Allied Practice

SAFE PRACTICES

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INTERNATIONAL DAY OF RADIOLOGY

THEME: PEDIATRIC IMAGING
NOVEMBER 8, 2015

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ERRATUM: The July Final Read column incorrectly reported Evelyn Y. Anthony, MD, as assistant professor of pediatrics. Anthony is the associate professor of radiology and pediatrics at Brenner Children’s Hospital.

MISSION STATEMENT
The ACR Bulletin supports the American College of Radiology’s Core Purpose by covering topics relevant to the practice of radiology and by connecting the College with members, the wider specialty, and others. By empowering members to advance the practice, science, and professions of radiological care, the ACR Bulletin aims to support high-quality patient-centered health care.
With image quality like this, you and your patients can both Breathe Easy.

Capture body MR images the first time by freezing motion.

MRI is "the best test for characterizing liver lesions" according to the ACR’s appropriateness criteria. While body MR imaging has grown 28% since 2013, abdominal MRI exams are still challenging and results can vary due to patient motion and breathing artifacts. At Siemens, we’re helping make body MR imaging easier with FREEZEit—the exclusive technology named by Frost and Sullivan as the industry’s most effective solution in abdominal MRI.

FREEZEit delivers robust, free-breathing abdominal exams by intelligently resisting motion artifacts. Patients who have difficulty holding their breath can now Breathe Easy and be imaged with consistent, high-quality results. This same technology enables motion-free imaging in other areas of the body including the head and neck.

Expand your service coverage in MRI and become a preferred provider for pediatric, geriatric, and very ill patients who have been excluded from "the best test" because of breath-hold challenges or difficulty laying still. Improve treatment with more accurate results that come from clear, sharp, motion-free MR images. And enhance efficiency by obtaining the best image the first time—no need for rescans. It’s time for consistently high-quality abdominal MRI for all patients. It’s time to Breathe Easy.

Another example of Sustainable Healthcare Technology from Siemens.

1 American College of Radiology Appropriateness Criteria 2014
2 IMV 2014 MR Market Outlook Report
3 This option is Pending 510(k) clearance, and is not yet commercially available in the United States.

MR scanning has not been established as safe for imaging fetuses and infants less than two years of age. The responsible physician must evaluate the benefits of the MR examination compared to those of other imaging procedures.
Remembering John Curry
ACR Executive Director from 1984 to 2003

JOHN J. CURRY, former executive director of the ACR, passed away April 5, 2015, but left behind a legacy for the College, his co-workers, and his family. Although John’s work at the College preceded my tenure on the ACR Board of Chancellors, I was privileged to work with John when I first became involved with the Commission on Economics. I remember well his vital contributions in integrating radiology’s relative value system for our procedures into what became the federal Resource-Based Relative Value Scale. According to William T. Thorworth Jr., MD, FACP, our current ACR CEO, John had a reputation for being a class act and possessed a unique ability to pull multiple stakeholders together to reach a common purpose. Through his work in the Council of Medical Specialty Societies and using his contacts in the AMA, John was able to garner consensus for many of our strategies that preserved radiologist reimbursement as part of Medicare’s physician payment system rather than seeing our professional services included in the Medicare payments to hospitals (known as the “RAPs Proposal” of the 1980s).

While this was quite the accomplishment, John also had a passion for research and developed one of the most important arms of the ACR — our research center in Philadelphia. John came to the ACR after serving as the administrator of the radiation oncology department at Thomas Jefferson University Hospital in Philadelphia. During his tenure, John helped create the Radiation Therapy Oncology Group (RTOG), a cooperative effort of physicians, physicists, and numerous other stakeholder groups across many institutions, all dedicated to improving cancer care.

When John came to the College in 1975, he established a research center for the ACR in Philadelphia, and shortly thereafter the College became the recipient for all of the RTOG grants and the coordinator of the many RTOG-sponsored multicenter clinical trials in radiation oncology. Over the years, RTOG opened over 460 protocols, enrolled over 75,000 patients, and published over 700 papers reporting the results of its findings. Under John’s leadership, the College also became the recipient of the NCI-funded Patterns of Care Study, later known as Quality Research in Radiation, which for over 30 years conducted national on-site surveys on the practice of radiation oncology.

The model of establishing the ACR as an honest broker for multicenter clinical trials in radiation oncology subsequently led to the ACR’s application to lead a National Cancer Institute–sponsored imaging network. Working with Bruce J. Hillman, MD, FACP, and Constantine Gatsonis, PhD, John coordinated the establishment of the ACR Imaging Network (ACRIN), which subsequently led to important multicenter diagnostic clinical trials such as the Digital Mammographic Imaging Screening Trial and the National Lung Screening Trial. It was also during John’s tenure that lobbying efforts by the radiology community, including the ACR, led to legislation establishing the National Institute for Biomedical Imaging and Bioengineering. This division of the National Institutes of Health increased the focus of government-sponsored research on imaging.

As executive director of the College, John oversaw the move of ACR headquarters from Chicago to Reston, Va., which resulted in increased access to government for the ACR’s vital advocacy efforts. John also led the development of ACR-sponsored standards and practice parameters for radiology and, beginning with mammography, our practice accreditation programs. It was also under John’s leadership that the ACR developed the ACR Appropriateness Criteria® for ordering diagnostic imaging examinations and therapeutic procedures. All of these have become the backbone of the ACR’s current portfolio of programs for our members. Finally, John expanded our government relations efforts through the establishment of RADPAC®, the ACR Association’s bipartisan political action committee dedicated to educating members of Congress about issues important to radiology. From its beginnings in 1999, RADPAC has gone on to become the second largest medical specialty political action committee.

