Episode 28: Leading by Example

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Geoff: Hello, and welcome to "Taking the Lead," a podcast from the Radiology Leadership Institute that profiles radiologists as leaders seeking insight and inspiration from a variety of perspectives and experiences. I'm Geoff Rubin. Today, I am speaking with Ezequiel Silva, an Interventional Radiologist and member of the board of directors of South Texas Radiology Group in San Antonio, Texas for over 17 years and medical director of radiology at the Methodist Texts and Hospitals since 2017. He is the immediate past chair of the American College of Radiology Commission on Economics and is a founding board member of the Neiman Health Policy Institute currently serving on their advisory board. Dr. Silva is co-chair of the AMA Digital Medicine Payment Advisory Group. He is also a member of the AMA specialty society, RVS Update Committee or RUC, and serves as chair of the RUC research subcommittee.

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Geoff: Zeke, welcome.

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Ezequiel: Geoff, thank you. And I will say it I've seen the list of individuals that you have interviewed as part of this series and I am honored to be a part of it, not sure I'm worthy, but I will do my best, Geoff.

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Geoff: The privilege is ours. I am certain that we will have a really interesting conversation. Let's start at the beginning. Texas has been your home for almost your entire life. Were you born in Texas?

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Ezequiel: I was born in a city called Brownsville, Texas and Brownsville, Texas in the Rio Grande Valley. It's on the Mexican-United States borders, sort of as far South as you can go, if you will, from the mid part of the United States. My parents were high school sweethearts. I was born when they were relatively young. In fact, I was a baby when my dad was in college. So, Texas has been home for the majority of my life with the exception of some time I spent in Boston.

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Geoff: Oh, terrific. And what do your parents do for a living?

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Ezequiel: Yeah. So, my father is a chemical engineer and he's retired now. He's in his early 70s, but he was a chemical engineer. And even though I was, like I said, born in Brownsville, he pursued his college degree and his education at the University of Houston and took a job in Houston. And so, that's where we settled since I was relatively young. My mother has a business degree and she was in, believe it or not, health insurance for a private insurer for many, many years. Sort of their marketing sales department, if you will. And they were both great parents, very busy, as you can imagine, but also always there for everything that me and my brother did.

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Geoff: Great. And your brother younger, older?

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Ezequiel: Yeah. My brother is about four and a half years younger than me. I've had the good fortune of him living here in San Antonio. So, I get to watch his kids, my nephews grow up, if you will. And he works for a company called Rackspace and they're a sort of cloud server company, sort of manages their accounts and keeps pretty busy.

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Geoff: Now, with a father as a chemical engineer and a mom who was in the medical insurance industry, how would you say their careers influenced your decisions?

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Ezequiel: Yeah, it's interesting because, you know, education was always a focus. It was never a question that that was something that was expected of us. And yeah, I think having an engineering father, you know, sort of analytical mathematical scientific, if you will, I think it was a natural draw early on to dive into, you know, chemistry, physics, those kinds of specialties, and translate that into college. And, you know, my mom, interestingly received her college degree around the same time that I did. So, she went to college relatively late, which I think was interesting just to go to college. And we actually literally graduated within weeks of each other from college, which was kind of an interesting experience actually. It's funny, Geoff, I actually remember, and this was when I was studying for the MCAT. So, I would have been, you know, a junior in college going to the library at her school while she was studying for whatever her course work was. And I was sitting a few tables down studying for the MCAT.

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Geoff: That's fantastic. What a special experience and tremendous commitment on your mom's part to get the education at that stage of life. In our conversation with Katherine Everett early on, she talked about earning her MBA with her daughter and must be a phenomenal memory for you.

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Ezequiel: Yeah. And you think about also for my father, you know, watching his wife and his oldest son achieved that at the same time, you had to imagine it was extremely rewarding for him and the family in general.

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Geof: I can't help, but wonder, you know, when you mentioned that your mom was in the health insurance industry, the extent to which, you know, her attention toward that, and, you know, ultimately the business degree may have influenced your interests in pursuing beyond clinical medicine, the economic side and payments side of healthcare.

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Ezequiel: You know, I think it did, Geoff. I mean, you know, what I always admire about my mom was she believed in it. I mean, she was out there. She was in sort of frontline, I say marketing, but she was...literally would go to these companies and she would set up, you know, a table at their "health fair," if you will, and talk to them about, you know, what their health insurance options were, you know, and this is 25, 30 years ago. So, the market was very different than what we see now. But I think what I admired was how strongly she believed in what she was doing and the good that it was bringing and providing health insurance for individuals, you know, on the surface, you know, sounds like a really basic thing. But when you dig a couple of layers deeper and you start really thinking about the impact that that has in other people's lives, you really put yourself in an empowering position. And I won't deny that, you know, I went to medical school focused on doing what I ultimately did, but I kind of always sort of had this sort of background and interest in what the other aspects, economics included, were surrounding healthcare.

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Geoff: So, when you were growing up, what was your first job?

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Ezequiel: Interestingly, Geoff, my first job was as a baseball umpire, but this was probably when I was a sophomore junior in high school. And I just, you know, I played little league and Friends was where I grew up, a town called Friendswood, Texas. And I had the opportunity. I met the head umpire and he

said, we need umpires. And I did it for several years. I did it, you know, even into when I was in college, I used to umpire for some of the intermural games, find me some lessons. I mean, sort of certainly taught me one, how to be confident in your decision-making ie, is that a ball? Is that a strike? Is he out or is he or she safe, but also, you know, accepting criticism, you know, you make a mistake and it's not fun, Geoff, to be out there on the field and say, "Oh, he's out."

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And then listen to the parent that's in your ear for the next 30 minutes saying, "No, my son or daughter was," you know, they were safe, you blew that call on them and you kind of knew, maybe you didn't blow that call, but at the same time, you have to maintain your own confidence to say, "Okay, maybe I made a mistake. Maybe that was the wrong call, but I've got an hour left in this game and I'm going to go through these teams and these coaches and these parents and these players depending on me to do my job" and you have to continue doing it.

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Geoff: Yeah. It's such an interesting first job, but with a lot of responsibility, you know, most kids, when they are doing their high school jobs, it's just much more sort of operational delivering things or shoveling this or that. It's interesting that this is where you started and that you have these reflections on the complexity of the decision-making that you were pursuing and the notion of moving on after difficult decisions. Do you see that as having a direct influence on some of the work that you do today and leadership in general?

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Ezequiel: Yeah, I think I do. I didn't realize that at the time, Geoff, I was, you know, 15, 16 years old, but as I reflect upon it now, and I think you kind of hinted that in your comments a moment ago was it takes a lot of confidence to walk onto that field with, you know, let's call it a couple of dozen, maybe three dozen people watching and the teams, it takes a lot of confidence to put yourself in that situation at any age. And I completely respect individuals, you know, empires, referees, coaches, where you go out there and you put yourself in a situation where, by definition, what surrounds you is uncertain. You don't know if, you know, the ball's going to go here or it's going to go there. You don't know if there's going to be conflict. You don't know if there's going to be an injury. And I think translating what I learned on the field and being able to make a confident decision, being able to deal with conflict, you know, I think now that I reflect back on it, I think it was a tremendous learning experience. And I'm not sure everyone at that age has that kind of an opportunity to do that job. But I do think getting out there and doing some sort of employment, if you

will, you know, really provides life lessons, which can potentially translate for the rest of one's life.

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Geoff: No doubt. When did you retire from your umpiring career or are you still doing it?

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Ezequiel: You know, it's funny you asked, well, I did it a little bit in college and that was more at the intramural level where I would just go to the intramural fields and you didn't really have hardball baseball at that point. It was more, you know, softball between the students, etc. So, I did it through college. Didn't really have time to go back and do it again later. But it's funny, I've talked to my wife about this actually, and my son's a big baseball player, no surprise there, right? He's a really good high school player. And I've talked to her about going back and doing it. I probably wouldn't even collect a paycheck because I've got the good fortune that I just don't necessarily need and maybe donate it back to the league, but just go out there and do it because I think it's something that gives back to the community number one, and number two, I think there's a need for frankly good umpires in youth sports.

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Geoff: Absolutely. That's marvelous. I hope you get a chance to get back to it. Looking back, what were some defining moments and influences from your childhood that you feel you carry with you today? Any specific event or occurrence?

