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Bulletin



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AMERICAN COLLEGE OF
RADIOLOGY

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OUR MISSION: 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 *Bulletin* aims to support high-quality patient-centered healthcare.

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

Digital edition and archives of past issues are available at ACR.ORG/BULLETIN.



All Things Unequitable

Health equity requires a commitment to thoughtful patient care.

D.H. LAWRENCE, THE WRITER AND POET, has been quoted as saying, “Ethics and equity and the principles of justice do not change with the calendar.” A fitting quote considering the times, when a pandemic has shed light on healthcare disparities and cast a long overdue call for health equity in our country.

We sometimes forget that while equality is a good thing (every individual or group of people is given the same resources or opportunities), equity is what we must strive for. Each individual or group must be offered tailored resources and opportunities to reach their optimal health outcome.

As radiology touches nearly every part of patient care, radiologists are uniquely positioned to spearhead efforts to address health disparities and accommodate diverse patient population needs.

When it comes to health equity, intentions are not enough. As John F. Kennedy said in September 1960, “Efforts and courage are not enough without purpose and direction.” We must gain a better understanding of action needed to promote health equity at societal, community, and individual levels. We need to familiarize ourselves with ongoing health equity initiatives within organized medicine and radiology. The role that radiologists play in ensuring quality patient care in their communities must be one of leadership.

The Radiology Health Equity Coalition (RHEC) is bringing together the radiology community to address health disparities and measurably change outcomes. This mobilized network of patient-focused radiology organizations and radiologists will collect and disseminate resources and best practices, advocate for and connect with patients and community members,

and collaborate on programs and services to empower others to act.

The ACR’s strategic plan has undergone review and revision that includes health equity — as it should. The strategic plan encompasses patient- and family-centered care, healthcare payment policy, data science and AI, member engagement, and building and strengthening external relationships. Which one of these is not critical for health equity?

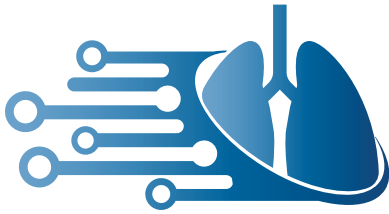
The RHEC, initially convened by the ACR, includes the American Association of Physicists in Medicine (AAPM), the ABR, the Association of University Radiologists, the RSNA, the Society of Chairs of Academic Radiology Departments, the Society of Interventional Radiology, the Society of Nuclear Medicine and Molecular Imaging, and the Radiology Section Councils of the AMA and the National Medical Association as core members, comprising its mobilization team. Coalition partners include the American Society of Neuroradiology, the RBMA, the Society of Breast Imaging, the SPR, and the Hawaii and Massachusetts state chapters of the ACR.

The RHEC’s growth, month after month relates to “strength in numbers.” In its unique role, the RHEC is able to leverage the areas of expertise of each of its member organizations to produce actionable results translating into improved health outcomes for all patients, regardless of ethnicity, socioeconomic status, care setting, or race. The full weight of the radiology profession will be needed to change policies and clinical practices that have allowed such disparities to persist.

As radiology touches nearly every part of patient care, radiologists are uniquely positioned to spearhead efforts to address health disparities and accommodate diverse patient population needs. I encourage all ACR members to pledge their commitment and action to advance this vital initiative. For more information on the RHEC, visit radhealthequity.org and commit to the cause. Taking inspiration from the playbook of the Olympic organizations, “We all win when everyone can get to their starting line.” **B**

**RADIOLOGY HEALTH
EQUITY COALITION**





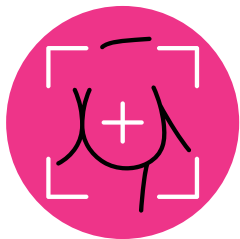
CMS Releases Instructions to Implement LCS Policy

CMS recently released guidance to physicians, hospitals, and other providers billing Medicare Administrative Contractors (MACs) of the expansion of lung cancer screening services (LCS) provided to Medicare patients. Medicare covers LCS with low-dose computed tomography if all eligibility requirements listed in the National Coverage Determination 210.14 are met.

The expansion, effective Oct. 3, closely aligns with the U.S. Preventive Services Task Force's recommendation. CMS is lowering the minimum age for screening from 55 to 50 years and reducing the smoking history from at least 30 pack-years to at least 20 pack-years.

CMS instructed MACs to deny claims submitted for beneficiaries that are not between the ages of 50 and 77 (55 and 77 for date of service prior to Feb. 10) at the time the services are rendered. CMS allows Healthcare Common Procedure Coding System code G0296 and Current Procedural Terminology code 71271 to be billed only if the beneficiary is between the ages of 50 and 77 for claims with a date of service on or after Feb. 10.

For additional information about LCS coverage and reimbursement, contact [Alicia Blakey](mailto:ablakey@acr.org), ACR principal economic policy analyst, at ablakey@acr.org. Read the full release at bit.ly/CMS-Instructions.



Mammography Screening Still Rebounding From COVID-19 Pandemic

A study conducted by the ACR's National Mammography Database (NMD) Committee and the Harvey L. Nieman Health Policy Institute® (HPI) showed that the use of breast imaging services has only reached 85.3% of pre-pandemic usage.

"These data raise concerns that screening mammography will remain underutilized among asymptomatic women," says senior author Margarita L. Zuley, MD, FACR, professor at the University of Pittsburgh Medical Center and chair of the ACR's National Radiology Data Registry Steering Committee.

While the rates of diagnostic mammograms, cancer diagnoses, and breast biopsies have increased since last year — around 90% of pre-pandemic usage — they have not reached pre-pandemic rates. According to study author Lars J. Grimm, MD, MHS, associate professor at Duke University Medical Center and chair of the ACR's NMD Committee, "This could lead to a rise in future cancer diagnoses and a larger proportion of later-stage diagnoses with associated worse prognoses."

You can read the full study in the *JACR*® at bit.ly/Mammography-Study.

MedPAC Meeting Focuses on Payment Policies

The Medicare Payment Advisory Commission (MedPAC) met virtually April 7–8 to discuss payment policy topics in preparation for its June report to Congress. The commissioners discussed social determinants of health (SDOH) and proposed ways to leverage Medicare policies to address disparities caused by social risk factors. Many organizations in the public and private sectors are prioritizing SDOH for measuring quality improvement, which aligns with CMS' push for advancing health equity as it relates to areas such as quality reporting and innovation models. The commissioners cautioned that while strong incentives for achieving value are critical, it is important to apply these incentives fairly. MedPAC has started analytic work examining safety-net providers who predominantly care for beneficiaries with SDOH to guide Medicare in reducing their financial strain.

The final session of the meeting focused on aligning varied fee-for-service payment rates across ambulatory settings, with the goal of reducing beneficiary cost sharing. The commissioners debated the best use for the hospitals' savings from aligning payment rates: whether to keep budget neutrality to offset the cost of the program, to keep the funds as savings, or temporarily support safety-net providers.

For more information, contact [Kimberly Greck](mailto:kgreck@acr.org), ACR's economic policy analyst, at kgreck@acr.org, or [Christina Berry](mailto:cberry@acr.org), ACR's economic policy team lead, at cberry@acr.org.



Sign Up for the AIRP's Four-Week Rad-Path Correlation Course

The ACR Institute for Radiologic Pathology™ (AIRP®) rad-path correlation courses will be held virtually through August 2022 with both synchronous and self-paced lectures. AIRP alumni are eligible to receive a 50% discount on the registration fee. This discount cannot be combined with any discounts on AIRP categorical courses.

The Sept. 12–Oct. 7, 2022, course will be held in person at the AFI Silver Theatre located in downtown Silver Spring, Maryland.

