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**QUESTIONS? COMMENTS?** Contact us at bulletin@acr.org.

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**MISSION STATEMENT**
The ACR Bulletin supports the American College of
Radiology’s Core Purpose by informing members on topics
relevant to their practice and by connecting the College
with members, the wider specialty, and others to support
high-quality patient-centered health care by empowering
members to advance the practice, science, and professions
of radiological care.

**ERRATUM**: In the February ACR Bulletin, the photo of Lluís Donoso-Bach, MD, PhD, was incorrectly placed with the information about Carl R. Bogardus Jr., MD, FACR. View the correct version at [http://bit.ly/ACR2015Awards](http://bit.ly/ACR2015Awards). We sincerely regret the error.
The Vision to Heal

The SIR’s vision of innovation, collaboration, and patient-driven care highlights the value of interventional radiology to our practices.

The SIR’s belief that the potential of image-guided therapy is the time for organized radiology to renew its efforts to communicate this message outside of radiology. We need to empower radiologists with the tools to deliver their message with a strong, unified voice. We at the ACR share the SIR’s belief that the potential of image-guided therapy to help solve our toughest medical problems is indeed limitless. We have a great story to tell about interventional radiology, and congratulations to the SIR for developing this campaign to take the message where it needs to be heard the most.

Interventional radiology’s message for the health care community and health care policy-makers is built on five key characteristics of interventional radiologists that also apply to the entire specialty of radiology: innovative, agile, confident, collaborative, and patient-driven. Interventional radiologists are innovative because they are leading the way for others and championing the development and use of new technologies; agile because they are inspired by the limitless potential of their specialty and take a nimble approach to problem solving, readily accepting the need to learn new skills; confident because they take pride in the care of their patients and the role that IR plays in leading medical care forward; collaborative because they seek ways to work with others to advance shared goals and build relationships that benefit their patients; and patient-driven because they believe that patients deserve informed choices, and clinical outcomes and patient satisfaction are the ultimate metrics of success, reflecting the best possible longitudinal patient care. Not surprisingly, these attributes are closely aligned with the ACR’s Imaging 3.0™ and the RSNA’s Radiology Cares initiatives.

Radiology has a strong role to play in team-based, value-driven, patient-centered health care, and promoting interventional radiology in the focused way outlined in The Vision to Heal is an opportunity for all of our practices to champion our IR services. Interventional radiology along with breast imaging are radiology’s time-proven areas that best demonstrate our capability in patient-centered care.

Both the SIR and the ACR realize that slogans alone will not be enough to achieve these ambitious visions for our future. A famous quote from Dr. Charles Dotter, venerated as the father of interventional radiology, warned that if radiologists did not provide clinical care, they would become nothing more than “high-priced plumbers.” Radiologists, not their specialty organizations, will be the ones to achieve this vision, and both diagnostic and interventional radiologists will need to foster a new paradigm of collaboration to achieve this goal. Recognizing this need, the ACR, SIR, and Society for Neurointerventional Surgery (SNIS) formed a joint task force to promote the clinical practice of IR and interventional neuroradiology. One of the outcomes was a revision of the joint practice parameter between the ACR, SIR, SNIS, and Society for Pediatric Radiology, outlining the best practices for integrating clinical interventional radiology service into our radiology practices. Access the practice parameter at http://bit.ly/IRparameter.

The Imaging 3.0 case study library has a section exclusively for interventional radiology (visit http://bit.ly/Img3-IR). A recent case study, “Walking the Talk,” articulates how practices can bring Dotter’s vision to their practices. Read the case study at http://bit.ly/CaseStudyIR. In the coming months, additional Imaging 3.0 case studies will show radiologists how to engage with hospital executives to promote the value of IR, interact with patients to demonstrate patient-centered care, and communicate with our colleagues through grassroots marketing to show the value of IR to patient care.

The College will also work collaboratively with the SIR to communicate the benefits of the clinical practice of IR to radiology practices, hospital administrators, referring physicians, policy-makers, and patients. The launch of the SIR’s The Vision to Heal brand creates an opportunity for our specialty to take a fresh look at how we provide and promote interventional radiology services in our practices.
Recommendations for Further Testing May Mean Less Timely Follow-up

DID YOU RECOMMEND FURTHER IMAGING in your report due to abnormal results? Don’t expect your patient to receive timely follow-up imaging referrals, says a paper recently published in the JACR®. Aymer Al-Mutairi, MD, and his colleagues performed a retrospective study of 250 radiology reports. Researchers found that 92 reports were cataloged as lacking timely follow-up by referring physicians. Of those, 75 percent included recommendations for further imaging. The researchers hypothesized that because referring patients for further testing requires additional steps, busy referring physicians are more likely to overlook these recommendations. “The finding underscores the potential need for developing additional safeguards that allow for better monitoring and tracking of patients with recommendations of further imaging to ensure appropriate follow-up actions,” the authors wrote. To read the article, visit http://bit.ly/JACRFollowup.
PCPs Value Imaging but Need More Details

**GOOD NEWS FOR RADIOLOGISTS** — primary care physicians (PCPs) are aware of the value of imaging and believe it improves clinical decision-making and patient care, according to a recent article in the *JACR*. Researchers surveyed more than 2,000 general practice, family practice, and internal medicine providers to find out their opinions on imaging. Researchers found that those physicians who had started their careers before advanced imaging was widely available tended to value imaging more, as compared to their less experienced colleagues.

Now the not-so-great news: researchers also found that PCPs did not have an accurate understanding of the cost of imaging. Many believed that the cost of an MRI was three times greater than it actually was, meaning that if greater price transparency could be achieved, PCPs might be able to better communicate radiology's value to patients. To read the study, visit [http://bit.ly/PCPOpinions](http://bit.ly/PCPOpinions).