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Ezequiel: A couple. I mean, I'm going to talk education because I think it's relevant. I went to a good public school, class of about 300 or a little more students. It was a smaller community. It wasn't too overwhelming, but it wasn't, you know, a very small private school with, you know, a fraction of that, but call it good fortune and call it luck or whatever. I had two amazing science teachers very early on. One was Mrs. Vagus, V-A-G-U-S. And the other was Dr. Wide. He was my chemistry teacher and she taught physics and they were college-level teachers that I happen to have in a public school that sparked an interest in science. I was always reasonably good at it. Same with math. We've already talked about my dad's influence on that, but to the point where I loved it and said that, "You know, this is what I'm going to do."

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I wasn't sure at that point if that meant going to medical school or that meant becoming a physician or radiologist, but what I did know was that, you know,

we didn't call it, you know, what they call it now, you know, STEM and all those different terminologies, if you will, for those types of disciplines. You know, I just knew that it was something that I enjoyed and in hindsight, I probably would have done it as well without those two individuals in my life. But the fact that they came along when they did at that kind of a developmental stage where you're sort of trying to find yourself in what you find interesting. I do think I was fortunate, you know, that was kind of my sort of educational piece. I mean, I think from just a sort of more personal level, you know, I think I was lucky to grow up in a community where, you know, I moved there when I was in second grade and was, you know, stayed there through high school graduation and just always felt as though I was a part of that community.

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And I always felt like my parents were always engaged in what was taking place in the community. A lot of that centered on youth sports, but not all of it. I mean, a lot of it centered around, you know, going to church on Sunday, interacting with others, and really feeling like that was that community that gave back to me. But also that we were able to give back to that community. And I think had you translate that into where we are today, I think being and recognizing this is who we are, this is what we claim as our community or tribe, if you will. And always recognizing the importance of what that gives us, but also what we can give back

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Geoff: Beautifully articulated. You went to college at the University of Texas, Austin. What did you study there?

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Ezequiel: I appreciate it. Yeah, I actually, I started out interestingly as a chemistry major, not surprising that my dad was a chemical engineer. I kind of evolved that to biochemistry and that eventually evolved into biology, but basically, you know, college of natural sciences, pretty standard science pre-med degree, if you will.

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Geoff: Did you have any major activities outside of the classroom during those years?

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Ezequiel: So, interestingly, so I knew early on and we've sort of talked about this as far as the umpiring thing was concerned. You know, I was your kind of classic kind of pre-med leader, there's a group called Alpha Epsilon Delta. You were probably a member if you remember from college, perhaps, because it's

all over the country. But, you know, I sort of became involved very early on with pre-medical not really education, but sort of pre-professional preparation, if you will, because I knew very early on that I was going or I aspired to go to medical school. So, I was in college very early on, was fortunate to have some sort of upperclassmen within these organizations, if you will. And that kind of provided guidance to help professors office, etc. So by the time I was a junior-senior, I was actually president of that organization.

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I was an advisor within the college of natural sciences, which wasn't exclusively working with undergrads and pre-med, but it was, there were quite a few, but also sort working across the spectrum, if you will. And sort of, again, this whole message of trying to take what people had given me in prior years and flipping that and sort of translating that to give back, if you will. I had the good fortune of being involved or building at the time when I was, this was probably my junior year, Geoff, we were working on a new Christian health center, and this is at the University of Texas, which you can imagine a pretty big effort. So, I had the good fortune of being involved in some of the early discussions on that basically providing the student perspective on what we needed or might expect from our on-campus, you know, healthcare services, if you will.

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Geoff: Yeah. What a great opportunity to be at the leadership table early on. I imagine there were a lot of lessons learned and probably some great leaders that you were able to learn from.

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Ezequiel: Absolutely. No question. When you think about the university setting, if you will, and my daughter's in California, UCLA, she just started, but you think about you go back and you see just how vibrant of a place that is. And for us, when we were at those levels, you don't realize it at the time, but just how powerful the opportunities are there before you, I mean, there's a complete open palette at that point in your life to pursue whatever you want, whatever you wish and then, yeah, I miss it. I loved the University of Texas and I thought for some time that my daughter was going to go there. She actually chose to go to the West coast, which I fully support. But yeah, I just dropped her off at college, Geoff, not too long ago. Yeah. It's a setting I won't deny that I miss. And maybe in addition to being an empire someday, maybe I'll have a chance to teach a little more, we'll see.

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Geoff: I see that there was five years between your graduation from UT, Austin and earning your MD from Baylor. Was there a gap year in there?

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Ezequiel: There was. Yeah. So, interestingly, so I did a year of research and this was...I'd already committed to go to Baylor College of Medicine. And I did a research project in a laboratory with a researcher named Dennis Rupe and coincidentally was dermatology research, but it wasn't specifically, I didn't specifically do that with necessarily the goal of pursuing that particular specialty, but it did give him the opportunity to really jump into some benchtop research. I mean, building out molecular constructs and plasmids and designing experiments and research and things of that sort, it was a good year. I can't complain them. I learned a lot. I was ready to start the medical school curriculum when I did. It was funny. I was there because my research lab wasn't far from where the medical students were taking their classes. And I knew a lot of them because I've known a lot of them from Texas. So, I interacted with them pretty regularly, and yeah, I was ready to start. It was a good year, but when it finally had to crack open the book and learn some anatomy, I was excited and really privileged to do it.

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Geoff: What motivated taking that time out instead of going directly from your undergrad to medical school?

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Ezequiel: I had the opportunity. I had a mentor at Baylor and he and I had talked a bit about it and he knew of this opportunity. There were a couple of labs that were really doing some pretty exciting work there at Baylor at the time. And I had sort of expressed to him then in addition to obviously wanting to become a physician, I wasn't ready to do the MD-Ph.D. program. That just didn't feel like the right choice at the time. But I did feel like I needed to improve my understanding of sort of research experimental methods. And this was a good way to do it. And it worked out, it worked out quite well.

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Geoff: You settled in at Baylor for nine years. That's a good long time. What attracted you to stay there for so much of your medical training as opposed to moving around?

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Ezequiel: The Texas medical centers. And you've probably been there, Geoff, it's an amazingly vibrant place. I mean, you've got everything from the County Hospital, the major trauma center, which has been top, and then you go across

the medical center and you've got MD Anderson, this unbelievable research institution. Then you've got Methodist Hospital, which is sort of the private, I always felt like I was getting good experience. I always felt I was getting good training. And when I was late in medical school, I will admit I made the decision to go into radiology probably later than most radiology applicants or potential residents, if you will. I thought I was going to do surgery and I was interested in procedures and I kind of stumbled on radiology somewhat late in my medical school career and had the good fortune of being accepted into their radiology program there at Baylor, which is a great program, a lot of independence.

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I mean, a lot of trauma, a lot of experience for the residents. I mean, trauma in the sense that trauma patients should be cared for and in the same spirit. And I didn't expect this discussion, Geoff, to go as it is. But if you think about now that I reflect on it, you know, sort of that independence I learned as an umpire when I was younger, I went to Baylor, they give you a lot of independence. You're sort of on-call kind of by yourself, learning, you've got back up, but you've got to make decisions. You got to make them confidently. Those lessons, I think still translate to this day. I didn't say there for fellowship as you know, but I didn't say that for medical school and then stayed there for residency, still have great contacts at Baylor. I went back not too long ago and I've done it actually twice now, sort of a grand rounds presentation, if you will. And it was kind of an interesting to go full circle like that. They did this big introduction and I just, I felt I don't know, that honor, privilege, but at the same time, you know, you've said, am I really worthy of this type of acknowledgment within this institution? I'll always be glad for what I did learn and what I did earn from Baylor. It's a great place.

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Geoff: It is a special feeling to be able to go back and you can't help but think back to the days when you were just starting out and when you were one of the young and it must be a great opportunity to sort of reflect back and to be in the position of giving the grand rounds. I appreciate that.

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Ezequiel: Right. Because you remember when you were in the seat and you were listening to the lectures from your mentors and those teaching you, you know, this is a ventricle on a brain CT. I mean, there's basic things that you learned early on and then you go back and you're the one teaching them. It's not necessarily that basic, but you've had that privilege and that honor of teaching them what you've learned since you left the institution.

