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FROM THE CHAIR OF THE
Board of Chancellors
By Bibb Allen Jr., MD, FACR, Chair

Keeping Radiology at the Vanguard

It’s more important than ever for radiologists to lead the way in technology innovation.

Radiology has always been at the vanguard of medical care, and it has been our scientific and technological innovation that has kept us there. In 2001, a survey of 225 leading internists rated the value of CT and MRI first among 30 medical innovations of the last 50 years. As such, it is no surprise that the use of advanced medical imaging expanded in the decade that followed, and perhaps even less surprising (to radiologists at least) are more recent studies that show patients who are imaged earlier in their hospital stays have better outcomes and decreased lengths of stay. There is little doubt that we must continue our efforts to be the owners of the research that discovers the next diagnostic innovation and translates that innovation to practice, yet we also have to be aware of the impact health reform is having on research funding now and over the next decade.

Federal health care reform legislation, with its focus on providing incentives to decrease costs, has impacted federal funding for research. The “Stimulus Package” of 2009 and the Affordable Care Act of 2010 have allocated over $3 billion for comparative effectiveness research through the Patient-Centered Outcomes Research Institute (PCORI), the Agency for Healthcare Research and Quality, and the National Institutes of Health. The legislation not only provides more funding for health services research but also adds incentives for clinical research to shift away from just saying, “Can we do it?” to asking, “Should we do it?” Pandharipande and Gazelle have suggested a number of ways organized radiology can support radiology researchers, including providing a vehicle for multicenter and interdisciplinary collaboration and supporting educational efforts that promote study design to compare effectiveness and emphasize long-term outcomes. Radiology organizations should be the developers of regional and national databases to serve as repositories of comparative effectiveness information and then disseminate this information to ordering physicians, radiologists, and patients. Finally, and perhaps most importantly, the researchers challenged the specialty to support the training of new investigators in comparative effectiveness and health services research.

To help our young researchers navigate this changing world, the ACR, the Radiology Research Alliance, the Radiology Alliance of Health Services Research, and the Association of University Radiologists (AUR) partnered to host a one-day Scholars Program for young researchers at the 2014 AUR Annual Meeting. The program highlighted key elements necessary for the success of radiology research in the era of health care reform and the new emphasis on comparative effectiveness research. The Scholars Program provided 20 scholarships for radiology residents to attend and participate with radiology’s leaders in discussions on health services research topics, radiation protection issues, translational research methodology, and multicenter trials. Specific focused sessions included “Funding Opportunities for Health Services Research in Radiology” and “How Do We Influence Health Policy to Support Practice?” Resident presentations highlighted many innovative research programs around the country that keep our specialty at the forefront of medical innovation and care.

In one notable presentation, Rebecca Rakow-Penner, MD, PhD, a diagnostic radiology resident at the University of California, San Diego (UCSD), presented her work on advances in diffusion-weighted imaging for prostate cancer. Then while I was in San Diego for the ARRS Annual Meeting, I was invited to the UCSD Multimodal Imaging Laboratory to meet with Anders M. Dale, PhD, the lab’s director, Rakow-Penner, and their colleagues to discuss how radiology organizations like the ACR can help empower researchers to thrive in the era of health reform.

In my recent travels, I have been pleased to see that many of the goals set forth in Pandharipande and Gazelle’s article are being realized. The RSNA Clinical Trials Methodology Workshop is one example of how radiology organizations are supporting education in comparative effectiveness research. ACRIN, which sponsored landmark trials such as the National Lung Screening Trial, is unique in its ability to support large multicenter trials. Meanwhile, the ACR National Radiology Data Registry program has the framework to be quite valuable to the specialty for collecting, storing, and disseminating data regarding outcomes in clinical practice. At the individual level, grants from organized radiology support many young researchers’ projects.

But there will be more challenges ahead and, hopefully, more research opportunities for organized radiology. Understanding how the College can best assist and empower our researchers in the era of health care reform is an important mission of the ACR’s Commission on Research. Our specialty cannot just be content with our past successes. Innovation is what will lead us into the future, and without innovation the entire specialty will suffer.
ACR Offers New Member Benefit

STUDENT LOAN REPAYMENT MAY BE ONE OF THE BIGGEST CHALLENGES facing young physicians and residents today. Starting this year, the College is offering a way to help members who have completed training consolidate and refinance their student loans. Through SoFi, a new ACR affinity program participant, ACR members receive competitive loan rates, as well as multiple loan terms, no application or origination fees, and fixed rates as low as 3.625% APR. SoFi will provide a $500 welcome bonus for ACR members applying for a loan through www.sofi.com/acr.

Like Our New Look?

YOU MAY HAVE NOTICED THAT THIS ISSUE OF THE BULLETIN LOOKS A LITTLE DIFFERENT. We’ve undergone a redesign to help readers access the information that they want faster and more easily. And although we’re dressing a little differently, we will continue to deliver the same great content from the College.

Next month, we will also debut a new digital issue. Look out for information in the November Bulletin about the new app.
MBAs Come With Positive Results

According to a recent study published in *Academic Medicine*, graduates who have training in both medicine and business increasingly pursue leadership roles and report better success in career acceleration. Mitesh S. Patel, MD, MBA, from the University of Pennsylvania in Philadelphia, surveyed graduates from the Wharton School MBA Program in Health Care Management about the effect of MBA training on their career. Nearly every graduate reported positively about their MBA training, citing career acceleration, professional flexibility, and credibility in multidisciplinary domains. Patel and his team also found that many of the graduates were pursuing leadership as well as nonclinical, administrative roles in their later careers as well. To read the study, visit [http://bit.ly/MBABoost](http://bit.ly/MBABoost). To learn about the Radiology Leadership Institute’s MBA pathways, visit [www.radiologyleaders.org/program/mba](http://www.radiologyleaders.org/program/mba).

Get Ready for IDOR

**ARE YOU READY** for this year’s International Day of Radiology (IDOR)? Now in its third year, IDOR will be held on Nov. 14. This year is dedicated to brain imaging.

To celebrate last year’s theme of lung screening awareness, societies hosted a variety of free courses on imaging, as well as special conferences to help make imaging more visible to the general public. For example, the Sociedad Española de Radiología Médica held a large public event with a series of lectures as well as an awards ceremony to honor renowned radiologists in lung screening. For more information about this year’s activities, visit [www.internationaldayofradiology.com](http://www.internationaldayofradiology.com).

If we do less of what doesn’t add value, we can do more of what does. We have to make room for the good when it comes along.

— Bibb Allen Jr., MD, FACR, chair of the Board of Chancellors, at the RFS Journal Club
ACR Leadership
Awarded Honors

IN JULY, James A. Brink, MD, FACR, vice-chair of the Board of Chancellors, and Sarah S. Donaldson, MD, FACR, ACR gold medalist, were awarded honorary membership by the American Association of Physicists in Medicine (AAPM) at their annual meeting in Austin. Brink and Donaldson were lauded for their hard work and support of AAPM and radiation safety.

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; and two member-in-training representatives to the Intersociety Conference. Additionally, the CNC will select a private-practice representative to the 2015 and 2016 ISC meetings.

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

A Positive for False Positives

OPPONENTS OF CANCER SCREENING OFTEN CITE FALSE POSITIVES and the anxiety they may cause as one of the downsides to screening. In a recent study, researchers surveyed 2,812 National Lung Cancer Screening Trial participants directly following their screening, with a follow-up six months later. At the six month interval, they found no increased anxiety among those who had been given false positives; their levels of anxiety in their responses matched patients given a true negative. Illana Gareen, PhD, professor of epidemiology at Brown University of Public Health and lead author of the study, said that the results should encourage physicians to recommend appropriate screenings, so long as patients are properly informed about the likelihood of a positive screening and its implications. For more information, visit http://bit.ly/FalsePos.

I used to think that doctors shouldn’t talk about money with their patients because [the conversation] has the potential to demean the relationship. As long as we have a largely private, insurance-based health care system, we – doctors and patients – need to talk about how much cancer treatments might cost.

— Elaine Schattner, MD, in “We Need to Talk About the Costs of Cancer Treatment.” (Read more at http://bit.ly/TreatmentCosts.)
DISPATCHES

INSTAGRAM ROUNDUP  Find us on Instagram at @radiologyACR.