Although John leaves a legacy of important professional accomplishments, he was also quite beloved by

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Locating the Reading Room

HAVING TROUBLE COMMUNICATING WITH YOUR REFERRING PHYSICIAN? The problem may be that they don’t know where to find you. Researchers from the University of Colorado School of Medicine in Aurora, Colo., surveyed physicians at their facility to determine the perceptions of referring providers regarding the accessibility and availability of the thoracic radiology department. They found that 38 percent of the physicians surveyed did not know how to contact the radiologists and 64 percent were unsure of the location of the reading room.

To remedy the situation, the team sent an email to clinicians with contact information for the thoracic radiology department, as well as information concerning the reading room’s location. They also began including a template at the end of every thoracic radiology report that included the position of the reading room as well as the contact information and hours for the radiologist sending the report. A follow-up survey reported improvement — only 10 percent were unsure how to contact the radiologists, and 48 percent were unsure of the location of the reading room. Read the article at bit.ly/RadLocation.
SBI Holds Briefing in Opposition to USPSTF

IN JUNE, THE SOCIETY OF BREAST IMAGING (SBI) co-hosted a briefing on Capitol Hill with the Prevent Cancer Foundation’s Congressional Families Program to address the USPSTF recommendations. The theme was “Breast Cancer Screening: Ending The Confusion.” Representative Debbie Wasserman Schultz (D-FL) joined SBI leadership in condemning the USPSTF guidelines.

Immediate past president Murray Rebner, MD, FCR, questioned the task force’s expertise on the subject as well as the transparency regarding the methodology in forming the recommendations. He also took issue with the task force’s priority to spare women the potential negative aspects of mammography, despite the task force’s own admission that screening starting at the age of 40 reduces breast cancer deaths by 18 percent.

“Basically the task force made a value judgement. They said, in their opinion, they are trying to maximize the number of lives saved per mammogram,” Rebner said. “What they should be doing is saying, ‘How many lives can we save, period?’” For more information on the briefing, visit sbi-online.org.

To view the breast cancer screening recommendations, visit bit.ly/USPSTF_Mammo.

HERE’S WHAT YOU MISSED

The new Bulletin website is home to a wealth of content not featured in print. Check out blog posts, extra articles, and multimedia content at acrbulletin.org.

The Stories We Tell
Change doesn’t come from mandates on high. bit.ly/StoryChange

Reimbursement Revolution
Value-based payments are coming. How is the ACR positioning radiology for success in the new system? bit.ly/ReimburseRevolt

CDS Not Just for Referring Physicians

CLINICAL DECISION SUPPORT (CDS) has been touted as a valuable tool for referring clinicians, but could it also be valuable for radiologists? According to researchers from the NYU Langone Medical Center, the answer is yes. The researchers created a CDS system based on a set of guidelines the researchers developed for managing incidental, asymptomatic ovarian cysts and integrated it into their institution’s dictation software. The study found that radiologists were able to order more appropriate follow-up exams. Radiologists’ adherence to clinical guidelines improved 50 to 80 percent. Additionally, the likelihood that clinicians would choose the follow-up exam the radiologist recommended also improved. To read more about the study, visit bit.ly/CDSforRads.

“Health care is changing too rapidly to be stuck in the old mode of performance optimization — the kind where high-priced consultants conduct surveys, produce slide-decks, and make recommendations that may or may not ever translate into action.

— Todd Rothenhaus, MD, in “Using Data to Increase Patient Engagement in Health Care.” (Read more at bit.ly/DataCare)
Mark Your Calendars for IDOR

ARE YOU READY for this year’s International Day of Radiology (IDOR)? For the fourth year running, IDOR will be held on Nov. 8, the day Wilhelm Conrad Roentgen discovered the existence of x-rays. This year is dedicated to pediatric imaging.

Last year’s festivities included special courses for patients, lectures on oncologic imaging, and more. Look for this year’s events at internationaldayofradiology.com.

New Resources for RADPEER™ Users

HERE’S ANOTHER REASON TO USE RADPEER™: now participants can receive discounts on ACR educational materials, including educational materials like select CPI modules. Simply click on the Education Resources tab in the RADPEER program for more information. Check back frequently for new additions and special offers or go to bit.ly/RADPEER_ACR for more information.

Who Will You Nominate?

IT’S TIME TO SUBMIT YOUR NOMINATIONS for next year’s elected and selected positions. Among the open elected positions are president and vice president of the College; two positions on the BOC, one of which is held by an incumbent eligible to run for a second term; four positions on the Council Steering Committee; three positions on the College Nominating Committee (CNC); and two members-in-training representatives to the Intersociety Conference (ISC). Additionally, the CNC will select a private-practice representative to the 2016 and 2017 ISC Conference.

Any ACR member may submit nominations to the CNC for elected or selected positions on or before December 15, 2015. Detailed information is available at bit.ly/NominationsACR or through the ACR Governance Office. All information should be sent to Katie Kuhn via email (cnc@acr.org) or to the ACR headquarters at 1891 Preston White Drive, Reston, VA 20191.

Patients Find Talking to Radiologists Beneficial

ACCORDING TO A RECENT STUDY in the American Journal of Roentgenology, both radiologists and patients benefit from consultations. The authors developed a pilot program in which patients with certain imaging-related issues met with a radiologist when they came in for their regularly scheduled consultation with referring physicians. During the meeting, the radiologists would explain their role as physicians and review the patient’s imaging results in detail. Patients reported better overall experiences and an increased awareness of the radiologists’ role.