Breathing Easy at ACR 2015

**IN THE WAKE OF CMS’ DECISION** to cover lung cancer screening for current and former smokers, it’s more imperative than ever that radiologists become well-versed in this important topic. Radiologists will be critical in effectively implementing CT-based screening practices. ACR 2015 is offering several courses that consider the science, implementation, and economics of lung cancer screening. Session attendees will learn about the costs of a screening program for practices, patients, and doctors. Attendees will also discover best practices for interpreting these studies and get a crash course in using Lung-RADS.

Check out these lung cancer screening sessions:


And I have to ask if the apparent epidemic of physician burnout is really about too little human contact rather than too many hours on the floors. Some have decided that rather than returning to patient care, we should be learning on simulators instead. But to me, that would represent the pendulum swinging even farther away from those we must eventually serve.

— Karan Chhabra, in “What Have We Lost With the Progress of Medical Training?”

Check out the *JACR*® Imaging Informatics Resource Center

**IMAGING INFORMATICS IS A QUICKLY GROWING AND INCREASINGLY COMPLEX FIELD.** Keeping a handle on the changing informatics landscape is critical for radiologists to continue to lead in their health care systems. The *JACR*® has developed an online portal for critical information, expert guidance, and insights on imaging informatics. Curated by Arun Krishnaraj, MD, MPH, and Christoph Wald, MD, PhD, FACR, the Imaging Informatics Center shares expertise from the College’s Commission on Informatics and provides free access to the imaging IT Reference Guide, selected *JACR* articles, and other sources. To access the center, visit [http://bit.ly/JACRITResource](http://bit.ly/JACRITResource). Follow along on twitter: @InformaticsRC.
Radiologists will change only when the pain of not changing exceeds the pain of changing.

— Bibb Allen, Jr., MD, FACR, chair of the Board of Chancellors

Pocket Guide for Meaningful Use


PI-RADS Now Available

THE US PREVENTATIVE SERVICES TASK FORCE AND AMERICAN CANCER SOCIETY have highlighted over-diagnosis and over-treatment as imperative issues within the prostate screening process. To answer those issues, the College, along with the European Society of Urogenital Radiology and the AdMe Tech Foundation, has come out with the ACR Prostate Imaging Reporting and Data System (PI-RADS). With PI-RADS, members can standardize the reporting process and expedite the transfer of high-quality MRI from laboratories to patients. PI-RADS is free to use. To access PI-RADS, visit http://bit.ly/ACRPRADS. Look for more info on PI-RADS in the upcoming June Bulletin.

New NCRP Recommendations Released

THE NATIONAL COUNCIL ON RADIATION PROTECTION AND MEASUREMENTS (NCRP) has released a new recommendation, “Outline of Administrative Policies for Quality Assurance and Peer Review of Tissue Reactions Associated with Fluoroscopically Guided Interventions.” The publication provides detailed recommendations for evaluating and managing fluoroscopically guided interventional radiation injuries, as well as advisories on managing dose. Several ACR members — Stephen Balter, PhD, FACR, Edwin M. Leidholdt Jr., PhD, Donald L. Miller, MD, and Joel E. Gray, PhD — were coauthors on the recommendation. The statement is available online at http://bit.ly/NCRPState11.

Check Out the New Bulletin Mission Statement

We’ve redefined our mission statement to more accurately reflect the College’s new strategic plan and core purpose. Turn to the table of contents to see the new mission statement.
DURING WHAT IS NOW KNOWN as the Governance Pathway of ACR 2015, the ACR Council will consider a broad range of policies, bylaws, practice parameters, and technical standard resolutions. Below are resolutions received by the February 16, 2015, submission deadline. The ACR Council, under the leadership of ACR Speaker Kimberly E. Applegate, MD, MS, FACR, and Vice Speaker William T. Herrington, MD, FACR, serves as the representative, policy-making body of the College and will deliberate on these resolutions during the meeting. To learn more about the council meeting at ACR 2015, the features of the program, and the specifics of these resolutions, please visit the Governance page of the ACR 2015 website at www.acr.org/Annual-Meeting/Governance.

Policy Resolutions
The policy resolutions include the following:

- **ACR-AAPM Collaborative Practice Parameters and Technical Standards.** Sponsored by the Council Steering Committee (CSC), this resolution would establish a process for the consideration of specific collaborative practice parameters and technical standards.

- **Extension of Review Cycle for Eight Practice Parameters.** Sponsored by the CSC, this resolution recommends that eight documents be extended for one year and presented for consideration at the 2017 ACR annual meeting.

- **Expedited Review of ACR Practice Parameters and Technical Standards.** Sponsored by the CSC, this resolution would establish a process for particular ACR Practice Parameters and Technical Standards to be identified for expedited review and would give the CSC authority to act on behalf of the council on those documents.

- **Election of Member-in-Training Representatives to the Intersociety Summer Conference.** Sponsored by the CSC, this resolution would allow the Resident and Fellow Section (RFS) Nominating Committee to nominate member-in-training candidates for the Intersociety Summer Conference representative positions and would allow the RFS to elect those representatives.

- **Coordination of National Board Examinations and Fellowship Interviewing.** Co-sponsored by the Board of Chancellors (BOC) and CSC, this resolution recommends that the ACR work with stakeholders to optimize the scheduling of fellowship interviews.

- **ACR Action on the CMS Professional Component Multiple Procedural Payment Reduction (MPPR).** Co-sponsored by the BOC and CSC, this resolution recommends that the ACR continue to dedicate appropriate resources for taking action on MPPR.

- **Diversity Is Central to Our Mission.** Co-sponsored by the BOC and CSC, this resolution affirms the importance of diversity within the ACR membership and the radiological professions in achieving our mission. It further recommends that opportunities to continually measure and assess ACR membership diversity be promoted.

- **ACR Commitment to Professionalism.** Co-sponsored by the BOC and CSC, this resolution defines professionalism and reaffirms the ACR commitment to upholding and promoting high standards of professionalism in all its policy-making, advocacy, and educational programs.

