will not be recognized
and compensated for our value unless that
value is obvious to our customers,” she says.
“We need to respond to what patients want.”
The ACR’s Imaging 3.0™ case study series
provides many examples of radiology prac-
tices already innovating to demonstrate their
value. (Check out the series at http://bit.ly/
Imaging3CaseStudies.) McGinty encourages
ACR members to “really understand and
familiarize themselves with the Imaging 3.0
concept and look critically at their practice.
Be informed about what’s happening in the
wider world of health policy. Make the dif-
ficult step to get off the treadmill of focusing
on quantity, not quality. Look closely at your
community and find the opportunities to
demonstrate value.”

Serve Others

The case of Starbucks provides another
piece of insight for radiologists — one that
benefits both the specialty and the community. In 2008 after Hurricane Katrina, Schultz asked 10,000 Starbucks managers to provide 50,000 hours of community service during their annual leadership meeting. The result was the largest volunteer effort in the history of New Orleans.

Many other companies are also committed to playing a positive role in the community through service and volunteering. One great example of this is the Microsoft Employee Giving campaign, a program that encourages employee donations and corporate matches, allowing the company to raise more than $1 billion since 1983.

Furthermore, contributing to the community can help raise the profile and local opinion of a business. Prabhakar says that radiologists can improve their perception among patients and the medical community by participating in community health fairs and awareness campaigns.

Meet Customer Needs

But what is perhaps the most critical correlation between business and health care? The need to listen to your customers (or patients). McGinty says radiologists should “find out what will make a patient’s experiences more positive, and provide it better than anyone else. Look where we can provide value. If our opening hours are not geared toward patients but to our own schedules, or if it’s difficult to schedule appointments online, we need to better respond to what patients want.”

RSNA’s Radiology Cares® campaign has many resources to help radiologists build patient-centered competencies. Learn more at www.rsna.org/Radiology_Cares.

One example Misono provides is the new venture startup company Uber. The mobile phone app connects passengers with hired vehicles with the tap of a finger. In doing so, Uber is providing a niche service that takes away the annoyances related to taxis: calling and being put on hold, not knowing when the cab will arrive, paying in cash. The Uber app is linked to your credit card information to avoid those hassles and provides a real-time map so you know exactly when your ride will arrive. “It’s a really efficient, easy, no friction way for someone to get a driver and go somewhere,” says Misono. According to Misono, radiology practices and departments can similarly work to provide seamless ways for patients to schedule imaging and access their results.

Misono, who formerly worked in the management consulting industry, emphasizes that radiologists are truly in the consulting business. Part of that business is appeasing the customer, which includes both patients and referring clinicians. “We need to continue to reinvent ourselves from a technology standpoint so that we can improve the way we treat patients,” Misono explains. He looks to IBM as another great example of this reinvention: the company used to focus exclusively on selling hardware and software. Over time, IBM has transformed itself into a service-focused company. Similarly, radiologists need to continue to evolve and innovate their services, prioritizing quality and patient care to keep up with the times — just like the most successful and smart 21st century business leaders. //

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ENDNOTES
Showing the Way
THE RLI IS CELEBRATING ITS SECOND BIRTHDAY. HOW MUCH HAS IT ACCOMPLISHED IN TWO YEARS?
By Meghan Edwards

Birthdays are an exciting time for most people. You eat cake, receive presents, and look back over all you’ve accomplished in the past year. This year marks the Radiology Leadership Institute’s® (RLI) second year of existence, and it has a lot to boast about, from a wealth of resources, including webinars and MBA course tracks, to providing leadership skills to over 1,700 enrolled radiologists. To celebrate the RLI’s second year, the Bulletin is taking a look at the institute’s legacy so far.

— Lawrence R. Muroff, MD, FACR, RLI faculty member

AUGUST 2011
RLI board and volunteer leaders announced; RLI website launches

RLI establishes its foundations and determines key volunteer leaders who will drive its strategic vision.

“RLI was created because we felt that there was a growing need for radiologist leaders. The ACR staff and leaders spent two years putting together a series of surveys, focus groups, and other research needed to make our visionary thinking a reality.”

— Cynthia S. Sherry, MD, FACR, Medical Director of the RLI and one of the founders of the RLI

JULY 2012
The RLI holds inaugural event at Northwestern University

The RLI holds its first course at the AIRP®

The RLI holds its first program for residents in a series of free events to reach future radiology leaders.

