Waiting to Exhale

OPTIMIZING YOUR PRACTICE

CONNECTING WITH LEGISLATORS

HANDLING INCIDENTAL FINDINGS
Radiology is changing. To answer tomorrow’s challenges, we must change how we solve for quality, cost, people, and process. More than ever, we need solutions that just make sense.

Bayer in Radiology leads with investment in innovation—from our roots in Medrad injectors and contrast R&D, to state of the art equipment service and radiology informatics.

We believe success comes from systems that are smarter by design, powered by people committed to making a difference.

That’s Radiological Imaging solutions, powered by people. The logical choice for today and tomorrow.
Radiology is changing. To answer tomorrow’s challenges, we must change how we solve for quality, cost, people, and process. More than ever, we need solutions that just make sense.

Bayer in Radiology leads with investment in innovation—from our roots in Medrad injectors and contrast R&D, to state of the art equipment service and radiology informatics. We believe success comes from systems that are smarter by design, powered by people committed to making a difference.

That’s Radiology Imaging solutions, powered by people. The logical choice for today and tomorrow.

Bayer, and the Bayer Cross are trademarks of the Bayer group of companies.

© 2015 Bayer, 100 Bayer Boulevard, P.O. Box 915, Whippany, NJ 07981. PP-CP-US-0049 March 2015
FROM THE CHAIR OF THE
Board of Chancellors
By Bibb Allen Jr., MD, FACR

Preparing Radiologists for the Future
How is the College supporting radiologists entering new payment structures?

In a recent article in the New England Journal of Medicine, Health and Human Services (HHS) Secretary Sylvia Burwell wrote that by 2016 she expects 85 percent of payments in the Medicare program, including those within the fee-for-service system, will have a link to quality or value. She went on to estimate that by 2018, 90 percent of Medicare payments will be value-based. Furthermore, she stated the HHS target for shifting care away from fee-for-service is to have 30 percent of reimbursements occurring within alternate payment models in 2016 and 50 percent in 2018. These alternate payment models (such as accountable care organizations or bundled payment arrangements for episodes of care) are designed to make health care providers accountable for both the quality and cost of the services they deliver to patients. Secretary Burwell went on to indicate that in order to drive progress toward these goals, HHS intends to provide incentives for delivering higher-value care, foster integration and coordination of care within institutions with emphasis on population health, and use IT to provide access to information so that physicians and patients can make better-informed choices.

Making sure radiologists have the ability to demonstrate their value to the Medicare system and other payers is the basis of the majority of the ACR’s strategic plan. In recent weeks, a number of members have asked me how radiologists will be affected by these changes and what the College is doing to prepare us for the future. Making sure radiologists have the ability to demonstrate their value to the Medicare system and other payers is the basis of the majority of the ACR’s strategic plan. It is central to our Imaging 3.0™ initiative and will be a major focus of this month’s ACR 2015 annual meeting. The ACR Commission on Economics has been working to ensure radiologists are well positioned to promote the value we bring to health care delivery. Secretary Burwell’s comments tell us that even under the ambitious plan being promoted by HHS, the agency also realizes that at least 50 percent of Medicare payments will remain in the fee-for-service system in 2018. So being able to thrive in a pay-for-value system will be important even for radiologists not participating in alternative payment models.

One of the College’s goals is to increase radiologist participation in current Medicare pay-for-value programs such as the Physician Quality Reporting System (PQRS) by making PQRS reporting easier and more meaningful. CMS recently designated our ACR National Radiology Data Registry (NRDR). (Find out more information on NRDR at http://bit.ly/NRDRACR.) Data can be collected automatically throughout our daily workflow and transmitted to document a radiologist’s commitment to radiation safety and other quality metrics. The ACR has also positioned itself to be a leader in influencing the metrics-development process. Participating in quality reporting will be enhanced if radiologists perceive that the metrics will actually make a difference rather than just being another hoop to jump through. To that end, our physician volunteers and staff are working on developing relevant PQRS metrics that can be used in the future. Additionally, the ACR is strengthening our registries to automatically collect, house, and benchmark data from our practices.

The College began preparing for the inevitable increase in alternate payment models more than five years ago. We have been developing tools that will assist radiologists in determining how to set up contracts with payers and integrated physician groups in risk-sharing models such as bundled episodes of care or in the management of imaging services for populations of patients. Recently, the Neiman Health Policy Institute™ developed a database defining radiology’s professional payments associated with Medicare Diagnostic Related Groups for inpatient episodes of care. For each of these groups, the institute determined the associated fee-for-service professional payments to radiologists, stratified by state. Access this information at http://i3.neimanhpi.org. This database will be very useful to radiologists if they are asked to participate and contract in a bundled episode such as heart failure or hip replacement. Meanwhile, for radiologists participating in ACOs, the payment structure may look a lot like capitation. The ACR Managed Care Committee and RBMA have recently updated the ACR RBMA Capitation Handbook as a guide for radiologists developing shared risk contracts. Find the handbook at http://bit.ly/CapHandbook. Additionally, the Neiman Health Policy Institute has created a database showing

Making sure radiologists have the ability to demonstrate their value to the Medicare system and other payers is the basis of the majority of the ACR’s strategic plan.

continued on page 21
CALENDAR

june

1–2  CT Colonography, ACR Education Center, Reston, Va.
6–10 Society of Nuclear Medicine and Molecular Imaging Annual Meeting, Baltimore Convention Center, Baltimore
18–20 Breast Imaging Boot Camp with Tomosynthesis, ACR Education Center, Reston, Va.
22–24 ACR-Dartmouth PET/CT, ACR Education Center, Reston, Va.

july


august

6–9 RLI Leadership Summit, Babson College, Wellesley, Mass.
14–16 Musculoskeletal MR of Commonly Imaged Joints, ACR Education Center, Reston, Va.
17–19 AIRP Categorical Course: Pediatric, AFI Silver Theatre and Cultural Center, Silver Spring, Md.

Check Out the Latest From the HII

WHEN REFERRING PHYSICIANS AND RADIOLOGISTS NEED TO SELECT THE MOST APPROPRIATE IMAGING PROCEDURE for patients with traumatic brain injury (TBI), there has been a lack of digestible, synthesized content that summarized the latest in evidence-based research. Identifying this gap in the information and education, the HII is now pleased to announce the publication of two peer-reviewed articles in the JACR® and the American Journal of Neuroradiology (AJNR).