For course registration or login questions, please submit your inquiries to AIRPRegistrations@acr.org or call 1-800-373-2204.

“Radiologists, medical centers, and national organizations must redouble their outreach efforts to encourage patients to return to their pre-pandemic screening mammography practices, especially for Asian women and older women.”

—LARS J. GRIMM, MD, MHS



IN MEMORIAM: James M. Moorefield, MD, FACR

James M. Moorefield, MD, FACR, former chair of the ACR BOC, passed away on May 18, 2022. After graduating from Georgetown University, Moorefield elected to continue his studies back at home in New York, attending the State University of New York (SUNY) College of Medicine at New York City. He continued his career as a medical officer in the U.S. Navy before starting his radiology residency at the University of California, San Francisco, before transitioning to a private practice in Sacramento.

Moorefield began work with the College as a councilor from California. One of the first accomplishments of his early years with the College came when he was chosen to lead a team to develop a radiology relative value scale that could be used by Medicare. Moorefield eventually served as vice chair and then chair of the ACR BOC, followed by ACR president. In 1997, Moorefield was awarded the ACR Gold Medal.

Colleagues describe Moorefield as a wonderful person with a fine sense of humor and an articulate and effective representative for the specialty of radiology.

Read more on the impact he had on radiology and those around him at legcy.co/3bbAgPv.

UnitedHealthcare Offers Prior Authorization Flexibility

As radiology practices around the U.S. feel the strain of contrast media shortages due to COVID-19 shutdowns in Shanghai, UnitedHealthcare has granted several flexibilities in the prior authorization process in response to a letter from the ACR and the Radiology Business Management Association (RBMA). In the letter, the ACR and the RBMA requested that providers be granted the option to change orders for CT scans with contrast to as needed, without having to repeat the prior authorization process, which could delay patient care. UnitedHealthcare granted a portion of this request, allowing providers to change a CT scan with contrast to a CT scan without contrast with no additional authorization. However, if a provider wants to change the type of procedure, they will still need to go through the prior authorization process. UnitedHealthcare also extended the authorization period from 45 days to 90 days for elective or non-emergency procedures while there is still a contrast shortage.

The ACR has compiled a contrast resource page at bit.ly/Clinical-Resources. Read the full letter at bit.ly/UHC_ACR and learn how radiology practices feel better equipped to handle the next interruption on page 12.

Register for the ACR Virtual Career Fair

Meet with top employers actively hiring for open positions during the ACR Virtual Career Fair on Aug. 16, 2022, 3–6 p.m. ET. The ACR Virtual Career Fair connects you to current career opportunities from top employers, one-on-one web chats with the employers of your choice, and new connections to broaden your network. Whether you are jump-starting your career or looking for a career change, the ACR is here to help you find the perfect fit.

How it works:

1. Upload your CV prior to the start of event. Your information will be available to employers ahead of time and easily accessible as you interact during the Career Fair.
2. Log in to join the event any time between 3 and 6 p.m. on Aug. 16, 2022.
3. Explore virtual booths and available career opportunities from exhibiting employers.
4. Choose which employers you want to engage with in a one-on-one chat.
5. Interact with as many employers as your schedule allows.

To learn more or to register, visit bit.ly/ACR_CareerFair.



ACR Supports Paid Family Leave

Paid parental or family leave is critical to the well-being of the radiology community. At ACR 2022, the Council passed Resolution 13, which lends ACR support to the push for leave. The resolution urges the leadership of trainee programs and attendings' departments and practices to strive to provide 12 weeks of paid family/medical leave and offers suggestions to mitigate the cost. “The passage of Resolution 13 demonstrates the power of bottom-up efforts to drive policy change at the ACR Council level and once again illustrates how radiology and the College lead the way in creating positive change in medicine,” says ACR Speaker Amy L. Kotsenas, MD, FACR.

Read the full resolution at bit.ly/Combined-Resolutions.

The Economics of Health Equity

The complexity of payment policy to physicians and hospitals makes moving the needle on access-to-care issues nearly impossible by simple regulation alone.

Health equity, according to the National Center for Chronic Disease Prevention and Health Promotion, is achieved when every person has the opportunity to “attain their full health potential” and no one is at a “disadvantage from achieving this potential because of social position or other socially determined circumstances.”¹ The issue is complex and requires many potential fixes beyond alteration of the fee-for-service (FFS) payment policy used to reimburse physicians under the Medicare Physician Fee Schedule (MPFS). Regardless, differential FFS payments can exacerbate or ameliorate access-to-care issues — and therefore must be considered as part of an overall strategy to effect change when striving for health equity.

The concept of differential FFS payments is already part of everyday payment policy under the MPFS. Medicare uses a complex payment formula that multiplies three different types of relative value units (RVUs) — malpractice, physician work, and practice expense — by an MPFS Conversion Factor to arrive at a payment amount due to a clinician. Each RVU is also multiplied by a Geographic Practice Cost Index (GPCI), which is a fudge factor to balance cost-of-living and cost-of-business differences between different regions of our country. Different GPICs exist for each of the three types of RVUs mentioned above. These adjustments account for regional business costs and other market factors so that Medicare does not overpay or underpay a certain geographic region. Currently, CMS has 112 different localities, defining regional GPCI values as established under the Protecting Access to Medicare Act of 2014 (learn more at [go.cms.gov/3bu5MbN](https://www.go.cms.gov/3bu5MbN)).

The physician work GPCI has a statutory defined floor of 1.0, which extends through Jan. 1, 2024 — as mandated under the Consolidated Appropriations Act of 2021. This was primarily set high to offset the stresses on

the healthcare system during the global pandemic. Areas of the country with higher costs have higher physician work GPCI values (for example, San Jose, Calif. has a GPCI of 1.096). The GPCI was designed not only to account for cost of business, but also to preserve regional access to care. In practice, Medicare has found these objectives conflicting outside of metropolitan areas and has instead encouraged use of other policy vehicles to maintain or improve access to care. In essence, Medicare uses GPCI almost purely as a tool to adjust payments based on costs of doing business and not on access to care. A potential reason to limit use of GPCI to cost-of-business and living variables may originate from the ever-present budget neutrality requirements. As throughout most of the MPFS, if Medicare increases one region's GPCI (payments to this region), then payments to other regions must go down — potentially creating new access-to-care issues.

Complicating matters of using GPCI as a vehicle for supporting health equity inside the MPFS is the parallel Medicare payment system for hospitals. The calculations for hospital payment systems contains a GPCI-like factor called the Hospital Wage Index. Medicare carefully sets both the GPCI and Hospital Wage Index by studying similar market data so as not to upset local labor markets between the physician practice and hospital practice.

Congress can fund policy-driven changes to GPCI not subject to budget neutrality and has used this mechanism to address health equity in the past. For example, physician work GPCI for Alaska is 1.5 (the highest in the nation and significantly higher than San Jose at 1.096), as established under the Medicare Improvements for Patients and Providers Act of 2008. While multifactorial and no doubt politically motivated, the higher GPCI in Alaska would theoretically help attract physicians to the region. Another example is the practice expense GPCI floor of 1.0 for frontier states (Montana, Nevada, North Dakota, South Dakota, and Wyoming) as established by Congress in the Patient Protection and Affordable Care Act. An artificially high practice expense GPCI is used as a tool to attract owners of advanced imaging equipment to these regions by paying more than the calculated cost of business.