Despite concerns about the meetings disrupting workflow, the authors argue that participating radiologists gain the support of referring physicians, boost job satisfaction, and possibly improve patient outcomes. To read the study, visit bit.ly/RadsConsult.

Absolute Recommendations Taken More Seriously

HOW RADIOLOGISTS WORD RECOMMENDATIONS for follow-up imaging in reports is important, says a recent article published in the JACR®. Providers are more likely to adhere to the recommendations and send patients for additional exams if the recommendations are absolute, meaning they do not mention the physician’s judgement (such as “Follow-up chest CT is recommended”). Referring physicians were less likely to act upon those statements that were conditional (such as “Consider following up”). Researchers examined 29,138 outpatient chest x-ray studies performed at a tertiary-care academic medical center in 2008. Studies that recommended follow up in absolute terms were followed 68 percent of the time. Only 45.8 percent of the conditional recommendations were followed. To read the study, visit bit.ly/JACRAbsolute.
Happy Birthday, Medicare and Medicaid!

Fifty years after their inception, both programs continue to evolve with the shifting health care landscape. Where do radiologists fit in?

This Summer Retired U.S. Senator Bill Frist, who (as most of you know) was a practicing physician before entering politics, and Drew Altman, president and CEO of the Kaiser Family Foundation, wrote an excellent overview of the Medicare and Medicaid programs in JAMA (read more at bit.ly/Fifty_Years). Even if you are not a health policy nerd like me and don’t read the whole article, you may enjoy the video that accompanies it (find it at bit.ly/At50Years). It includes a clip of President Lyndon B. Johnson signing the bill into law on July 30, 1965, with former President Harry S. Truman (“The real daddy of Medicare,” quipped Johnson) by his side. It’s a fascinating story and included significant opposition from the physician community. Meanwhile, as the two programs celebrate their half-century, they cover one in three Americans and cost a combined trillion dollars. Medicare and Medicaid are extremely popular with beneficiaries even as both programs have seen fundamental changes in how care is delivered and paid for. The future of the programs is a subject of extensive debate, and both were integral to the Affordable Care Act’s intention to reform health care delivery and payment.

So as Medicare and Medicaid continue to evolve, how do we in radiology interact with these programs? And how does the ACR represent you in dealing with the body that administers them (the Centers for Medicare and Medicaid Services, or CMS)?

Let’s start with Medicare. Most of us in radiology participate in the Medicare program, and for many of us it is a significant portion of our overall revenue. Medicare has chosen to significantly decrease payments for imaging services over the last several years, contending that inappropriately high payments have led to overutilization. Your ACR economics team has fought that misperception tirelessly. We dedicate a team of our best and brightest volunteers to responding to Medicare’s rules and participating in the CPT and Relative Value Scale Update Committee (RUC) processes that develop codes and valuations for the services we provide. Not only do these volunteers spend at least nine days each year away from their practices attending CPT and RUC meetings, but they answer countless emails and, at least once a year, travel to CMS headquarters in Baltimore to make the case for the value of the services we provide. We may not always agree with Medicare’s decisions, but we engage with the team at CMS in a way that respects its perspectives and constraints while clearly putting the needs of our patients in the forefront. We believe that this strategy of active engagement has been instrumental in CMS’ decision to cover lung cancer screening and in the agency’s thoughtful approach to the Protecting Access to Medicare Act legislation as it relates to clinical decision support. (Read more at bit.ly/SGRPatch.) Our crack team of ACR staff experts is available at all times to help you understand Medicare’s rules and regulations. You’ll also find great resources on the ACR Medicare Payment Systems page at bit.ly/ACRMedicare.

We also engage with the lawmakers whose legislation affects the future of Medicare. This year was a clear example of the effectiveness of our Government Relations team as the flawed SGR payment formula was repealed by a huge bipartisan majority. This legislation provides us in radiology with a major challenge and a significant opportunity to not only participate but also take the lead in the transition from volume to value about which we have heard so much. I’ve written about the College-wide effort to respond to this new payment policy (read more at bit.ly/ACR-APMs), and you’ll be hearing much more about it in the future.

Moving on to Medicaid, this joint state and federal program covers the poor, especially poor children. It has been a focus recently because expansion of Medicaid eligibility was a key factor in the ACA. This provision was subsequently derailed in part when the Supreme Court ruled in 2012 that states could choose whether or not to expand their Medicaid coverage. Far more physicians participate in Medicare than in Medicaid, whose payment rates have traditionally been lower with confusing rules about which services are covered. The ACR’s task of tracking and influencing this program is made much more daunting than our work with Medicare because Medicaid programs vary by state and many states have transitioned to managed care programs to control costs.

Despite the obstacles, we decided to engage actively because we believe that all our patients deserve the best care possible and we saw some real opportunities. Our

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Precision Imaging: The Next Frontier

Radiology’s next great advancement is as small as the cells in our bodies.

In recent years, Angelina Jolie has made headlines with a series of New York Times op-eds detailing her efforts to avoid developing cancer. In 2013, the Oscar-winning actress, whose mother, grandmother, and aunt all died of cancer, wrote that she had a mutation of the BRCA1 gene and detailed her decision to have bilateral mastectomy. In 2015, she published another op-ed about her decision to have bilateral salpingo-oophorectomy.