The JACR article provides practical imaging recommendations for patients presenting with TBI across different practice settings and presents the rationale and background evidence. These recommendations aim to assist referring physicians in ordering appropriate imaging tests for patients with TBI and help radiologists advise their clinical colleagues on appropriate imaging utilization. Meanwhile, the AJNR article assesses the current evidence and determines the appropriateness of advanced neuroimaging techniques to the needs addressed in the JACR article. Both articles support radiologists and other stakeholders across the health care spectrum, including emergency medicine physicians and rehabilitative medicine physicians. Links to the articles are available on the HII’s new website at www.headinjuryinstitute.org, or access them at http://bit.ly/JACRTBI and http://bit.ly/AJNRTBI.
Learn From the Leaders in Ultrasound

IMAGE SOUNDLY, the 25th Annual Meeting and Postgraduate Course of the Society of Radiologists in Ultrasound, will be held October 23–25, 2015, in Chicago. The conference will include a plenary session, “Evolving Applications of Ultrasound: What’s New and Different,” as well as a keynote address, “Musculoskeletal Ultrasound: The Arthroscope of the Future?” by SRU Fellow Levon N. Nazarian, MD, FACR. Additional sessions will focus on vascular, head and neck, obstetrical, gynecological, and liver imaging. The experts session will include a film panel and a discussion of missed cases. A series of 35 small workshops will include sessions on abdominal and pediatric imaging. Registration opens in early June. For additional details, visit www.sru.org.

ACR Pqi Project to Launch at ACR 2015

CHECK OUT THE TURNKEY ACR Value-Based Radiology Process Quality Improvement (Pqi) Project that launches for member-wide participation during ACR 2015. The project’s web portal (www.acr.org/pqi) provides access to the resources needed to conduct a successful Pqi project that fulfills the ABR’s maintenance of certification Pqi requirement. You’ll find a wide variety of educational material for you and your colleagues and a step-by-step guide that eliminates guesswork.

Participating radiologists will engage referring physicians in a learning process that promotes delivering the best possible imaging care. And access to a customized, stand-alone version of ACR Select®, the Web-based clinical decision support system, puts the evidence-based ACR Appropriateness Criteria® at your fingertips.

Max Wintermark, MD, who leads the Value-Based Radiology Pqi Project, says, “The all-member ACR Pqi project will not only allow you, as an individual or a practice, to obtain Pqi credit, but it will also allow the ACR to collect nationwide data to demonstrate the role of radiologists as stewards of the appropriate use of imaging in the care of our patients.”

Spreading the Word About Imaging 3.0™

IMAGING 3.0 TOOK CENTER STAGE in the March issue of San Francisco Medicine, the journal of the San Francisco Medical Society. The issue explored radiology’s role in a transforming health care environment. “Radiology is in the midst of a major evolution, if not revolution. I know it sounds dramatic, but it’s true,” wrote Roger S. Eng, MD, MPH, FACR, president of the San Francisco Medical Society, in his introduction to the issue. “And as physicians who order imaging studies, you should know how this transition will impact you and your patients.” To read the full issue, visit http://bit.ly/SFMS-Img3.
Your Guide to ACR 2015
The annual meeting is just around the corner. Here’s the info you’ll need to hit the ground running.

EDITOR’S PICKS
Be sure not to miss these sessions.

Sunday

Monday

Tuesday

Wednesday

Thursday

REGISTRATION TIMES AND LOCATIONS
Registration will occur at the following times and places:

Saturday, May 16
For members of the Board of Chancellors and Council Steering Committee: 6:30 a.m., next to the Thurgood Marshall Ballroom, Marriott Wardman Park
For residents: 6:30 a.m., Pre-Function Blue Room, Omni Shoreham
For all attendees: 2:00 p.m.–6:00 p.m., in the Wilson A-C rooms, Marriott Wardman Park

Sunday, May 17–Thursday, May 21
Register in the Marriott Wardman Park lobby

CHECK OUT THE BULLETIN BOOTH AND WIN A PRIZE!
Stop by our booth, located on the mezzanine at the Marriott Wardman Park with the other ACR services. Download the new ACR Bulletin app and pay attention to the push notifications — you could win a prize!

GET DIGITAL WITH ACR 2015

THINGS TO DO

DINING OPTIONS
We’re Stronger Together

As we gather for ACR 2015, our message is magnified by our numbers.

“Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.”
— Margaret Mead

Margaret Mead’s oft-quoted exhortation is apt as we gather together as a profession this month in Washington. The power of our combined voice is never stronger than when we flock to Capitol Hill en masse to meet our legislators and tell them the story of what we do for our patients and how we deliver high-value health care. In 2013, many of you visited your representatives with the beta version of the ACR Select™ mobile app loaded on your smartphone. The app showed exactly how we can contribute to lower costs and higher quality through the use of clinical decision support for imaging. Don’t doubt for a minute that you made a very real contribution to building support for the Protecting Access to Medicare Act that in 2017 will embed the use of CDS into the Medicare program.

But lest you think that our advocacy efforts stop when we all go home, nothing could be further from the truth. I see everything that we do as radiologists and at the ACR as advocacy for our patients. We advocate for fair reimbursement for the services we provide to make sure that our patients have appropriate access to those services. We advocate for quality metrics that differentiate high-value imaging so our patients can rest assured that they are receiving, as Dr. Bibb Allen, our board chair, said, “all the imaging care that is beneficial and necessary and none that is not.” And our efforts to serve our patients must be integral to everything we do. From our individual practices to our unified efforts as a profession, we need to be a strong, clear voice on behalf of our patients.

Could a cynical person suggest that we are thinking only of ourselves as we advocate around payment policy issues? Well, there will always be skeptics. But we have been successful in influencing policy-makers and payers on issues, such as CMS’s decision to cover lung cancer screening, because it has been readily apparent that our goal is the best care and appropriate access for our patients. Have we sent a clear message that reimbursement has to reflect the costs of providing the service? Absolutely. For example, based on the input of clinical experts such as Dr. Ella Kazerooni, who led the ACR’s lung cancer screening effort, we believe that a low-dose screening CT with all the associated quality management activities and outcomes tracking requires more physician and technologist work than a non-contrast chest CT, and we’ve made that representation to CMS.