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Geoff: Yeah. And it is privileged and an honor, and the humility that you express is a valuable characteristic to carry forward. And one that I'm sure that helps you as a leader to this day.

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Ezequiel: I think so. Thank you.

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Geoff: Yeah. Did you take on any leadership roles during your time at Baylor?

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Ezequiel: Yeah. I did actually. So, I was president of first-year medical school class. I was later the president of the...it was the Baylor Students Association, which was basically our equivalent of student government. So, pretty early on, I had the privilege of kind of helping guide discussions and communications between the students, and administration, and faculty. And it was a real privilege and those were elected positions, if you will. So, that in and of itself was really an honor to represent those classmates.

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Geoff: Yeah. I think it's really interesting that you held so many leadership roles through your educational years, I've had a chance to tiptoe through your CV. And none of them are mentioned there, but the fact that you were so engaged in leadership is really remarkable. Can you provide us any insight into what it was that you think led you both to pursue so many leadership roles and to successfully attain them at this early stage of your career?

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Ezequiel: Yeah, it's interesting. Geoff, I think back and I've had many years or so to reflect on those periods of time. And as I think back on it, I think you sort of have two sort of pathways if you will, to leadership. I think the one we've kind of talked about so far during this conversation is just putting yourself out there with two or three other people and running a campaign and getting elected. And I think that's an important way to do that. And I think that's kind of what I did when the positions we've talked about when I was in medical school and even going back to some degree when I was in undergrad. But I think the other path is when you go into an organization or you go into a body or an effort wherever it is, and you're just, you know, you're sort of one of the group, one of the members, if you will.

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And I think that's been for me at least the one that's probably been the more common where I've just said, "I'm interested in this organization. I am going to find a way to join and learn what they do to contribute where I'm able and in those roles," which at the time, I didn't necessarily think or know that I would someday be a "leader" within that organization. But as I was there and I did what I did eventually, I sort of ascended to those types of titles. I guess my point is you can look...I don't know that it's the most effective way to become a leader to go into an organization or an effort and say, "I am going to be the leader. I'm going to be the president. I'm going to be the chair of this organization." I think my approach and my philosophy is that a more effective way to do it is to go in there and learn, to go in there and contribute, and then make a decision about where you want to go within that organization. And I think when that happens, I think leaders kind of naturally sort of evolve into those different roles as a team member, as a contributor, as someone that's...it's just natural. I think it's just a natural progression.

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Geoff: It's an excellent reflection. And a key element of leadership is followership. And to assure that you have a team coming with you and that the followers see you and resonate with your leadership and by being a team member and working organically within the organization to be recognized as the person to lead an effort has a little bit more of a built-in mechanism toward followership.

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Ezequiel: Yeah. I agree with that, Geoff, and to be clear, it's not a matter of just signing up and smiling and being present, I mean, it's a lot of work. I mean, it's effort. I mean, you have to go into that. And once you realize that this is something I care about, this is something, if you're lucky, I feel passionate about, then you sort of find ways naturally to contribute in its work. I mean, we're physicians, we're busy. I mean, it's hard on a Saturday morning to read regulatory documents like I do to try to understand what policy is affecting our profession in general, and then be able to translate that and summarize that and contribute that, and have people listen to that and do it effectively and have it be recognized as something that we want to see more of.

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And then what I have to say, Geoff, what's even hard is, and this is something that I think I've done a pretty good job in, but maybe not always as well as I could have is when you're in the position of guiding those nuts and bolts activities. I mean, not guiding, actually performing those nuts and bolts activities, at some point, when you go to a different position where you're now leading those activities, but not necessarily the individual charged with those

activities, it's kind of hard to relinquish control of that. And you have to because you have to give those coming into those roles after you, behind you, you know, chronologically, if you will, in that manner, you have to allow them the opportunity to succeed or fail, but more than likely succeed, you have to give them the tools to success. You have to be a resource to them, but at the same time, you don't want to be overbearing.

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And that that's a really challenging leadership trait at times. I mean, John Pat is one of my earliest mentors. John, I had the good fortune of going to the Massachusetts Medical Society to their building and delivering for the state radiology chapter a lecture. And I know John had been a big leader, he had been president. I mean, he had pretty much had every role you can imagine within that association. And he wasn't there at the meeting. And I think he probably didn't know I was going to be there. I mean who knows the exact circumstance that, you know, when I talked to him later about it, I said, "I thought you were pretty involved with it." And he said, "You know, what I learned was what a good leader does is he or she does their service, he or she does their job. And then they get to a point where they have to hand that off to another group of individuals or another individual."

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And he said, and then you get out of the way. In his case, that was basically not necessarily holding any more positions. Now there's a balance there, Geoff, because you don't want to have, you know, a cliff where, you know, you're past leader where, you know, he or she falls off and disappears. You want to have that as a resource because there's so much chronological and historical knowledge there that can help guide a decision making and help guide policy, you know, finding that balance. It's an important task for really all organizations.

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Geoff: Very well stated and such an excellent point. Immediately following your fellowship at the Massachusetts General Hospital, you joined South Texas Radiology. What were the key factors leading to that decision?

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Ezequiel: I had a pretty good idea, Geoff, that I was going to come back to Texas. My wife's from West...actually she's from Midland. We had friends, family here. We actually had our first child was born at the Mass General Hospital in 2002. And we were kind of in Boston by ourselves. My family would travel up there. Our parents would travel up there. I won't get into too much detail, but the birth of my daughter didn't go exactly smoothly. And there

was some complications afterwards. It was a trying time. So, the consequence of that was I think that we were both sort of ready to get back to Texas, to home, if you will. So, once you sort of made that decision, and this is kind of true, you know, for all trainees residents, fellows that are coming out and looking for the jobs, I think that's an early decision is, you know, what part of the country do you wish to settle on?

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What are the reasons for doing so? And then I start looking at Texas and I'd never lived in San Antonio. I'd always, sort of, lived in Houston as we discussed. And I had the good fortune. I was at the SIR meeting, it was in San Antonio when I was a fellow. And I had the good fortune of talking to a couple of the practice members there at the meeting. I knew about the practice, I knew it was a strong, large sub-specialized group within radiology. And I knew they did a great job, had a great reputation within the community. And that was my second metric was one, I was going to go to a certain place, which was Texas. Number two, I'd very early on said I wanted to be part of the practice that was recognized as the leader in radiology within that respective community. I didn't necessarily, Geoff, have a size of that community where I said, it's going to have to be a city this size or a town of this size. But I did know that I did want to be a part of a practice that had that presence and had that history. And as I've learned since then and repeated over and over again is really had a forward-thinking mindset to how to approach the specialty.

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Geoff: Can you describe South Texas radiology as it was in 2002 for us, how many were in the group and what was the scope of practice?

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Ezequiel: Yeah. I think at the time when I joined, Geoff, we were probably around 45 to 50 members. So, it was already when I joined a pretty sizable practice. Now that I look back on sort of when I think about practices and practice management, that in the these days, you know, I think back on that and that was a large practice. And so, when you have a large practice, your governance and your policies are a little bit different. It had a very strong interventional radiology section if you will. So, I knew that I was going to walk into a place where I would be challenged from an interventional radiology perspective, but that I would have resources because one thing I learned early in private practice, and I think this is true in academics. This is true in our specialty is you can do, you know, the best fellowship in the world and you can do the "best residency in the world" but you are going to see things when you go into practice that you've never seen before.

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And I looked at some jobs in the Rio Grande Valley where my grandparents and my family is from, we talked about Brownsville and I had this great opportunity, but I would have been the interventional radiologists that would be basically building the practice. There was no other IR there in this hospital, and we thought about it. We talked about it, but I wanted to be in a setting where I sort of had some practice partners who had experienced where I could continue to learn and I did. And it wasn't really just the IR, I mean, even the diagnostic radiology piece, I mean, even really learning really how to approach CT and MR. And how to interface with physicians in that setting. You really want to have that strong background from your practice partners. And I've had that ever since I joined the practice, and not surprisingly, Geoff and I didn't again, expect it to go in this direction, but now you think back to my earliest experiences, I reflect back on it. And, you know, now I provide that to some really talented, younger radiologists coming out of practice, you know, that same, I hope degree of mentorship as they develop themselves in practice. We're up to about, I don't know, Geoff, I'd have to even like 80, 90 radiologists now, which used to probably be one of the biggest practices you could find. Now that's probably for a large practice, relatively average.