The complexity of payment policy to physicians and hospitals makes moving the needle on health equity nearly impossible by simple regulation alone. Congress will need to act, but at least there is a track record of past interventions paving a road map to effect change by legislating bolstered payments to areas of our country that need better support from the healthcare community. **B**



ENDNOTE available in the digital edition at [acr.org/bulletin](https://www.acr.org/bulletin)



Health Equity: Commit to Act

You can support the Radiology Health Equity Coalition at radhealthequity.org and join the conversation online at [#RadHealthEquity](https://twitter.com/RadHealthEquity). You can also download the Radiology Health Equity Coalition Community Outreach Guide, designed exclusively for partners to use in their local community. For more information on becoming a Coalition Partner, visit bit.ly/RHEC_Partner.

MOBILIZING FOR HEALTH EQUITY

State and local efforts are fueling an ACR-backed healthcare movement.

“Hawaii is a very diverse state. Many are somewhat aware of the challenges the native Hawaiian population faces, but I did not realize how large the healthcare barriers were for all historically marginalized communities in our state, including Chinese, Japanese, and Filipino peoples,” says Elizabeth A. Ignacio, MD, FACR, past president and board member for the Hawaii Radiological Society (HRS).

“I’m lucky enough to work with the HRS, our ACR chapter here,” Ignacio says. “I wear different hats. I’m the chair of the legislative committee for the Hawaii Medical Association as well, so there is a convergence there of a lot of advocacy efforts in addressing health equity and access.”

The HRS is also working with the University of Hawaii Cancer Center to address breast cancer rates. “This disease doesn’t just affect women here who are over the age of 50,” she says. “We see cases starting at age 40 and up, particularly for Japanese American women. In Hawaii, the native Hawaiian women are most likely to have increased morbidity and mortality from breast cancer compared to the rest of our population,” Ignacio says.^{1,2} “This is one reason we joined the Radiology Health Equity Coalition (RHEC).”

A COMMUNITY EFFORT

The RHEC’s goal is to bring together the radiology community to address health disparities and measurably change outcomes. This mobilized network of patient-focused radiologists will collect and disseminate resources and best practices, advocate for and connect with patients and community members, and collaborate on programs and services to empower others to act.

Ten major radiology organizations have collaborated in the formation of the RHEC to positively affect healthcare equity in the radiology arena and beyond. “Disparities and inequities in healthcare have been evident for many years — and the COVID-19 pandemic has magnified the disproportionate

numbers of people of color and rural residents in the U.S. affected by barriers to care,” says Carla Brathwaite, MS, RHEC team lead. “We are coming together to do something about it.”

These are among some of the disparities the RHEC is focusing on:

- Life expectancy is three years shorter and heart disease, cancer, and stroke death rates are significantly higher in rural areas (23% of the U.S. population) vs. metropolitan areas.^{3,4}
- Black women are 42% more likely to die from breast cancer than White women; Black men are 52% more likely to die from colorectal cancer (CRC) than White men.^{5,6}
- U.S. Latines are more likely to die from CRC than those in many Central and South American nations. The CRC death rate for U.S. Latines has dropped more slowly than for Whites.⁷
- Asian Americans are twice as likely to die from stomach cancers, eight times more likely to die from hepatitis, and have a tuberculosis rate more than 30 times higher than White Americans.⁸
- 39% of U.S. women without health insurance had a mammogram in the past two years versus 75% of those with health insurance.⁹

AWARENESS/EDUCATION, RESEARCH AND ADVOCACY

“Stories of healthcare disparities are in the news nearly every day,” says Ian A. Weissman, DO, FACR, president of the Wisconsin Radiological Society and chair of the ACR’s Patient- and Family-Centered Care Outreach Committee. “There are three main things we must address. The first is awareness/education, and we are working on this with the RHEC and through social media,” he says. “The second part

“Equity is a concrete issue, and advocacy, particularly grassroots efforts, can improve the situation.”

— Ian A. Weissman, DO, FACR

is research — making sure that there is research underway to promote health equity.” Included in this research, Weissman points out, is AI and efforts to eliminate unconscious bias.

“The third part is advocacy. That’s what we are trying to do at the local, state, and national levels — through starting the process of joining the RHEC, by holding lectures, and through our work with RAD-AID and the U.S. Women’s Health Access Program,” Weissman says. The COVID-19 pandemic, he notes, has brought health equity issues to the forefront. “We are effecting change, for example,” he says, “by raising awareness through a health equity panel discussion scheduled for the next Wisconsin Radiological Society annual meeting.”

“The pandemic has impacted everything. Another day goes by — and maybe a systemically disadvantaged woman doesn’t get her breast screening exam or her cervical cancer screening,” he says. “This is the kind of critical health issue that we are trying to address, showing how radiology can help. Equity is a concrete issue, and advocacy, particularly grassroots efforts, can improve the situation.”

GRASSROOTS ACTION

“We were always, and still are, a grassroots organization that has many physicians and laypeople — all working to push legislation that will benefit all patients,” says Priscilla J. Slanetz, MD, MPH, FACR, immediate past president of the Massachusetts Radiological Society (MRS). “We were the first state chapter to join the RHEC, back in April of 2022, and did so as we recognize how important it is to promote equitable access, especially to imaging care.”

MRS members have always been committed to finding ways to help the most vulnerable segments of the state’s population, she says. But one of the challenges is that “when we look at where radiology research funding actually goes, it often goes to the very well-off institutions that are not necessarily serving the most vulnerable populations. If we really want to make strides in addressing health equity and minimizing the disparities that exist, research funding must start going to those institutions providing care to these vulnerable patients,” Slanetz says.

In fact, building on work at Boston University Medical Center, the largest safety-net hospital in New England, “we recently received a state chapter grant to develop a radiology waiting-room program that will help identify patients at increased risk for lung and breast cancer and to connect these patients to indicated screening. We are also working with grassroots organizations to push forward legislation that will provide all women free and equal access to screening and diagnostic mammography,” Slanetz says.

What’s Your Diversity Story?

An effort of the ACR Medical Student Subcommittee, the Diverse Stories in Radiology Campaign aims to highlight the importance of diversity and inclusion in the field of radiology by sharing real stories from ACR members. Check out the latest story on Twitter and Instagram, and stay tuned for monthly updates. Want to share your story? Contact jlynch@acr.org.

STRENGTH IN NUMBERS

Washington State was among the first ACR state chapters to establish a committee on women and diversity, which strives for diversity and health equity — when everyone has access to resources and treatment that is tailored for fair and positive outcomes (learn more about how to create a committee on diversity in your ACR state chapter at bit.ly/diversity_committee). “A lot of our emphasis when we started out was to establish activities that might foster camaraderie among women in radiology in Washington State,” says Sammy Chu, MD, FACR, chair of the ACR Contractor Advisory Committee Network and president of the Washington State Radiological Society (WSRS).

“We have to acknowledge, as radiologists, that we are not a very diverse group. People within our specialty need to understand the challenges that historically marginalized communities face within the profession,” he says. As part of its diversity and inclusion efforts, Washington State’s office currently runs two activities — one is a mentoring program and the other is more of a social event.

“The social event was created so that radiologists have a chance to swap stories and experiences,” Chu says. “It’s also an opportunity to talk about how they can better work together and help one another face the many challenges that can plague radiology groups.”

“We hold a Women in Radiology mentoring event every year in conjunction with the University of Washington,” says Rachel F. Gerson, MD, chair of the WSRS Women and Diversity Committee. This is a resident-run event that brings together residency programs throughout the state, a panel of women radiologists in diverse practice settings, and community radiologists to promote mentorship, frank discussion, and networking.

“Through engagement in broad issues of equity in our community, partnering with community and healthcare organizations, and working with state legislators, we strive to demonstrate the important role radiologists play in health equity,” Gerson says. “Our participation in the White Coats for Black Lives March and our Breast Imaging Task Force’s collaborative event really highlighted the aspect of partnering with and engaging health equity issues in our community.”