But what if we lived in a world where none of her procedures had been necessary? What if the growing number of women electing to undergo mastectomies in the U.S. could have undergone a highly targeted form of treatment that stopped the cancer the moment it was detected? This may sound like science fiction, but it is the promise of a new approach to patient care gaining acceptance within both radiology and the wider medical community.

Finding the Phenotype

Precision imaging is a relatively new concept that’s built on the foundation of precision medicine. In a 2011 white paper, the National Research Council of the National Academies defined precision medicine as “the tailoring of medical treatment to the individual characteristics of each patient.” As an offshoot of precision medicine, precision imaging can be used to combine data about a patient’s clinical phenotype and genotype/gene expression. (See “Glossary of Terms.”) Doing so can help categorize patients into subgroups based on similar clinical presentation and disease biology.

Phenotyping patients is something radiologists have been doing since the beginning, argued James H. Thrall, MD, FACR, chair emeritus of the department of radiology at Massachusetts General Hospital in Boston, during a recent interview. Only, he said, radiologists haven’t traditionally thought of themselves as experts at subcategorizing patients in this manner. During his Moreton Lecture at May’s ACR 2015 meeting, Thrall said it is high time radiologists shift their thinking.

“Although it has never been articulated explicitly in the past,” noted Thrall, “radiologists are fundamentally in the business of creating imaging phenotypes through their systematic application and analysis of imaging studies, enumeration of findings, and the application of grading, scoring, and classification systems linked to their findings.”
Why is this type of disease categorization significant to the future of the specialty? One of the most important reasons, said Thrall in a recent JACR® article, has to do with clinical trials. “Imaging methods play a key role in categorizing patients into subpopulations for clinical trials through scoring and classification systems,” Thrall explained. “These systems establish imaging phenotypes that distinguish important characteristics between patients such as relative prognosis and likelihood of benefitting from a particular therapy.”

**A Tailored Approach**

Giles W. Boland, MD, FACR, professor of radiology at Harvard Medical School and vice chair of business development at Massachusetts General Hospital Cancer Center, agrees that precision imaging can play a big role in selecting patients for clinical trials. “Right now, clinical trials are clunky from an imaging perspective,” said Boland. “We often use generic CT scanning or MRI depending on the particular patient or disease, or we may use plain film. Using a generic test, for want of a better word, to image a particular subtype of disease is not very precise. More precise imaging techniques identify, delineate, and quantify the extent of disease better. They can often be the earliest predictors to the likely patient response and outcome to specific therapies and can, in some circumstances, predict the genetic mutation responsible for the disease.”

In Boland’s estimation, precision imaging will see radiologists collaborating with pharmaceutical companies from the ground up to discern which modalities and tests are most likely to yield useful information for each particular subset of patients. “We’re going to tailor the imaging to the question being asked,” stated Boland.

**GLOSSARY OF TERMS**

In an upcoming JACR® article titled “Imaging in the Age of Precision Medicine: Moreton Lecture,” James H. Thrall, MD, FACR, defines several terms key to the practice of precision imaging.

**Phenotype**

The term “phenotype” is used in medicine — and, more generally, in biology — to reference all of the observable traits or characteristics of an organism. The concept of phenotype also encompasses phenomena made observable through technologies including imaging, laboratory testing, and various kinds of pathology studies. Disease phenotypes encompass all of the observable characteristics related to a particular disease or condition.

**Imaging Biomarker**

A biomarker is defined as any finding or parameter that is linked to the presence, severity, or behavior of a disease or condition. In current usage outside of radiology, the term “image finding” would be replaced by “imaging biomarker.”

Today the imaging toolkit on which to build imaging phenotypes has expanded to include diverse applications encompassing the categories of molecular, metabolic, micro-environmental, and functional imaging biomarkers.

**Genotype/Gene Expression**

All or part of the genetic constitution of an individual or group.
This may sound like science fiction, but it is the promise of a new approach to patient care gaining acceptance within both radiology and the wider medical community.

“Clinical trials with pharmacological drugs should be married to precision imaging in the context of specific molecular targets (e.g., proteins found only on the surface of cancer cells),” said Sam Gambhir, MD, PhD, chair of radiology, professor of clinical investigation in cancer research, and professor of bioengineering and materials science and engineering at Stanford University. During clinical trials, he asked, why not customize the imaging so that it’s matched to the particular drug or treatment in question? “For example,” said Gambhir, “if I have a drug that is used to treat lung cancer, and the drug affects a specific receptor only found on lung cancer cells, then the imaging for this patient isn’t only a CT scan. It’s a PET scan that measures that same receptor that the drug interacts with.”

So instead of watching the tumor either shrink or not shrink, concluded Gambhir, the radiologist could ascertain that the drug is working because it’s occupying the receptor it’s designed to hit.

The benefits of this level of precision are myriad. “We can use precision imaging to help more effectively identify, evaluate, and monitor patient subpopulations,” asserted Boland. “And maybe as a result, a given clinical trial can be reduced from five years to two years.” This would mean a significant reduction in cost to the pharmaceutical companies, not to mention major benefits to patients who would gain access to new drugs more quickly.

Communication Is Key

Beyond helping select patients for clinical trials, radiologists can also utilize imaging phenotypes to make diagnoses, estimate the severity of a disease, and track a patient’s prognosis. However, according to Thrall, to accomplish all of this, radiologists need to communicate clearly so that everyone in the care pathway understands each other. Since many referring clinicians use words associated with precision medicine, this means that radiologists should update their lexicons, replacing antiquated terms like “Roentgen signs” with more updated terms like “imaging biomarkers.” (See “Glossary of Terms.”)