1 ACR Faculty Bryan Barriger, MD, and Don C. Yoo, MD, get a crash course on creative teaching. Want to read about it? Visit http://bit.ly/ACRCreativeTeaching.


3 Members of the ACR Commission for Women and General Diversity meet up at the 2014 National Medical Association conference.

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TIPS FOR YOUR TOOLKIT

The value that radiologists demonstrate to the public is vital in value-based care. Yet many patients do not realize that radiologists are even doctors (for extra help on how to bust this misconception, visit http://bit.ly/RadMyths). The College has a host of resources for radiologists to share with their patients, including materials that explain what radiologists do, informational videos on radiology safety, and imaging fact cards for patients. The Image Wisely® and Image Gently® campaigns also seek to ensure patient safety in imaging. To check out these resources, visit http://bit.ly/PatientResources.

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Check out the Ed Center Lab at ACR 2015

AT ACR 2015, you can get a taste of radiology’s best hands-on clinical courses at the Education Center Lab. Each Education Center course offers the perfect combination of expert didactic and intensive case reviews, with immediate feedback and access to rationales and reports. And the Education Center Lab will be no different. The lab will have 50 workstations where you will be able to sample each of the 14 course topics. Faculty will be on hand to help guide you through the difficult cases and answer questions. For more information, visit www.acr.org/Annual-Meeting.

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Radiologists Working More, Retiring Later

ACCORDING TO RESEARCH PUBLISHED IN ACADEMIC RADIOLOGY, radiologists of all ages are working more hours than they’d like and retiring beyond their expected date. Researchers surveyed over 2,000 practicing members of the ACR, the Association of University Radiologists, and the Society of Chairs of Academic Radiology Departments, who reported their current and preferred work levels, as well as their retirement age. Because radiologists are retiring much later than they predicted they would at the start of their career, the authors projected that there would be fewer available full-time employment positions by 2016 than there are currently. To read more, visit http://bit.ly/HardworkingRads.

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Instead of being discouraged by their less-than-ideal journeys to medical school, students who have endured educational, financial, and social hurdles should be encouraged to use their learned experiences as a frame of reference to positively impact the delivery of health care.

Imaging 3.0™: Where Are We Now?

Taking stock as the radiology-wide initiative takes hold and transforms the specialty

In last October’s column, I wrote about how Imaging 3.0™ had taken hold across the profession. A year later, I’m pleased to report that it is embedding itself in our culture and informing every activity of the College.

We continue to gather success stories from around the country (and you can read them on our Imaging 3.0 website at www.acr.org/imaging3). From an ACO in Kansas where the radiologists are in the driver’s seat (http://bit.ly/KansasACO) to an Indiana practice that demonstrated to a skeptical hospital administration the sheer breadth of the group’s contributions to the health system, driving away the threat of losing their contract (http://bit.ly/Img3Indiana).

We had a big win on the policy front with the March 2014 legislation that mandated the use of clinical decision support for advanced imaging in the Medicare program, effective 2017. At the time of writing, we are still waiting for Medicare’s decision on coverage of lung cancer screening. If, as we hope, CMS makes the right decision and extends this life-saving benefit to our seniors, it will be in large part because of the Imaging 3.0 approach that our team has taken. Members throughout the College have been building the program, which centers on the principle articulated by our board chair Bibb Allen Jr., MD, FACR: “All of the imaging that is necessary and none that is not.”

We have told CMS that we will hold ourselves accountable for providing the highest level of care and commit to improving our knowledge through outcomes tracking and registry participation.

Meanwhile, the Imaging 3.0 toolkit continues to grow. Whether it is the ACR’s Qualified Clinical Data Registry (a tool that will make participating in value-based payments significantly easier for radiologists) or the exciting products that health IT companies are developing to facilitate innovative ways for us to connect with patients, there are more and more ways to make your practice an Imaging 3.0 hotspot.

So is everything rosy in the Imaging 3.0 garden? Alas, there is always a thorn or two. I wrote last month about some continued frustrations delivered by CMS in the proposed rule. (Read more at http://bit.ly/ACREconChair.) We know that CMS recognizes our specialty’s commitment to value but that doesn’t seem to stop them from trying to wrest a few more dollars of savings from our work. Is every radiologist and group on board with Imaging 3.0? Clearly we have more work to do, but the momentum is building. Those who have not embraced change are starting to look like outliers. Does the Imaging 3.0 toolkit contain everything we would like? Hardly. In my fantasy world, no patient ever has to make a phone call to schedule an exam or track down their images to take to a different provider. Every report is actionable, searchable, and meaningful to everyone who needs to access it. I hope to see the means whereby radiologists can seamlessly document their value-added activities during the workflow. We’re getting there, but there are a lot of barriers.

We have work to do on every area of Imaging 3.0, but overall I am resolutely optimistic about our specialty’s future. I know there is still anxiety out there, and I feel especially concerned for our graduating residents and fellows for whom the job market has been so difficult. Imaging 3.0 is the change that we hope will open up much needed opportunities for young physicians as practices recognize the value that these new graduates can bring.

Your economics team will continue to work tirelessly to secure fair reimbursement for the work you do. That is entirely congruent with the principles of Imaging 3.0: What we do for our patients is valuable, and we need to make our services available to those who need them. We’ll continue to push for better tools and sensible payment policy to support you. But, very importantly, we will continue to learn from you and your successes. Because some of the most exciting changes are not happening in Washington; indeed, it is you who are creating them. Please share your stories with us at http://bit.ly/Img3CaseStudies.

As always, you can reach me at gmcginty@acr.org and I encourage you to follow me on Twitter at @DrGMcGinty.
Massachusetts and Missouri have become the 18th and 19th states, respectively, to enact breast density notification laws.

**On Notice**

**ASSACHUSETTS GOV. DEVAL PATRICK** signed MA House Bill 3733 (S. 2181) into law on June 26th. The statute will require mammography services providers to supply a patient with written notification “in terms easily understood by a lay person” if the patient’s mammogram reveals dense breast tissue, as determined by the interpreting physician. The law also tasks the department of public health to promulgate implementation regulations by Jan. 1st, 2015, but it specifies that the notice state the following, at a minimum:

1. That the patient’s mammogram shows dense breast tissue;
2. That dense breast tissue is common and not abnormal, but that dense breast tissue may increase the risk of breast cancer;
3. That dense breast tissue can make it more difficult to find cancer on a mammogram, and that sometimes additional testing is needed for reliable breast cancer screening;
4. The interpreting physician’s determination whether or not additional testing is recommended for the patient. If additional testing is recommended, then the interpreting physician shall make or note the need for an appropriate referral;
5. That the patient has the right to discuss the results of the patient’s mammogram with the interpreting radiologist or the referring physician; and
6. That a report of the patient’s mammogram has been sent to the referring physician, and will become part of the patient’s medical record.

In addition, Missouri Gov. Jay Nixon signed the state’s breast density notification bill into law on July 2nd. The new law (Mo. Senate Bill 639), effective Jan. 1, 2015, requires mammography facilities to provide the following notice to patients following the completion of a mammogram:

If your mammogram demonstrates that you have dense breast tissue, which could hide abnormalities, and you have other risk factors for breast cancer that have been identified, you might benefit from supplemental screening tests that may be suggested by your ordering physician. Dense breast tissue, in and of itself, is a relatively common condition. Therefore, this information is not provided to cause undue concern, but rather to raise your awareness and to promote discussion with your physician regarding the presence of other risk factors, in addition to dense breast tissue. A report of your mammography results will be sent to you and your physician. You should contact your physician if you have any questions or concerns regarding this report.


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**ENDNOTES**


By Eugenia Krimer-Brandt, ACR director of state affairs
State of the Union
Where does your state stand on breast density notification?

To date, 19 states have passed some form of dense breast legislation that requires breast density notification or disclosure for patients. An additional four states have provisions that are not direct mandates. Find out the status of your state in the map below.