“Part of when we go to Olympia — the state capital — is about trying to increase recognition or trying to make state chapter radiologist members aware of what we’re doing in the state,” Chu says. “The impetus for any good healthcare-equity movement is motivation — and that means showing our chapter members how our advocacy positively benefits radiologists and patients,” he says.

“The Hawaii chapter is very motivated — and its officers are very strong advocates (despite being a small group),” Ignacio says. “We are all involved in advocacy, both at the state and local levels. We have provided a good deal of in-person testimony to legislators and knocked on doors.”

The RHEC is calling on all professional radiological societies — diagnostic radiology, IR, nuclear medicine, radiation oncology, nuclear physics, and other subspecialties under the umbrella of radiology. According to Ignacio, “It was an easy decision to join the RHEC — not just because of what is happening in Hawaii, but because we understand the significance of the healthcare equity challenges in communities everywhere.” **B**

By Chad Hudnall, senior writer, ACR Press

ENDNOTES available in the digital edition at acr.org/bulletin

WEBINAR SERIES: Breaking Imaging Barriers

Healthcare disparities and inequities in the U.S. have been well-documented for decades, but the COVID-19 pandemic increased the focus on these inequities like never before. The Radiology Health Equity Coalition offers a five-part webinar series — Breaking Imaging Barriers: A Collaborative Approach to Advancing Health Equity in Medical Imaging. The series delivers practical, actionable tools for individual radiologic professionals, imaging practices, and healthcare institutions looking to improve imaging health equity

Access the on-demand series at bit.ly/Breaking_Imaging_Barriers.



“People within our specialty need to understand the challenges that historically marginalized communities face within the profession.”

—Sammy Chu, MD, FACR

An Exercise in Crisis Management

With the contrast media shortage mostly in the past, practices are better prepared for the next supply disruption.

The radiology and medical communities are still recovering from a shortage of GE's Omnipaque™ that began in May, caused by COVID-19-related lockdowns at GE's major iodinated contrast production facility in Shanghai, China. For those affected, the shortage necessitated canceling non-emergent imaging exams and procedures that required contrast and led to new ways to stretch contrast supply and reconsider potentially wasteful practices. However, this was a vendor-specific issue and some departments and practices had no interruptions to their contrast media supply. "Groups that don't use GE Omnipaque likely did not have a problem," says Carolyn L. Wang, MD, chair of the ACR Committee on Drugs and Contrast Media. A similar issue could occur with any vendor or product for which there is no redundancy in the system.

Production in China was only part of the issue. Even if the facility had been at 100% production — which, according to GE, was achieved in early June — the iodinated contrast still needed to be delivered to its customers around the globe.¹ This process required local drivers in Shanghai to voluntarily be away from their families for the then-mandatory 14-day quarantine period each time they traveled out of the city, a tall order. A seemingly obvious option to alleviate issues once organizations receive their contrast media orders was to share with those institutions that were in dire need. However, facilities are generally not contractually permitted by vendors to transfer contrast to another institution in need, as they could be seen as a secondary supplier. "There needs to be some waiver of this prohibition against being a secondary supplier," says Amy L. Kotsenas, MD, FACR, ACR Speaker. "There has been some discussion locally about possibly setting up some kind of exchange or process whereby those who have a really critical shortage and aren't able to provide emergency care are able to access the contrast. That's the greatest concern. Some practices may have been so short that they weren't able to provide emergency care."

In May, Wang and other members of the ACR Committee on Drugs and Contrast Media developed a statement (available at bit.ly/Contrast_Shortage) to provide short-term options on how to handle the shortage. Long-term changes, however, may be more difficult to achieve, such as moving to multiple vendors for contrast media instead of a single vendor. "A lot of organizations have gone through group purchasing organizations, which negotiate with vendors to get the best deal, and often they go to one vendor to get best pricing," says Alan H. Matsumoto, MD, FACR, vice chair of the ACR BOC. "This is a vulnerability."

After demonstrating the fragility of the contrast supply chain, it's wise to consider when, not if, the next shortage might occur,

and how groups might insulate themselves from such impacts. "This crisis may cause a lot of practices to rethink whether they should have a single supplier for something that is so critical to what we do," says Kotsenas. "Both in diagnosis and treatment, this shortage has had a huge impact on radiology groups who now may be thinking as they go forward, 'Is this the best practice?'"

One aspect of the supply chain that's easier to control is the route from pharmacy to institution or practice, which requires an understanding of the importance of contrast in all medical specialties. "GE sent out the notice in early April, when the plant was shut down," says Wang. "However, the notice was sent to the pharmacy purchasing group, and it didn't circulate quickly enough; I first learned about the shortage on social media." To support this radiologist-pharmacist relationship, the American Society of Health-System Pharmacists also released a statement guiding its members on the importance of contrast media and the various vial sizes required for imaging and interventional procedures (read more at bit.ly/ASHSP_Statement). While organizations looked for ways to conserve contrast (e.g., using multi-dose vials, conserving and using leftover contrast, and triaging patients), Matsumoto said they were able to reduce their contrast usage by 75% (e.g. by using the vials of contrast as multi-dose vials, using leftover contrast for non-sterile GI procedures, and delaying scheduling of CT scans and procedures requiring the use of iodinated contrast on "less-emergent" patients).² Wang also considered the bigger picture of imaging — waste. "If you have a patient who requires 125MLs of contrast, and there are no 125ML vials, you're using a 150ML vial and wasting 25MLs," Wang says. "Everyone is starting to question waste, and everyone was unaware of it, particularly radiologists, prior to the shortage."

"Both in diagnosis and treatment, this shortage has had a huge impact on radiology groups who now may be thinking as they go forward, 'Is this the best practice?'"

AMY L. KOTSENAS, MD, FACR

In conserving contrast, Wang noted there were a few positive unintended consequences, including patient comfort. "We've always done weight-based dosing, and with the shortage we've reduced the weight class. As a result, several patients who received smaller volumes of contrast reported having fewer side effects from the contrast — they didn't feel the typical burning or warmth that accompanies contrast injection," she adds, pointing to an opportunity to reexamine dosage guidelines.

Given that the contrast shortage seems to have resolved, lessons learned this spring may be applied to the next major shortage, whatever it may be. "This is what COVID-19 has taught us," says Wang. "Supply chains are very fragile, and just-in-time inventory — while it may make some business sense — for things like healthcare-related items, might not be good enough." **B**

By Raina Keefer, contributing writer, ACR Press

ENDNOTES available in the digital edition at acr.org/bulletin

ECONOMIC INCENTIVES: Key to Sustainable Equity Efforts



Disparities by race/ethnicity, sex, age, and income are present in nearly every instance they are examined — creating concerning inequities for medical professionals.

A common and somewhat implicit assumption is that discrimination is a prerequisite for disparities. However, disparities may exist in the absence of discrimination, such as economic/business decisions that result in disparities as an unwanted — but predictable — secondary consequence. While discrimination should never be ignored where it plays a role, the importance of economic incentives in driving disparities is too often overlooked. The Harvey L. Neiman Health Policy Institute® (HPI) is researching how economic incentives and supporting health policy can ensure more equitable access to radiology services.

To understand how economics may lead to disparities, consider geography. We know there are substantial differences in economic prosperity across communities, such as between rural and urban residents, or within an urban area. Yet, even high-income rural residents would have less opportunity to prevent, detect, treat, and survive disease than their urban peers due to the geographic proximity to equivalent medical care.