In the area of breast tomosynthesis, we have strongly advocated to private payers that it is not, as many have continued to state, experimental. Tomosynthesis is a technology that can improve patient outcomes. But if it’s not reimbursed, it will not be available to as many women as can benefit from it. We’ve seen the power of local advocacy in this area, with payers responding to efforts at the state level from many of you. Your patients are better off for those efforts.

But advocacy is also important at your practice or institution. Your expert voice is critical to making sure imaging is used wisely and appropriately. You advocate for your patients when you tell the story of clinical decision support to your physician colleagues and health system leadership. Across the various ACR commissions, we are always looking for ways to amplify the voice of radiologists. One of the things that keeps me awake at night is the continued attacks on the validity of mammography. With real screening compliance much lower than one might expect (more information at http://bit.ly/ScreeningRates), I worry that our patients are being told they don’t need this scientifically proven life-saving service. It’s been frustrating to see experts in our field ignored and accused of bias when they try to respond to misinformation and bias from others. I was delighted therefore to participate in a program under the joint auspices of the ACR’s Commissions on Breast Imaging, Quality and Safety, and Economics to train a new generation of advocates for the benefits of screening mammography. Luminaries such as Drs. Daniel B. Kopans, Edward A. Sickles, R. Edward Hendrick, Mark A. Helvie, and Carol H. Lee, as well as Dr. Robert Smith from the American Cancer Society, gave generously of their time to host weekly webinars digging deep into the science that supports screening. A group of dedicated “trainee” radiologists who are already in practice and many in leadership positions spent not only the 10 hours of the webinars but did pre-reading, answered questions, and responded to last minute requests for comments on news articles to hone their skills. The group finally assembled during the Society of Breast Imaging Symposium last month for media training. We should all sleep easier knowing that the torch will be carried by this talented and passionate group of advocates.

Some might think that advocacy is only about political donations and emailing our representatives about the latest SGR legislation. Those things are critically continued on page 21
Helping you breathe a little easier™

The Vest® System and The VitalCough® System

www.thevest.com
www.vitalcough.com
www.hill-rom.com

© 2015 Hill-Rom Services, PTE Ltd. ALL RIGHTS RESERVED.
192142 rev1  26-MAR-2015  ENG – US
NEWS FROM THE
Council Steering Committee
By Kimberly E. Applegate, MD, MS, FACR, Speaker of the Council, and William T. Herrington, MD, FACR, Vice Speaker of the Council

Coming Through the Crossroads
Accomplishments of the 2014–15 CSC and a view of the year ahead

WAT A YEAR IT HAS BEEN! The 22 members of the 2014–2015 CSC were extremely busy over the past year, working on new and ongoing projects in preparation for ACR 2015 and for the council at large. As the College developed and approved a new strategic plan and expanded the format of the annual meeting, we took an active role in charting the future course for the organization. All the while, the CSC found innovative ways to enhance our traditional work of planning the annual governance meeting, liaising with chapters and societies, stewarding the process of member comments on the parameters and standards, and facilitating and sponsoring policy resolutions.

CSC Contributions to Policy Resolutions at ACR 2015
During the summer of 2014, CSC members were fully engaged in the development of resolutions and drafted resolutions covering a broad range of topics, including patient advocacy, professionalism, diversity, diagnostic interpretation by radiologists, the multiple procedural payment reduction, maintenance of certification, and processes for handling select practice parameters and technical standards.

All told, 24 resolutions were drafted during what we called the See One, Do One, Teach One Initiative. Each was considered by CSC Work Group II, under the leadership of chair Richard Strax, MD, FACR. From those draft documents a total of 12 policy resolutions have been put forward to the council for consideration at ACR 2015. In a nod to the collaborative work of our legislative and executive branches, eight of the 12 resolutions are jointly sponsored by the CSC and Board of Chancellors. Additionally, a total of eight draft resolutions became the basis of newly adopted board policies and/or internal process documents. Overall, this exercise was a resounding success.

Planning, Promoting, and Orienting Members at ACR 2015
As speaker and vice speaker, we have been fully engaged in planning the Governance Pathway at ACR 2015. Our goal has been to communicate that “AMCLC content” has been preserved within the context of an expanded meeting format. As in previous years, attendees will have an opportunity to engage in the council meeting, hear from leaders in the field via the presidential address and Moreton Lecture, and celebrate the achievements of our new fellows and gold medalists. They will also get to experience the best of what the ACR has to offer through expanded programming in advocacy, economics, and health policy; leadership; quality and safety; informatics and innovation; clinical education; and clinical research. Equally important, the new meeting format offers an expanded audience of members the opportunity to witness the council in session, participate in the deliberation of ACR resolutions, and engage in a moderated open-microphone discussion of the challenges we face in our practices.

CSC members have taken an active role in promoting the meeting to their colleagues via their liaison outreach and through participation in chapter and society meetings. With the input of CSC Work Group I, under the leadership of Jacqueline A. Bello, MD, FACR, we have developed materials to orient both returning and new attendees to the council meeting. We also provided recommendations to market the meeting within the radiology community. As speaker and vice speaker, we developed a webinar as part of the newly launched Chapter Leadership Advancement Series to provide an overview of the ACR Council and ACR 2015. This webinar was offered live in early March and is available online to provide orientation to meeting attendees.

Improvements and Enhancements to Liaison Outreach
Under the leadership of Joseph G. Cernigliaro, MD, FACR, Work Group III continued to improve liaison outreach by developing resources, facilitating enhancements to outreach tools, and using liaison feedback to be responsive to chapter and society contacts. In the fall, as part of the newly adopted approach to outreach, CSC members were encouraged to introduce themselves to the full delegation of chapter and society councilors and alternate councilors. In addition, resources were developed to enable CSC members to provide pertinent information regarding current ACR activities and CSC initiatives on a regular basis.