[00:30:50.676]
Geoff: What was that journey like coming straight out of fellowship and then, you know, joining a medical staff that you didn't know at the time and needing to establish credibility and leadership and to build the practice?

[00:31:05.343]
Ezequiel: I think the lessons I learned in that first four or five years in practice, I think I was probably pretty well able to translate into that opportunity. And I think, you know, I think it's building trust with the staff. You know, when you come into practice, one of the first things that you really want, and I tell this to radiologists who joined my practice is you really need to build the trust of the rest of the medical community. You really want to make sure that the physicians, the referring physicians that send us imaging and that send us procedures that they're confident in your abilities. And that's not to imply for a second that we walk into those settings and they don't think we're competent. It's just, they just don't know. They just don't know us. We're a new face. They've been in practice in that community, these physicians, some of them for 20, 30 years, they're used to dealing with a certain individual. When they see a new face, which is by definition, the younger, you know, that confidence by definition just hasn't matured.

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And so, you have to enable that. And it's communication. It's continuing to learn once you're in practice. I have to say, it's building the competence of your hospital staff. And one of the first things I do, Geoff, I walk in, whatever the time I walk into my hospital, or sometimes in the outpatient setting when I'm out there, the first thing I do after I log into the pact is I walk around and I try to find every technologist in the department. And I say, "Good morning, is there anything I can do for you?" Because what that does right from the beginning is they realize, "Okay, one, okay, Dr. Silva's here, you know, take that for what it is."

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But immediately what they realize is that if I have a circumstance that comes up today where I need physician radiologist backup, you know, "Hey, I know Dr. Silva's there, because he's already said hi to me." Now, sometimes they'll say, "Oh yeah, I do need you for something." And then we just deal with that at the moment. And I think I don't quite do that with the medical staff. There was a time, Geoff, where I did, where I would just first I'd do that, go into the doctor's lounge and say hi to whoever was in there. Maybe try to walk around the wards a little bit, see what the docs that I knew were doing, but those personal interactions for we as radiologists, that's a really important part of building the competence of the medical community in what we do.

[00:33:10.970]
Geoff: Another beautiful lesson to discipline oneself, to do that, to make those connections at the beginning of each day and building trust through those interactions. I also think that the message that four to five years to prepare yourself to be effective in moving into the new hospital and setting up the practice and what you gained during those years is really an important one as well. Do you think that you would have been prepared coming straight out of fellowship to get that ask right?

[00:33:46.067]
Ezequiel: Possibly I think from an interactions or professional-personal level, I think so. I don't know at the time, and I think I would make this general comment about really anyone coming directly out of training is you learn so much in those first few years in practice, whether it's your private practice or academics or really wherever is, you learn so much about your craft and your skill and your profession from a purely nuts and bolts perspective. You know, you really, you learn, you hone your imaging skills. I mean, you're doing new procedures, you learn new techniques and you walk into a room to do a biopsy. And, you know, I went to mass general and I felt extremely well trained on how to do a CT guided biopsy, but, you know, you walk in the technologists there,

they look at you, you ask for a certain device and they say, "I'm sorry, we don't have that."

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But Dr. Thomas likes to use this. And so, you grab that device and then things work out and you evolve your practice in that manner. So, I didn't answer your question, Geoff. I don't know that I would have at that point had the technical skill, but I think what I probably would have done was probably done my best. Probably been pretty purposeful about reaching out to my faculty colleagues back in my fellowship program in Boston. And I think I probably could have done it. I mean, the other piece is sort of the CME pieces. You just, as you're learning your craft and you're learning your trade, you go to the meetings and you learn what people are doing. You read the journals, you know, in my case, as interested as I was in what I was doing from a patient care perspective, you know, my interests sort of diverted, or at least complemented, if you will, a lot of what I do now, which is, you know, economics, health policy research, things of that sort, something that, to be honest, Geoff, I didn't expect one.

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I shouldn't say I didn't expect, I wouldn't have predicted. I've had this kind of pattern in my life where I, if I stop in a moment in time and think about what I'm doing, and I say 10 years ago, would I have predicted that this is what I would be doing, the answer is probably no. And I think that's true for many professionals. I think it's true for many leaders. I don't want to imply for a second that that's some unique dynamic to me, but I do think as I reflect back on my career at this point, it has been a trend that has repeated itself multiple times.

[00:36:02.241]
Geoff: Within two years of joining the practice you were chair for coding and compliance for the practice. Was it common for associates to take on leadership roles so soon after joining the practice?

[00:36:14.125]
Ezequiel: The group does a good job of bringing us on board for the types of discussions that the practice have from a management perspective. And when I was a resident I had...I'm just going to be straight up, Geoff. I don't have a business degree. I don't have an economics degree in college. I don't even know if I took an economics class in college. And I say that humbly, because everything I'd been able to do up to this point in time, I've sort of been very purposeful to teach myself, to learn on my own, learn from others, but particularly that drive has been internal, but as far as...so the point of that reference is when I was a resident and I was learning, this was my first

interventional radiology rotation. I had in attending St. Cliff Wigam. I mean, one of my earliest mentors.

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And Dr. Wigam's thing was that in addition to being a great interventional radiologist was after we did a case, we had to take this, you know, what we call kind of a chargemaster, if you will. And we had to indicate all the CPT codes for what we just did, you know, 36020 to select the aorta, you know, 36245 for the SMA, etc. To this day, I don't know, Geoff, what it was that I thought was interesting about the fact that everything that a physician did had a numeric digit to describe it, but I just, I did. And I started following all these sort of CPT sort of discussions. When I went into practice, I would listen to all the SIR webinars about coding and what the RBMA and the ACR were doing. And so, I practiced...my practice manager, his name's Phil Russell, another one of my earliest mentors.

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So, just one of our imaging centers. And he calls me, I guess he had somehow heard or known that I had watched the SIR webinar about the new codes for the next year. And this is probably now 2003, 2004. I don't exactly remember. And he said, "You know, we sure could use some help from a physician with our CPT coding, are you interested?" And I said, "Sure." And typical sort of me fashion, if you will, I took...I dove straight in. I started looking at what our processes were, how we were translating the procedures into code, particularly interventional, but not exclusively interventional. I sort of went to the business office. I kind of met with the business leaders and met with the coders. I started having meetings with the coders so I could provide them backup, if you will, from a physician-clinical side to guide their efforts.

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And then I think for about the next 10 years, I said, you know, the anatomy for interventional radiology coding is difficult. It's a lot to ask a non-medical trained person to understand all the branches of the external carotid artery when they're coding. So, what I did was I said, I will code every interventional radiology code within the practice. And so, they were just, I mean, they were seeing rains and rains of reports, Geoff, and I would just sit there and I'd memorize all the codes by this point, I would just sit there and just assign CPT codes, seven or eight per case to where I really started to understand how those translated. Then I started getting involved with the groups that were writing the codes, SIR, ACR, etc. And then the cliche is the rest is history, but that was where it started.

[00:39:21.429]

Geoff: That's a great recounting of how, you know, just sort of scratching the itch of interest and drilling down made you uniquely relevant and valuable to your organization. And then ultimately to other organizations through the development of knowledge base and skill. And it speaks very much to the principle that you described of sort of, you know, finding the need and filling it and doing the work to become the leader.

[00:39:51.372]
Ezequiel: And it's interesting, you know, this whole thing of sort of giving back that we've kind of talked about a few times now. And so, now fast forward to where I am now. And I've been given this lecture, Geoff, to the residents called "How a dictation becomes a dollar." And I've been doing this lecture for many years now, I've gone to state chapters. I've done it at the ACR meeting. And it's really just, basically this is a CPT code, this is an RVU, etc. But one of the things that I learned from my own experience, and I've said this during this lecture with the residents several times is I said, you know, these are some areas where you can go into your practice immediately and contribute. These are even some questions you might be able to ask during your interview for that practice. And I kind of jokingly say, but not really jokingly say, but be careful because if you start asking these questions and express this interest and start caring for these actions, they're going to ask you to be treasurer.