- **Lead Chapter Contact for CSC Outreach.** Co-sponsored by the BOC and CSC, this resolution recommends that each chapter be encouraged to select a primary contact with whom the CSC liaison will communicate.

- **ACR Patient Advocacy Liaison Program.** Co-sponsored by the BOC and CSC, this resolution recommends that the ACR continue to explore ways to enhance existing relationships and build liaisons with patient advocacy groups in the United States.

- **Supporting Diagnostic Imaging Interpretations by Physicians.** Co-sponsored by the BOC and CSC, this resolution reaffirms ACR’s policy that only appropriately trained physicians may interpret diagnostic imaging examinations and recommends continued support for advocacy activities related to non-physician scope of practice expansion proposals related to the interpretation of diagnostic imaging.

- **AMA Liaison Role for the Council Steering Committee.** Co-sponsored by the BOC and CSC, this resolution recommends that the CSC have a
supporting role with the College’s AMA delegation and utilize its liaison role with ACR chapters to develop relationships with state medical and specialty societies.

- **Review of Evidence Concerning the Patient Care Impact of ABR MOC/CC Participation, Costs of Participation, and Optimization of Member Participation.** Sponsored by the Iowa Radiological Society, this resolution recommends that the ACR create or identify a committee to evaluate evidence concerning the impact of maintenance of certification/continuous certification (MOC/CC) on patient care, provide recommendations to assist with the creation of tools to fulfill MOC/CC, and determine the typical costs to members to comply with MOC/CC requirements.

- **Radiologist as “Clinician.”** Co-sponsored by Jonathan Flug, MD, MBA, councilor for the Resident and Fellow Section, and Vanessa Van Duyn Wear, MD, councilor for the Young and Early Career Physicians Section, this resolution recommends that ACR promote the usage of the term “clinician” when referring to diagnostic and interventional radiologists, radiation oncologists, and nuclear medicine physicians; it further recommends that the term be used in future documents and publications as appropriate.

- **Honoring the Massachusetts Radiological Society on Their Golden Anniversary.** Sponsored by the Massachusetts Radiological Society (MRS), this resolution commends the MRS for 50 years of imaging excellence and extends best wishes for the golden anniversary of the chapter.

- **Eliminate the Resident Conference Registration Fee.** Sponsored by the Minnesota Radiological Society, this resolution recommends that the resident registration fees be eliminated for the ACR annual conference.

### Additional Resolutions

The following will also be considered at the meeting:

- **Proposed Bylaws Resolution.** The BOC has submitted and sponsored one amendment to the ACR bylaws. This amendment, to Article VI – Board of Chancellors, would allow those societies represented on the board (RSNA, ARRS, ARS, and ASTRO) to present the incumbent chancellor to the College Nominating Committee for consideration for a second term.

- **Extension of 10-Year Policy Resolutions.** There are 14 policy resolutions up for 10-year renewal.

- **Practice Parameters and Technical Standards.** The council will consider a total of 39 practice parameters and technical standards.

### Meeting Features

In addition to the official business of the ACR Council, the expanded meeting format in 2015 will feature outstanding programs and CME opportunities. Among the 100+ concurrent education sessions are presentations that have had a traditional place within the annual meeting program. These include the Presidential Address, Fellowship Convocation, the Economics Forum, and Capitol Hill Day.

On Sunday, May 17, Paul H. Ellenbogen, MD, FACP, will open the meeting by giving the Presidential Address. The council will convene following keynote speaker, General Colin L. Powell, USA (Ret.), who will speak on the topic “Leadership: Taking Charge.” That evening, the ACR will hold its annual Fellowship Convocation, which will honor 103 new ACR Fellows and two Honorary Fellows: Luis Donoso-Bach, MD, PhD, of Spain, and Valentine Sinitsyn, MD, PhD, of Russia. The convocation will also include the awarding of the ACR’s highest distinction, the ACR Gold Medal, to Carl R. Bogardus Jr., MD, FACP, of Oklahoma City.

On Monday, May 18, the Economics Forum will commence and include a keynote address by Patrick Conway, MD, MSc, deputy administrator for innovation and quality and CMS chief medical officer. The forum will be moderated by Geraldine B. McGinty, MD, MBA, FACP, chair of the ACR Commission on Economics, and will feature several economics committee chairs. Monday will also feature elections for multiple leadership positions and reference committee hearings.

Tuesday, May 19, will include the installation of new ACR officers and the introduction of the 2015–2016 BOC and the CSC members. The Moreton Lecture, entitled, “Imaging in the Era of Precision Medicine,” will be delivered by James H. Thrall, MD, FACP. Following Thrall’s lecture, an open-microphone session focused on structured reporting and communicating recommendations will be moderated by Eric J. Stern, MD. That afternoon, the council will consider reference committee reports and attendees will receive an advocacy update and prepare for Capitol Hill visits.

On Wednesday, May 20, members will travel to Capitol Hill to convey the College’s message. The meeting will also include additional presentations and updates from ACR leaders and focused programming for the Resident and Fellow Section and the Young and Early Career Physician Section. The meeting promises to be an action-packed, informative, and productive experience.

**By Trina Madison. ACR director of chapter and member engagement**
INCE ITS INCEPTION TWO AND A HALF YEARS ago, and with more than 2,100 enrollees, the Radiology Leadership Institute® (RLI) has prepared hundreds of radiologists to meaningfully shape the future of health care. As part of this effort, the institute and several ACR state chapters have awarded scholarships each year to promising leaders in the field of radiology, inviting them to attend the annual RLI Summit or to enhance their business management skills by participating in the Harvard Emerging Leaders Seminar. The Bulletin caught up with three 2014 scholarship awardees to see how they have integrated lessons learned during their experience at the RLI into their own institutions.