Availability of new medical technology is a common issue in both rural facilities and

urban facilities that serve low-income communities. These availability and access issues often have economic factors as a root cause. To the degree that proximity to technology matters, it will also yield disparities as an unwanted but predictable secondary outcome.

As imaging technology advances and becomes more costly, it takes a larger population of patients to justify allocating this technology to a specific location. There must be a return on investment. Research shows that more affluent areas are the first to have access to new medical technology. Such areas will have a higher concentration of patients with commercial insurance, which typically pays 1.2 to 1.8 times more than Medicare for physician services.² For radiologic services, that range is 1.2 to 2.8.³ Hence, some supply-side economic factors result in disparities that are unrelated to discrimination. We ignore a host of incentives if we assume that, absent discrimination, the distribution of outcomes would be identical across groups.⁴

Urban safety-net hospitals demonstrate these economic realities in the care for low-income populations. Unfortunately, neither not-for-profit status nor altruistic motivations negate the financial constraints. Even the most altruistic of organizations cannot fulfill their mission if they are not financially viable. While such organizations may wish to do more, constraints matter.

Economically driven disparities are not a failure of the medical community. Because healthcare organizations must remain

continued on page 22



HPI Celebrates 10 Years of Excellence

In 2012, the ACR and the late Harvey L. Neiman, MD, FACR, made a bold move to impact the national health policy debate by forming the Harvey L. Neiman Health Policy Institute® (HPI). To celebrate a decade of accomplishments and progress, the *Bulletin* is looking back at the highlights the HPI has provided these past 10 years. Stay tuned for future issues that will explore the HPI's recent work and upcoming opportunities. To learn more about the HPI and how it is having an impact, visit neimanhpi.org.

Empowering YPS Members

Several early-career radiologists are serving as presidents of their state chapters, expanding the voices of YPS members throughout the ACR.

The ACR's newly adopted strategic plan is focused on Empowering the Radiologist of the Future, and a key initiative places emphasis on engaging young members and developing future leaders. This is happening not only at the national level, but also at the local level. Early-career radiologists who become involved in their state chapters expand their opportunities to network and find mentors, while also having an impact on state and national legislation and ACR policy. Alysha Vartevan, DO, owner and founder of Camelback Radiology, a teleradiology practice based in Arizona, started her two-year term as president of the Arizona Radiological Society (ARS) in December 2021. Like many of the YPS chapter presidents, Vartevan hadn't planned to lead her state chapter so early in her career, but when the opportunity arose, she knew it was the right time.

“I think a lot of residents and young physicians are shocked at how much happens on the state level. We think of policy taking place at a national level, but a lot of it happens much more locally.”

— DAVID C. GIMARC, MD

“It was mainly the encouragement of one of my colleagues to get me involved in a leadership role during this part of my career,” she says. “It allows you to meet radiologists in your state that you may not have the opportunity to meet otherwise.”

Vartevan had met ARS Immediate Past President Dane C. Van Tassel, MD, around 2014 at an ACR meeting when they were both residents. When Van Tassel learned that Vartevan was interested in neuroradiology, he recommended she apply to be a neuroradiology fellow at the Barrow Neurological Institute in Phoenix. Vartevan applied and completed her fellowship there, staying in Arizona afterward. Van Tassel knew Vartevan had been involved in the Florida Radiological Society as a trainee and invited her to get involved in Arizona, later asking her to become vice president of the ARS.

Getting involved first at the state level isn't as intimidating as it might be to jump straight to the national level, Vartevan says. “It's been a great experience,” she says. “I'm very fortunate I've been involved as a resident and fellow with the ACR because it's really helped foster a lot of relationships early in my career with people in very different settings.”

Amplifying YPS Voices

Getting involved early also amplifies the concerns and issues that matter most to young and early-career professionals at the national ACR level. “In recent years, the YPS has gotten a lot louder in their ability to make their voices heard,” says YPS member David C. Gimarc, MD, president of the Colorado Radiological Society and assistant professor of radiology at the University of Colorado.

Some issues, such as work-life balance and practice structure, may be more important to radiologists just starting their careers, he says. At ACR 2022, several resolutions were co-sponsored and advocated for by the YPS. Adopted Resolution 13 called for radiology practices, departments, and training programs to provide 12 weeks of paid family/medical leave in a 12-month period for attending and trainee physicians as needed.

As part of the discussion, YPS members were able to make the business case for family leave. “When you have happy radiologists and they know they're going to have family leave, they're more likely to come to your group and stay with your group,” says Jacob Ormsby, MD, MBA, president of the New Mexico Society of Radiologists and an assistant professor of radiology at the University of New Mexico. Ormsby is also the communication liaison with the ACR YPS Executive Committee.

Another adopted resolution of special interest to early-career radiologists focused on the current job market. Ormsby pointed to the number of private practices being bought by national groups that are not radiology specific. “While the person who has been in practice a long time might see the benefits of being bought out, our YPS individuals were usually left to the sidelines in the sense that they wouldn't get any money from the buy-out,” he explains. The YPS co-sponsored a resolution that passed at ACR 2022 recommending in part that partnership-track associates receive at least some proportional monetary compensation and be included in discussions related to substantial changes in practice structure or ownership as legally permissible.

Advocating for State Legislation

State and federal legislation can also have an impact on how radiologists train and practice. YPS members can easily get involved

Be Active in Your State Chapter

ACR chapters serve as a pathway to service at the national level and provide a variety of opportunities to get engaged at the state level.

Every chapter receives a slot for an alternate councilor earmarked for a young or early-career physician.

View a list of all chapters to identify your local contacts at acr.org/chapters.



at the state level to advocate for or against legislation, educating lawmakers about radiology and the needs of their patients.

“I think a lot of residents and young physicians are shocked at how much happens on the state level,” Gimarc says. “We think of policy taking place at a national level, but a lot of it happens much more locally.”

There are often opportunities for young radiologists to educate their legislators on specific issues. “Maybe we don’t view ourselves as experts on a national level, but in reality, we’re what a lot of these legislators are looking for in terms of being able to speak intelligently about things we do every day,” Gimarc says.

In recent years, Colorado members spoke in favor of legislation that included making diagnostic imaging a first line of coverage for women needing breast screening beyond mammography and allowing licensure for genetic counselors who work with radiologists across the state. The breast screening bill became law, but the Colorado governor vetoed genetic counselor licensure. “Those are all issues that very much affect radiology, and it was important for members of our state to be involved in testifying,” Gimarc says.

In Kansas, YPS members were active in the fight against legislation that increased the scope of practice of nurse practitioners to be able to practice without physician oversight, says Mary M. Mitchell, MD, president of the Kansas Radiological Society and a breast radiologist at Saint Luke’s Health System and clinical assistant

professor at the University of Missouri–Kansas City (UMKC).

While the bill ultimately passed and was signed into law, it showed the need of continued involvement of Kansas members. Mitchell speaks to residents at least once a year about the opportunities to join the state chapter and get more involved.

Her efforts seem to be paying off: Several Kansas radiology residents attended ACR 2022. “I do feel like younger voices are heard, respected, and being received well at the national meetings,” Mitchell says. “Obviously, we are the future of radiology.” **B**

By Melanie Padgett Powers, freelance writer, ACR Press

Get Involved with ACR and YPS

The YPS represents more than 6,000 ACR members in practice who are either under the age of 40 or within eight years of completion of training. The YPS focuses on issues that impact professionals within this demographic and provides opportunities for engagement at the national level. Learn more about how to get involved at [acr.org/Member-Resources/YPS](https://www.acr.org/Member-Resources/YPS).



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A Century of Quality, Integrity, Leadership, and Innovation

The ACR's 100th anniversary will celebrate the world-changing achievements realized by ACR members during the centennial celebration.