STATES WITH BREAST DENSITY LEGISLATION
ALABAMA
ARIZONA
CALIFORNIA
CONNECTICUT
HAWAII
MARYLAND
MASSACHUSETTS
MINNESOTA
MISSOURI
NORTH CAROLINA
NEVADA
NEW JERSEY
NEW YORK
OREGON
PENNSYLVANIA
RHODE ISLAND
TENNESSEE
TEXAS
VIRGINIA

SPECIAL CASES
ILLINOIS
Insurance carriers reimburse for follow-up ultrasound screening upon physician’s recommendation.

INDIANA
A new law requires the state Board of Health to craft a notification for patients and mandates the state employee health plan to provide coverage for “an appropriate medical screening, test, or examination for a female covered individual who is at least forty (40) years of age and who has been determined to have high breast density.”

MAINE
Following the recommendations of a designated stakeholder work group, the physician community voluntarily agreed to the recommendation of including breast density information in the letters to patients without a legislative mandate.

UTAH
In Utah, breast density notification is encouraged but not mandatory.

PATIENT CONVERSATIONS
MammographySavesLives.org offers a variety of resources for physicians to pass along to their patients. Download a PDF of the breast density information brochure (in both English and Spanish) at www.mammographysaveslives.org/Tools.

CHARITABLE CHOICES
October is the time for pink ribbons, pink shirts, and pink products. Fun as it can be to get together and show your support for a cause, you also want to be sure your time and donations are doing as much good as possible. If your practice is planning to raise funds for charity this year, follow these steps to find a good fit for the proceeds of your project:

1. **Get acquainted.** Once you’ve narrowed down some choices, review a copy of each charity’s annual report or call the office to get a sense of the organization’s goals and programs.

2. **Do some digging.** Look at how much of each dollar goes to charitable services. The American Institute of Philanthropy recommends choosing a charity that devotes at least 60 percent of donations to programs. While resources spent on overhead and fundraising are important to the success of an organization, the general rule of thumb is that the majority of funds should be devoted to programs.

Look for financial information in the annual report or ask about it when you reach out to the organization. Trustworthy charities should be open about their finances and should welcome questions from potential donors. Organizations may also be listed on a charity watchdog website, like www.charitynavigator.org or www.guidestar.org.

3. **Look for a long-term partner.** Once you’ve found a charity whose work you want to support, consider sticking with them for your next fundraiser too. As you establish a relationship with a charity, no matter how much or how little you’re donating, fundraising becomes more meaningful. You and your staff will feel more connected with the mission of the organization as you follow its progress over time.

ENDNOTE
Adopting a Patient Perspective
When Karin Charnoff-Katz, MD, was diagnosed with breast cancer, she entered the patient experience and left a changed physician.

In my way to work as a general radiologist in Memphis, I detoured to stop for a routine screening mammogram. I was 41 and a few months late for my second annual screening. I was not overly anxious. My white attending physician coat provided me with an illusory protective shield. I believed the coat granted me a special immunity of sorts. I did not even wait for an official read after the imaging, as I was in too much of a rush to get to work. It seemed at that phase of my life, I was always multi-tasking and perennially in a hurry. Between working, losing my mother and mother-in-law to ovarian cancer deaths at young ages, and having three small children at home, every moment was teeming with activity and responsibility. I often put on makeup in the mornings while stopped at red lights in my car. Maybe that explained my less than stellar driving record.

As I passed through suburban Memphis neighborhoods on the way to my office, my cell phone rang. It was the senior attending at the spa-like breast imaging facility, asking me to return to her office for biopsies. I stopped the car suddenly, eyes brimming with tears. I pulled into a parking lot to be alone and process the news.

After a brief respite in the parking lot, I raced back to have the procedure done. I was not yet convinced I had cancer. I still felt perfectly healthy. And I had no family history, no known risk factors for breast cancer. At the office, the radiologist showed me a snowstorm of calcifications that riddled nearly my entire right breast. I am uncertain whether she demonstrated the findings to me because I was a colleague, a radiologist, and she wanted confirmation, or if this was her modus operandi. They were little white flurries, where on my baseline mammogram one year prior, there had been none. The white flecks of calcium were so extensive that a stereotactic biopsy was unnecessary. The radiologist explained that she could randomly, almost blindly, perform biopsies in all four quadrants and she was certain her specimens would yield calcifications. Later, when I reviewed my previous year’s mammogram, I was awed by all the invisible, imperceptible changes that had occurred within my body as I went about my life.

The biopsies revealed extensive DCIS. I would have to undergo a mastectomy. I felt as though I was entering a new era in my life. As Jerzi Kozinski in The Painted Bird writes, “Disease enters a person when he (or she) least expects it. It might be sitting behind you in a cart, jump on your shoulders as you bend down to pick berries in the wall or crawl out of the water as you cross the river in a boat. Disease sneaks into the body invisibly, cunningly.” I was now part of the kingdom of the sick, a place consumed with doctors’ appointments, treatments, and uncertainty.

As I recovered from surgery, I was also surprised at how difficult the simplest movements became. Even sitting upright in bed, something I once took for granted, was no simple maneuver. I stared with horror into my wall-length

“Everyone who is born holds dual citizenship, in the kingdom of the well and the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.”
— Susan Sontag

As I recovered from surgery, I was also surprised at how difficult the simplest movements became. Even sitting upright in bed, something I once took for granted, was no simple maneuver. I stared with horror into my wall-length...
bathroom mirror at my wounded chest as I belted the numerous drains to my waist before a morning shower so that they would not tug at the incision sites. Even raising my arms above my head to shampoo my hair was challenging. But the worst part was the interminable waiting for the final pathology.

At last the results arrived. I was so grateful that the pathology implied an excellent prognosis, and I began my gradual journey back to wellness. I marveled at how quickly a person travels from the kingdom of the well to the kingdom of the sick — and yet how slowly one transitions in reverse.

When I was blessed to be deemed in remission, I was in no hurry to return to work. In fact, I was in no rush in any realm of my life. I took poetry seminars and simply savored unmeasured time with my three amazing children and my supportive spouse. I seriously contemplated a major change in my professional trajectory. I could not, however, help but reflect on all the years of training I had invested in medicine. I eventually elected to do a fellowship in breast imaging at Cornell, where I had trained as a medical student over a decade earlier. A mammogram had saved my life, and I hoped to pay that early detection forward as a breast imager.

For the past 10 years, I have been working at Cornell’s Women’s Imaging Center, detecting and biopsying breast cancers. My patients are often anxious and ever so vulnerable, not knowing what their mammogram may reveal. “Vulnerable” comes from the Latin word “vulnus,” which means to carry a wound gracefully. My goal, beyond the early detection of breast cancer, is to help my patients do precisely that, to carry their wounds gracefully. I try to be as present as I perceive they want me to be. If I am blessed to simply let another breast cancer survivor know that I see nothing suspicious on her follow-up mammogram, I am privileged to witness a smile of relief. I know what it’s like to feel the lingering vulnerability dissipate for a moment. On the other hand, when I diagnose a new cancer, if I deem the setting appropriate, I may share with the patient that I too have had breast cancer. This connection can sometimes replace some of the fear with a sense of hope. When patients express disbelief at this news, what they are really saying is, “You mean one day I can be well again too?”

In the years since my recovery, I’ve found myself thanking God for my breast cancer. As a direct consequence of my illness, my career was refashioned and I now find more fulfillment in my work. I am undoubtedly still multitasking. However, I have learned that patience is key in my interactions with patients. I appreciate that each person comes from a different place. I’ve learned to modulate my response contingent upon the patient’s particular needs and questions. When a patient is forced to enter the kingdom of the sick, my own experience with breast cancer facilitates my capacity, as a physician, to come along with them as their lives are forever changed.

By Karin Charnoff Katz, MD, attending breast imaging radiologist at Cornell New York Hospital
Bringing Mammography into Focus
Conflicting information in the media often leads to patient confusion.

DO YOU REMEMBER THE MAGIC EYE stereograms you may have had as a kid? At first, the image is a confusing, distorted mess of pixels. As you stare at the page, your eye cannot rest on one thing; it’s just endless rows of patterns. But after a moment, your eyes focus, and the distorted pixels sort themselves into a 3-D image. Everything makes sense.