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And then you may eventually move up. And this is a great place potentially to find that niche. And I said, "Just be careful because that may happen." And I gave that lecture, let's say, I don't remember when this is, let's say it was 2009 or something when I gave it. And sure enough, a few years later I was back at a medical school and I was giving that similar lecture a little bit different, but similar lecture and sure enough, one of the individuals in the audience came up and said, "You know, I heard that talk and I did what you said. And I am now treasurer of my practice." He's actually in San Antonio down the street. And it was that whole sort of full-circle thing where you learn from others, you make yourself sort of the expert as best as you're able, you contribute back. And then that goes back full circle. So someone else does the same thing. It's remarkable.

[00:41:24.876]
Geoff: Yeah. I want to turn our attention to your work with the ACR at this point and begin by asking you how you initially became involved in the American College of Radiology.

[00:41:36.040]
Ezequiel: It sort of builds on sort of a little bit of the references I've made already. So, one of the first, because I was interested in CPT coding and

subsequent revenue cycle management, you know, I started to get involved with the SIR, which was a natural progression because that was my sub-specialty organization. And eventually became chair of the economics committee for the SIR. And eventually became, actually was editor of the coding guide. So, I actually helped write the coding guide for the subspecialty pretty early in my career. And it was around this time, this is, gosh, Geoff, probably 2004, 2005, that we started to see the radiology diagnostic coding set being subjected to some rave review, it's kind of wonky stuff. But basically every CPT code in the Medicare physician fee schedule by statute has to be reviewed at least every five years. And a lot of our codes hadn't necessarily been reviewed in that period of time, no fault of theirs, and they just hold the codes.

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And so the combination that we were talking about at the time was CT the abdomen and pelvis. I mean, that is as bread and butter as it gets for a diagnostic radiology practice, hospital or outpatient-based. And I was going to meetings for the SIR. I knew that I was involved with the ACR as a member. I'm in all of that. I knew what the ACR was facing with this major code setting. And so, I started to learn more about it. I am Bib Allen, Geraldine McGinty, I mean, another two of my earliest and still current mentors. And I started talking to them about it. I started doing some modeling of some of those codes. We started talking about what the best solution for radiology was going to be. And that kind of prompted me to start to become more involved directly with the ACR and what we were doing from a coding perspective and evaluation perspective. And eventually, I became the advisor to the RUC, their alternate advisor, I should say, Geraldine was the advisor and then eventually brought panel member and then eventually started to broaden out my interest in a lot of what the ACR does largely from an economic level as you've described, Geoff. But that was sort of the on-ramp reentry point, if you will.

[00:43:39.122]
Geoff: Yeah. For our listeners who may not be familiar with the RUC or the RVS, Relative Value Scale update committee, would you explain what it is and how it works?

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Ezequiel: Yeah, it's important and it's not as well understood in general as it could be. So, yeah, I appreciate the question, Geoff. So, when we talk about services within what's called the Medicare physician pay schedule, it's basically how Medicare pays for physician services. Well, ever since the late '80s, early '90s, the way that the payment amounts have been determined for radiology, let's imagine the CT of the abdomen because we've already sort of referenced that at the moment. So, what the RUC does is it looks at that service and says,

where does this service fit on a relativity scale? In other words, is it more physician work than another service? Is it less? Is it the same? And you take the scale. That is the, every service that physicians may be able to provide or do provide in the United States. And you take new services and you find where that radiology or that new surgical service or that new preventive service fits in that spectrum.

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And that relativity determines its relative value units, which eventually is translated into payment, dollars and cents payments. So, what we do is in this district, we meet about three times a year and we actually go and a presenter goes and says, "This is my new service or my established service I'm revaluing." And we talk, we compare it to existing services and we find where it fits on that relativity scale. And this is the, you know, the AMA is the Rutgers administrating this. Then we make those recommendations to the Medicare program. We hope that they're going to accept them and when they don't, we comment. And then eventually, that becomes part of the permanent Medicare physician fee schedule determining payment.

[00:45:26.697]
Geoff: Great. What was your specific role on the committee? Initially as advisor and then panel member, what were you expected to do?

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Ezequiel: The advisor role is very, I mean, I was very ACR centric as it should be. My job was to look at a service and we would survey our members that provided that service. It was random, but we would purposely imagine CT admin, we would send surveys out to practicing radiologists and asked them, how does this fit within your...what's the work involved with the service? We would gather that data, we would organize it. We would make a presentation and I would physically go to the meeting, sit at the front of the table and discuss with the RUC what my and our recommendation was for the valuation of that service. And invariably, there would be questions. Well, what about this? What about that? Is this really work in this regard? You know, where does PACS and soft copy imaging fit in compared to this, what are the office based practice expenses?

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What about malpractice? How do these different metrics and different variables factor into the ultimate valuation? And I was by definition very much an advocate for what radiology does and what we do. That was my job. That was my role. That was my responsibility. When I went, Geoff, onto the RUC and the ACR has the good fortune of having a permanent seat on the RUC. And

we've had that seat since the inception of the group in the early '90s. And when I went onto the RUC, that role very much changed because no longer was I an advocate for radiology or an advocate for the ACR, but I was an independent panel member. And in fact, in that forum, I'm not even allowed to comment on radiology proposals and radiology discussions, but I do comment on other specialty discussions to help make those determinations. And it makes sense. I mean, you want that body to have the credibility and the independence to make recommendations that are pretty far-reaching as far as not just what the payments are, but subsequently what the availability are for those services.

[00:47:26.705]
Geoff: Yeah. Way back in 2000, I joined Jim Borgstead and James Moorefield at a RUC meeting in support of the valuation of the initial ACT angiography codes. And I was struck by the alliance building and balanced adversarial relationships in getting code values and an agreement amongst different specialties. Can you speak to that aspect of the RUC and what strategies you found that enabled you to succeed within that in milieu?

[00:47:57.754]
Ezequiel: Yeah. Absolutely. And this just gets into sort of a lot of what I'm doing currently that's a little less radiology specific and radiology-centric, but sort of more sort of multi-specialty, if you will. But to your points with the RUC, if you look around the table, it's, you know, you have radiology, we've already talked about that, but you've got every other specialty there. You've got pathology, you've got internal medicine, you've got the surgical specialties. I mean, it is a true multi-specialty body coming together to independently reach a common conclusion, a common recommendation, a single recommendation. So, to your point, that's exactly right is my approach as the RUC advisor, and this came through many years of experience and from guidance from those before me, who I've already mentioned Geraldine and Bib and others who came before me. But my approach in that setting was the following.

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I always went to that table and made sure that number one, I was meticulously prepared. I would spend however much time I needed to understand every aspect I could of that service, of that survey of our recommendation. I could never have been... I didn't purport to understand it from a clinical perspective, as well as someone like you coming to the table, but I knew I had that clinical backup. You know, imagine like cardiac alarm is something very specific where, and CTA to your point as well, where you see the clinical complexity, really complimenting those discussions and recommendations. And then when I would go to the table, I always treated that body in that panel with absolute respect. I mean, in my mind, and I know this now that I'm on it, but in my mind,

those were 29, 30 medical professionals all accomplished within their local domains, all accomplished within that body and all accomplish nationally.

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And in my mind, I said, these individuals have come to this table. They are giving up their weekend to help contribute to physician input, inpatient care for patient betterment. So, I never viewed that role as being adversarial at all. I viewed my role as being a humble individual whose job was to come to the table and make sure that they understood what I was discussing because everyone sort of knows what radiology does and interventional radiology does from a non-radiology perspective from physicians. But what we do, Geoff, is different. And what we do is it requires a description of how we approach it, to understand how really complex and intense what we do is and then that sort of combination of preparation, respect, humility at the table, but also never, never letting myself get pushed in the wrong direction. You know, I'd like to think I was pretty effective. And I learned a lot from that. I mean, I walked in now into different settings with multiple specialties. Now, I'm really very purposeful to understand how they view what we do in radiology, but also purposefully for me to understand what they do within their specialty. I think it's really important.

[00:50:59.408]
Geoff: Yeah. What would you say was your proudest moment on the committee?

[00:51:03.876]
Ezequiel: Well, I've sort of already mentioned the CT abdomen pelvis. And I think during those discussions, I thought, I'm going to give you two. I mean, this is my more technical and I'm going to give you another one that's more humble. I thought we did a great job, really modeling out what it meant to combined CT of the abdomen, and CT in the pelvis, and how that might've affected the efficiencies gained when doing those two together. I thought we understood that there was some overlap when you're doing the abdomen and pelvis, but we also understood that there's some differences in the diagnoses, there's some differences in how a radiologist might approach a pelvis by itself versus the pelvis when the abdomen is included. And I thought we did a very credible responsible job of sharing that information. That's number one. Number two, I was at the RUC meeting and this was, oh, gosh, you probably have it on my CV.