Ann M. Leylek, MD
Massachusetts Radiological Society Leadership Scholarship Awardee
During her time at the 2014 RLI Summit at Babson College, one moment stood out for Ann M. Leylek, MD, diagnostic radiology resident at Beth Israel Deaconess Medical Center (BIDMC) and Harvard Medical School. She and her fellow attendees were tasked with exploring ways to overcome future challenges to the profession: “Some of our ideas included utilizing social media for community education, and using iPads for ICU rounds and specialized patient encounters,” Leylek recounts. Seasoned radiologists added their perspectives to the thought experiment, helping to generate a healthy discussion of future health care trends. The exercise showcased the enthusiasm and adaptability of young radiologists. “The summit was a positive sign for our profession that trainees are welcomed and wholly included in organizations like the RLI and the ACR,” says Leylek.

After attending the RLI Summit, Leylek returned to her institution determined to make a difference. Her experience in the RLI program, she explains, led her to identify “a need for more formalized curricula to develop and encourage aspiring leaders in training” at BIDMC. This resulted in the establishment of an alumni-supported academy to help radiology trainees build a multi-faceted professional skillset, foster career development, and encourage involvement in leadership enterprises. Called the Radiology Leadership Academy, the program will begin in July 2015 and will be open to BIDMC trainees during their four years of residency or one year of fellowship.

“The academy will cover a broad variety of topics, including finance, professionalism, quality improvement, networking, interpersonal communications, and marketing/branding,” says Leylek. The overall goal is to provide trainees with a basic foundation in the business of radiology. “The fact that the leadership academy is derived from the RLI, which has cemented a place for itself in the profession, just further convinced BIDMC’s leadership that there is a place for a leadership program for radiologists in training,” she says.

Adam H. Kaye, MD, MBA
Pennsylvania Radiological Society Leadership Scholarship Awardee
“I attended business school prior to my radiology training, but I had very little context for applying the material I studied to my everyday life and future leadership responsibilities,” says Adam H. Kaye, MD, MBA, fellow in oncologic imaging and nuclear medicine at the Hospital of the University of Pennsylvania, who attended the 2014 Harvard Emerging Leaders Seminar (HELS). Attending the seminar allowed him to see the business of radiology with a fresh pair of eyes. “I was able to study things like competitive strategy and organizational behavior with a whole new perspective,” explains Kaye. “The course encouraged me to think about how these topics apply specifically to radiology and my leadership perspective.”

Kaye adds that the interactive assignments allowed him and his fellow attendees to practice their newfound leadership skills. “In particular,” says Kaye, “I very much enjoyed our assignment to apply Porter’s Five Forces, which we’d studied earlier in the course, directly to a radiology practice [read more at http://bit.ly/5Forces]. The assignment prompted a wonderful discussion about the unique forces relevant to our field.” The mixture of speakers, which included both prominent radiologists and Harvard Business School professors, enriched the experience.
Kaye goes on to note that his HELS training has prepared him for his newest role: chief fellow of his nuclear radiology fellowship. “I have numerous responsibilities in my capacity as chief fellow,” explains Kaye, “including leading and managing a group of four fellows. Many of the skills I learned during the HELS have been very useful in navigating potentially difficult interactions between my co-fellows, as well as promoting an atmosphere of shared learning and responsibility in patient care.”

Ian Amber, MD
RLI Scholarship Awardee
Ian Amber, MD, radiology resident at Pennsylvania Hospital in the University of Pennsylvania Health System, took several lessons to heart during his time at the 2014 RLI Summit held at Babson College (read more at http://bit.ly/LeadingAuthorities). “Our instructors challenged us to not only show that radiology matters in general, but that our particular groups matter to the hospitals with which we’re associated,” Amber reflects. In addition, lecturers emphasized the need to think outside of the box. “Any time you pursue the same-old, same-old — whether in business or medicine — you’re going to be left behind,” Amber states.

Among other skills, Amber left the RLI with a better understanding of how to set appropriate performance metrics for his department. When tracking performance numbers, he elaborates, “it’s helpful to establish what the building blocks are for patient satisfaction, for instance. These can include length of wait times, whether or not a doctor met directly with a patient, and so on. With the changing face of healthcare,” continues Amber, “there is nothing better than being able to show hospital administrators quantifiable metrics that prove a practice’s or department’s value to an institution.”

After synthesizing the information gathered from the conference, Amber sat down with his department chair to evaluate how best to improve his department’s performance metrics. They decided to start with improving patients’ experiences during the CT scanning process. Based on the knowledge gained from the summit, Amber designed a survey to assess both patient baseline satisfaction and patient understanding of the exam. Once Amber and his colleagues finish collecting data, they will draw conclusions and make appropriate, evidence-based adjustments to their processes.

Whether a radiologist wants to establish a more formalized curricula to develop and encourage future leaders, learn how to set appropriate performance metrics for a practice or department, or get a better grasp on how to become a leader, the RLI offers something for everyone. In these challenging times, radiologists must diversify their skillsets to add value to the care team, and the RLI is the place to gain such skills.

“Any time you pursue the same-old, same-old — whether in business or medicine — you’re going to be left behind.”

— Ian Amber, MD

By Chris Hobson, Imaging 3.0 content manager
Radiology leaders prepare for the future by creating a strategic plan.

In one scene from Shakespeare’s “Measure for Measure,” circumstances align to provide Claudio with a keen sense of his own mortality. Instead of fearing the unknown, however, Claudio chooses to embrace it, saying, “I will encounter darkness as a bride, / And hug it in mine arms.” Health care reform combined with declining reimbursements have conspired to cause many radiologists to feel that the profession’s future is ambiguous at best. However, like Claudio, radiologists would do well to move forward despite this ambiguity, taking practical steps to change their business outlook for the better. One proven way to navigate the darkness is to adopt a strategic plan.
A Measure of Control
Staying one step ahead of the challenges facing radiology today requires an aggressive response. Formulating a strategic plan can help radiologists realign their business priorities to keep pace with a rapidly changing industry. According to Bob Maier, CEO of Regents Health Resources, Inc., a health care consulting firm specializing in medical imaging development and strategic planning, groups often realize they need to make a change when they begin hearing negative messages from unsatisfied clients. Maier says a common warning signal entails “a hospital telling the group that they’re no longer going to refer all of their patients to the group because another practice does a certain aspect of patient care better.”