For some patients, understanding mammography may feel like a first look at a stereogram. With headlines on research such as the Canadian National Breast Screening Study and comments from Swiss Medical Board members expressing concerns about mammography, patients often receive conflicting information. Many aren’t sure about the process, when they should get screening, and if they need a mammogram at all.

With so much confusion around the topic, how do you address your patients’ concerns about mammography? Carol H. Lee, MD, FACR, head of the ACR Committee on Breast Imaging Communication, simply has a conversation with concerned patients, sticking to the facts about the value of screening. The recent update of the Canadian breast screening study that showed no benefit from screening received a great deal of media attention, but it needs to be put into context, Lee says. “This study is an outlier among several other randomized trials, all of which show a benefit from screening mammography. Lee also reminds her patients we now have real-life experience with screening that shows that since widespread mammography screening was introduced, mortality from breast cancer has declined 30 percent in the United States. Relying on studies done 30 years ago, Lee says, is like looking at last week’s weather forecast to tell you if it’s raining outside.

And in order to provide the best information to patients, breast imagers must ensure that they are aware of all the facts and figures about mammography. “Everyone — patients, other clinicians, and even radiologists — can get confused about this data,” says Lee. “So you have to present your evidence to the patient and let them make an informed decision. It’s important that you have an open dialogue, rather than simply dictate what a patient should or shouldn’t do.”

One way to encourage an open dialogue is to start it yourself, says Debra L. Monticciolo, MD, FACR, head of the ACR Committee on Breast Imaging Education. She verbally reminds her patients to come in every year for a screening. She also tries to take every opportunity to address patients’ concerns. “When I’m giving results or when I’m acquiring a consent form, I always pause to ask if the patient has any questions or concerns. I find that my patients really appreciate that opening, even if they do not have any pressing issues.” Lee agrees. “We’re all busy,” she says, “but it helps radiology in general when we present ourselves as physicians who patients can relate to rather than just names on a report.”

Your staff can also be a big help in opening communication, especially as they are frequently interacting face to face with your patients. “I’ve had patients tell my technologists that they weren’t sure they should get screened every year,” says Monticciolo. “My technologists will go ahead and remind them how important it is. I make sure my staff is as informed about current mammography data as I am.”

Another thing Lee says to make sure you think about is the way you speak with patients. You have to make sure what you’re saying is understandable without being condescending. And show empathy. “When I do procedures like mammograms or breast biopsies, it’s an everyday procedure for me. But for my patients, it’s a new and frightening experience,” she says. Patients will have concerns and be afraid. It’s important to reach out to them and understand they may have a whole slew of questions for you, despite the time it might take to answer them.

“We’re all busy, but it helps radiology in general when we present ourselves as physicians who patients can relate to rather than just names on a report.”

—Carol H. Lee, MD, FACR

Ultimately, both Lee and Monticciolo agree that these tips could be used across the spectrum of modalities and that every radiologist should brush up on communication. “Open communication creates an informed patient,” says Lee. “And an informed patient can make good decisions and take charge of her health care.”

By Meghan Edwards, ACR Bulletin copywriter
Imagine that you’ve just landed in a foreign country. Problematically, you don’t speak the language, you don’t know how to get to your hotel, and you don’t know any of the social customs. Dead ends seem to hit you everywhere, and you don’t know whom to call for help.

Cancer patients often find themselves in a similar state following treatment. They are elated to find that they are well, but soon realize that life as a cancer survivor is entirely different than it was before. They have a host of unfamiliar issues, including dealing with the side effects of their treatment.

One way to ease the patient’s transition is for radiation oncologists to arm them with survivorship plans, semi-comprehensive reports that summarize what occurred during treatment, explain what is expected in terms of side effects and follow-up care, and provide resources for further information. “A survivorship plan is like a roadmap,” says Ann H. Partridge, MD, MPH, head of the survivorship program at the Dana-Farber Cancer Institute in Boston. “Patients don’t know what to do or expect after cancer, and a survivorship plan is a good way to guide them.”

Survivorship plans can do a lot to quell anxiety and help patients transition to a healthy lifestyle. After cancer treatments, patients have a whole different host of needs, says Partridge. Radiation oncologists are already a step ahead of most oncologists because the summary — a detailed overview that radiation oncologists give at the end of treatment — is like a partial survivorship plan.

One roadblock to implementing survivorship plans, however, is the debate as to who should write them. “Some say that oncology nurses are perfectly capable while others say it’s the doctors’ responsibility. Still others feel that multiple members of the care team should contribute,” says Abram Recht, MD, deputy chief of the department of radiation oncology at Beth Israel Deaconess Medical Center in Boston. Both Recht and Partridge suggest making survivorship planning a team effort, whether it involves your staff or the patient’s entire care team. By communicating with other physicians, you are not only sharing some of the work, but you are also making sure that you avoid miscommunication, says Partridge.

Radiation oncologists should be involved in the team effort to create survivorship plans because they are radiation experts and have the best, most current understanding of the side effects of treatments. Partridge notes, “Radiation oncologists are at the forefront of studying the side effects of radiation; they’re the first ones to learn about new problems the patient may encounter.” Recht adds, “There’s a great deal of mystery around what radiation oncologists do. Other specialists may not understand as well as we do the potential side effects to radiation therapy.”

No matter the misgivings, says Partridge, survivorship plans can be a critical tool in patient care. “We often land patients in the foreign world of survivorship without any kind of map. And that contributes to a lot of anxiety and excess visits and tests,” she says. “Survivorship plans can help mitigate some of that.”

By Meghan Edwards.

Mapping Out Success
Survivorship plans are a critical tool for patient care, yet they are not always implemented.

START HERE
Looking to find out more about survivorship plans? “You don’t need to reinvent the wheel,” says Abram Recht, MD. Here are examples, guidelines, and resources to get you started.


JourneyForward has plans for patients to fill out, as well as a program that helps physicians create plans for their patients. Visit http://bit.ly/JourneyForward.

The American Society of Clinical Oncology has a variety of links to choose from at http://bit.ly/ASCOTools.

By Meghan Edwards. ACR Bulletin copywriter
Identity Crisis
BY THE END OF 2014, Internet users will total more than 3 billion worldwide. This digital revolution has affected health care — particularly radiology, a specialty relying on technology — in many ways. It has revolutionized communication between physician colleagues and between physicians and their patients. It has made document and data management more accurate and seamless. And it has improved access to information at the point of care, resulting in enhanced diagnoses.

Yet the introduction of some websites, from social media to sites for reviews and ratings, also puts physician reputations at risk. For example, anyone from patients and referring clinicians to future employers routinely perform Google searches for their radiologists or interviewees. If they find an inappropriate personal post or negative review, it could sway their perception or increase their likelihood of changing physicians. Here are some tips for putting your best foot forward online.
Facebook Follies
William F. Shields, JD, LLM, CAE, ACR general counsel, says members should be aware that anything they say or do online can come back to haunt them. “I could search for you,” Shields says, “and had you done something foolish on spring break ten years ago, it could still be online. There’s no law that prohibits a future employer from looking for past indiscretions on the Internet. Anything you say or do could come up on a search engine.”

David M. Naeger, MD, assistant professor of clinical radiology at the University of California, San Francisco, agrees, pointing out the challenging gray zone between personal and professional social media accounts (read his tweets @DavidNaegerMD). “Facebook is an example of a social media site on which many physicians try to keep their accounts 100 percent personal — by not reaching out to colleagues or patients and not making any attempt to promote themselves or their practices. Even then, private information can sometimes be found by people who know you professionally,” he says, also noting the importance of privacy in personal accounts. “That’s why I’m an advocate of protecting personal information on these sites. You absolutely need to learn about the privacy settings available.”

Naeger adds that even when content is made private, posts about you can still be made public without your knowing. As a rule of thumb, Naeger advises limiting any personal information you post, even on a private or non-professional account: “If you don’t want something to be seen by colleagues and patients, you just shouldn’t post it.”

Tweet With Caution
When it comes to Twitter, Saurabh Jha, MBBS, assistant professor of radiology at the Hospital of the University of Pennsylvania in Philadelphia, believes the benefits outweigh the risks for most physicians. Joining Twitter in December 2013 after his colleagues advised him to try it, Jha was initially opposed to any form of social media (read his tweets @roguerad). Now Jha appreciates Twitter because it helps him disseminate articles he’s written, gaining exposure and feedback, while also engaging other health care professionals. “I like when people challenge me and call me out,” Jha explains, adding that he doesn’t shy away from controversial issues.