"Much has changed since 1923, when 20 radiologists created the ACR after radiology was officially endorsed as a specialty by the AMA. What has not changed is our commitment to advance the practice and support improved health equity, quality, delivery, and outcomes for patients."

— William T. Thorwarth Jr., MD, FACR, ACR CEO

In 2023, the ACR will celebrate a major milestone — a century of quality, integrity, leadership, and innovation. The College has formed the Centennial Steering Committee to help celebrate this historical achievement. "The 100th anniversary is a major anniversary for any organization," says James P. Borgstede, MD, FACR, co-chair of the Committee. "This longevity demonstrates the importance of the College and its relevance to patient care and to radiologists."

The Committee has begun planning for the centennial, starting with a celebratory gala at ACR 2023. The Committee plans to celebrate the centennial throughout 2023 into 2024. Co-Chair of the Committee Catherine J. Everett, MD, MBA, FACR, says that the Committee wants as many people as possible to be involved in the historic celebration. "We think it's really important that we make something available for all members," she says. "We can't just limit it to the people who happen to be in a certain place at a certain time. The Committee is making sure the celebrations are inclusive."

Looking Back

The Committee plans to use 2023 as a celebration of the College's history and all that it has accomplished in the last 100 years. With so many achievements to look back on, Everett and Borgstede were able to reflect on which moments in ACR history they believe deserve recognition. "There are so many accomplishments that it's hard to name them all," Borgstede says. "The

initial accomplishment was the vision of the College's founding members of the necessity of an organization to promote radiologists as physician specialists and to advocate for the socioeconomic and government relations related to our specialty. The continuing emphasis on radiation safety is another."

"The ACR has been an economic juggernaut for radiologists," Everett adds. She noted how important the ACR has been to ensuring radiologists are fairly compensated for their work. "If we don't get paid, we can't ensure radiology quality and safety," she says. "We can't care for patients. We can't attract the brightest and the best in our profession."

Along with a look at the timeline of the ACR's history, the Committee plans to recognize key contributors to the success of the College and its growth, along with history-rich trivia. Chapters and organizations that have become a staple of the College will be recognized as the Committee makes sure to highlight all accomplishments of the ACR and the role each department has played.

Looking Ahead

The 2024 portion of the centennial will look toward the future of the College. The centennial will be the time for members of the College to celebrate not only what the ACR has achieved but also the significant moments still to come. "Radiology is the absolute center of medicine," Everett says. "Every single imaging study is looked at by radiologists, and patient care decisions are largely based on imaging results. So I think the ACR should continue to elevate the profession."

"There are so many things the ACR will accomplish because the organization is vibrant and vigilant," adds Borgstede. "In the future, the ACR will continue to promote patient-centered care and diversity and inclusion. Our interactions directly with patients are paramount, so they personally know their radiologist. The ACR must also continue to pursue quality endeavors."

For now, the Committee is ready to get the party started. More information about the centennial celebrations will be made available on the ACR's website so that everyone can see how they can participate (see sidebar). "We have several subcommittees, all of whom are just amazingly excited," Everett says. "Every time we get on the phone, you can just feel the excitement and the interest and the great ideas. It's going to be a memorable event." **B**

By Alexander Utano, editorial assistant, ACR Press



Come Celebrate With Us

Look for more on the celebration in the coming months, including historical trivia, terrific stories from members, articles in the *Bulletin*, a gala at ACR 2023, and more, at acr.org/About-ACR/Centennial.

RAN 3.0: A New Era of Rad advocacy

In an increasingly competitive and passionate healthcare environment, radiology political advocacy is imperative, now more than ever.



Advocacy is one of the fundamental missions of the ACR. It entails representing the interests of radiologists and their patients to Congress, state legislatures, and regulatory agencies; educating radiologists and radiologists-in-training regarding legislative and regulatory developments; and supporting grassroots participation via Capitol Hill Days, legislative calls to action, and the Radiology Advocacy Network (RAN).¹

The RAN is comprised of over 200 trainees and radiologists representing their training programs, practices, or institutions. The RAN leader serves as the point person between their group and the ACR. Currently, each state and residency program has a main RAN leader. However, a YPS RAN is currently being developed with almost 30 states represented across the country. The goal is to have the main RAN leader work in concert with the YPS RAN leader and residency program RAN leader to ensure efforts are collaborative and synergistic — and to foster and sustain a leadership pipeline. These RAN leaders ensure federal legislative calls to action are being disseminated to their respective peers, as well as other RAN communications on federal issues.

I am honored to have assumed the role of RAN chair at ACR 2022, from David C. Youmans, MD, FACR, who did a tremendous job during his term as RAN chair. In the five years that Dr. Youmans was at the helm, he moved the RAN into a new way of advocacy that involved social media and advocacy through the RAN app as well as platforms such as Twitter, Facebook, and ACR Engage. Dr. Youmans saw the potential that social media brought into the world of advocacy and he embraced it. The RAN developed a strong social media presence and was a top influencer during ACR 2022 in Washington, D.C.

One of my first acts as RAN chair was to devise an inaugural RAN board, comprised of members at all levels of training, practice type, and government relations representation. Our board is going to implement increased communication via digital media and boots-on-the-ground advocacy efforts, including providing more robust state support on pressing policy issues as needed (e.g.,

state calls to action). One digital media improvement currently underway is a new rad advocacy (i.e., radiology political advocacy) website where comprehensive information about the RAN will be available at one's fingertips. On this new website, we will provide advocates at all levels of engagement with the resources and tools they will need to advocate for and promote radiology and overall equitable healthcare for our patients.

Along with a new one-stop-shop website for advocacy, the RAN is committed to providing training on a quarterly basis, some of which will offer CME credits. This year, our installments of Advocacy 101 include “Learning How to Amplify Your Voice” (bit.ly/Advocacy_BootCamp) and “How to Effectively Advocate for Your Patients and Profession” (bit.ly/Advocacy_Patients). Involvement from members like you in the RAN is crucial to tackling state and federal policy issues affecting our patients and profession. Hence, this expansion of the RAN, known as RAN 3.0, will propel us into the next era of advocacy.

Along with a new one-stop-shop website for advocacy, the RAN is committed to providing training on a quarterly basis, some of which will offer CME credits.

In an increasingly competitive and passionate healthcare environment, radiology political advocacy is imperative, now more than ever. It will take a concerted effort from all in the house of radiology, regardless of practice type, to battle what lies ahead when it comes to the many challenges facing us, including reimbursement and, most importantly, equitable access to care for our patients. The days of being siloed and passive are over.

Join us as we enter this new chapter of rad advocacy to ensure a brighter tomorrow for our patients and profession. I urge you to get involved in any capacity and at your comfort level. We must all rise up to ensure a stable and prosperous tomorrow. The time is now. **B**

By Amy K. Patel, MD, chair of the ACR RAN, medical director of the Breast Care Center at Liberty Hospital, partner of Alliance Radiology, and assistant professor of radiology at University of Missouri-Kansas City School of Medicine

ENDNOTE available in the digital edition at acr.org/bulletin

Become a Radvocate

You can start small by acting on calls to action or go big and develop relationships with your elected officials, both at the state and at federal levels. If you do not know where to start, take a moment to fill out the “Become an Advocate” form at bit.ly/Become_Advocate so that ACR RAN and state government relations staff can provide you with opportunities that will fit your comfort level. For questions on the RAN, contact Melody Ballesteros at mballesteros@acr.org. RADPAC® is a separate operation under the American College of Radiology Association® (ACRA®). For questions on RADPAC, contact Haley Brown at hbrown@acr.org.