“Providing education for these young physicians is investing in the relevance and success of what we will do for the next three decades. Teaching non-clinical skills to residents and fellows is not a whimsical luxury; rather, it is a necessary expenditure for the survival of our specialty.”

— Lawrence R. Muroff, MD, FACR, RLI faculty member

SEPTEMBER 2012
RLI Common Body of Knowledge™ published

After consulting with business schools, academic institutions, corporations, and health care organizations, as well as hundreds of private practice and academic radiologists, the RLI created a compendium of the skills and knowledge essential to leadership success.

JANUARY 2013
First ACR-RLI Practice Leaders Meeting held

Under the RLI, the ACR’s Practice Leaders Meeting welcomes radiologists at all levels.

AUGUST 2014
2014 RLI Leadership Summit is held at Babson College

The RLI partners with Babson College to hold an innovative course to bring participants together as they learn to navigate today’s health care environment.

Click here to listen to Immelt’s address and other highlights from the inaugural event.
It is a conundrum most radiologists face at some point in their careers: how to stay true to the needs of their patients while consistently meeting business goals for their practices. As the health care industry moves toward value and away from volume, some facilities are finding both challenges and opportunities as they turn to a more service-oriented business model. The benefits of strategic planning have become paramount as radiology practices begin to change how they respond to the multifaceted needs of their patients more efficiently and effectively. Ricardo C. Cury, MD, president and CEO of Radiology Associates of South Florida (RASF) and director of cardiac imaging at Baptist Hospital of Miami and Baptist Cardiac and Vascular Institute, has been a leading force for helping radiologists transition into becoming consultants with the ability to develop clinical pathways based on Appropriateness Criteria® for imaging, thereby enhancing coordination of care.

Formulating a Strategy

To kick off his own practice's transformation, Cury's team began holding annual strategic planning sessions. These planning sessions helped the team formulate a mission statement, prioritize goals for the practice, establish context for the strategy by examining internal and external issues, and evaluate the practice's strengths, weaknesses, opportunities, and threats — also known as a SWOT analysis (see sidebar).

Looking back at the process, Cury suggests that a critical first step in the strategic planning process is to develop a formal mission statement — including specifying the practice's vision and core values. Next, it is time to define specific goals and objectives — and identify actual timelines for achieving those goals — in order to align all members of your organization with a shared direction. Equally important, the practice's leadership needs to be accountable for executing the plan and achieving the established goals. In that context, it is imperative to establish metrics by which your organization can measure its progress.

For Cury, one of the most important goals within the strategic planning process involves strengthening the radiologist and hospital relationship. “We need to answer how we are adding value to our...
hospital partner and what activities we are implementing to contribute additional value," states Cury. Other objectives include improving personal service in the delivery of care to patients and referring physicians, investing in IT and marketing initiatives (such as creating an annual report), participating in community events involving breast cancer awareness, and redesigning the practice’s website. When Cury’s practice implemented strategic planning, the team developed metrics for each of its goals and hired a data analyst to review measurements, oversee reports on subspecialty expertise, and tally surveys on patient and physician satisfaction.

For the next phase of the strategic planning cycle, Cury suggests looking at both external and internal issues affecting a radiology practice. For example, this could involve considering how health care reform is impacting new payment models — particularly in the evolution from fee-for-service to quality-based payments, such as pay-for-performance, bundled payments, and shared savings. He also recommends observing how other practices are positioning themselves during this time of transition.

For internal issues, Cury believes it is crucial to have governance and oversight to create a successful strategic plan. Having a small core group serving on an executive committee, with oversight by a board of directors, creates a sense of support that is vital for implementation. “I think it gets everyone in your practice on board with the same vision,” he states.

**Executing the Plan**

Cury says that while the strategic planning process is critical, departments should spend the majority of their time on the execution of the plan. According to Cury, doing the work of increasing the visibility of radiologists is a key factor for success. Being part of hospital committees, establishing clinical pathways that lead to the best imaging test for specific conditions, improving imaging protocols to ensure the quality of images, and having a peer-review process that provides subspecialty expertise can all be part of creating a more visible presence for radiology.

Cury provides a key example of how his practice is working to improve radiology visibility among its stakeholders, including referring physicians and hospital administrators. RASF implemented an initiative called Radiology Rounds, where radiologists perform rounds with other clinicians on the hospital floor. They currently have two pilot programs operating, one in neuroradiology and one in cardiac imaging.