According to Jha, the best approach to Twitter, which he utilizes for primarily professional reasons, is not tweeting anything you wouldn’t feel comfortable saying in public. “You need to be able to stand up for every tweet,” he says. “If you’re not willing to do that, you shouldn’t tweet something. There should be no difference between what you would say in real life, at a forum, or in a journal.”

“‘There’s no law that prohibits a future employer from looking for past indiscretions on the Internet. Anything you say or do could come up on a search engine.’” -William F. Shields, JD, LLM, CAE

Still, radiologists need to be cautious about sharing clinical experiences. Jha says it may be okay to make general points about their work, but radiologists should avoid tweeting about their experiences with patients. Even venting online about one’s day can create a problem, says Naeger. “If you’re in a public forum, you may not be violating a law with the information you post, but you might be revealing patient details that seem personal,” he says. “Someone might read your post and think ‘I wonder if that’s me’ or ‘I wonder if this doctor would post about my office visit.’ A sense of privacy is violated.”

Ultimately, Naeger believes, “The number one riskiest part of being online is violating patient privacy laws.” Of course, you should never share patient information online due to HIPAA. But some physicians will ask for help in diagnosing or managing a challenging case online. “I have seen situations where people are trying to have an
intellectual or professional discussion but accidentally include patient information in an uploaded image, thereby violating the law,” says Naeger.

Making the Grade
Radiologists’ online reputations aren’t only made or broken on social media: they’re also deeply affected by physician review websites like Health Grades, RateMDs, and even Yelp. Shields says it’s common for dissatisfied patients to turn to these sites, and reviews could impact a referring physician’s decision to employ a particular radiologist or radiology practice for image interpretation.

In fact, a federal law protects the website from being required to take negative reviews down. Plus, Shields adds, “Physicians aren’t free to respond. If it has something to do with the patients’ condition, HIPAA prevents you from discussing the case. You really can’t respond without the patient’s permission.” On the bright side, many websites have policies against defamatory statements, so contacting the website directly could potentially compel the managers to take down an off-putting comment.

But should you take legal action upon finding a defamatory, or even false, comment about you? Shields notes that several physicians have tried to sue patients for posting negative reviews to no avail. One Minnesota doctor tried to sue an individual who posted negative reviews and wasn’t even his direct patient. The doctor not only lost the case but was ordered to pay the attorneys’ fee for the defendant. Shields emphasizes that there is relatively little upside to suing over online comments, but there is significant downside. “Just as doctors settle some malpractice claims even when they think they’ve done nothing wrong, these online scenarios require a cost-benefit analysis that seldom finds sufficient potential benefit,” he concludes.

Solicit Positivity
Nonetheless, there are proactive actions you can take if your reputation is being defamed on a review site. Many of the search engine site algorithms allow positive reviews to push down the negative ones. Shields says radiologists can even hire a company to design an online reputation management strategy. “Often, if physicians are finding themselves on the receiving end of a multitude of negative reviews, it’s an indication of a much larger systematic problem, which may be tied to other factors such as the office staff’s behavior, administrative procedures, the patient’s ease in setting up an appointment, and so on,” explains Jeremy Nelson, CEO of Afia, Inc., a health IT consulting firm. “Any service that affects a patient directly and is related to the physician or the office could be the culprit — not necessarily the physician’s bedside manner or quality of services.”

Another suggestion given in the Physician Risk Management Newsletter is providing your patients the opportunity to voice opinions directly to you. That way, they’ll be less likely to turn to websites when feeling frustrated. Try surveying patients via email or having an office manager contact dissatisfied patients directly because they may be too intimidated to speak up to doctors.

“You can solicit positive reviews by having a flyer or sign at the front desk when a patient checks in, saying, ‘Go to www.healthgrades.com if you’re happy with your treatment here,’” says Shields.

But the best way to keep your online reputation positive? Put your patients first by focusing on quality care and align your goals with the ACR’s Imaging 3.0™ campaign. “If patients feel well taken care of and heard, you can spend more time worrying about their health than their negative online reviews,” says Naeger.

By Alyssa Martino, Freelance writer for the ACR Bulletin

ENDNOTES
In the classic Road Runner cartoon, it’s hard not to feel a bit sorry for poor Wile E. Coyote. Every time he thinks the Road Runner is within reach — BAM! — something happens that makes the coyote wonder whether he’ll ever catch the long-legged bird. It’s a scenario that many radiologists are familiar with. While they’re not chasing the Road Runner’s signature “beep-beep,” they are pursuing the myriad changes facing radiology in this era of health care reform. And for many, just when they think they are close to grasping the requirements, a new initiative is introduced that leaves them wondering how they can ever keep up.

In addition to maintaining their day-to-day operations, radiologists are being challenged to implement several new initiatives — each with its own acronym and laundry list of hurdles. They are expected to implement the Physician Quality Reporting System (PQRS), Meaningful Use, clinical decision support, and new International Classification of Diseases (ICD-10) codes. Radiologists are also being urged to join accountable care organizations and increase their value to patient care teams by adopting quality improvement programs for which no standard strategies currently exist. Some of the initiatives are optional, but many are mandated by CMS and carry financial penalties for practices that do not implement them.

With so many initiatives and limited resources to implement them all, radiologists must determine which programs meet their needs and which they can realistically adopt. From there, they must develop plans and engage their teams to execute the programs. “It’s easy to become overwhelmed as these regulations change and evolve so quickly,” says Ezequiel Silva III, MD, FACR, director of interventional radiology at South Texas Radiology Group and vice chair of the ACR Commission on Economics. “Radiology practices must be proactive about implementing programs that improve their financial status and position them well as the industry moves toward value-based care.”

Poised for Change

Many of the initiatives take time, additional personnel, and up-front costs to implement, making it difficult for most practices to adopt them all at once. Therefore, practices must take a systematic approach to enacting the programs. “As practices make the philosophical commitment to do these quality initiatives, it is important to be mindful of the extra expense they will incur,” Silva says. “They must have the resources available and be smart about how they deploy those resources.” For instance, implementing ICD-10 may require additional staff training, while installing clinical decision support software is an obvious technology cost.

John H. Lohnes Jr., MD, FACR, president and chief operating officer of Wichita Radiology Group, says that practices should consider where they stand in the marketplace as they weigh which initiatives to invest in. “Like any business, radiology practices have to evaluate where they are in their local community, where the community’s heading, and which players are driving various changes within the community,” he says. To conduct such an evaluation, practices must stay abreast of the current trends by maintaining communication with referring physicians and other members of their health care system. “Once they have this background information, practices can determine which initiatives will help position them in a positive manner and advance their goals,” Lohnes says.

As they begin prioritizing the initiatives, radiologists will notice that many of the programs require input from referring physicians and hospital administrators. Gathering that input and implementing those initiatives takes a significant amount of time, but Silva says that radiologists shouldn’t shy away from them. Instead, they should use those initiatives to engage their health care partners and highlight the value that radiology brings to patient care. “I love that radiology’s presence is evolving so quickly, and we are having a role in a number of immediate initiatives such as clinical decision support that impact the larger health care team,” Silva says. “But initiating
all of these things takes effort. The practices that do it right are the ones that are going to come out on top, regardless of how payment reform evolves.”

Priority One
One initiative radiologists say all groups should adopt is PQRS. When it was introduced in 2007, PQRS (formerly the Physician Quality Reporting Initiative) was an incentive-based program that paid practices 1.5 percent of their estimated allowable charges for Medicare Part B in exchange for their participation. Silva says that although the incentive wasn’t significant, his group implemented PQRS in 2007 as part of its mission to be a premiere radiology group. “From a philosophical perspective, we thought we couldn’t call ourselves a quality group if we weren’t participating in the quality initiatives that CMS was asking us to take part in,” Silva says.