Maier begins his consultations by developing an accurate picture of the marketplace and the practice’s place in it. Regents uses its national database of markets and practice benchmarks to understand the market share and relative strength of a practice when compared to its competition. Maier looks at client relationships, brand reputation, geographical coverage, and competition.

Once the market evaluation is complete, Maier conducts a SWOT analysis. SWOT — which stands for strengths, weaknesses, opportunities, and threats — helps the group determine its strengths and weaknesses using criteria such as subspecialization, coverage, support services, and client satisfaction levels to make its determination. SWOT also looks inward at the operational, technological, and organizational aspects of the practice to support its strengths and correct its weaknesses. Shoring up weaknesses often means understanding needs and meeting client expectations, whether those clients be hospitals, referring physicians, patients, or all three. Maier notes that this type of alignment can mean a number of things: gaining a better understanding of who constitutes the client base, becoming more proactive about exceeding customer expectations, and identifying opportunities for expanding services, the latter of which is a key feature of strategic planning. With reimbursements on the decline, every opportunity to expand with existing clients or perhaps with new clients needs to be explored and evaluated. One of the best ways to assess these deficits is by interviewing and surveying customers and prospective customers to see if their needs are being met.

THE ANATOMY OF A SWOT ANALYSIS
According to Bob Maier, CEO of Regents Health Resources, Inc., a SWOT analysis assesses not just a practice’s market advantages, but also looks inward at the operational, technological, and organizational aspects of the practice. Here are some items that might appear on your practice’s SWOT analysis.

**Strengths**
Examples of strengths a practice might accentuate to distinguish it from competitors can include the following:
- Subspecialized expertise
- Strong relationship with hospital
- Support from administration
- Regional recognition
- Quality of physicians
- In-house coverage

**Weaknesses**
Weaknesses in need of improvement may include the following:
- Lack of income diversification
- Being tied to one hospital system
- No significant hard assets
- Lack of IT support
- Divisive politics within the group

**Opportunities**
Opportunities might range from the external — pouring more resources into marketing efforts, for instance — to the internal, which might involve the need to better leverage existing technology. Some other opportunities might include the following:
- Align with hospital
- Align with other radiology practices
- Gain market share
- Improve contracts
- Bring in new business
- Create awareness of radiology services

**Threats**
External threats can come from many quarters, such as the following:
- Decreasing reimbursement
- Increasing after-hours work
- Increasing numbers of non-compensated cases
- National radiology practices
- Competing local radiology groups
- Leakage of studies
- Health care reform and ACOs
- Turf wars
- Self-referral/in-office imaging

To learn more about strategic planning, read the Imaging 3.0™ case study “The Metamorphosis of a Practice” (http://bit.ly/Imaging3StrategicPlanning).

ENDNOTE
Strategic Planning: ACR-Style

Practices aren’t the only ones who can benefit from a strategic plan; the ACR is in the midst of implementing its own strategic plan, endeavoring to become the most effective organization it can be for its members. Bibb Allen Jr., MD, FACR, chair of the ACR’s Board of Chancellors (BOC), has made strategic planning a high priority during his term as chair.

“We recognized as an organization that there were many changes taking place — health care reform, the potential for new payment models, changes in how our members practice day-to-day — that made us believe that we had to reexamine our approach,” explains Allen. “There are more opportunities than resources, so we wanted to make sure the programs offered by the College align with our members’ needs.”

So the ACR put together a Strategic Planning Task Force to guide the College through the strategic planning process. According to William T. Thorwarth Jr., MD, FACR, CEO of the ACR — who began his tenure after the strategic planning process was already underway — care was taken to include a diverse group of radiologists on the task force. Task force members included both private practice and academic radiologists, those from various subspecialties, and not just long-tenured radiologists but also residents and young physicians. The group put forward a core ideology, vision statements, and goals and objectives against which College programs would be compared (for more on ACR’s Strategic Plan, see http://bit.ly/BulletinStrategicPlan).

Once the groundwork was laid, ACR hired an outside consulting firm to help develop the strategic plan. They began by assessing what ACR does well and where opportunities exist for improvement. The firm, Tecker International, evaluated ACR’s strengths and weaknesses by performing surveys and holding interviews with both internal stakeholders (such as state chapter leaders, councilors, and individual members from both academic and private practice), as well as external stakeholders (such as representatives from other radiological organizations). Tecker also facilitated the development of the strategic plan that took place over several meetings last summer and was approved by the Board of Chancellors in September 2014.

However, developing the plan was not an end unto itself. The next phase involved a program assessment in which all of the College’s programs were measured against the tenets of the strategic plan. In addition to this, programs had to also prove valuable to the membership as well as be financially viable.

Going forward, says Allen, the next step is called a “gap assessment” in which the College works to identify any gaps in services and explores how to fill them. It’s important, explains Allen, “to determine if there are areas in the strategic plan where we don’t have a program, and if existing programs can be modified to cover the gaps.” If new programs are considered to fill gaps in the strategic plan they will be assessed using the same process as the original program assessment to ensure they represent the best use of College resources. Additionally, each program will be monitored against agreed-upon metrics to be sure the College stays on track.

One major finding of the strategic planning process so far, concludes Thorwarth, is that radiologists are looking for the College to partner with them in order to succeed in this new era of health care reform. Allen agrees: “It used to be that we radiologists could look to the College to do things for us. We’d send in our money and the organization would do the things we couldn’t, like working toward coding policy and reimbursement values.” But in the future the ACR will have to do more than that. “The
This isn’t news to you: health care is changing. Reimbursements are decreasing, value is king, and competition is high. In order to adapt, some practices are choosing to ally themselves with other practices or hospitals through mergers, consolidations, or acquisitions. Changing the size of your group can have implications for everyone — leadership, employees, other physician colleagues, and patients. With a growing number of practices opting to join together, radiologists share the issues they’ve encountered and the strategies they’ve developed to make change easier for everyone involved.