“The radiologists conducting Radiology Rounds have made a major impact with our referring physicians and the administration by offering just 30 minutes of their time,” he explains. “It has also had an effect on patient care and satisfaction. We review images on an iPad directly with patients. We can see the reaction of patients as they understand how they can change and become more compliant with medications and the modification of risk factors.”

Cury admits that the strategic planning cycle is a continuous journey as changes to health care and new payment models will impact radiologists far into the future. “Strategic planning lets you take a proactive approach by anticipating changes in the industry while engaging stakeholders who will need to lead that change,” he says. “The key component for strategic planning is engaging all radiologists, not only in your practice but also across the entire radiology community. And if we continually focus on what is best for the patient, then everything else will follow.”

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**The Benefits of Strategic Planning Have Become Paramount as Radiology Practices Begin to Change How They Respond to the Multifaceted Needs of Their Patients.**

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**The Tools of Strategic Planning**

Here are some sample tools that can help you make the transition from volume to value in your practice.

What I Wish I’d Known
RADIOLOGISTS FROM AROUND THE SPECIALTY SHARE THEIR BEST ADVICE FOR A YOUNGER VERSION OF THEMSELVES.

No matter where you are in your career, chances are someone else has already been there. This month, the Bulletin brings together radiologists from throughout the specialty to give advice to their younger selves about what they wish they’d known earlier in their practices.

Dear Dr. Chin,

Over the course of your clinical practice, you will work in many different environments, from a small single-hospital practice to a 70-radiologist group covering most of the greater Los Angeles area to a free-standing diagnostic and interventional radiology center. Here are some things that will help you on your way:

• **Maintain and increase your skill set**, seeking out opportunities to learn new skills needed to address the changing demands of your practice environment and the requests of your clinical colleagues.

• **Grab every opportunity** to learn about billing, operations, and the business of radiology. Don’t simply depend on your associates to do this work for you. Either you can have a fighting chance of controlling the business of radiology or it will control you.

• **Network in your hospital.** Become well known and liked by your administrators, middle managers, and clinical colleagues. Seek out opportunities to get to know your referring physicians to share your expertise and make yourself invaluable.

• **Network in your practice.** In the era of productivity benchmarks and PACS, it is more and more difficult to get to know your own associates. View your group as a team, and share cases. It will make your practice more interesting and rewarding professionally, and you will learn.

• **Network in your specialty.** Take every opportunity at local, regional, or national meetings to connect with other radiologists. They will be your eyes and ears to the world of radiology beyond your own practice.

• **Expect change.** Everyone is comfortable with the status quo, but you must embrace change with renewed vigor and vision. You cannot always know what’s coming next. But you should practice scenario planning and try to prepare for the foreseeable challenges. Never assume that what happened to your neighbor can never happen to you. Burying your head in the sand is just not effective.

• **Help create a better system.** We exist in a world of productivity benchmarks. But instead of gaming the system of RVUs, work to envision a new blueprint for health care, one that builds on teamwork, professionalism, and improved patient care.

• **Give back.** Look for ways to do good, like teaching, volunteering in your community, and mentoring others.

• **Get to know your patients** every chance you get. These encounters will become the most rewarding, meaningful, and magical moments of your career.

Kenneth W. Chin, MD, FACR
Medical director of interventional radiology at San Fernando Valley Interventional Radiology and Imaging Center, Encino, Calif.

CROWDSOURCING CAREER ADVICE

Check out these online resources for more physician-specific advice.

• **What Would Paul Revere Do?** Networking advice from ACR members at all stages of their careers

• **Building a Healthy Financial Future**
  Four lessons from successful physicians

• **Finding Vocation in Retirement**
  Retiring from practice and exploring new ways to define and structure day-to-day life
Dear Dr. Chokshi,

The most important advice I can give you relates to mentorship. When you're in training or recently finished, you are learning to balance new priorities both professionally and personally. You will find that it is better to be part of a team than to travel along your career path solo.

A network of mentors is the key to navigating the often murky waters of career advancement, work-life balance, and organizational radiology involvement. Yes, that's right — a network of mentors, not just one. A single mentor has his or her own biases, perspectives, and skill sets. With a network of mentors, you can harness the advice, talents, and support of many experts, depending on your particular questions and needs.