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I can't remember exactly what year it was, but it was the year that I became a fellow for the ACR. And I had to leave the RUC meeting early so I could travel

to Washington for...now to prepare for this etc. And so, as I'd mentioned to the chair of the rock, I'd mentioned to her that I had to do this and the staff knew, they moved up my items, etc. But during my discussion, during our presentation, as the RUC advisor, the chair very kindly said, I'd like to acknowledge that Dr. Silva is going to be leaving this early because he is going...about to be acknowledged as a fellow of the ACR. And if you know me, Geoff, I mean, I'm the first one to say, I never liked that kind of...I'm not comfortable always with that kind of attention being put on me for that particular reason.

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It's just not how I'm built. So, I was kind of a little embarrassed that she had brought it up in a good way. The entire RUC stands up and gives me a standing ovation because they knew what I had done in that setting, in that office, in that area, in that room and that they knew the relationships I had built, they knew the mutual respect that we all shared. And, you know, the joke to this day is, you know, it's the first time, the only time a radiologist has gotten a standing ovation at the RUC, but it was...that weekend was such a whirlwind for me because, you know, getting the fellowship, getting that recognition and having that carry forth from what I'd just experienced at the RUC. Yeah. I've never thought about myself in that way, Geoff. I've never thought of myself as being someone that not...deserved isn't the right word, to say deserved a standing ovation, but someone that saw that kind of a standing innovation, I've always just been someone that did their best, was always prepared, was always organized, always treated my colleagues with respect, always knew what the big picture meant, and also always remembered why I was doing what I was doing. And so, all of those types of accolades and recognition that came later in my mind were just a continuation of what I'd always done.

[00:53:55.149]
Geoff: What a proud moment. That's fantastic. How about your most challenging moment on the RUC? Anything that, I mean, it sounds like, you know, your focus on preparation ideally sets you up to be prepared to avoid challenges and surprises, but as we all know, events can go in directions that we don't anticipate. So, are there any, you know, recollections where, you know, you had sort of that sinking feeling in the pit of your stomach, like, "Oh no" and, "What am I going to do right now?"

[00:54:26.281]
Ezequiel: There have been moments. I mean, I kind of gave what I just gave was a very collegial and I think that's generally the tone. Yeah. But there are times where the discussion becomes pretty pointed and it has the potential to be a bit contentious and the discussions are kind of confidential so, I'm just staying

very general on my terminology here, Geoff, but there was a discussion where I felt like at that moment in time that my sort of honesty, and integrity was being questioned to the point that I was discussing a topic and it was, I kind of don't really believe that. I mean, that's not quite what was said, but just in general terms. And for me at that moment in time, I don't remember a time really where I'd felt like that particular part of my character was questioned. I mean, you can say, you know, you're not prepared or, you know, you didn't need to research or you predicted something and you didn't come to me. I mean, I can accept that level of criticism, but I'd never felt that something that inherent was being questioned. Thankfully at the moment and times, someone else rescued me.

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I don't think I was going to say anything that would have had negative consequences. In fact, I know I wouldn't have, but it was an initial moment just to take a step back and learn that sometimes, Geoff, it's best to not speak when you feel that what you might say may not be long-term as productive as you might wish.

[00:55:46.960]
Geoff: Excellent. Simultaneous with your appointment to the RUC, you took on a number of roles within the economics commission and ultimately becoming the commission's chair in 2016. What is the scope of activity of the economics commission? And where was your attention focused during your years on the commission?

[00:56:06.307]
Ezequiel: So, I've talked a lot about CPT and the RUC because that's kind of what brought me into the commission. But the one thing that I learned very early on in the commission was to your point, and exactly as you described, Geoff, was just how far-reaching the commission's responsibilities are. We talk about the Medicare physician fee schedule, but there's other payment systems. You think about payment systems that pay the hospitals for inpatient care, of the hospitals for outpatient care, you think about the private payer space and how they manage their payment policies. And then you think about what really was, I think, the most sizable significant change, while I was chair, was the emerging focus on quality, and quality metrics, and some laws that were passed during my time on the commission. And particularly during my time as chair where we in radiology had to find a way to position ourselves for success within some rapidly evolving payment models.

[00:57:09.654]
Geoff: Yeah, it's interesting. You know, when considering the breadth of topics encompassed within the domain of economics payment revenue generation, and

particularly in the setting of the emergence of what has been referred to as value-based payment and quality as an element of value are obvious areas to occupy the attention the economics commission. I'm curious though, when you think about value more holistically, and even as schematized in some equations that have been put forward, costs, for example, and the reduction of costs are an important element in raising value. To what extent does the economics commission have a 360-degree view on the value equation and the value proposition, and particularly perhaps focusing on productive ways that we can reduce costs as well as increase payments?

[00:58:11.643]
Ezequiel: One of the things that I did say early on during this discussion. So, if you think about it chronologically, it wasn't a dramatic shift because we sort of saw it coming from any mirrors, you know, going back to the mid-2000s when a program called the Physician Collegial Reporting System came out. So, we sort of saw this evolving, but it really was when the Affordable Care Act passed in 2010. I think that was a pretty important change from a quality perspective, but really when it became really particularly accelerated on a practical level was the passage of MACRA, the Medicare Access Chip Reauthorization Act, which was in 2015. That was actually right before I became chair, but it was when I was a vice-chair that I was definitely involved in those discussions pretty purposefully. So, one of the things that I thought very early on during this shift was, and I've written this many times, I've said this many times, was we need to be mindful of the criticism that fee for service and volume-based care is receiving and is going to receive. If you go back 20 years and you think about a system where you say, when a physician does this, he or she has paid this amount of money and that is a national fee schedule.

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On the surface, it kind of actually sounds like it would work pretty well. You know, I do what I do. I get paid for what I do. Last time I went to the grocery store, I bought some eggs. I paid for the eggs. I mean, it's a very logical sort of transactional way to manage what physicians do. The challenge became, it was twofold. Number one, that we saw utilization going up. And this was for a number of reasons. I think it was because what we were doing was better, what we were doing was improved, our indications to treat disease became more far-reaching and more appropriate and more impactful. But there probably in fact there was, we know from studies, there was some inappropriate increases in utilization, over-utilization, if you will. That was one shortcoming that we knew we had to address.

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The second shortcoming, and this is not a radiology-specific dynamic. This is across all of medicine, was that we were seeing that quality wasn't necessarily being validated and being recognized and being scored and judged. And you look at some of their, you know, to air as chairman, some of what came out of the National Institute of Science and some other bodies where you saw some really concrete manifestations of, for quality or decrease or lesser quality. But then when you start looking at what we were doing in radiology, you started to say, you had to ask yourself, where can we do better if they're going to determine metrics to decide if we're providing a quality service or not, you know, how are we going to define those? What is our process going to be to enter those discussions? So, we are determining what the quality is and how we're going to judge that.

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And it's not being judged necessarily by others. So, if that's my twofold question, then let's talk about the first one. So, when you talk about overutilization, you know, I have to give the ACR credit. I mean, when we started creating appropriate use criteria, and this was many, many years ago, the motivation for the college to do that was as holistic and really as purposeful and meaningful as you could expect, I mean, it was resource-intensive and the college said, we're going to get panels together. We're going to look at studies. We're going to look at why we do that. We're going to score for these conditions what's appropriate. And we're going to put that out in the public domain for people to make decisions. We didn't know at the time necessarily that that was going to be a part of a clinical decision support paradigm to help doctors with point of care ordering, etc.

[01:01:49.265]
We were just doing it because we thought it was the right thing to do. I mean, to be fair, there was some regulatory pressure, if you will, there were some focused on utilization even going back then. So, it was in response to a need, but the response that we brought forward I thought was extremely well done, which brings us to where we are currently, where you see there is a clinical decision support mandate where referring physicians are asked or expect are mandated to consult that platform when they're ordering. Well, I think at the most basic level, I think that's a logical, reasonable thing to do and a reasonable thing to expect. Now, it is and is going to have some challenges in implementing that and making that as far-reaching as maybe it potentially could be. But I think the college's effort to bring that to the forefront, I think really is tremendously laudable.