Connection Creation
Unsurprisingly, uniting with hospitals or other organizations can often inject new life into radiology groups. Radiological Associates of Sacramento (RAS) was recently acquired by the health system Sutter Health. Jonathan Breslau, MD, FACR, former president of RAS, says that he’s found the acquisition process to be positive for his practice, in which all of the radiologists transitioned to employment within Sutter Medical Group. One of the best changes has been closer collaboration with his clinicians.

Because the radiologists are now working in the same medical group as their referring physicians, they’re better able to understand some of the issues their clinicians face. “We’re seeing some of the challenges they face in their clinics, such as how they deal with their patients and their resources. I’ve been able to talk with them and get a sense of the issues that they’re facing with compensation too. It’s given me a better perspective of how the imaging department can deliver value to them,” he adds.

Paper Pushing
Despite these positives, acquisitions and mergers can be challenging, especially if you are acquiring more people or becoming part of a larger system. You may have to face increased bureaucracy. Everything becomes more complicated and time consuming when you’re part of a larger group, notes Breslau. “It’s extremely frustrating at first,” he says. “It takes months to execute on certain initiatives because there are many stakeholders who have to be brought into the decision-making and implementation.” According to Breslau, that bureaucracy also makes it harder for the department to take risks with certain innovations it might want to try.
But red tape and risk management also hold some advantages. Syed F. Zaidi, MD, whose group is pursuing a divisional merger with other radiology groups (an arrangement in which practices agree to share the costs of certain services, such as imaging and transcription, but maintain autonomy in other key actions, such as marketing), says that becoming a larger group can help cut certain expenses, such as overhead and malpractice insurance costs. Staffing costs can also change. If you’re becoming a larger practice, you may be able to consolidate your business management or office staff. And becoming part of a hospital means that you likely won’t pay these costs at all. Breslau adds, “We now have access to the full range of specialized back office functions that you would expect from a multi-billion dollar system like Sutter Health, including HR, compliance, IT, legal support, and billing. The risk of not doing those things well over time will undoubtedly increase.”

**Culture Clash**

The culture of your practice is also going to change. Are you merging with a practice that values speed whereas yours prefers to take more time to ensure quality? How do your ideals about work-life balance fit with those of the health system or practice you are coming into? Cynthia S. Sherry, MD, FACR, observed this friction when her practice merged with another to become Radiology Associates of North Texas several years ago. When practices merge or consolidate, there will initially be a cultural clash, she notes. For example, quality and service may mean different things to different groups, so it’s important to be sure everyone is on the same page, Sherry says.

Radiologists may also have to address the shift from a small group to a large one. Sherry notes that employees and leadership in small groups are often accustomed to having a loud and clear voice on how the group is run. She adds, “In a large group or a hospital, the needs or wants of each individual can no longer always be met — or sometimes even considered.”

A merger may also bring a shift in the leadership structure of the group. For Breslau, that meant going from the president of RAS to an employee of Sutter Medical Group, and having several bosses. “I definitely went through the stages of grieving — complete with lying under the workstation in a fetal position,” he jokes. “It’s certainly different. But I needed to ensure that our 60 doctors and hundreds of employees had a secure future, and this was the way to do it.”

And sometimes, notes Zaidi, a change in leadership can be a good thing. “It’s understandable that you want to keep the same leadership,” he says. “You have a voice, and there’s stability in knowing that you have a say in your day-to-day practice and know exactly how decisions will turn out. But it’s also worth considering that while your leadership may have had success with your older model of business, they may not be as successful in this new territory. A new, diverse group of voices may do better.”

**Helping Hands**

The leadership of your practice may change, but it’s possible to take the lead in other ways by helping facilitate change and make the adjustment easier for the rest of your practice. As you encounter issues, put them into perspective, suggests Breslau. Although he and his colleagues were concerned about the changes ahead, Breslau says that he considered what he believed to be the alternative: gradual unemployment. “We did a lot of scenario planning before moving forward and ultimately decided this was best for our interests. The planning helped change our perspectives and made things clearer for a lot of people,” he notes.

It’s also important that you communicate well, says Zaidi. Your staff may be concerned about job security or benefit changes, and leadership should be very clear about what is happening on those ends, says Sherry. Prioritize maintaining morale and get your human resources department involved in assuring stability. Some practices offer retention bonuses to keep valuable employees. And continue to reassure employees that you ultimately have their best interest in mind by doing what you can for those that might separate from the practice during your merger, Sherry says. Make sure they know you will act as a reference should they look for another position. You want to make everyone feel supported during what may be a challenging time.

Communicating well with the other group is important too. In the case of nebulous terms like quality and service, you should spell out what these things mean to your group up front, so that each practice can be clear about the other’s goals before merging. And don’t expect one perspective to necessarily win over the other; refusal to compromise could potentially cause a divide between your practice and the system with which you are merging.

**Greater Good**

Consolidation is a reality for many groups, but how the process goes is ultimately up to each member of the practice. “Allying with other groups is an opportunity and a risk,” says Zaidi. “How well it goes depends on how your group reacts to it.” Breslau adds, “No matter how difficult it is at first, remember that you all have the same goal. Your goal is to provide quality care for your patients, and working together will allow you to achieve it.”

By Meghan Edwards, copywriter for the ACR Bulletin
Constructing a Game Plan
Strategy was front and center at the BOC winter meeting.

THE ACR BOARD OF CHANCELLORS AND COUNCIL STEERING COMMITTEE conducted their winter meeting Jan. 17–18, 2015, in Reston, Va.