Here are a few key points for establishing a successful mentee-mentor relationship:

- **Take the lead.** The mentee should drive the relationship. The mentee should seek out the mentor, ask for advice, and be the one to initially frame the relationship. It's you — not your mentor — who needs the guidance, so ask for it.

- **Prepare for your meetings** with your mentors. Having a written agenda for the meeting will enable an efficient and productive session and it shows your mentors you respect their time.

- **Get specific.** Although big-picture discussions (such as overall career plan and general advice) are important, you will benefit most by narrowing down your questions. For example, asking your mentor how to get involved with specific health policy initiatives in the ACR will be more productive than just asking how one can “get on committees.”

- **Don’t force it.** Not all relationships are meant to be. The mentorship relationship is a dialogue and both parties should benefit. If mutual respect for each other's time, intelligence, and effort is lacking, it is best not to continue. The key is to always be respectful and avoid burning any bridges.

- **Show your appreciation.** If you find someone who takes an interest in you, make sure you recognize it. A simple thank-you can go a long way.

Falgun H. Chokshi, MD
Assistant professor of radiology, Emory University School of Medicine, Atlanta
Director of neuroradiology services, Emory University Hospital Midtown, Atlanta

Dear Dr. Davila,

I have a few things to tell you. The first is to be patient. Change takes time. When you finish training, you will be ready to engage your new career to the fullest. You will want to do what is best for your group (in your opinion) and do whatever is necessary to make this happen. The process with which you try to spark change will have lasting effects that will take years to reverse if not done in the appropriate fashion.

It is important to keep in mind perspective. The perspective with which you interpret any situation is based on your life up until that point. Others in your group will likely see things much differently than you. Group members will be facing individual challenges and will be at various stages of their lives, which will give them perspectives much different from yours. Neither is necessarily correct or incorrect. As you learn about specific issues within your group, keep in mind that there is usually more than one right way of doing things successfully. You will not be right all the time, and it is important to remember that when standing firmly on any issue.

Timing is paramount to implementing any good idea. You will see many good ideas rise up only to be defeated within your practice. This is okay. Don’t take it personally and don’t forget about the ideas or think that they will never be implemented. Be patient. Change takes time. If an idea has merit and withstands the test of time, it will eventually be implemented in some form.

Stay engaged, but take breaks. You are on a marathon. If you are lucky, you will be with your group for a long time. It is important not to burn any bridges or sever communication with others in your group. There will be times when you will be exhausted or frustrated from the group politics or specialty-wide issues. Be patient. Change takes time. But never give up or say that your opinion doesn’t matter. Always get back into the marathon.

In the end you will find that, regardless of how many issues you won or lost within your group, the people with whom you ran your marathon will be the most important aspect of your career.

Jesse A. Davila, MD
Department chair at Baptist Hospital, Jacksonville, Fla.
Diagnostic radiologist at Drs. Mori, Bean & Brooks Radiology, Jacksonville, Fla. //
Meeting Momentum

WHETHER IT’S AMCLC OR ANOTHER BIG MEETING, COMING DOWN FROM THE CONFERENCE HIGH CAN BE A MOMENTUM-KILLER. THE BULLETIN ASKED MEMBERS ON TWITTER FOR THEIR BEST TIPS ON KEEPING UP THE MOTIVATION AFTER THE FLIGHT HOME.

Learn more about RADPAC at www.radpac.org.

Get involved in your state chapter, contribute to RADPAC, volunteer for an ACR committee, and practice Imaging 3.0 principles.
— Tirath Y. Patel, MD (@TirathPatelMD)

Get started volunteering in the ACR at www.acr.org/Membership/Volunteering.

Access the growing list of Imaging 3.0 resources at www.acr.org/Imaging3.

Network within and outside of radiology, build strategic alliances, participate in the RLI.
— Robert F. Mackey, MD (@RobertMackeyMD)

See what the Radiology Leadership Institute (RLI) has to offer at www.radiologyleaders.org.

Stay in touch with contacts from AMCLC and collaborate on projects.
— Nate E. Margolis, MD (@NateMargolisMD)


Thursday night RFS journal club!
— Jonathan Flug, MD, MBA (@Radsdoc82)

Check out the JACR®’s Twitter how-to videos at http://bit.ly/JACRTwitter.