For outreach in the spring, we used member feedback to further refine liaison work, provide materials to address common issues identified by chapters and societies, and develop a survey that would collect aggregate information for analysis by the CSC. Continued focus on refining liaison outreach to councilors proved valuable. Data from the fall

THANK YOU
As I complete my second year as council speaker, I look back with pride on the CSC’s achievements, including the new procedures, orientation tools, and areas of collaboration with councilors, chapters, and staff. It has been a privilege to work with the CSC team and, most importantly, to work well with our outstanding vice speaker. I believe that I’ve left a solid foundation for Dr. Herrington to build on as council speaker for the next two years. Thank you for your support and for the opportunity to serve the College.

— Kimberly E. Applegate, MD, MS, FACR

continued on page 21
Standing Out From the Crowd

Indiana radiologists develop an imaging consult service and a targeted messaging campaign as part of a value-based imaging program in their ACO.

When a referring physician orders a common imaging test, the next steps are straightforward, and the scan is usually preauthorized by a radiology benefits manager (RBM) with little delay. However, when presented with a complex or unfamiliar case, many referring physicians do not have the time or resources to quickly determine what type of advanced imaging is most appropriate for the patient, much less conduct a lengthy negotiation with an RBM to obtain authorization. The radiology group at Indiana University Health (IU Health) in Indianapolis has tackled the issue head on, as it transitions into a new realm of value-based reimbursement as part of an ACO, while maintaining a focus on improved outcomes for its patients.

Instead of following a traditional RBM structure, a consultative approach was developed alongside IU Health’s multispecialty physician practice and its insurance company. Marc D. Kohli, MD, radiologist and director of informatics in the IU Health department of radiology and imaging sciences in Indianapolis, and representatives from these groups formed an imaging consult team, which met regularly to establish the current consult service. “There aren’t many arrangements in medicine where you have hospitals, providers, and payers on the same team, working together,” says Kohli. “It was a unique opportunity for us, where the insurance plan was willing to give us some flexibility on how we could implement the plan.”

Improving Communication

As a key focus of the initiative, Kohli and his colleagues developed a strategy to improve communication between radiologists and referring providers through a three-pronged approach:

1) They implemented an outpatient imaging consult service where physicians can call one number to access a subspecialty radiologist within 10 minutes, integrating radiology more closely with the outpatient arena (view details at http://bit.ly/ConsultWorkflows). IU Health already provides similar consultation for inpatients, which most hospital providers know how to access quickly.

2) If an IU Health radiologist makes an advanced imaging recommendation during the consult, patients covered by IU Health insurance are automatically preauthorized. This allows radiologists to interact with providers earlier in the imaging process — one of the major goals of Imaging 3.0”.

3) IU Health took all aspects of the American Board of Internal Medicine’s Choosing Wisely® guidelines pertaining to imaging and tailored them to individual providers based on past imaging ordering information. For example, a neurosurgeon’s practice would not encounter information about ordering pelvic ultrasounds.

Recently profiled in a Forbes magazine article, the on-demand consult service has been well received throughout the provider community and is now being used throughout the physician network. “Our consultation line allows a provider to speak directly with one of our radiologists. After talking with a radiologist in real time, if the clinician agrees with our decision, then we can guarantee preauthorization for additional imaging without further bureaucracy or delay in patient care,” says Kohli.

Building Alignment

“In the instance of IU Health, there is a high degree of alignment between referring physicians and radiologist consultants,” explains Daniel J. Durand, MD, radiologist and vice president at Evolent Health, who partnered with IU Health on the initiative. “If you’re a primary care physician with a practice that is engaging in value-based contracts, trying to deliver high-quality care at a low cost and hoping to avoid unnecessary radiation for your patients, you will be pulling more for advice from radiologists and other specialists.”

IU Health is part of a federal accountable care organization (the Indiana University Health ACO). By avoiding unnecessary exams and spending less on imaging, IU Health’s approach is gaining momentum among those interested in increasing shared savings while delivering better patient care.

To see the rest of the case study, visit http://bit.ly/ACRStandingOut.

By Amena Hassan, freelance writer for ACR Press

ENDNOTE

Most Valuable (Radiology) Practice

A new ACR resource offers radiologists a blueprint for taking their practice to the next level. Take a tour of the basic building blocks here and access the full resource to get started.

**THE CLINICAL JOURNEY**

*Guiding referring clinicians’ decision-making process and ensuring optimal patient care*

1. **CONSULTATION**
   - Collaborate with referring clinicians throughout the cycle of patient care.
   - Confer on imaging appropriateness, value, and outcomes.

2. **INTERACTION**
   - Increase visibility, availability, and understanding of radiologists’ role in quality care.
   - Seek opportunities to engage with patients before, during, and after imaging.
   - Be courteous, professional, helpful, and knowledgeable.

3. **ANALYSIS**
   - Leverage integrated health care systems to access clinical and imaging history.
   - Apply imaging informatics tools — such as ACR Select® — to advance patient care.

4. **COMMUNICATION**
   - Build relationships by quickly communicating unusual and critical results.
   - Deliver clear, precise, and actionable information that simplifies diagnosis and treatment.

**DESTINATION**

Radiologists are integral to clinical care pathways and direct patient care.

---

**THE PHYSICIAN ADMINISTRATION JOURNEY**

*Providing superior patient care while maintaining a healthy business*

1. **TRAINING**
   - Ensure physicians gain appropriate clinical training, certification, and peer review.
   - Deliver comprehensive training for quality and safety, clinical decision support, and reporting.

2. **QUALITY**
   - Capture and report metrics for quality, PQRS, and reimbursement.
   - Participate in ACR registries, benchmark outcomes, and ensure efficient processes of care.

3. **WORKPLACE**
   - Manage efficient and effective scheduling, coverage, and personnel utilization.
   - Provide top-notch practice environment, equipment, and resources.

4. **GOVERNANCE**
   - Standardize and optimize policies, procedures, and practice dynamics.
   - Offer opportunities for team-building, mentoring, and camaraderie.

5. **LEADERSHIP**
   - Demonstrate value to the hospital and health system.
   - Engage in RBMA, Radiology Leadership Institute, and other leadership programs.