In the fall of 2014, the BOC approved the ACR Strategic Plan to assure that future activities are aligned with the College’s mission, goals, and objectives. Implementation of the plan began in earnest with a College-wide program assessment. This process was governed by three major assumptions: 1) there are more opportunities than resources; 2) the organization should avoid duplication of efforts; and 3) a few high-level programs meeting widespread needs are a better investment than many programs with low projected utilization. More than 300 ACR programs across 51 areas were reviewed based on program attractiveness, competitive positioning, and alternative coverage. From there, the implementation phase will begin this spring with the consideration of the FY 2016 budget. During the budgeting process we will begin aligning resources to ensure the College is moving toward the strategic goals and objectives over a three- to five-year horizon.

The ACR, along with other key stakeholders, was successful in securing low-dose CT lung screening coverage for high-risk Medicare patients. ACR leaders supporting the Economics, Government Relations, and Public Relations departments saw their diligence rewarded with last week’s National Coverage Decision. While efforts to bring lung cancer screening to patients continue, this success of the ACR team cannot be understated.

Cynthia Moran, executive vice president of ACR government relations, provided an update on the November elections, noting that Congress has undergone significant partisan shifts since the fall BOC meeting. The Senate has switched from a Democrat to Republican majority, thus giving the Republicans control (but not veto override strength) in the Congress. She also stated that it may be difficult to duplicate the significant legislative accomplishments of the College in 2014, including victories on clinical decision support, provisions limiting physician payment reductions to a maximum of 20 percent in a one-year period starting in 2017, and a mandate that CMS disclose the data behind the multiple procedure payment reduction. Moran predicted that although Congress will likely engage in initial efforts to repeal the Affordable Care Act, adjustments to the current law are more likely, such as a revised definition of full-time workers, a narrower employer mandate, a possible repeal or delay in the device tax, and a reduction in funding for the Independent Payment Advisory Board. The 2016 presidential election has the potential to impact legislative activity significantly by underscoring the partisan divide that has taken hold over the last few years.

The board also reviewed recent decision support activities and future Imaging 3.0™ initiatives designed to help radiologists take an active role in patient care and help shape America’s future health care system. Geraldine B. McGinty, MD, MBA, FACR, provided a report on a pilot Imaging 3.0 Practice Visitation Program, which would allow leaders to analyze critical characteristics of their practices and integrate concrete strategies into their practice culture. Imaging 3.0 aims to provide better value and outcomes to patients in five key areas: imaging appropriateness, quality, safety, efficiency, and satisfaction. The College continues to increase the number of resources on patient-centered care, quality metrics, and health reform to help practices to best position themselves for the future.

Keith J. Dreyer, DO, PhD, FACR, gave an informatics update covering meaningful use, clinical decision support legislation, future federal programs, and an overview of recent activities of the Informatics Commission. Dreyer also discussed the Imaging 3.0 Informatics Portfolio, a set of tools to support radiologists providing patient-centered care in new payment structures. The portfolio’s components include the following:

- ACR Select®, the digitally consumable version of the ACR Appropriateness Criteria® for clinical decision support
- ACR Common™, a collection of common radiology terms and semantic structures that facilitates interaction with ACR products and services
- ACR Connect®, a communication framework designed to facilitate bi-directional information flow between vendors and ACR products and services
- ACR Assist™, a clinical decision support framework designed to provide structured clinical guidance to radiologists

The CMS Medicare Imaging Demonstration Project results reinforce the need for ACR Select as a decision support tool for ordering physicians. Between 2011 and

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UNDER THE LEADERSHIP of Lawrence A. Liebscher, MD, FACR, the ACR Audit Committee has focused its most recent efforts on a risk assessment of the College. The committee examined potential vulnerabilities, past issues, system safeguards, and employee and member training. Although this work is a key ongoing function, the committee also responds to increased scrutiny of non-profit organizations by the IRS. The risk of internal threats such as theft, embezzlement, and employee or vendor lawsuits always exists and could result in monetary loss. However, government action by entities like the IRS could cause much greater harm to the College. For example, if the IRS were to revoke its 501(c)(3) tax exempt status, the results would be disastrous for nearly every aspect of the College and its members. The College would lose the public appeal of serving the community as a (c) (3) organization. Additionally, members would not be able to contribute to the ACR and obtain a charitable deduction. This type of risk underscores why we spend so much effort to ensure that the ACR complies with federal and state laws and regulations.

Your radiology or radiation oncology practice is no different in having to anticipate and manage risk. A malpractice lawsuit, employee misconduct, fire, or cyber-attack on IT systems might be the most obvious threats to a practice. Yet even greater risk could lay in routine daily activities that federal and state governments — and payers — closely regulate by imposing strict referral, coding, claims reimbursement, and reporting requirements.

Law enforcement focuses intensely on health care, particularly since the Affordable Care Act became law in 2010. Each year, the U.S. Department of Health and Human Services’ Office of Inspector General (OIG) issues its work plan of current and new activities. Why does this matter to radiologists? Because the work plan details arrangements OIG believes cost too much or could violate federal fraud and abuse laws. Therefore, you and your staff should understand what’s on OIG’s radar and prepare for more oversight of your practice. You can access the OIG’s 2015 Work Plan at http://bit.ly/OIGWorkPlan15.

In FY2015, OIG listed three ongoing imaging-related projects. The regulator will continue to audit payments for Medicare Part B imaging services. It will examine “selected imaging services” practice expense components, including the controversial equipment utilization rate. A report should emerge by September 2015. Additionally, OIG will continue to audit Medicare payments for high-cost imaging studies, such as MRIs. Auditors will determine whether those studies were medically necessary and the degree to which “use has increased for these tests.” The ACR will continue to monitor this project closely.

Finally, OIG will carry over a third imaging project from prior years: auditing hospitals’ security controls over networked medical devices. OIG indicated that it will decide whether such controls “effectively protect associated electronically protected health information (ePHI) and ensure beneficiary safety.” Significantly, OIG identified radiology systems as one venue in which computerized medical devices may jeopardize the privacy and security of patient data. The ACR also will closely track this audit’s progress. If OIG issues an audit, its findings might influence hospitals to impose additional IT requirements on radiologists and their electronic records systems.