I’ve found Twitter to be a great way to stay in touch with contacts and make new ones.
— Neil U. Lall, MD (@NULall)

Get the latest from the JACR at www.jacr.org.

Talk to people who inspire you, read constructively, and contribute to the greater good of our profession.
— C. Matthew Hawkins, MD (@MattHawkinsMD)

Commit every day to 1) maintain relevance through added value and to 2) always remember that patients are why we’re here.
— Richard Duszak Jr., MD, FACR (@RichDuszak)

Learn about patient-centered care through RSNA’s Radiology Cares® campaign at www.rsna.org/radiology_cares.
The Benefits of Having Friends

THE STATE GOVERNMENT RELATIONS COMMITTEE FOCUSES ON BUILDING CONNECTIONS AND CREATING SOLUTIONS.

Christopher G. Ullrich, MD, FACR, discusses making a difference, challenging misconceptions, and keeping up the good work as his four-year term as chair of the State Government Relations Committee comes to an end.

What were your goals over your term?

I wanted to continue to enhance the committee’s mission to support our chapters on state legislative and regulatory issues. Another main focus was to provide consistent constructive guidance to the College on state legislative matters. I also prioritized promoting state political action committees (PACs) to develop state e-advocacy networks and supporting state advocates at the national level.

How has chairing the committee affected your perspective of state-level government relations?

State government relations are the foundation of our federal government relations efforts. I was continually impressed with the commitment, enthusiasm, and political engagement exhibited by many of our state chapters. I also became more aware of the struggle that less-developed chapters face to be politically engaged and effective.

Do you agree that 50 states equal 50 different problems?

All politics are local, and states have very different political processes, cultures, and challenges. However, many legislative issues pertaining to radiology are startlingly similar across the country. The political process in Texas is very different from the political process in Vermont. Mississippi’s political culture is very unlike New York’s, but political coalition building is a key strategy to radiology’s success in any state. For example, breast density reporting bills have come up repeatedly in multiple state settings. By responding consistently from state to state, many states have achieved manageable legislative outcomes. In a variety of states, we’ve proven that it is feasible to carry out a strategic plan that serves both patients and practices.

What are the top three misconceptions about state government relations?

1. The notion that you cannot make an impact is absolutely false.
2. Many people think it takes large amounts of money to get attention. It does not! It does require a reliable fundraising PAC process, but a $1,000 donation at the state level is a big contribution.
3. People also believe you need to dedicate large amounts of time to succeed. But consistent and small amounts of time build relationships. State politics is a marathon, not a sprint.

How much of state advocacy is about building relationships?

Different political issues require different political solutions, but it’s all based on the fabric of relationships. Your local city council member today could be your next federal senate or house representative a few years from now. Supporting candidates in the early stages of their careers opens doors for you later, but lasting friendships are not made overnight.

Making a friend in politics doesn’t require enormous amounts of time every day. Rather, it is a sustained effort over months and years. Practices must make time to support political engagement in their communities because there is value in being prepared before a situation breaks. For maximum impact, a state PAC and good representation by a first-tier lobbyist are a must.

What’s the hardest part of state-level advocacy?

We don’t often get to do victory laps because the vast majority of the wins are about preventing potentially harmful situations. We rarely need to pass a bill. It’s more likely that we will be working to modify or defeat a proposal that is detrimental to radiology.

Unfortunately, after a while, it becomes challenging to sell playing defense to ACR members. But there is work to be done, and it is worthwhile work. Keeping a consistent and comprehensive state effort alive takes serious commitment by both the state chapter and local practice leaders. //

Consistent and small amounts of time build relationships. State politics is a marathon, not a sprint.
Claim Denials

PRACTICES MUST IDENTIFY REASONS FOR NON-PAYMENT AND FIND WAYS TO CAPTURE REVENUE.

Claim denials can be a major source of frustration for physicians and their practice managers and can have a real impact on cash flow and the financial performance of a practice. “Depending on the office doing the billing, we have seen as many as 35 percent or more of the claims denied for various reasons,” says Michele Redmond, vice president of Solutions Medical Billing in Rome, New York. “If office procedures are good in gathering correct information and submitting clean claims, you can still expect to see at least 5 percent of denials for claims,” Redmond says.

Redmond and Alice Scott, president of Solutions Medical Billing, who have co-authored 15 books on medical billing, are also noticing more errors by insurance carriers than in the past. “Claims can be denied incorrectly,” Redmond explains. “If the person responsible for reading the explanation of benefits (EOBs) doesn’t understand or recognize the error, the provider may lose out on that money.”