PQRS has since changed from an incentive program to a payment-adjustment initiative. That means that beginning in 2015, groups that don’t participate will incur a financial penalty. Max Wintermark, MD, chief of neuroradiology at Stanford University, says PQRS is relatively easy to implement, so all groups should adopt it to avoid the penalties. “PQRS is completely in our control to implement and doesn’t require a lot of assistance from other departments, so that’s a good one to start with,” Wintermark explains. “From there, you can make a priority list of the initiatives that are a bit more complex and that require buy-in from referring physicians, hospital administrators, and patients.”

Practices considering how to prioritize other initiatives to implement after or alongside PQRS should examine the consequences associated with each initiative. For instance, practices that aren’t ready for ICD-10 when it takes effect in October 2015 stand to lose a lot of money. “Groups want to be proactive because they don’t want to have their claims denied and their revenue stream suffer while they try to figure out what is wrong with their ICD-10 codes,” Silva says. He adds that all practices should also be prepared for a delay in payments as the new codes take effect late next year. “I hate to be crass and say that everything is about money, but you owe it to your group, patients, and practice to remain financially viable through all of this,” Silva says. “You need to make sure you have either a line of credit or some cash in the coffers to pay your staff and maintain your operations in the event of claims processing delays.”

Embracing the Future
Once practices establish a plan of action, they must get their staffs on board with the changes. Wintermark says that one of the best ways to ensure everyone is committed to the changes is to include everyone in the planning discussions early on. “The practice leaders need to sit down together to look at the needs of the practice, its patients, and its referring physicians,” he says. “It’s much easier to engage colleagues and staff if everyone is involved from the start in selecting which initiatives the group is going to participate in.”

Still, it’s unlikely that everyone will welcome the changes right away. Practices can take a variety of approaches to get their staffs and radiologists to comply with the new workflows. For example, Silva says that when his group implemented PQRS, it created what it called a dictation clarification system. Every time a radiologist submitted a report that failed to meet the PQRS parameters, the system automatically sent an email asking that the report be corrected. “We saw the number of inadequate reports decrease dramatically in a short amount of time thanks to the system,” Silva says. “That’s important because whatever your cynical thoughts are about these CMS mandates, they are still the law and you still have to comply with the statutes.”

While opinions about the usefulness of the initiatives vary, embracing the programs rather than working against them can help radiologists demonstrate their value to the care team. “We’re in the best position to define our patients’ needs, so radiologists need to take the lead in these initiatives and be actively involved in them,” Wintermark says. In concurrence, Silva says that radiologists should use the initiatives as icebreakers to inject themselves into the health care reform discussion. “These initiatives are gifts that are being handed to radiologists, and we can use them to establish and solidify ourselves as experts — from traditional imaging all the way to clinical support as consultants in patient care,” he says. Practices that leverage the initiatives successfully will be more likely to turn the tables — becoming the Road Runner rather than the coyote.

By Jenny Jones, freelance writer for the ACR Bulletin

HEALTH CARE INITIATIVE CHECKLIST

- Identify initiatives that align with your goals.
- Weigh the implementation costs and benefits of each initiative, while also considering the penalties of not participating.
- Start with the simplest initiatives and work toward those that are more complex, engaging practice and hospital leadership along the way.
- Discuss the initiatives with your colleagues and staff, and encourage them to comply with the changes.
A Breath of Fresh Air
Get up to date with all of the changes in lung cancer screening with these resources.

Over the course of the past year, many exciting developments have occurred in the world of lung cancer screening. According to Ella A. Kazerooni, MD, FACR, principal investigator at the University of Michigan in the National Lung Screening Trial (NLST), “We’re committed to widespread coverage for lung cancer screening, and providing an array of tools radiologists need to make that happen.” Given all of the changes taking place, there is no better time than now to get caught up on what lung cancer screening resources are available through the ACR and elsewhere to comply with best practices. The following are some of the most important:

ACR CT Accreditation and Designated Lung Cancer Screening Center program. The ACR’s CT Accreditation Program involves the acquisition of clinical and phantom images, dose measurements, and the submission of scanning protocols. Providers that bill under part B of the Medicare Physician Fee Schedule must be accredited in order to receive technical component reimbursement from Medicare.

In addition to the CT Accreditation Program, the ACR also offers the Lung Cancer Screening Center designation. This is a unit-specific credential that demonstrates to patients that your facility meets best practice standards for lung cancer screening. All sites applying for the certification must have active ACR CT accreditation in at least the chest module on the designated units and must meet additional requirements outlined by the ACR. All facilities that meet the prescribed conditions will be identified as being an ACR Designated Lung Cancer Screening Center on the ACR’s Accredited Facility Search web page. Between announcing the program in early May and the end of July, 147 facilities have applied for ACR’s lung cancer screening designation, with 93 facilities approved and another 54 in process. For more information about the application process, visit http://bit.ly/LungCancerScreeningCtr.

Lung-RADS. The ACR’s Lung-RADS is the product of the ACR Lung Cancer Screening Committee subgroup on Lung-RADS. This quality assurance tool is designed to standardize and structure lung cancer screening CT reporting and management recommendations, reduce confusion in lung cancer screening CT interpretations, and facilitate outcome monitoring. Forthcoming features include a lexicon of lung cancer screening CT terms and a reporting format meant to standardize the language used in lung cancer screening CT reports, along with an atlas that will include images that illustrate the lexicon and findings as well as a description of a medical audit and outcome monitoring process. More information on Lung-RADS may be found at http://bit.ly/LungRADS.

ACR-STR Practice Parameter for the Performance and Reporting of Lung Cancer Screening Thoracic Computed Tomography. This new document, developed collaboratively with the Society of Thoracic Radiology and adopted at AMCLC 2014, is an educational tool designed to assist practitioners in optimal performance of thoracic CT for lung cancer screening. It is not a compilation of inflexible rules or requirements of practice, but rather a guideline to help practitioners deliver safe and effective medical care. Visit http://bit.ly/ACR-STR for more information.

AAPM Protocols for Lung Cancer Screening. Building on the foundation of the ACR-STR Practice Parameters, the AAPM developed lung cancer screening CT protocols across a wide array of CT scanner makes and models to facilitate scanner specific protocols in practice. Visit http://bit.ly/AAPMCT to learn more.

New England Journal of Medicine article detailing NLST results. Review the results of the NLST as reported in the New England Journal of Medicine. The NLST was conducted to determine whether screening with low-dose CT could reduce mortality from lung cancer. In all three rounds of the trial, there was a substantially higher rate of positive screening tests in the low-dose CT group than in the radiography group. In addition, the percentage of all screening tests that identified a clinically significant abnormality other than an abnormality suspicious for lung cancer was more than three times as high in the low-dose CT group as in the radiography group. Based on these and other results, the research team concluded that screening with the use of low-dose CT reduces mortality from lung cancer. To read the full text of the article “Reduced Lung-Cancer Mortality with Low-Dose Computed Tomographic Screening,” visit http://bit.ly/NLST-NEJM.

By Chris Hobson, ACR Bulletin associate editor

Find more resources at ACR’s lung cancer resource page: http://bit.ly/LungResources

Lung Screening at ACR 2015
Learn more about the future of lung screening at ACR’s upcoming annual meeting. Sessions include “Lung Cancer Screening: From Science to Practice” and “Implementations and Economic Considerations for a Screening Program.” See the complete program at https://bit.ly/ACR2015Program.
In the recent “imaging 2.0” past, radiologists conducted their work in isolation. Most of the day, they sat in darkened rooms where they reviewed images and dictated reports, with little interaction with referring physicians and almost no contact with patients. But as the industry evolves from a fee-for-service model focused on volume to a clinical-care model centered on value, radiologists can no longer afford to cloister themselves in the shadows of their reading rooms. Instead, they must take proactive steps to highlight the value they bring to patient care.

Radiology Consultants of the Midwest, P.C., a private radiology practice serving the Omaha and Council Bluffs metropolitan region in Nebraska, has strengthened its role on the medical team by developing a customer service–oriented culture in which its radiologists regularly collaborate with referring physicians and meet with patients. The approach allows the practice’s 26 radiologists to become true consultants in patient care rather than mere image interpreters, says Patricia A. Helke, MD, FACR, president emeritus for Radiology Consultants of the Midwest. “The idea is to make radiologists valuable,” she says. “And the way you do that is by providing service, so we’ve made a concerted effort to try to provide the best service to our local health system and patients.”