As physicians, you’ve dedicated yourselves to care for others. As members of a practice — whether a partnership, corporation, or limited liability company — you also need to protect your business vigorously. We have written in prior columns that ACR members must develop and use compliance programs. Why? The government rewards physician practices that commit to these programs and often penalizes those that lack effective programs. Follow these important compliance steps to help minimize business risk:

• Hire a compliance officer or appoint someone from within the group. This individual should have worked in at least one health care organization and be able to teach essential health care laws and rules. She or he also must

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Connecticut — New London — Hospital-based private group of 11 radiologists in shoreline southeast Connecticut looking to replace retiring partners. Job consists of daily rotations in CT (including CT intervention), MRI, mammography, US, and PET. Call-time divided equally. Teleradiology after 8:00 p.m. weekdays and after 6:00 p.m. weekends and holidays. Must be ACR board-certified/eligible. Contact: Thomas Manning, MD, by email at tmanning36@hotmail.com.

Montana — Libby — General radiologist wanted for position in Libby, Montana. Affiliated with a progressive, growing private-practice group of 12 radiologists and two RPAs. Must be comfortable in all modalities and basic interventional (thoracentesis, paracentesis, and myelograms). Part-time work could be considered. Contact: Ty Weber by phone at 406-751-7545 or by email at tweber@hcnwmt.com.

Oklahoma — Tulsa — Diagnostic radiologist needed in Tulsa, Okla. area. Small, independent radiology group seeking a board-certified diagnostic radiologist for full-time, salaried position; no mammography, no call, and no weekends to begin immediately. Mainly MRI and CT with heavier neuroradiology and MSK. No agencies please. Contact: by email at radiology@mail.com.

Texas — Wichita Falls — 8-member lifestyle-oriented group seeks to replace retiring partner in July 2016. Ideal work environment with PACS and state-of-the-art equipment. Partners get 12 weeks vacation plus post-call days off. Teleradiology coverage 11:00 a.m. – 7:00 a.m. Excellent benefit package and competitive salary. Partnership-track position. Contact: by email at rawfjob2@yahoo.com.

constructing a game plan

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2013, just 20 percent of radiologists were participating in meaningful use. Without further modifications to the regulations, penalties for non-participation are expected to affect radiologists no later than 2019. Meanwhile, ACR government relations staff will continue to work toward resolving outstanding challenges regarding CMS and the Office of the National Coordinator for Health Information Technology.

As part of the strategic plan, the board also established guidelines for the approval of unbudgeted initiatives. Additionally, the board put forth a number of new policies to increase involvement and transparency in ACR activities.

The Board Meeting featured several other items of interest, including guidance on safe and effective patient care in biocontainment situations, a recent survey on the ABR change in initial board exam dates and the impact the adjustment may have on hiring practices, and an in-depth discussion on the future of research activities. The BOC will next meet at ACR 2015 in May.

RISKY BUSINESS

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lead a culture of compliance throughout your practice.

• Educate your team and yourself about new developments. You can take advantage of a substantial library of resources that OIG has established for physicians at http://bit.ly/OIGLibrary.

• Promptly act on allegations that your practice may have violated federal or state law. Work with your compliance officer and qualified outside counsel to decide whether and how to report incidents to government agencies. We urge all ACR members not to “self-disclose” potential violations without first knowing the impact. It is the legal equivalent of getting informed consent from patients.

• Reinforce among your team how to stay compliant. You already communicate with referring colleagues and patients. Here, you have to lead decisively on compliance matters.

• Enforce disciplinary standards through clear, practical guidelines. Post these on your practice website and refresh everyone through training.

• Apply disciplinary measures consistently but flexibly. For instance, an employee who accidentally transposed one or two CPT® codes when preparing a long claim form should receive less correction than someone who intentionally offers and gives kickbacks to referring physicians.

Your practice has to reinforce that acting in a non-compliant way has consequences. Will disciplining colleagues cause hard feelings? Yes. But would you rather risk dealing with a whistleblower lawsuit because your practice failed to address problems?

endnote

How can state chapters work together with the ACR?

ENGAGING RESIDENTS AND FELLOWS IN RADIOLOGY LEADERSHIP is an important goal for the Washington, D.C., chapter. We often look for ways to marry leadership education with the chapter so that our next generation of physicians will be able to take on leadership positions within the College. One way our chapter did this was to invite ACR leadership to come speak with our residents, fellows, and young physicians at a chapter meeting. After Dr. Lawrence Muroff kindly accepted our invitation to lecture on the Affordable Care Act’s impact on radiology at our chapter’s October 2014 meeting, I decided to dedicate our resident quiz hour, which precedes our lecture, to teaching residents and fellows about the value and importance of the ACR. The session was led by Dr. Peter van Geertruyden, our chapter’s very able resident liaison.

We also invited ACR leadership, including CEO Dr. William T. Thorwarth, BOC Chair Dr. Bibb Allen, and several ACR staff members to share their insights at this session, which went very well. ACR leadership also attended dinner after the lecture, which allowed our residents and fellows to ask questions and gain further insight about the ACR and its contributions to the radiology field.

Our chapter also established a sponsorship relationship with the Radiology Leadership Institute*, which will continue on an annual basis and will be mutually beneficial to both organizations (read more on page 10). The RLI will sponsor lectures for our chapter and offer our membership the opportunity to obtain RLI credit from these sessions.

Q: How can state chapters work together with the ACR?

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ACR Bulletin (ISSN 0098-6070) is published monthly by the American College of Radiology, 1891 Preston White Drive, Reston, VA 20191-4326.

From annual membership dues of $850, $15 is allocated to the ACR Bulletin annual subscription price. The subscription price for nonmembers is $90. Periodical postage paid at Reston, Va., and additional mailing offices. POSTMASTER: Send address changes to ACR Bulletin, 1891 Preston White Drive, Reston, VA 20191-4326 or e-mail to membership@acr.org. Copyright ©2015 by the American College of Radiology. Printed in the U.S.A.

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