Claim Denial Trends

On a broader scale, research by the AMA indicates that claim denials dropped by 47 percent in 2013 after a sharp increase in 2012 among most commercial health insurers. Overall, the denial rate for commercial health insurers decreased from 3.48 percent in 2012 to 1.82 percent in 2013. Among all insurers last year, Medicare had the highest denial rate, at 4.92 percent, while Cigna had the lowest denial rate, at .54 percent.

“The National Health Insurer Report Card is the cornerstone of an AMA campaign launched in June 2008 to lead the charge against administrative waste by improving the health care billing and payment system,” Ardis Dee Hoven, MD, president of the AMA, told Medical Economics. “The campaign has produced noticeable progress by health insurers in response to the AMA’s call to improve the accuracy, efficiency, and transparency of their claims processing.”

Hoven says that the health insurance industry’s efforts to address claims efficiency have a long way to go and that the AMA report card has consistently demonstrated the inconsistency and confusion that result from each health insurer using different rules for processing and paying medical claims. “This variability requires physicians to maintain a costly claims management system for each health insurer. The high administrative costs associated with the burdens of processing medical claims should

(continued on page 29)

1. A duplicate claim was submitted when a practice hadn’t received reimbursement.
2. The patient isn’t eligible for services because his or her health plan coverage has ended, and the patient hasn’t shown proof of new insurance.
3. A patient hasn’t met the deductible for the calendar year.
4. Some services are bundled. For example, laboratory profiles with multiple tests don’t qualify for separate reimbursements, or an all-encompassing rate covers the minor procedure and the pre- and post-procedure visits. The provider receives one combined payment.
5. The benefit has been exceeded, such as the maximum allowed number of physical therapy visits covered by the health plan within a calendar year.
6. The claim form is missing one or more modifiers, or the modifier(s) are invalid for the procedure code (as in the case of bilateral codes billed on both sides).
7. An inconsistent place of service is marked on the claim form, such as an inpatient procedure billed in an outpatient setting.
8. A particular service isn’t covered under the plan’s benefits, or there appears to be a lack of medical necessity. In another example, there could be a mismatch between the actual diagnosis and the service performed.
9. The claim is deficient in certain information. It may be missing prior authorization or the effective period of time within which the pre-approved service must be provided for reimbursement to occur.
10. When the physician isn’t an in-network provider, the insurer may pay a lesser amount if the patient has out-of-network benefits.
11. There is a coding or data error with mismatched totals or mutually exclusive codes.
12. It may be necessary to coordinate benefits when dual coverage issues arise, such as with secondary insurance or worker’s compensation.
13. The filing deadline has passed. If a claim isn’t submitted to the insurer within the permitted time frame, it is likely to be rejected. The limit to file can be as short as 90 days from the date of service.
14. Errors or typos were made while collecting pertinent information from the patient or during the data entry process for a claim.
15. The claim includes outdated current procedural terminology (CPT) codes, or it lists deleted or truncated diagnosis codes.
Claim Denials

continued from page 28

not be accepted as the price of doing business with individual health insurers,” Hoven says. Although the AMA has advocated for a standardized system, “insurers continue to hold on to their complex proprietary rules that create a variety of paperwork bottlenecks. We must move toward an automated approach for processing medical claims that will save precious health care dollars and free physicians from needless administrative tasks that take time away from patient care,” she adds.

Denials Expected to Surge

Relatively comparable to the AMA’s findings are recent figures from the Medical Group Management Association (MGMA). The percentage of claims denied on first submission is 3.8 percent, according to a recent MGMA study, “Cost Survey Report: 2013 Report Based on 2012 Data.”

Laura Palmer, a senior industry analyst with the MGMA, predicts that more claim denials are looming on the horizon. “I would expect to see a multitude of denied charges for coding and billing errors when the industry changes to ICD-10 (International Classification of Diseases, 10th revision),” she says. “When diagnosis codes change to more specific coding, there may be mismatches with medical necessity and provider payment guidelines. Payers have not changed or may not have released their payment determinations for the new codes.”

According to an estimate by CMS, claim denial rates could skyrocket by 100 to 200 percent in the early stages of coding with ICD-10.