[01:02:39.119]

The second piece, and we've talked about that, and this gets back to your question, Geoff, is what do we do about the quality piece and how do we decide what is a quality or a value-based formula for radiology? Well, I think that comes down to your point, Geoff, to some of the basic equations that you see where you talk about cost, value being cost over quality, etc, or I'm sorry, quality over cost, is if those are your two variables, then the question becomes pretty simple as, okay, I'm going to increase value by doing one of two things. I'm either going to increase the quality of what I do or I'm going to lower the value of what I do. We knew pretty early on, even though there were some really bright academic individuals who were creating really complex formulas for value, or you had waste driven in, you had different lean principles, etc.

[01:03:27.000]
I mean, pick a metric, but we knew pretty early on that the way that policymakers, in general, were going to look at value was based on those two variables, quality and cost. So, we knew that we had to decide how were we going to prove, validate, and measure the value of what we were going to do. We didn't know how we were going to do. We knew that we needed to make that definition. And then on the flip side, we had to determine what we're going to do about costs. Where we are today, Geoff, I think that we probably thought that some of the quality initiatives were going to evolve faster than they have. And I say this not just for radiology, but I say this from a public policy perspective in general, it's been challenging to see the regulations evolve, to see those metrics defined, and to see that diffuse into the medical practice, into the medical community.

[01:04:15.511]
Geoff: Yeah. There's a lot to unpack and I appreciate the detail of your answer. There's kind of two directions I'd like to go from here. One relates to the time course and the external factors that impact the uptake in transition to value-based care. But before we do, I just want to follow through on your comments about, you know, the value equation and responsiveness of policymakers to, you know, a fairly simple model quality over cost or outcomes over costs. And I just want to ask you one other perhaps wonky aspect of it. And that is, is, you know, when you communicate with policymakers and try to represent the value of imaging in particular, one aspect that is not specifically articulated in the equation but is implicit, is the time horizon and the extent of the episode of care or the disease management that is resulting from the intervention of doing a diagnostic imaging test.

[01:05:22.902]
And when you try to ascertain outcomes or quality, or in particular, when you look at costs and the impact of the information from a medical imaging test,

which introduces a cost unto itself, but may save downstream costs because of the availability of information at that moment in time. Can you talk to us a little bit about how you contextualize the scope of that information longitudinally and where you feel sort of the sweet spot is to rest when talking to policymakers and what opportunities we might have from a research perspective, perhaps to better drive the conversation in a data-driven fashion for the downstream implications?

[01:06:06.419]
Ezequiel: It's such an important point. And that's one of the reasons I mentioned the fee for service piece was because, and I still believe this to this day. We're seeing it evolve a little bit, but I still believe that whatever new and alternative payment models we see, whether those are the episodes of care you described or how we are determining outcomes, research, or how we're looking at cost, there is going to continue to be a need to assess and evaluate per unit payment. Maybe that doesn't determine how much actually a physician receives, but within those models and within an organization, and as one moves away from volume to value, the ability to quantify what is being done on an individual sort of almost cost accounting basis, I think will remain relevant. So, it's at that piece where I think that the per-unit fee for service needs to be maintained.

[01:06:54.717]
But then to your point, the risk of that strategy, the risk of saying reading a chest x-ray is worth this much. The risk of that is that you lose potentially quite a bit of what that chest x-ray contributes. And that's to your point, because now you take a step back and you say, okay, let's look no longer at a patient that's admitted to the hospital with COPD and let's no longer look at that patient's care from the chest x-ray and the CT and the pulmonary consult and the pulmonary function tests and the nursing and the gloves, and, you know, pick a unit. You know, let's no longer look at that as individual instances of care, but let's look at it as the entire episode, and let's look how much this is. Policymakers are thinking about this. How much are we going to pay for that episode of care to that facility?

[01:07:47.074]
How is that determination going to be made? Well, one of the determinations has been made based on the point of things I've already described. But number two, it's going to be determined by things like how well the patient did from an outcomes perspective. It's going to be determined by what was the risk of that patient, the risk stratification of the patient coming into the hospital. What you don't want to do is incentivize taking care of only the most well COPD patients and ignoring the ones that are the most sick. You have to re-stratify and

potentially pay more for those that are more ill or less ill, then you want to decide okay, if I'm going to do this episode of care, how long is that going to last? Is that just before the time that the patient is in the hospital, is it a week before when they're getting their pre-op or pre admission workup, is it a week or two after when they go home and I'm waiting to see if they have a complication? That becomes a little more imperative for procedures, rather than sort of medical or chronic care like we're describing, but how we define those episodes really remains to be seen.

[01:08:47.182]
And you say yourself, "Okay, that's great, doc, but what does that mean in the big scheme of things?" Well, one, it determines what's going to be paid, but think about it from a different perspective. Okay now let's no longer look at that episode of care for the purpose of determining how much we're going to pay, but let's look at that episode of care and see how much cost the system incurred from a fee for service perspective and let's compare that to other facilities, other physicians, other institutions, and see how they did. And if our costs, "is higher or lower," maybe that adjusts the ultimate payment, maybe that adjusts our quality score, maybe that adjusts how we're viewed by public and private payers and why this is important for radiology is the following. Because if you ask yourself, great, we're looking at clinical episodes of care, we have a pretty good idea of about appropriate use.

[01:09:40.484]
We have a pretty good idea in general, about what studies are meaningful and relevant for our patients. We have a pretty good idea that the importance of the quality and the accuracy of the imaging is important and relevant. But the question really becomes to your original about sort of the research agenda is there's a balance there because there is an absolute need for imaging when these patients are in the hospital, but there's also a balance to avoid overutilization or imaging too much. There's a risk to not imaging enough, there's a risk to imaging too much. And then there's the quality pieces, the quality of the turnaround time, the quality of the interpretation, the quality of the equipment, the quality of the technologists, the quality of the patient experience. And then to your point, we talk about outcomes and you think, "Bro, what's an outcome?"

[01:10:28.470]
Well, the patient went home. Did that person come back a week later? Well, maybe that's one outcome, but what about long-term functionality? What about long-term quality of life? What about aspects that we in radiology don't typically think of necessarily as being one of our metrics, but, you know, someone comes in and has a joint replacement and they have a complication and we do complex musculoskeletal imaging. You know, we want to be

accurate, but we also want to inform decision making from our physicians. So, we talk about what we see in the image, but we also go to the multi-specialty multidisciplinary conference and we say, this is what we see on the imaging. This is based on our experience. We think that this is the potential next direction in therapy or the next direction in potential intervention. And we are willing to make that recommendation. And we are to some degree willing to have our performance and the quality of our recommendation impacted by the patient's ultimate outcome looked at retrospectively.

[01:11:28.626]
Geoff: It is a complex multidimensional question. And I can imagine that within the context of leading your economics commission of the college, there's a balance between the tactical elements of dealing with policy decisions as they are emerging and being able to position radiology to be appropriately treated based upon the value it brings within the context of that question of the day. But also there is this whole strategic consideration of how do we drive the conversation? How do we help to influence CMS and other payers to think about imaging less transactionally and more sort of holistically in terms of its impact on care, understanding that ultimately, it is a transactional payment that needs to be accommodated. Can you speak just a moment about how you view that blend of the tactical strategic engagement?

[01:12:31.075]
Ezequiel: One of the things, and this is something that I said early on when I was chair of the commission. I told the commission, I said, "We're in a quickly, rapidly evolving healthcare space." And we were seeing challenges in the fee for service side. We're seeing pressures from the value-based side. We're seeing changes in the administration in DC, we're seeing statutory, etc. And I said, "We don't know what's going to ultimately happen here." But what we do know is the following is we've got a tremendous specialty. We're hugely valuable. We've got talent at multiple levels, including in this room but within our specialty. So, I said, "What we're going to do is even though we don't know the outcomes, we're going to put ourselves in a position where we're going to establish ourselves with actions, organization, processes, structure, so that we do everything that we can do to move this agenda forward so it is productive no matter what the outcome."