Radiology Consultants of the Midwest makes customer service a priority in every aspect of its operations and has formed committees that are responsible for developing ways to improve service quality. The practice has many strategies in place to meet its customer service objectives. Recently, the radiologists began emphasizing three core initiatives tailored to increase dialog between the practice’s radiologists and referring physicians: call reporting, concierge radiology, and traveling interventional radiology. Helke says the initiatives have been key to establishing relationships with referring physicians — leading to increased referrals and greater patient satisfaction.

Direct Communication
Under the call reporting initiative, the practice targets a percentage of referring physicians to call with exam findings each month. At first, radiologists called physicians who already referred a lot of patients; now, they’ve expanded the effort, calling physicians who aren’t frequent referrers. The calls initially focused on critical results, but gradually they also included less significant findings. “We wouldn’t necessarily call a physician about a normal chest X-ray,” Helke explains. “But if there is a finding that we feel warrants a closer physician follow up, we make a personal connection with the doctor to relay the patient’s results.” Most referring physicians have been receptive to the calls, which have proven to be a simple, effective way to forge connections between referrers and radiologists, Helke says.

Radiologists are also building relationships with referring physicians through the practice’s concierge radiology initiative. Through that program, radiologists travel to referring physicians’ offices, including oncology and primary care practices, to read scans on certain days. The program allows radiologists to meet referring physicians in person to consult about appropriate imaging and communicate findings. This collaboration leads to improved patient care and allows referring physicians to get imaging results faster. Radiologists also meet patients as part of the program for more personalized care that puts a face with the radiologist’s name on the bill, Helke says.

As part of the concierge program, the practice compartmentalizes its workflow, with subspecialty radiologists reading images only in their areas of expertise. For instance, neuroradiologists read only neuroimaging and generalists read only traditional films. The approach ensures high-quality reads while also pairing referring physicians with subspecialty radiologists who can best answer their questions, says Erik A. Pedersen, MD, chief information officer for Radiology Consultants of the Midwest and chair of the radiology departments at Bergan Mercy Medical Center and Boys Town National Research Hospital.

Similar to the concierge radiology program, the traveling interventional radiology initiative sends interventional radiologists out to provide care at local physicians’ offices and hospitals that don’t have large enough case-loads to justify hiring a full-time interventional radiologist.
“We’ve had our interventional radiologists meet with the physicians who work at these hospitals and explain the kind of services they provide,” Pedersen says. “Then a couple of days a week or as needed, the interventional radiologists take cases at these institutions that otherwise wouldn’t have an interventional radiologist there to provide these services.” The program increases the number of cases the interventional radiologists receive and also allows them to work directly with the referring physicians, Pedersen says.

**Benefits Package**
Radiology Consultants of the Midwest has experienced many benefits from its recent initiatives, perhaps most notably increased collaboration with referring physicians.

Pedersen says that the referring physicians now call the radiologists to discuss things like appropriate imaging and request rereads of images their patients have received at other imaging centers. “We get lots of phone calls and lots of referring physicians who drop by the department to have us look at cases,” he says. “It shows that the relationship is solid, and the physicians trust that the studies we’re recommending are going to help answer their questions.” Helke adds that those relationships have also led to a roughly 10 percent increase in referrals at a time when many institutions have seen referrals decline.

Mammography has helped reduce breast cancer mortality in the U.S. by nearly 1/3 since 1990

Help women understand the importance of annual mammography screening. Download ads, podcast videos, public service announcements, customizable breast density patient information brochures, and more at Mammographysaveslives.org

CT lung cancer screening significantly reduces lung cancer deaths

Educate patients about the benefits of CT lung cancer screening. Send them to radiologyinfo.org where they can find out what lung cancer screening is, who should consider it, how the procedure is performed, and more.

What your patients need to know
Protecting Our Smallest Patients

The Commission on Pediatric Radiology advocates for its patients and advances the subspecialty.

Through the work of these committees, the commission works with the ACR to advance the benefits of subspecialty care to children; to provide safe, appropriate, and effective imaging for children; to optimize access to pediatric imaging services; to educate radiologists who provide imaging services to pediatric patients; and to encourage research to discover truly noninvasive and effective pediatric imaging procedures and protocols.

The commission works closely with the Society for Pediatric Radiology (SPR). Why is it important for pediatric radiologists to also join the ACR?

The Society for Pediatric Radiology is the home for our subspecialty. One of my goals as chair of the ACR commission is to work closely with the Commission on Membership and Communications to communicate to SPR members the immense value of membership in the ACR. This membership translates not just into many benefits for the individual, such as access to educational opportunities, but more importantly, it benefits our specialty and our profession. Moreover, within the ACR, the voice of pediatric radiologists can resonate within the mission and various commissions of the ACR, with the College’s successes accruing to our pediatric patients.

What about radiation dose optimization in pediatric patients?

We believe that diagnostic imaging examinations should be optimized for patients of all ages. However, children need special treatment when it comes to imaging, which goes back to the oft-quoted axiom that children are not little adults. There are many reasons children must be imaged differently: because their cells are dividing, because they are likely to have many other studies in their lifetimes, because their remaining lifespan is sufficiently long to extend beyond the latency stage for development of malignancy, and because using the same imaging parameters appropriate for adults results in larger effective doses in smaller patients.

The Commission on Pediatric Radiology strongly supports the use of appropriate imaging parameters in the pediatric patient, and our members are involved in the Alliance for Radiation Safety in Pediatric Imaging (better known as the Image Gently® campaign), begun by the SPR, the ACR, the American Society for Radiologic Technologists, and the American Association of Physicists in Medicine. A major goal of the alliance has been to raise awareness of the importance of dose optimization for children in diagnostic imaging. One of the effects of this campaign and of the Image Wisely® campaign (which focuses on radiation dose for adult patients) has been to encourage vendors to engineer equipment that can deliver improved imaging with lower radiation doses. In fact, newer CT equipment design has greatly improved radiation dose, even compared to the equipment that was being used at the inception of the Image Gently and Image Wisely campaigns and the formation of this commission.

Within the commission, the Quality and Safety Committee focuses on optimization of radiation dose during pediatric imaging. In particular, the CR-DR Steering Committee is working with ACR Registries and, in cooperation with other groups, is determining the appropriate exposure for diagnostic imaging using computerized radiography.

Commission members also collaborate with the Alliance for Radiation Safety in Pediatric Imaging to educate radiologists, technologists, referring physicians, and families on the benefits and appropriate use of imaging studies. Radiation optimization does not mean no imaging — it means appropriate imaging. To that end, one of our immediate goals is to encourage imaging facilities to use the ACR Appropriateness Criteria® from within the medical record.

What type of research has the commission prioritized?

Our Research Committee is focused on multi-institutional pediatric research that leads to important and meaningful information. From there, the data can be translated into measurably improved care to pediatric patients.

Heike E. Daldrup-Link, MD, co-chair of the committee, recently published a widely circulated single-center preliminary manuscript showing the effectiveness of ionizing radiation–free diagnostic imaging staging for pediatric cancer patients.1

How has imaging changed since you entered the field?

When I was a medical student, many trauma patients underwent exploratory laparotomy to ascertain the site and severity of injuries. Now CT accomplishes a knifeless laparotomy, enabling appropriate triage of the injured...
The stakes for ACR members and their practices have risen dramatically, particularly in relation to accreditation. As of January 1, 2012, CMS began requiring accreditation from designated organizations such as the ACR for suppliers that furnish the technical component of advanced diagnostic imaging services in a non-hospital setting. Any supplier that fails to obtain accreditation will not receive reimbursement from CMS for those services. Consequently, obtaining and keeping accreditation signifies high quality and will help practices to remain in good financial standing with Medicare. This column will outline what a facility can and must do if it receives an adverse decision from the ACR and initially cannot obtain or renew its accreditation.