For radiology to enter the precision imaging era, radiologists must bring more to the table than simply interpreting scans. Understanding the clinical significance of findings and leveraging this knowledge to influence the course of treatment is the future of imaging. It is time for radiologists to begin thinking of themselves as the physicians most equipped to subcategorize patients and monitor their treatment on a molecular level.

By Chris Hobson, Imaging 3.0™ content manager

ENDNOTES

5. Thrall JH. Moreton Lecture: imaging in the age of precision medicine. JACR. In press.
ALLIED PRACTICE

Making your practice a safe place for transgender patients requires subtle yet vital considerations.
In 2011, the National Center for Transgender Equality and the National Gay and Lesbian Taskforce published a report analyzing the current state of discrimination against transgender individuals in the United States. They found that 25 percent of the surveyed group of transgender people experienced some form of harassment in a medical setting. Further, 19 percent had been denied medical care due to their transgender status. Others — about 28 percent — avoided medical care due to fears about harassment or because of past medical experiences.¹

The tide of health care is changing. With the transition to value-based care, it is more important than ever to consider patient needs. And that goes for all patients, including those of social and gender minorities who have experienced stigma and discrimination leading to significant health-care disparities, notes Katarzyna J. Macura, MD, PhD, FACR, chair of the ACR Commission on Women and General Diversity.

For transgender and other gender non-conforming patients, a variety of needs must be met in order for patients to have a safe and positive imaging experience.

Expressed Identities

To understand the individual needs of a transgender person, we must first understand what “transgender” means. Transgender individuals experience their gender as different from the one assigned at birth. It is important to note that gender falls along a spectrum, rather than the binary of male or female. The term “transgender” can include individuals who are agender (having no gender), are bigender (having more than one gender), or experience gender in other ways outside the gender binary. “Transgender is a broad term that includes a wide range of people with varying concepts of gender identity and at different stages of transitioning. We are not talking about one specific group but individual people with varied needs and varied levels of comfort in a medical setting,” says Jordana Phillips, MD, radiologist at Beth Israel Deaconess Medical Center and lead author of the article “Breast Imaging in the Transgender Patient.”²

Charles Girard, a transgender man and activist, explains being transgender like this: “I was raised female, but as I got

We are not talking about one specific group but individual people with varied needs and varied levels of comfort in a medical setting.

— Jordana Phillips, MD
older I realized it wasn’t an accurate representation of who I am. I couldn’t figure out what felt wrong, but I often felt this nagging feeling in the back of my mind. Once, someone spoke to me about my being an aunt and I remember thinking, ‘I could never be an aunt. I’d be an uncle.’ Once I began taking hormones and people began calling me ‘sir’ in public, I felt social anxiety melt away and I began to feel happier. It’s ultimately about happiness and being comfortable in your skin.”

Communication Breakdown
How can you help your transgender patients feel comfortable in the imaging suite? One of the simplest and easiest ways is to consider the language you use with your patients verbally, on your intake forms, and in your reports. “In our office, we make sure to use our transgender patients’ preferred names and pronouns, rather than the ones assigned at birth. It’s important not to make any assumptions, and it’s also okay to ask,” says Phillips.

Girard adds that not asking for a patient’s preferred name can have damaging consequences for the transgender patient. For example, consider a transgender man who goes by James while his legal name is still Jessica. If a staff person calls out, “Jessica?” in the waiting room, James — and potentially other patients in the room — may feel the space is no longer safe or comfortable, says Girard. He notes that you can also help address preferred pronouns and gender by allowing patients to fill in the space for gender, rather than having a checked box for “male” or “female.” It’s also helpful to provide a space for the patient’s name and pronouns.

Cultural Competencies
Training your staff on cultural competency is also key, notes Phillips. Girard says, “It’s important that staff react appropriately in the office and over the phone. As a trans person, each time you call a physician to make an appointment, you have to come out all over again. Hearing the other person sound confused or judgmental over the phone is devastating.”

Physicians should also consider the way they and their staff interact directly with the patient. For example, if a staff person is helping the patient and needs to discuss a part of the body that is specifically gendered, such as the chest or genitals, have your staff ask what kind of language to use, says Girard. If a transgender man is having his reproductive organs imaged, using the terms “ovaries” or “womb” may be uncomfortable for him. He may have other words the physician could use. The physician could also offer to point to the body parts on a chart.

Safe Spaces
You can also help transgender patients feel more comfortable by evaluating the way your waiting, imaging, and changing rooms are laid out. “Lesbian, gay, bisexual, and transgender patients search for subtle cues in the environment to determine acceptance — it’s important that practices have ways of acknowledging that they are safe spaces for these individuals,” says Macura. One of the things she suggests is to develop and display non-discrimination policies that include sexual orientation and gender identity.

Adds Girard, “Try making your office and waiting area more gender neutral. For example, the excessive use of pink or of female images on the wall at a breast imaging facility might invalidate a transgender man’s identity as male. By coming into an office like that, you stand out. You’ve come out to the entire office just by walking in.”

Also consider your changing areas, says Phillips. “Many breast imaging practices have changing rooms for women, and our transgender women feel comfortable there. However, these areas may not be comfortable for transgender men — one of our patients once commented that he felt out of place and exposed there. That discomfort frequently makes transgender men who have not had top surgery skip mammography. And as a physician, that is concerning to me — these patients may be more likely to present with more advanced breast cancer because they are not getting routine screening,” she says.

Phillips says that her institution addresses this issue by escorting their transgender male patients directly into the mammography rooms, so that no one has to use a changing area.