Leveling Up Radiology Leadership

For 10 years, the Radiology Leadership Institute® has armed radiologists with business and leadership skills through custom educational programming designed by fellow radiologists.

The ACR recognizes that fostering leadership skills is critical to the delivery and advancement of high-quality healthcare. In 2012, the ACR launched the Radiology Leadership Institute® (RLI) — the specialty’s first program dedicated to professional development and leadership training for radiologists.

The ACR knows that to survive and thrive, every radiologist needs to fill gaps in non-interpretive skills. That’s where the RLI comes in. Built by radiologists for radiologists, the RLI helps boost business skills through valuable training and customized professional development opportunities.

In the third of a four-part series commemorating the RLI’s 10-year anniversary, the *Bulletin* connected with some of the RLI’s world-class faculty to learn how they design RLI programs to help radiologists navigate leadership at all career stages. A key commitment for the RLI is to continuously enhance its programming to keep pace with changing times, and the organization knows that collaboration is key to creating a successful course. To that end, RLI faculty engage with and solicit feedback from participants and other stakeholders to ensure that the program delivers on its goals. This process ensures that the RLI is able to offer the type of customized, essential, high-impact content that keeps ACR members coming back.

Fostering Future Leaders

Young physicians enter the workforce armed with comprehensive clinical and interpretive skills but often lack the valuable business skills that are necessary to thrive in today’s healthcare settings. Although programming is strongly guided by RLI’s knowledgeable faculty, the RLI knew it was also important to represent learner voices, especially early-career learners, regarding the unique career challenges that they felt residency did not adequately prepare them for — as well as course formats that would be most attractive for them. The RLI used feedback from over 200 residents to help design a few of the resident-focused programs that empower these new radiologists and equip them with the knowledge and tools they need to excel in their careers.

The RLI created the Leadership Essentials program to fit into the busy schedules of residents and fellows and give them the

foundational, non-clinical business skills they need. Based on the survey feedback, as well as input from a working group of residency program directors, the inaugural program co-chairs, Richard Duszak Jr., MD, FACR, chair of the Commission on Leadership & Practice Development, and C. Matthew Hawkins, MD, director of pediatric vascular IR at Children’s Healthcare of Atlanta, developed a program to provide training for residents and fellows in the non-clinical and leadership skills most relevant to early-career success.

“Our learner audience is very different from the typical private-practice radiologist,” Duszak says. “Residency is hectic, so we specifically and deliberately designed the course to accommodate residents’ schedules and help prepare them for practice.”

“Residency is hectic, so we specifically and deliberately designed the course to accommodate residents’ schedules and help prepare them for practice.”

RICHARD DUSZAK JR., MD, FACR

In 2021, Ann K. Jay, MD, vice chair of education and program director of diagnostic radiology residency at MedStar Georgetown University Hospital, and Ryan B. Peterson, MD, assistant professor and associate program director of diagnostic radiology residency at Emory University School of Medicine, assumed the roles of co-chairs and expanded the Leadership Essentials program to focus on content for both residents and early-career radiologists:

Leadership Essentials 101: Skills for Residency and Beyond

This curriculum focuses on all years of residency and offers content that can be put into practice during residency and in the first years of a resident’s career. Topics include rookie leadership, communication skills, and personal finance.

Leadership Essentials 201: Preparing for Practice

New in 2022 and geared for R3s or later, this course offers content that will be helpful in the first few years of a radiologist’s career. Topics include basics of radiology business, tips to building and growing your practice, and the value of being a mentor yourself.

The two Leadership Essentials curricula will be offered on a rotating basis, with Leadership Essentials 201 launching in fall 2022.

Preparing to Enter the Job Market

Radiology residents report that finding and landing a job that’s right for them is an area where they’d like more support. Informed





“Something like this never existed when I was a new radiologist looking for my first job,” Nathan says. “I wish it had because I would have learned so much and been more prepared.”

— JENNIFER E. NATHAN, MD

by the initial resident survey results, co-chairs Frank J. Lexa, MD, MBA, FACR, who serves as RLI chief medical officer, and Jennifer E. Nathan, MD, RLI board member, developed the Kickstart Your Career workshop, a one-day course that provides the content that residents said they needed to land that first job, but that wasn't being addressed in their residency.

The Kickstart program provides essential advice on topics such as interviewing skills, evaluating job offers, communicating with challenging personalities, and understanding the differences between employment opportunities in academia versus private practice. “Something like this never existed when I was a new radiologist looking for my first job,” Nathan says. “I wish it had because I would have learned so much and been more prepared.”

Nicholas T. Ferguson, MD, a then-radiology resident in Loma Linda, California, agrees. “As a relatively fresh fourth-year resident in my early thirties, I began to think about getting a job,” he says. “Surprisingly, no one had ever really formally taught me this type of skill — after all, it's not on the boards. Then I found out about the Kickstart Your Career workshop, looked at the speakers and subjects, and decided it would be worth the time. It was definitely worth every second I spent on it.”

Mentorship also remains a highly requested and important topic. While the Leadership Essentials program aims to highlight why and how residents can go about finding a mentor and getting the most out of a mentoring relationship, Kickstart actually provides an opportunity for residents to work with a mentor.

The RLI added the Transition Mentorship Program in 2021, allowing attendees of the Kickstart program to be matched with a mentor who has experience in their area of interest to help with the transition from residency into fellowship or a first radiology job. Nathan echoed the survey feedback and strongly believes mentors are an invaluable resource for young radiologists. “You can get all the information and try to figure things out for yourself, but I think having that person who's a little further along in their career to help guide you, that's probably the most critical thing,” she says.

Confronting New Challenges

As physicians gain experience, they often seek out — and land — leadership roles. New and aspiring leaders wish to be as effective as possible in their new roles, but often require a specific skillset to be successful. The RLI recognized this skills gap, and asked Geoffrey D. Rubin, MD, MBA, FACR, RLI board member, to create a program designed to give these aspiring and new leaders the skills, tools, and language to be effective in these new roles and environments.

“As radiologists begin to take on leadership roles, many point to key moments that reveal how much more there is to learn about their organization and how it functions,” Rubin says. His own experience stepping into a leadership role directly informed the curriculum, which emphasizes the importance of understanding organizational structures. “I showed up to the first meeting like a fish out of water — there was a huge table with 30–40 people, and after 16 years at this medical center, I didn't know more than three of them,” Rubin recalls. “They would pass out papers to everybody, things like financial statements, strategic plans, organizational design plans, and it was like another language to me.”

Rubin eventually accumulated the set of competencies that allowed him to become a strong leader. Yet he always wished that he had been more prepared to enter that environment and be more effective from the start.

The Maximize Your Influence and Impact program is cohort-based and structured into the three topic areas that Rubin and his co-educators found to be most relevant in their own leadership experience — managing the hospital boardroom, stewarding the radiology department, and influencing change at the hospital level. Participants learn the business skills necessary to run a

2022 RLI Summit: Focus Inward to Drive Forward

Join your colleagues Sept. 9–11 at Babson College in Massachusetts at the 2022 Radiology Leadership Institute (RLI) Summit to connect, share, and find new inspiration for your leadership journey. The RLI Summit helps radiologists at all career stages gain new insight into where radiology is headed through trainings focused on how their practices can adapt to the future. Equally important, it provides radiologists with an unparalleled opportunity to network with the specialty's best and brightest. Learn more and register at acr.org/RLISummit or contact Anne Marie Pascoe at apascoe@acr.org.



“We were thinking if adaptability is an important character trait — if you’re supposed to react to the market around you by giving patients and insurance companies what they need, then you want a partner that understands the value of responsiveness.”

— ALEXANDER M. NORBASH, MD, MS, FACR

radiology practice or department with confidence and gain soft skills such as interpersonal relationship-building, team support, and conflict management.