Preventing Denials

To increase the likelihood of problem-free reimbursement, good office staff training becomes paramount. Staff members should be well-versed in submitting clean claims and, even more important, in understanding why claims are denied. It takes specific expertise to address a claims adjustment with various carriers as well as to respond appropriately to each denial. Writing an effective appeal for a denied claim is essential to receiving a thorough claims review, Redmond says.

Sometimes staff may be “overworked to the point that they do not have time to work on claim denials, which often seem like the least important job during a busy day,” she adds. “Ignored claim denials are extremely costly to a physician. This is actually one of the reasons that many providers decide to outsource to a professional billing service. A lot of money can be lost if the denials are not handled correctly and in a timely fashion,” says Redmond.

Payers’ Perspective

The rate of denials has declined steadily as more claims are filed electronically, according to America’s Health Insurance Plans (AHIP), the association representing commercial payers. Health plans and providers are studying processes to ensure accurate and complete claims submission. Most denials are due to inaccurate or incomplete data, duplicate claims, and services provided before coverage started or after termination.

“Health plans and providers share the responsibility of improving the accuracy and efficiency of claims payment,” says AHIP spokeswoman Clare Krusing. “Health plans are doing their part to streamline health care administration to reduce paperwork, improve efficiency, and bring down costs.” //

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ARIZONA — Phoenix – MDIG is looking for a diagnostic radiologist to work in a hospital-based position in Phoenix. This is an in-house, overnight position, 8:00 pm–6:00 am, seven days on/seven days off. Starting salary $350,000 per year. Active Arizona license required. Anticipated start date is December 2014. Board certification required. Contact: Aaron Wittenberg, MD, by email at awittenberg@mdigradiology.com.

ARIZONA — Yuma – Interventional radiology position is available to work in a growing IR department at Yuma Regional Medical Center, a 445-bed hospital in Yuma, Ariz. This is a three-year partnership track with competitive salary and benefits. There is no buy-in into the professional corporation. Contact: Aaron Wittenberg, MD, by email at awittenberg@mdigradiology.com.

OKLAHOMA — Oklahoma City – Fellowship-trained breast imager needed to run a private practice, hospital-owned breast imaging center. Approximately 8,700 screening and 2,700 diagnostic mammograms performed annually. No-call employee position and general radiology call partnership track position available. Contact: Gregory Salomon by phone at (405) 326-8092 or by email at radiologysvcs@gmail.com.

Pennsylvania — Part-time opportunity working two weeks on/one week off for hospital-based private practice. Must be proficient in all modalities, specifically nuclear cardiology and PET/CT. Board-certified candidate must be a team player willing to speak with referring physicians when necessary. Most shifts are 1–9 p.m. with 8–5 shifts as needed. Contact: By email at resumes@rawv.com.

Wyoming – Immediate opening for a board-certified diagnostic radiologist. Located in the beautiful mountains of Wyoming. Benefits and pay are negotiable. Contact: Dan Alzheimer, MD, by email at roxdan78@hotmail.com.
attended my first ACR annual meeting over 10 years ago near the warm waters of South Beach, Fla. (This was back when the meeting was held in a different location each year.) At the time, I was a resident. While the name, format, and faces at the meetings have evolved over the years, the quality of the people attending has remained constant. I continue to develop a wonderful network of like-minded colleagues from throughout the country. Active ACR members are a special subset of radiologists, radiation oncologists, and physicists who care deeply about the quality and safety and future of their specialties.

This community keeps me energized within my day-to-day practice. I enjoy the healthy debates among our members at the annual meeting. And members who have made great achievements independently are able to share diverse perspectives. These often novel ideas collectively lead our specialty into the future.

Through the tireless efforts of our economics staff and volunteers, we continue to be fairly compensated for the value we bring to our patients.

Our government relations staff makes our voices heard on Capitol Hill, and many members work hard at grassroots advocacy within their states. Given all this, the most important development since my first meeting has been the *JACR*®. This publication has taken education within our specialty to an entirely new level. It is my go-to publication for relevant, up-to-date articles (and many offer CME credit).

I look forward to next year’s all-member meeting. Perhaps the Council Steering Committee will be able to import some warm sand so I can again dip my toes in while working towards a stronger profession.

— Seth M. Hardy, MD

"Active ACR members are a special subset of radiologists, radiation oncologists, and physicists who care deeply about the quality and safety and future of their specialties."

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