**DESTINATION**

Radiology practices are operating at peak performance, quality, and value.
THE BUSINESS ADMINISTRATION JOURNEY
Supporting the organization’s mission and vision with sound business operations

1. CODING
• Comply with all PQRS reporting requirements and participate in value-based payment models.
• Reduce denials for CMS reimbursement related to medical necessity.

2. BILLING
• Ensure 100 percent of claims submitted to payers are considered “clean” for payment.
• Provide electronic filing for 100 percent of claims.
• Eliminate denials due to timeliness of filing.

3. COLLECTIONS
• Ensure collection of fees from all self-paying patients at time of service.
• Improve management of aging accounts and collection of bad debt.

4. PATIENT FOCUS
• Produce clear, patient-friendly statements that reduce questions and streamline payment.
• Communicate transparently about fees for services.

DESTINATION
Group demonstrates best business practices, while reducing expenses and providing quality care.

THE LEADERSHIP JOURNEY
Delivering effective leadership and organizational structure for perpetual success

1. PROFESSIONAL
• Fulfill responsibilities to group, local hospital, and professional, medical, and scientific societies.
• Develop leadership style in keeping with practice culture and goals.

2. SOCIAL
• Be active in the local community, including schools, organizations, and foundations.
• Work with charities and non-profits, and look into public speaking opportunities.

3. POLITICAL
• Assume leadership positions on local, state, and national government committees.
• Support political action and advocacy efforts to advance radiology’s interests.

DESTINATION
Radiologists are ideally positioned to become leaders in today’s health care environment.
*According to the American Cancer Society, 158,040 people in the U.S. are expected to die of lung cancer in 2015. Each figure on these pages represents 1,000 patients.
Like a lot of stories, this one starts with a prologue, some background to remind us where we’ve been and how far we’ve come. Lung cancer screening’s prologue begins with the ACRIN-sponsored National Lung Cancer Screening Trial (NLST), which studied the effects of low-dose CT (LDCT) screening on over 50,000 individuals who were at risk for lung cancer. The NLST found those patients who had received LDCT screening were 15 to 20 percent less likely to die from lung cancer.\(^1\) The trial was published in August 2011.

In 2013, due to the data in the NLST and other research on LDCT screening, the USPSTF gave LDCT lung cancer screening a new, higher grade “B,” recommending smokers ages 55–80 with a 30-pack-year history should be screened. Under the newly passed Affordable Care Act, private insurance companies were now required to cover LDCT screening for patients.\(^2\)

But what about the steadily increasing population of patients covered by Medicare? Following the USPSTF’s recommendation, CMS launched a decision process to determine the fate of screening for Medicare patients.

**Dramatis Personae**

“The College wanted to start a coalition for lung cancer screening because we knew that while private insurance coverage was good, Medicare coverage was an even bigger issue. Most Medicare patients fall into the age range in the USPSTF’s recommendation. That meant a vast number of patients should have been receiving screening and couldn’t,” says Chris Sherin, director of congressional affairs for the ACR.

The ACR brought together a group of organizations committed to fighting for screening, including the Society of Thoracic Surgeons and the patient advocacy group the Lung Cancer Alliance. “LDCT screening isn’t just about radiologists. It also impacts both the public and the other health care professionals involved in patient care. So it was vital we worked alongside other organizations that represent other parts of the health care team to get their perspectives,” says Ella A. Kazerooni, MD, FACP, chair of the ACR Committee on Lung Cancer Screening.

The majority of the work involved in advocating a decision for CMS consists of submitting comments and letters arguing your position. The coalition’s first letter provided 28 pages of guidance on how LDCT screening should be implemented. The coalition agreed with USPSTF’s recommendations, and so its subsequent recommendations to CMS followed the USPSTF’s as closely as possible. This first letter was signed by 40 organizations and delivered in March 2014.

What does it take to create a unified plan among three societies? “A lot of long days and nights,” laughs Anita McGlothlin, ACR economics and health policy analyst. “The coalition meant a lot of meetings, a lot of research, and a lot of coordination. Without the combined efforts of staff from the Government Relations, Economics, and Quality and Safety departments, we couldn’t have gotten it all accomplished.”

**Storms Ahead**

April 30, 2014, was dark and stormy in Washington, D.C. The deluge of rain seemed like an omen as the LDCT screening coalition gathered at an official hearing held by the Medicare Evidence Development and Coverage Advisory Committee (MEDCAC). MEDCAC is a panel of
The primary results of the National Lung Cancer Screening Trial are published.

AUGUST 2011

The ACR, along with the Society of Thoracic Surgeons and the Lung Cancer Alliance, composes a letter to CMS, outlining how LDCT screening should be implemented.

MARCH 2014

The primary results of the National Lung Cancer Screening Trial are published.

SEPTEMBER 2014

The ACR sends a second letter of support to CMS, with signatures from over 75 organizations.

FEBRUARY 2015

CMS decides to cover LDCT screening for patients ages 55–77 who are at high risk for lung cancer.

DECEMBER 2013

The USPSTF gives a grade B recommendation to lung cancer screening with LDCT.

APRIL 2014

Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) hearings commence. MEDCAC ultimately decides to advise CMS not to cover LDCT screening.

MARCH 2015

The ACR is approved as a registry body for LDCT screening. Practices can register to become lung cancer screening centers through the ACR’s lung cancer screening registry beginning in May.

LOOKING TO THE FUTURE

For health care, coverage for lung cancer screening is only the first part of the story. Radiology practices should start implementing screening centers now, says Kazerooni. She notes, “The coverage decision is made, the research is out there, and the ACR now has a wealth of resources available. There are no excuses anymore.” To get started, visit the ACR Lung Screening page at http://bit.ly/ACRLungScreen.

EXHALE

On the Hill

Although MEDCAC seemed like a setback, other battles were fought that day in Washington. On the same day as the MEDCAC hearing, members of the ACR visited Capitol Hill as part of AMCLC’s Hill Day to discuss important topics with their legislators. That day, the goal for the ACR members was lung cancer screening. And after discussing the importance of LDCT with their members of Congress, ACR members were able to have a bipartisan letter of support for LDCT screening signed by hundreds of members of the U.S. House of Representatives and at least 40 senators. “We were able to show CMS that Capitol Hill was watching its decision and supported LDCT as a patient benefit. That’s why Hill Day is so important. We couldn’t have done it without our members,” says Sherin.