Most of the considerations made for transgender patients can be so subtle that cisgender (non-transgender) patients wouldn’t notice, but they make a huge difference in the lives of transgender patients. “There are so many places that are unwelcoming to transgender people, so having a safe space — especially a medical one — is vital,” says Girard. “Radiologists can help make that happen.”

ENDNOTES

LEARN MORE
The American Society of Radiologic Technologists recently launched “Patient-Centered Care for Diverse Populations,” an online series to aid medical professionals in caring for patients from a variety of backgrounds. More information at bit.ly/ASRTDiverse.
The Value of ACR Membership

A Call to Action

With over 37,000 members, there are many reasons to join the ACR. While each benefit adds to the collective value of ACR membership, two characteristics distinguish the College among radiological organizations: foresight and leadership.

The College is constantly striving to develop programs, products, and services that address the changing landscape of radiology and health care. For instance, the ACR Appropriateness Criteria®, which were first developed over 20 years ago, are now integrated into recent federally mandated clinical decision support systems. Beginning in 2017, referring clinicians must consult these systems prior to ordering advanced imaging exams. These evidence-based guidelines assist referring physicians and other providers in making the most appropriate imaging or treatment decision for a specific clinical condition. Employing these guidelines helps providers enhance quality of care and contribute to the most effective use of radiology. More recently, initiatives such as Imaging 3.0™ provide steps that allow all radiologists to take a leadership role in shaping the U.S. health care system. More than just a collection of resources aimed at educating radiologists about health care reform, Imaging 3.0 is a mindset: imaging specialists must demonstrate their value in delivering high-quality patient care, and Imaging 3.0 is the pathway to that goal. Learn more about taking the first steps at bit.ly/Img3FirstSteps.

The ACR also leads in defending and advancing the profession. It is the foremost organization advocating for the entire profession of radiology. Issues like physician self-referral, telemedicine licensure, and the radiology relative value scale would not have occurred without the steadfast efforts of the ACR to bring them to the attention of Congress, state legislatures, and the public.

Successes like these do not occur by happenstance but rather through strong leadership and foresight, backed by a dedicated volunteer base of over 2,000 individuals, a committed professional staff, and the direct support (including member dues) of the profession.

We live in challenging times. We face issues that include greater evidence-based justification for covered services, an aging population, computer-aided diagnosis, potential for commoditization through telemedicine, cost-cutting pressure from payers, greater consolidation with continued expansion into multi-disciplinary care, and shifting employment models. The ACR has and will continue to take on these challenges on behalf of the profession.

It is critical to understand that although the College provides benefits for the collective good of the profession, roughly 30–35 percent of eligible prospective members do not join. It is also critical to know that nearly all of our advocacy and economics support comes directly from member dues. Hence, our ability to best serve our members, the profession, and patients may be restricted by the lack of support from these eligible non-members. By receiving the ACR Bulletin, you are an ACR member and we thank you for your contribution. However, there are likely peers or members of your practice who have not joined the College. Please take the time to reach out to them and encourage them to join. Learn more about ACR membership at bit.ly/ACRbenefits.

We recognize that all of you have invested much to reach your professional position. Through leadership and foresight, we hope to ensure that the investment in your career and commitment to patient care is protected, promoted, and advanced. And as valued members, you can also protect your investment by responding to this call to action and bringing your non-member colleagues into the fold. The ACR is 37,000 members strong, but it could be stronger by expanding its reach to the thousands of eligible non-members who benefit from our services yet are not part of the community. As valued members, we hope you will reach out to your colleagues. The profession’s ability to help shape its future is greatly enhanced when everyone belongs. We thank you for your membership and appreciate your ongoing support of the ACR and the profession.

By Brad Short, ACR senior director of governance and membership services
Researchers estimate that the number of academic peer-reviewed papers increases by around 3 percent each year. Which doesn’t sound like that much until you consider just how many papers are being published: 1.8 million in 2012. Although exact numbers are not yet available, that puts us at almost 2 million papers for 2015. In this sea of articles, getting your work published, shared, and cited may sound like climbing Mount Everest. But keeping a few key tips in mind can help you navigate the treacherous terrain of academic publishing.

**Keep It Simple**

*JACR* Editor in Chief Bruce J. Hillman, MD, FACR, says that the ingredients to success are simple language and direct declarative sentences. Medical professionals sometimes use specialized jargon, obscure acronyms, and convoluted sentence structure, he says. Hillman encourages writers to be aware of this challenge and to constantly make sure their work is clear and relatable. “Produce the shortest article possible to make your point and more people will read it,” he says.

**Consider Your Audience**

Academic writing, as with any form of communication, is futile without an audience. University distinguished professor and director of the Campus Writing and Speaking Program at North Carolina State University Chris Anson, PhD, urges writers to consider their audience as they choose their words. “You start thinking about your work and you are already steeped in that language,” he says.

*JACR* Deputy Editor Ruth C. Carlos, MD, suggests that writers “need to be able to translate their findings into language that is accessible to the average practicing radiologist, showing how it is meaningful in a radiologist’s day-to-day practices.” To help facilitate this, Anson encourages writers to share writing with their radiology colleagues before publication. “Have them tell you when they are totally bamboozled or don’t understand something,” he says. “Draft readers are a litmus test for giving us feedback.”

**Add Narrative**

Telling a story can also be a good way to invest readers in your research. “There is room to contextualize,” Carlos offers. Adding narrative or anecdote can help readers see the big picture. It also can illuminate why the research matters and whom the findings help. This allows readers to feel personally connected to the information and makes for a more engaging read.