When recruiting faculty for the Maximize course, Rubin strives to find nationally recognized and experienced leaders that bring a diverse perspective. “It’s not just a matter of finding academic departments chairs to lecture — we have teachers from community practice, teachers that run health systems and who have run radiology departments, we have gender and racial diversity wherever possible,” Rubin says.

The RLI takes an in-depth approach to addressing the spectrum of valuable leadership skills, and uses learner feedback to guide decision-making, including appointing new faculty members. Rasu B. Shrestha, MD, MBA, chief strategy and transformation officer and executive vice president of Atrium Health, recently joined RLI as an instructor in the Maximize course. “Rasu personifies an outside-of-the-box approach to leveraging radiology expertise toward healthcare leadership,” Rubin says. “He embodies the best qualities of a leader — humanistic, creative, strategic, and team-oriented. I know our cohort of radiology leaders will find his approaches and thought processes to be eye-opening and empowering.”

Tackling Complex Demands

The evolving demands of healthcare directly affect practice environments, and mid-career and experienced radiologists require timely educational offerings to help navigate complex management settings. That’s where the RLI Summit comes in (see sidebar on page 19).

Designed in collaboration with business school experts, the Summit helps radiologists at all career stages gain new insight into where radiology is headed and receive focused training that will help guide how their practices adapt in the future. Since 2014, the RLI Summit has been held at Babson College, one of the nation’s top entrepreneurial business schools.

Alexander M. Norbash, MD, MS, FACR, RLI Summit co-chair, emphasizes the organization’s desire to partner with a business school that would be responsive and nimble. “We were thinking if adaptability is an important character trait — if you’re supposed to react to the market around you by giving patients

and insurance companies what they need, then you want a partner that understands the value of responsiveness,” Norbash says. This collaborative approach allows busy physicians to gain crucial business and management skills without the commitment and expense of pursuing a business degree.

At the Summit, subject matter experts apply a radiology lens to the latest business models and tools to help attendees learn how to improve both patient care and the practice of radiology. The sessions are created to give radiologists a deeper understanding of some of the biggest issues facing the specialty and offer insights and solutions to transform challenges into opportunities.

Norbash has found that the case studies and discussions at the RLI Summit resonate with radiologists at all levels. “We bring in challenges and problems that other leaders have faced,” he says. “Whether it’s diminishing margins, the corporatization of radiology as an opportunity or challenge, teleradiology, or a hospital giving up contracts for bids — we have individuals who have special expertise at drawing these very detailed cases.”

Transforming Leadership Education Alongside Healthcare Demands

Over the last decade, more than 9,000 radiologists from across the U.S. have participated in numerous RLI programs, gaining the essential, non-clinical skills to survive and thrive in today’s complex and ever-changing healthcare landscape.

The RLI is staying ahead of those changes by bringing in radiology and business experts at the forefront of healthcare. Engaging with ACR members and soliciting participant feedback is also critical to creating valuable, tailored content. This engagement, combined with the strength and expertise of its world-class faculty, sets the RLI apart from other leadership programs. Many radiologists come back year after year for additional leadership and business skills training as their roles change and the RLI programs expand and evolve.

With programming for radiologists who are leading change at all levels, the RLI can help every radiologist advance their careers and master the challenges ahead. “Radiology leaders aren’t created overnight,” Nathan says. “Leadership is a marathon, not a sprint.” **B**

By Meredith Kleeman, freelance writer, ACR Press

With programming for radiologists who are leading change at all levels, the RLI can help you advance your career and master the challenges ahead. Explore all of the leadership training opportunities on the RLI website at acr.org/RLI or contact RLI@acr.org.

How is the ACR supporting medical students and fostering the next generation of radiologists?



“My favorite part of attending ACR 2022 was the networking opportunity at the RFS meeting, where I was able to talk to peers who were several years ahead of me in medical school or in residency and hear advice about studying and preparing for my future. The RFS meeting also had great content — with one valuable talk about the future of AI — allowing me to better understand a radiologist’s relationship with advancing technology. I also appreciated my mentor at ACR 2022 who helped me to understand the ACR, the prestige that comes with being an ACR fellow, and the importance of resolutions.”

— Isaiah Ailes, medical student at Sidney Kimmel Medical College at Thomas Jefferson University

“Discovering radiology at the beginning of my third year, I was worried I would not have meaningful involvement in radiology, but the ACR has provided me with life-changing support over the last year. Through events such as the Medical Student Symposium and the ACR 2022 RFS programming, I’ve been able to learn about radiology as a career, the subspecialties, the challenges facing radiology, and #radvocacy. As an ACR 2022 Medical Student Travel Scholarship recipient, I felt energized watching hundreds of passionate radiologists carefully craft practice parameters and resolutions. I have felt welcomed into a community of caring, brilliant physicians.”

— Ashley Lau, medical student at A.T. Still University School of Osteopathic Medicine in Arizona, Santa Maria, California, campus



RESEARCH ROUNDS

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financially viable, they cannot ignore the economic incentives they face. For the medical community to reduce disparities, their well-meaning efforts within the scope of their practices alone is akin to treating the symptoms rather than curing the disease. To address the disease requires changing the incentives so that it is financially sustainable to serve various populations equitably.

To explore these issues, the HPI has been conducting a series of studies on disparities using access to breast cancer screening as its area of focus. Prior research has shown devastating statistics including 40% higher breast cancer mortality for Black women compared to White women.⁵ In the transition period from existing technology to newer technology as the standard of care, we found disparities in the use of the newer versus older screening technology, such as tomosynthesis compared to 2D mammography for women with the same insurance (manuscript currently under review). This disparity lessens as newer technology becomes universal — but the problem is not improving. Medicare reimbursement relative to resources committed (i.e., cost of the technology plus interpretation time) was less with tomosynthesis compared to previous technology. Not surprisingly, safety-net hospitals — which are more reliant on public insurance — are slower to adopt tomosynthesis, creating an economically driven disparity. CMS has the opportunity to reduce these disparities by adjusting reimbursement to incentivize investment in new technology.

Related to the HPI's study of transitional disparities, Jinel A. Scott, MD, MBA, RSNA member representative to the RHEC, says, "Urban safety-net hospitals are burdened with addressing the long-term effects of historical, government-promoted and -sanctioned systemic discriminatory practices perpetrated on the disadvantaged communities they serve. To reverse the legacy of poorer health outcomes that these policies produced, the government should utilize economic policies and incentives that would allow safety-net institutions to facilitate access to newer medical technology."

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— JINEL A. SCOTT, MD, MBA

In another study in progress, the HPI identified disparities in mammography rates for Native American women compared to White women or women of other races/ethnicities. The findings suggest the effects of rurality on mammography screening rates are worse for Native American women, and income is less of a protective factor for Native American women than for other groups of women.

Where to physically locate screening technology is a business decision that yields disparities as a byproduct. CMS as a payor could lessen such disparities with reimbursement policy or other financial incentives. According to Jacqueline A. Bello, MD, FACR, chair of the ACR BOC, "We are striving to leverage radiology's central role in achieving health equity, but as long as reimbursement policy continues to drive disparities, addressing them will be an uphill battle. The HPI plays a critical role in framing and broadening the health equity discussion."

It is the HPI's hope that its research program serves as a launching pad to shift the discussion of health equity to broad-scale policy that creates incentives that make equitable care a sustainable path for hospitals and radiology practices. **B**

By Eric W. Christensen, PhD, principal research scientist, health economics, at Harvey L. Neiman Health Policy Institute®

ENDNOTES available in the digital edition at acr.org/bulletin

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