The movement seemed to be gaining steam. In September, the coalition sent another letter of support for LDCT screening to CMS — this time signed by 75 organizations. And then the waiting game began.

Endings and Epilogues

In February 2015, the wait came to an end when CMS issued the final rule announcing it would cover LDCT screening for smokers or former smokers ages 55–77 with 30 pack years. It was an emotional moment for Kazerooni. “I sat back in my chair and thought, ‘Oh my goodness. It’s really gone through,’” she says. “By the time I retire, I hope the face of lung cancer looks different than it does today because of what we’ve accomplished.”

By Meghan Edwards, copywriter for the ACR Bulletin

ENDNOTES

Managing Incidental Findings, Without Incident

We’re encountering more incidental findings than ever, thanks to exciting advances in imaging technology. How are radiologists managing these unexpected discoveries?

Referring Physician Suspects that a patient with flank pain has a kidney stone and orders a CT study. But while interpreting the imaging exam, the radiologist detects something abnormal in the patient’s pancreas. Unexpected and unrelated to the patient’s clinical condition, the finding is classified as incidental. With few formal guidelines about how to manage incidental findings, the radiologist and referring physician must work with the patient to decide what to do next. Should they schedule more imaging? Arrange a biopsy? Monitor the patient? Or ignore the finding altogether?

As imaging technology has advanced over the past 25 years, such incidental findings — and the many questions they raise — have become increasingly common. Modern modalities and improved imaging techniques allow radiologists to identify findings that would have been undetectable with early X-rays. While these technological advances have no doubt improved patient care, radiologists and referring physicians don’t always know how to handle incidental findings. “It’s a hot topic in organized medicine because there are no clear-cut guidelines for addressing every incidental finding,” says Jonathan W. Berlin, MD, MBA, FACR, radiologist at North Shore University Health System and clinical professor of radiology at the University of Chicago Pritzker School of Medicine.

Without comprehensive guidelines, radiologists often act on incidental findings by recommending further imaging or interventional procedures. Lincoln L. Berland, MD, FACR, professor emeritus in the department of radiology at the University of Alabama at Birmingham and chair of the ACR Commission on Body Imaging, says radiologists do this for two reasons: first, they want to be as certain as possible about every finding’s risk to patients, and second, they don’t want to be legally liable if they minimize the importance of a finding that causes a negative outcome down the line. But Berland says that acting on every incidental finding can actually do patients more harm than good. “Instead, we must differentiate between the findings where action is going to benefit the patient versus the ones in which action may lead to unnecessary biopsies or surgeries,” he says.

Guiding Principles

To help radiologists determine whether incidental findings warrant action, the ACR, the Society of Radiologists in Ultrasound, the Fleischner Society, and other specialty groups have drafted incidental findings recommendations. The ACR began developing its recommendations in 2006, when Berland formed the College’s Committee on Incidental Findings, an expert panel responsible for forming a consensus about how to handle the most common incidental findings in the abdomen and pelvis on CT exams. In 2010, the JACR published the committee’s first white paper, with recommendations for incidental findings in the liver, kidneys, adrenal glands, and pancreas. To date, the paper remains one of the journal’s most popular articles. “The interest in the paper really highlighted, somewhat to my surprise, how hot this topic was and how much radiologists yearned for guidance about how to handle incidental findings,” Berland says.

Since then, the JACR has published five additional incidental findings papers from the committee. The papers cover 10 topics, including vascular and ovarian incidental findings, and each offers recommendations for different incidental finding types. “Most of the papers have flow charts, so the recommendations are often based on the size and characteristics of the lesion.

Learn More at ACR 2015

Radiologists attending the annual meeting can explore the challenges, controversies, and recommendations associated with incidental findings. Don’t miss the session entitled “Recommendations for Incidental Findings on CT and MRI: How Useful, How Dangerous, and How to Make Them Work.” The panel discussion will be led by Lincoln L. Berland, MD, FACR, professor emeritus in the department of radiology at the University of Alabama at Birmingham and chair of the ACR Commission on Body Imaging; Jonathan W. Berlin, MD, MBA, FACR, radiologist at North Shore University Health System and clinical professor of radiology at the University of Chicago Pritzker School of Medicine; and Mark A. Baker, MD, FACR, diagnostic radiologist at the Cleveland Clinic. For more information, visit http://bit.ly/ACR15Findings.
Incidental Findings

“It’s a hot topic in organized medicine because there are no clear-cut guidelines for addressing every incidental finding.”
— Jonathan W. Berlin, MD, MBA, FCR

“We must differentiate between the findings where action is going to benefit the patient versus the ones in which action may lead to unnecessary biopsies or surgeries.”
— Lincoln L. Berland, MD, FACR

“These data have the potential to substantially benefit the way we practice by allowing us to shape our recommendations in response to patient outcomes.”
— Pari V. Pandharipande, MD, MPH

and, when appropriate, the patient’s age,” Berland says. Radiologists can use the recommendations to determine whether additional action is necessary to manage particular incidental findings effectively. Radiologists who can make these determinations will bring greater value to the health care team, as outlined in Imaging 3.0™. “The white papers help radiologists provide greater value because they offer credible, supported, and consistent recommendations for managing similar incidental findings in different patients,” Berland says.

While the papers attempt to offer a consistent approach to managing incidental findings across patients, they do not address every finding and case imaginable. “It’s impossible to standardize everything because every patient and every case is different,” Berlin notes. The committee hopes to make the recommendations more robust by incorporating the insights of experts outside of radiology and formalizing the recommendations as guidelines. Achieving this will require a more in-depth validation process, with consensus from a much larger panel of experts and revisions to some of the existing recommendations. “These recommendations have been put out there, but most of them haven’t been tested with subsequent research to demonstrate that they’re appropriate to use,” Berland says.