Though adding narrative can be a good way to add personality to an article, writers must remain committed to the facts. “Storytelling has its place, but you want to make sure it doesn’t overemotionalize a topic,” Carlos cautions. In other words, make sure the narrative you provide is focused, stays brief, and bolsters the research rather than overshadowing it.

**Start Sharing**

And your job isn’t over once the paper is published. Now it’s time to market your work. In addition to publicity from the publisher, many individuals are turning to social media to network.

In fact, a retrospective study directed by Jenny K. Hoang, MD, neuroradiologist at Duke University Medical Center, found that a blog post shared on social media received more than ten times the views of articles on the same topic that were not shared.

Facebook and Twitter are good places to start and both allow you to promote work to your friends, colleagues, and other followers. ResearchGate allows members to access and share research; acquire statistics about views, downloads, and citations; connect and collaborate with colleagues and other specialists in the field; and even pose questions to other researchers about similar topics. Similarly, LinkedIn provides a platform to link articles to professional resumes and facilitates connecting with colleagues and other specialists.

**Practice, Practice, Practice**

“Writing is a skill as much as exercising is a skill or ballroom dancing is a skill,” says Carlos. “You have to practice it.” And that means sitting down at your keyboard and getting started. “After all,” Anson says, “you can’t get good just by thinking about it.”

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ENDNOTES


Surprising Strategies
The RLI’s first graduate shares lessons learned along the way.

**When you imagine a successful leader,** it’s easy to picture a scene not unlike that famous painting of George Washington crossing the Delaware: he’s standing in the prow of his boat, the American flag streaming behind him. Washington is clearly bound for victory.

Yet for those studying the art and science of leadership, success often looks very different. Sometimes, to be a leader, you have to get creative. For Ian A. Weissman, DO, and other individuals studying at the Radiology Leadership Institute® (RLI), this is a lesson learned throughout the RLI’s coursework. Weissman has become the first to achieve the highest level of mastery that the RLI offers. Now that he’s reached the top, Weissman shares some of the more surprising leadership lessons and tactics he’s learned.

**Lead from Behind**
In that famous painting, Washington is literally and figuratively leading from the front. Weissman’s first tip is to dispel that image: sometimes, he says, leading your team to victory requires you to take a backseat.

Weissman has found that some of the most successful initiatives and practices take a synergistic approach. To make true collaboration happen, however, everyone’s voice needs to be heard. Some of your group members may be more introverted and prone to keeping their thoughts to themselves, while others have no problem voicing their opinions.

In situations where everyone’s voices are not equally heard, notes Weissman, the leader’s role is not to be the loudest voice in the room. Rather, she should act as a facilitator, making sure everyone is heard and no one point of view dominates. “It’s got to be a team approach,” says Weissman. “If everyone follows one voice, things may go well for a while, but there’s a good chance you fail to consider other options and viewpoints. You’ll never be as successful,” he adds.

**Listen to the Masses**
Here’s a tip you probably never thought you’d hear: sometimes it really matters what people think. In this case, it’s your referring physicians. The RLI and Imaging 3.0™ both insist that to survive, radiology must present its value to other members of the health care team. But how do you do that?

Weissman notes that sometimes you need to make sure that your referring physicians realize the underlying work you’re doing. For instance, Weissman’s time in the RLI has helped him ensure that the reports he provides are clear and actionable. Part of making those reports involves reading the patient’s chart or any other information available. Weissman includes a note saying that he’s read all patient information, and he makes references to it in his reports — that way, referring physicians know he’s working to provide value. “I actually state outright that I reviewed the chart when I make a specific interpretation. It’s the radiologist’s responsibility as a consultant to tie together all the available information. We need to remember that a referring physician faces just as many challenges as we do, and we should try to make their work easier when we can. It improves the end result for our patients, and it demonstrates our value,” says Weissman.

**Play the Long Game**
Change doesn’t always come easily. It’s a tough lesson, but one that most RLI attendees face, says Weissman. “Organizations can be very slow to change, and sometimes it’s hard to circumvent the status quo. You have all these great ideas, and people aren’t always receptive to them,” he adds.

One way to combat this is to go for the little victories. Bring up ideas you find interesting as often as you can; eventually, some will take hold. Another way Weissman shares principles he’s learned is through his residents. Physicians in training are still forming their habits and are often more receptive to new ideas, says Weissman. And, whoever they are, when an idea strikes a chord with someone, they may share with their peers, who in turn share with others. By creating change through a kind of grassroots method, you can disseminate good information and slowly change minds.

By Meghan Edwards, copywriter for the ACR Bulletin

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If you’re looking to find more leadership tactics and tips, check out the RLI at www.radiologyleaders.org.

WWW.ACR.ORG 19
OR 15 YEARS, RADIOLOGYINFO.ORG has been bringing information to the public about a wide range of radiology exams. The collaborative effort between RSNA and the ACR recently underwent a major redesign with two goals in mind: to offer seamless access on a variety of devices and to convey the information in a way that would be easier for the general public to digest.

**Seeking Patient Input**

Conceived in 1997 and operating since 2000, RadiologyInfo.org offers more than 200 radiologic procedure descriptions, disease/condition topics, and screening/wellness articles with easy-to-understand descriptions about what to expect from imaging exams, how to prepare, and more.

“Our research shows that in the past, the site has been a little bit daunting for the public,” said Geoffrey D. Rubin, MD, MBA, FACR, co-chair of the RSNA-ACR Public Information Website Committee that oversees RadiologyInfo.org. “With this redesign we have not sought to ‘dumb down’ or reduce the quality of content in any way — we have simply made the more advanced content available for secondary reading once the person has identified they want to know more.”