**Diagnostic Imaging Accreditation**

**Q** My facility did not pass diagnostic imaging accreditation. May we appeal the decision? If so, what’s involved?

**A** Yes. Facilities that receive a deficiency or a failure may appeal the determination in writing within 15 days of the final report. You must send the original images for all of the submitted cases in the category that did not pass along with a letter describing your reason for appealing. Only images from the same patient study or phantom testing originally submitted will be considered during the appeal evaluation. These will be forwarded to an arbitrator (a reviewer who did not participate in the initial review) with a copy of the previous reviews and the appeal letter written by the facility. No other images will be sent to the reviewer for consideration in the evaluation. The arbitrator’s determination will be final.

**Q** We recently appealed an adverse accreditation decision. When should we receive the results of the appeal?

**A** You should receive the appeal results within 30 to 45 days of the date all required appeal materials were received by the ACR.

**Q** We did not pass accreditation because our technologists selected and submitted the wrong images. May we appeal the decision and submit new cases?

**A** Although you may appeal the decision, you may not submit new cases. During accreditation review, the ACR reviewers assume that the submitted cases were reviewed by the modality’s supervising physician (as specified in the Testing Instructions) and are examples of your best work. Consequently, during an appeal, you may only submit the original patient or phantom testing images.

**Q** We did not pass accreditation because our technologist did not submit all required images and provided insufficient information with the images that were submitted. May we appeal the decision and submit the rest of the required information?

**A** You may appeal the decision by submitting the original patient study or phantom testing along with the missing information, as long as all of the images and data are from the original patient or phantom testing. If the submission was electronic, an opportunity to upload additional appeal information and images is provided in the online option form. Please call the Diagnostic Modality Accreditation Information Line at (800) 770-0145 for further guidance on your specific situation.

**Mammography Accreditation**

**Q** My facility failed mammography accreditation. May we appeal the decision? If so, what’s involved?

**A** Yes. Facilities that receive a deficiency or a failure may appeal the determination in writing within 30 days of the final report. The original films or data must be submitted with a letter describing your reason for appealing. Only those films reviewed for the original determination will be considered during the appeal evaluation. Both fatty and dense cases must be submitted for clinical appeals in order to allow the reviewer to assess the overall clinical performance of the facility. Films will be reviewed by an arbitrator (a reviewer who did not participate in the initial review) with a copy of the previous reviews and the appeal letter written by the facility. No other films or data will be sent to the reviewer for consideration in the evaluation. The arbitrator’s determination will be final.

If a unit is denied accreditation after an appeal of a failure (second deficiency), the facility may appeal directly to the FDA. However, such an appeal will stop the ACR application process until the FDA renders a decision.

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CLASSIFIED ADS

These job listings are paid advertisements. Publication of a job listing does not constitute a recommendation by the ACR. The ACR and the ACR Career Center assume no responsibility for accuracy of information or liability for any personnel decisions and selections made by the employer. These job listings previously appeared on the ACR Career Center website. Only jobs posted on the website are eligible to appear in the ACR Bulletin. Advertising instructions, rates, and complete policies are available at http://jobs.acr.org or e-mail careercenter@acr.org.

Massachusetts — Congenial, democratic group seeks full-time, fellowship-trained interventional radiologist to replace retiring partner. The position is a partnership track with excellent salary and benefits. Will require some general radiology work. Must be board-certified/board-eligible. Location is in the Southcoast region of Massachusetts, a short drive to Providence, Boston, and Cape Cod. Contact: John Mungovan, MD, by phone at (508) 973-7161 or by email at mungovanj@southcoast.org.

New Jersey — Clinton — Seeking full-time board-certified/board-eligible radiologist with fellowship training in interventional radiology. Must be able to perform all IR procedures, including embolization, angiography, and non vascular/biopsy. Position is 50 percent IR and 50 percent general radiology. Contact: Heidi Postma by phone at (908) 806-2635 or by email at heidi@hunterdonradiology.com.

New Jersey — Lyndhurst — Radiologist with board certification, insurance, and New Jersey license needed for busy private practice. Areas of specialty needed are CT and mammography. P/T onsite position available immediately. Contact: Dojee Nodong by phone at (201) 729-1234 or by email at d nodong@yahoo.com.

New York — Williamsville — Full-time radiologist. Candidates must be board-certified and fellowship-trained; advanced interventional and/or neuroradiology training preferred with 3–5 years significant proven experience in neuro or women’s imaging. Role will be up to 50 percent exposure to outpatient interventional services and 50 percent to other imaging modalities. Contact: Cheri Petrus by phone at (716) 631-2500 ext. 2212 or by email at cpetrus@windsoradiology.com.

CONTINUED

Chancellor’s Report
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patient to the appropriate level and type of care. Yes, we are doing more CT scans, but this translates into fewer unnecessary surgeries — from any point of view, a great advantage for patients of all ages. That is the importance of diagnostic imaging. And to our commission members, this translates into the right study, done right, for the right patient at the right time, a principle embodied in our appropriateness criteria.

ENDNOTE


RADLAW
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Further, the facility making the appeal may not perform mammography during the FDA appeal process.

Note:

ACR accreditation requirements do not represent an applicable legal standard of care. While they may lead to best clinical practices for many facilities in a particular region, the ACR does not intend that each facility, its radiologists, and staff be held legally accountable to adhere to them. The CMS mandate should motivate members and their health care team to seek and maintain accreditation. However, it’s not just the government that cares. Patients increasingly recognize the value of accreditation and ask about a facility’s status. Their concern provides added incentive for you to understand your rights and obligations in the accreditation process. For more information about the accreditation process, visit www.acr.org/Quality-Safety/Accreditation.
Q: Why is it important to participate in your state chapter?

CURIOSITY LED ME TO ATTEND MY FIRST Missouri Radiological Society (MORADS) meeting. I felt like a confused child looking into a bowl of alphabet soup — unintelligible acronyms, like HIPAA and MU, constantly floated by in discussions. As I attended more meetings, my familiarity increased, I learned new things, and I found I could follow and contribute to discussions. From the beginning, I realized that I got more out of MORADS than it got out of me.

Eventually I assumed the role of secretary-treasurer. I was able to clarify our organization’s finances, enabling MORADS to better prioritize its spending. Others appreciated my work. I was able to use the information I learned from the MORADS meetings to update my group’s business practices.

My involvement with my state chapter has helped me fight burnout in my practice. As secretary-treasurer, I attend annual AMCLC meetings in Washington, D.C., allowing me to network with radiologists across Missouri and from other states as we work together to improve our shared specialty. The collegiality I experience in my chapter is an important asset in staying engaged and excited about my work.

My chapter activities have been a relatively small commitment of time, but my involvement helps me personally and professionally, while benefitting radiologists and patients throughout the state. I strongly encourage radiologists to participate in their state chapters. Even a meager time commitment pays dividends.

“I strongly encourage radiologists to participate in their state chapters. Even a meager time commitment pays dividends.”

— Karen F. Goodhope, MD, FACR
November 8 is the International Day of Radiology — but imaging makes a world of difference every day

Recognize Radiology’s Role in Diagnosing and Treating Brain Disease and Injuries

The 2014 International Day of Radiology theme is brain imaging. Around the world, the radiology community will be highlighting the important role medical imaging plays in the diagnosis and treatment of brain disease and head injuries.

The ACR Head Injury Institute™ has been formed to help advance the diagnosis, understanding and treatment of head injuries. For more information, visit acr.org/HII.

Join us in building awareness of the contributions of radiology and radiation oncology. Access customizable ads, press releases, op-eds and e-newsletter articles at acr.org/IDOR.

Share your International Day of Radiology photos with us using the hashtag #IDoR2014.
Trust the Leader in Breast Imaging Accreditation

When you display the ACR gold seal, your colleagues and patients are confident that your breast imaging facility meets the highest quality and safety standards. Our application and image submission process is designed by medical imaging experts and guided by expert staff technologists.

Your ACR Breast Imaging Accreditation programs include:

- Breast Ultrasound
- Breast MRI
- Mammography
- Stereotactic Breast Biopsy

October is Breast Cancer Awareness Month. Use this time to apply for or renew your breast imaging accreditation.

Apply or renew today.
acr.org/accred | 1-800-227-6440 | 📲📱💻

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The ACR Breast Imaging Center of Excellence (BICOE) designation recognizes your dedication to improving women’s health. Become a BICOE and get free participation in the National Mammography Database!

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