Improving Access

Another challenge the committee faces is making the recommendations accessible to radiologists. Currently radiologists who want to consult the recommendations during their interpretations must memorize them, access them through the JACR online, save them to their desktops, or post them in hard-copy form near their workstations. “Right now, compliance with the recommendations is relatively low because there are obstacles to accessing them at the time of interpretation,” Berland explains. “This makes it difficult to apply the recommendations.” The ACR is addressing the issue by developing ACR Assist™, a tool designed to support computer-aided reporting systems, which will automatically display the recommendations at the point of image interpretation. ACR Assist will enable such reporting systems to recognize when the radiologist describes an incidental pancreas nodule, for example. Once the radiologist enters the size of the nodule, the reporting system will automatically couple that information with the patient’s age, medical history, and risk factors. It will then display the recommendations for managing that specific incidental finding. “As time goes on and the recommendations are more refined, they will be integrated into our dictation systems and will automatically pop up based on the radiologist’s description of the finding,” Berlin explains.

Pari V. Pandharipande, MD, MPH, director of the Massachusetts General Hospital Institute for Technology Assessment and chair of the ACR Committee on Incidental Findings, says that once the recommendations are integrated into dictation systems and more radiologists use them, it may be possible to track how these findings impact patients in the long term. “These data have the potential to substantially benefit the way we practice by allowing us to shape our recommendations in response to patient outcomes,” she notes. They may also increase the possibility of standardizing the management of incidental findings across the country so that a patient with an incidental finding detected in one center, in one part of the country, would receive the same care in a completely different practice setting, Pandharipande says.

In addition to improving the existing recommendations and increasing their accessibility, the Committee on Incidental Findings is developing recommendations for the chest and other body regions that are not addressed in the existing papers. All of the recommendations will likely evolve over time as physicians research the recommendations’ impact on patient care and gain a better understanding of incidental findings overall. “Every recommendation in medicine is subject to change with increasing medical knowledge,” Berlin says. “These recommendations are here to stay, but they will continue to evolve along with the rest of medicine.”

For a roundup of JACR articles on incidental findings, visit http://bit.ly/IncidentalJACR.

By Jenny Jones, freelance writer for the ACR Bulletin
In this era of health care reform, radiologists must demonstrate value to a variety of audiences. To communicate with patients, it might mean seeking out face-to-face interaction and clarifying the role of the specialty. With other physicians, it could mean discussing critical results and joining hospital committees. But what about policy-makers? How can radiologists guarantee that members of Congress understand radiology’s significant contributions in delivering quality care?

One way to accomplish this goal is by inviting members of Congress to visit your practice or hospital through the ACR’s site visitation program. In October 2014, Elizabeth Ann Ignacio, MD, radiologist at Maui Diagnostic Imaging in Kahului, Hawaii, participated in a tour and discussion with Rep. Tulsi Gabbard (D-Hawaii). How can your practice — and the entire specialty — benefit from personal visits with legislators?

Scheduling the Details
In April 2014, Maui Diagnostic Imaging extended invitations to its U.S. representatives and senators to visit the radiology practice, receive a tour, and discuss health- and policy-related issues. In part because Hawaii is such a small state, Ignacio and her colleague Andrew V. Kayes, MD, had already met with their members of Congress in Washington, D.C., as part of the ACR annual meeting. “We wanted to build on that relationship,” she says. “There’s always lots of health and medical issues we face statewide, and members of Congress just want any physician’s input. We wanted to start a dialogue.”

Plus, Ignacio believed this to be a real opportunity to explain radiologists’ roles and significance to patient care. “The legislators I’ve met are all well-meaning, but they don’t know a lot about what we do. Often, they think they’re talking to a bunch of technologists or that it is oncologists and surgeons who read scans, not us.”

Site Visit Rundown
After receiving some tips for the visit from the ACR’s government relations staff, Ignacio and colleagues received word that Rep. Gabbard would be able to visit the practice in late October 2014. They scheduled a short tour of facilities and then opened up the meeting to discuss relevant topics in radiology, including breast cancer and CT lung cancer screening guidelines. Because the...
“It meant a lot to Rep. Gabbard to meet with administrators, who are on the front line and see how hard it is to get approval for studies.” —Elizabeth Ann Ignacio, MD

visit occurred in October — Breast Cancer Awareness Month — Ignacio says they made sure to show Rep. Gabbard the mammography equipment. “She’s in her thirties and had never had a mammogram,” says Ignacio, “but even young women should know about mammography because they have moms and sisters and aunts, and you want to reach these people.”

Ignacio says another key portion of the visit was having staff present to ask questions and bring up important issues. “Two of our administrators brought up really good local issues for radiology, such as the difficulty in getting studies done for veterans. It meant a lot to Rep. Gabbard to meet with administrators, who are on the front line and see how hard it is to get approval for studies,” Ignacio explains. “It’s heartbreaking: these patients are very sick and they have to wait a long, long time to get the care they need.”

Positive Outcomes
On the whole, the visit was fruitful, according to Ignacio, who was especially surprised by the personal experiences relayed by Rep. Gabbard and her staff members. “They shared some of their personal medical experiences involving radiology, and I was excited to hear them discuss these experiences in a positive way,” says Ignacio.

Ignacio adds that this experience created a more intimate bond between Maui Diagnostic Imaging employees and Rep. Gabbard. In fact, the practice has already followed up with her on several issues they discussed, including services for veterans. “We’ve spoken to Rep. Gabbard and her staff once or twice just to say hello,” says Ignacio. “And to say we’re available if they ever have questions or need support.”

By Alyssa Martino, freelance writer for the ACR Bulletin

TIPS FROM THE COLLEGE
Over the past seven years, the ACR has organized more than 150 successful visits with members of Congress. Below, Ted Burnes, ACR’s director of political education, provides some tips for setting up and preparing for a visit.

Q What is the first step for ACR members interested in setting up a site visit with their legislators?

A The first step is contacting me (tburnes@acr.org) at the ACR’s Government Relations Department. Doing so allows us to make sure a similar visit with the same member of Congress hasn’t already happened recently with another practice in the same Congressional district. Additionally, through our political relationships with members of Congress and their staff, we are able to more easily schedule the visit.

Q How does the ACR help support the practice or department and prepare them for the site visit?