**Updating Technology**

Keeping up with changing technology was central to the redesign, Rubin said. The site now adapts to any screen size regardless of whether a person is using a desktop computer, smartphone, or tablet.

“Everything about the way people access information has changed in the intervening years since we began RadiologyInfo.org,” said Elliot K. Fishman, MD, FACR, co-chair of the committee. “We wanted to be certain we were ahead of the curve, not behind it.”

**Reframing Content**

Staying ahead of the curve also required a thorough vetting of the content on the site to make it as user-friendly as possible. The process began in 2013 with several rounds of focus groups and usability testing. The research sessions involved medical personnel and members of the general public interacting with the site and discussing how they research medical information.

One major undertaking involved the many videos on the site. Before the redesign, the videos were PowerPoint presentations with an audio overlay. New videos developed by the committee feature radiologists describing radiology procedures directly to viewers.

“We looked at what users said they wanted and took that to heart,” said Fishman, professor of radiology at Johns Hopkins School of Medicine. “With videos, users told us they wanted to see a real doctor explaining the information rather than a PowerPoint presentation. It was a very simple, but effective, change to make.”

Another change involved segmenting the content into two tiers. The first tier contains basic information about a particular test. Focus group members indicated that sometimes they prefer easily digestible...
CONTINUOUS

Remembering John Curry
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his co-workers. He venerated the accomplishments of others when projects were successful and shouldered the blame when things did not work out as planned. According to Pam Wilcox, RN, MBA, ACR executive vice president for quality and safety, John’s enduring leadership style included celebrations for accomplishments of our staff members and even birthday dinners at Chez Francois in Great Falls, Va. Pam says rumor has it that after John retired, Chez Francois lost its best customer and had to close its doors! Apparently the celebrations often included dancing because it is said that John really loved to dance.

In addition to his service to the ACR, John also leaves a legacy of dedication to family. On behalf of our profession, I thank John’s wife, Meg, and his daughters and grandchildren for sharing John with the College and our profession for those 26 years. [2]

ENDNOTE

Redesigning Patient Communication
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snippets of information to get a general idea about a particular exam. The second tier of information includes more in-depth procedure descriptions for users who want information beyond the basics, along with technical aspects of an exam.

“Even the names of some imaging tests can be daunting and scary or disorienting,” said Rubin, chair of the radiology department at Duke Clinical Research Institute. “Our goal is to demystify the tests so that patients and those who support those patients are as reasonably informed as possible to allay anxiety and concern.”

Bringing Information to Patients

The committee believes the redesign will lead to increased traffic, which will then help the site’s placement on Google searches, a key in differentiating it from myriad competitors. “It’s a Google world, where people expect to find what they’re looking for within one click,” Fishman said.

“The redesign brings the site up to where it should be. Diseases haven’t changed, but we’ve learned how to present the information better.”

Rubin added that in an effort to maximize the value of the site, the committee encourages radiology practices and other medical professionals to emphasize the resource to their patients. Referring physicians can help their patients prepare for an exam by pointing them to the site so they arrive at the radiologist’s office ready.

“The site is really alive and evolving,” he said. “We don’t want it to become static. It will always be a work in progress.” [2]

Happy Birthday, Medicare and Medicaid!
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Medicaid network, chaired by Raymond K. Tu, MD, FACR, now includes representatives from almost every state. We have chosen to frame our conversation around quality and appropriateness, and we have made contact with the leaders of several of the managed care organizations that are contracted with states to administer benefits.

We have been concerned to see imaging utilization controlled by radiology benefit managers and have advocated strongly for clinical decision support instead.

We have also collaborated with the Society for Pediatric Radiology. Although CMS, recognizing that low payment rates may result in reduced access, made payment rates for primary care services to Medicaid beneficiaries equal to Medicare’s in 2013 and 2014, it did not extend that parity to imaging services. We are always looking for new volunteers to help us with our Medicaid team, so please email me if you are interested.

As you can see, your ACR Economics team is hard at work representing you at the table with these two important programs and ensuring that the imaging care delivered to beneficiaries is of the highest quality and value. As always, you can reach me at gmcginty@acr.org, and I encourage you to follow me on Twitter at @DrGMcGinty. [2]

By Paul LaTour, senior communications manager at RSNA
Tell us about a colleague who inspired you.

MENTORS. What an essential ingredient to success in one’s professional career. I have been blessed to have one at every stage of my life. All my mentors have had a part in shaping me, but one individual in particular inspired me to become the radiologist that I am.

Col. Alfred B. Watson Jr., MD, USAF (Ret.), was the director of training at my program. On day five of my surgical internship, I showed up in his office asking for a slot in the next year’s radiology residency class. I remember his incredulity when he asked me how I could be sure, given that it was only the fifth day of my internship.

As a mentor, he taught me all of the skills that I now have and those we consider essential in our profession. Dr. Watson was and is a man of character. He was the consummate professorial father figure whether in instruction or in time of discipline. He was selfless, never asking of us what he would not do himself. In short, he taught me that with those character traits you could have the following philosophy in life: Always take the high road and everything else will take care of itself. In reliving my medical school experience so many years ago, I realized that I have modeled my professional life after the one he taught me to have. I hope that I have taught that same model to others.

Mark H. LeQuire, MD, FACR, radiologist at Montgomery Radiology Associates, in Montgomery, Ala.
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