A We provide talking points for the visit based on our latest legislative activities. It’s important to walk the member of Congress and their staff through the process for a patient receiving imaging, what a typical day is like in a radiology practice, and how expensive it is to run a practice (especially accommodating large equipment and upgrading it). We also recommend doing a “show and tell” session to introduce the technology we use. Members of Congress may have as many as five to seven other appointments on the same day as their visit with the radiology practice, so they might not remember everything discussed. But they will definitely remember what they see because the technology associated with radiology is so impressive.

Q How can practices continue the relationship after the visit?

A Offer to serve as a resource for the member of Congress and their staff. Health care is a complicated, ever-changing industry. Less than 10 percent of members of Congress have a professional background in health care before being elected, so offering to help them on all things related to health care is a great foot in the door to building a relationship.
We’re Stronger Together
continued from page 8

important, but, again, they are rooted in our commitment to the work we do as physicians. They are meaningful because of the impact they allow us to have on the health care delivery system in which we practice and on the patients for whom we care. As always, you can reach me at gmcginty@acr.org, and I encourage you to follow me on Twitter at @DrGMcGinty.

Coming Through the Crossroads
continued from page 10

outreach showed the highest response rates to date, with approximately 80 percent of outreach attempts resulting in success.

Additional CSC Highlights

The CSC, through Work Group IV, led by Sanjay K. Shetty, MD, MBA, continued to engage in IT-enabled projects this year and contributed to the use of ACR’s audience response system at ACR 2015, the development of a mobile app for the annual meeting, the introduction of a new grassroots module, and the vetting of collaboration tools for use by the College. We have also retained our focus on leveraging communication tools to engage members at the annual meeting, which includes the use of Twitter during open-microphone sessions and the popular social media training session.

In an effort to further inform and engage members, CSC members have drafted a series of three ACR® articles to provide background on the role of the BOC and CSC and address the chapters’ vital contributions to the ACR and the field of radiology.

A Look Ahead to 2015–2016

The 2015–2016 CSC, a combination of veteran and newly elected and appointed members, will build on the progress and achievements of the group before them. Work groups for 2015–2016 will be developed to ensure that the CSC continues to fulfill its mission: “to be the representative voice of the ACR membership, by facilitating and developing ACR policy.”

We will continue to focus on ensuring a successful annual council meeting, facilitating further IT enhancements to enable the work of the CSC and council, developing and facilitating policy resolutions as needed, serving as liaisons to chapters and societies, and facilitating the approval process for practice parameters and technical standards. The council is the representative body of our organization and the CSC is in place to represent the full council between meetings. As members, we encourage you to engage your representatives to identify the issues you are facing, to share the ideas for improving our profession, and to inform the work of the CSC. Please keep in touch by contacting us at Speaker-ViceSpeaker@acr.org.

Preparing Radiologists for the Future
continued from page 4

total radiology spending and volumes by state so that radiologists can understand local variation. Access this tool at www.neimanhpi.org/almanac.

These are just a few of the tools the College has been developing to help radiologists transition to a value-based payment system. At the expanded ACR 2015 annual meeting, attendees will have an opportunity to engage with experts on how to make the changes in our practices that will allow our specialty to deliver higher value care and thrive under value-based payments and alternative payment models. I look forward to seeing you in Washington.

ENDNOTE

How does your practice demonstrate the principles of Imaging 3.0™?

**AS A BATTLEFIELD RADIOLOGIST** in Kandahar, Afghanistan, I was privileged to serve as chief of radiology on a multinational and multidisciplinary team. Serving during a war reinforced to me how critical Imaging 3.0 principles are to the success of health care. Our radiologists inserted themselves at the beginning of the care process for trauma patients, determining whether the patient needed to go directly to the operating room or get further CT evaluations. We also worked hand in hand with surgeons, performing angiograms while the surgeon was working — which, to my knowledge, had never been done in a wartime environment.

Radiologists need to create and embrace opportunities to get out of the sandbox and jump into action, thereby creating and validating our value. By serving as physician leaders and stepping up, we can become integral in molding hospital policies, improving patient experiences, and optimizing multidisciplinary care. We must purposefully create an environment in which radiologists are valued as essential team physicians rather than dispensable commodities.

Portland VA Healthcare system, where I currently serve, is unique in that over 35 percent of physicians within the department are veterans. Our radiologists live out Imaging 3.0’s patient-centric concepts by volunteering for non-RVU activities, and the department provides protected time to make this possible. These contributions include participating in hospital committees, clinical teaching, clinical rounds, quality and safety initiatives, multi-disciplinary conferences, and tumor boards. We are grateful to be integral to improved patient-centered care. It is one way we are remembering our identity beyond radiologists — we are physicians.

---

**Final Read**

Ronald J. Boucher, MD, Chief of Radiology at VA Portland Health Care System, Clinical Professor of Radiology at Oregon Health and Science University
Changes in health care continue to increase in speed and scope. Is your practice prepared for the new business of health care and to capitalize on the changing environment?

In-depth, hands-on sessions, with facilitated breakouts, provide for maximum interaction with both faculty and fellow attendees. The 2015 RLI Leadership Summit will help you:

- Identify opportunities for practice growth using core marketing concepts
- Generate a strategy, make the optimal choice for your business and create a road map for execution
- Make financially sound investments in your practice that will help you operate capital-intensive practices in an increasingly demanding environment
- Connect with relevant parties to negotiate and create lasting agreements for both sides

“The format of the RLI Summit was really ideal. During the breakout sessions, we had the ability to network, which was terrific, but we also got to see how a lot of times your biases are anchored in a certain point of view and if you just listen and are open to some other ideas, the intelligence of the group turns out to be more than you would think of on your own.” – Michael H. Lev, MD, FACR

Learn more and register today at radiologyleaders.org/leadership-summit
ACR Bulletin
1891 Preston White Drive
Reston, VA 20191-4326

Offer the ultimate in taste, convenience, and patient satisfaction with Breeza flavored beverages for CT imaging procedures.

- Refreshing taste, patient-friendly bottle
- Easy to drink and tolerate
- Encourages patients to drink full amount
- Sugar-free, gluten-free

To learn more about
Breeza™ flavored beverage for neutral abdominal/pelvic imaging
or Breeza® flavored beverage for use with oral iodinated contrast
contact your Beekley Medical Business Development Manager at 1-800-233-5539 or info@beekley.com

www.beekley.com