[01:13:27.674]
That was number one. Number two, Geoff, and I have to say, and this is I have to compliment the ACR on. I have to thank my fellow board members at the time and others. The other thing that I told the board very early on in these discussions was I said, there are a lot of different bodies that are commenting, deciding, impacting this change we're seeing in the healthcare payment space. I

said, my recommendation is that we are going to find ACR members, radiologists, and we are going to put ourselves at every table that we can to at least listen to and inform those discussions as best as we can even though we don't know necessarily at this juncture how positive or influential those bodies are going to be. And I told the board, I said, the reason I'm telling you this is not that I don't think you're going to agree with what I just said because it's completely logical that you would do that.

[01:14:19.905]
The reason I'm telling this board this is because it's expensive to travel. I mean, we're in a virtual climate now, but, you know, thinking about flying a radiologist into D.C. for these policy meetings or having to send multiple radiologists around the country for all the RUC meetings and the CPT meetings and the hops and the AAC panel mean, you know, pick an acronym. And we decided we were going to put a radiologist in those discussions. And I'm pleased to report that the board looked and said, "We get it. We understand, we know you'll do this responsibly. And we have your back when you have those resources." And I think to this day, Geoff, I think it's been a smart strategy. You know, I think we did need to look at it responsibly. And once in a while say, you know, maybe we don't necessarily need a radiologist in that particular discussion, but I think enabling more than less is probably a sensible strategy.

[01:15:10.364]
Geoff: Yeah. Excellent. I'm going to switch gears now. We are in the 9th or 10th month of the COVID-19 pandemic and everybody has been touched by it. I want to ask you, how has the pandemic influenced your leadership work?

[01:15:27.538]
I've actually found myself, and, this, Geoff, this kind of gets into that theme that I've talked about a couple of times where I'm doing things now that in the past, I wouldn't have predicted that I would be doing. And so I've had the good fortune since this pandemic started, of being able to contribute in a way that's not necessarily radiology specific. Now, of course, I still do radiology specific activities because that's still part of my job. But one of the areas where I've had the good fortune of contributing is something that was massively accelerated by the COVID-19 pandemic. So, when you saw a national lockdown and you saw patients no longer able to go to their physician's office because the physician's office is closed, or they're not seeing patients, we saw this massive explosion of telemedicine and telehealth. You mentioned in the introduction that I co-chair a group on the Digital Medicine Payment Advisory Group, where we sort of looked at telemedicine-telehealth standards, we sort of looked at payment paradigms.

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We sort of looked at what the evidence base was in that space to kind of inform what we knew was an evolving trend. We knew that the teleradiology and telehealth platform, teleradiology has been around for years. We can talk about that separately. But we knew that these platforms were evolving and we knew that there needed to be. And we predicted some physician input into those. What we didn't know in late 2019 was that you would see this massive explosion of telehealth in a completely appropriate and important way. So, in that vein, I've been really involved this last few months in really trying to understand what the payment paradigms are to help construct the coding constructs for things like how the telehealth visits are going to be paid or how this is going to fit into COVID-19 testing and therapeutics development. And then in parallel to that, I've sort of had the good fortune also of looking at other digital health solutions.

[01:17:18.828]
For example, digital therapeutics, imagine a scenario where we could send a patient with COVID-19 home that perhaps doesn't need to be admitted to the hospital, but where we need to monitor, say, the road to saturation, we call it remote patient monitoring. You know, having been able to walk into this role where I can inform policy for an acute national crisis in a way that honestly like we've talked about already, Geoff, I never would have predicted. And the reason I have been able to do that and have the good fortune of doing that is everything we've talked about during our time together today is learning CPT when I did, learning valuation processes when I did, learning organization in the way that I did, having the support and the backbone that the ACR provided so I could sort of translate those skills and that leadership into a not radiology specific domain in an acute crisis. Which gets, again, back to my whole thing with the economic commission was, I said, you build these processes, you build this foundation. So, you're strong, no matter what the outcome becomes. So, you're ready to respond. I mean, no one predicted it would be a crisis of this magnitude, but the fact that we had moved a lot of these telehealth platforms and we can talk augmented intelligence as well, but we had moved a lot of that to the point that we had had us to some degree ready to respond in the way that we did.

[01:18:43.627]
Geoff: Yeah. I'm really glad you were able to share that aspect of your activity. The point that we cannot always anticipate the ways in which our experience and our skills can bring value into the future. And it's fantastic that you have taken on these roles to help develop the payment processes that underlie the successful management of patients during the pandemic in the ways that you've described. So, kudos and congratulations for that. You mentioned the digital

side, the engagement around remote sensing, or actually the word I'm looking for, the...

[01:19:25.302]
Ezequiel: Remote patient monitoring.

[01:19:26.295]
Geoff: Yeah, exactly. Remore patient monitoring. And, you know, I have to, it kind of steered me into another very topical area, which is artificial intelligence and, you know, from an economic payment policy, I'm interested in what your thoughts are on the anticipated revolution in AI. I mean, you know, surely I think many of us appreciate that there has been a certain amount of hype associated with the introduction of AI and machine learning. Although I think we also can see the empowering characteristics that this technology is going to bring. So, I'd really be interested in your thoughts around AI and economic payment and policy.

[01:20:07.376]
Ezequiel: Yeah. Well, just to make a general statement, I think this is another great example where the ACR said, this is something new. Okay? It's not entirely, it's been around since the '50s, but as far as the rapid innovation we're seeing is relatively new and impactful to the specialty and the ACR said, we're going to put resources into this, not knowing the outcome, but ensuring that we can inform that direction as best as we can. And that goes to the informatics commission, you know, Keith Dryer, Mike Tilke, and these individuals that really came very early on and said, we are going to inform this discussion. From an economic perspective, it's been interesting. I think a couple of the challenges that I think we're seeing from an economic perspective really is a pretty simple question is how are we going to get paid for this?

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It's the question that organizations that are implementing these platforms and this technology that they're asking because it's expensive. I think there's two ways you can look at that, Geoff, as far as how we're going to pay for this economically, I think number one is you just say, you know what, we're going to do it the way we've done, everything else that you and I have talked about on this call. And we're just going to pay it under a per unit basis. We're going to say a head CT gets paid this much and a head CT with artificial intelligence applied or an algorithm applied to inform decision-making gets paid this much. I mean, that's one potential approach. Now, the other approach is you look at organizations and you say, they're going to implement this technology and the payments that they're going to receive is going to be based on the efficiencies that they gained or the improved outcomes.

[01:21:41.208]
Some of what we talked about earlier with episode-based care. Yeah. The challenge there becomes now you're no longer dealing with per unit payment, but now you're getting into those broader discussions we talked about earlier is, you know, what is the impact of this technology on factors that might affect payment, that might affect outcomes, that might affect patient experience, physician experience, etc. And I've been, I don't want to say pleasantly surprised, but it's been notable that I've encountered a lot of organizations that they don't care how much they get paid for this technology because they are being paid from different payment models. So, imagine an organization and I don't love the term capitated, but people understand, so, I'm going to use it where they're getting paid a certain amount of money for a certain population of beneficiaries. Let's imagine it's 500,000 beneficiaries. Well, they're getting paid a certain amount by an insurance company to pay for that population of patients. Well, if they can put an AI solution in there that improves their efficiency, not for radiology necessarily, but for other parts of their operational processes and they can gain efficiency. So, their overall relative payments for those individual patients under the capitated model are improved, then it makes sense for them to do them independent of whether they're paid individually or not per unit or not. I think that's not, necessarily, Geoff, the rule, but I think it's a sentiment that I've heard expressed previously.

[01:23:05.081]
Geoff: Yeah. And it makes sense. And it is probably not entirely fair to just apply a blanket term of artificial intelligence or machine learning because, you know, when we break down the ways in which machine learning contributes across the imaging value chain, you know, there are areas where it will augment our capabilities. There are areas where it will make us more efficient. And from the standpoint of the acquisition of the image, the preparation of the image, the derivation of information from the image, and the contextualization of that information, it is a broad and complex discussion to be had. And perhaps we'll be able to have it sometime in the future. But I think your initial perspectives are very, very valuable.

[01:23:48.617]
Ezequiel: I do think, Geoff, real quick and I'll make a quick point, because I know is the one opportunity that I do think we have as physicians and radiologists is informing nomenclature and taxonomy and standards. I think this is evolving so quickly, this technology and the application of this technology that we need consistent language, both internally with institutions, but particularly with policymakers, even with sort of CPT coding and the type of nomenclature we use in medicine. And I feel pretty strongly that physicians and

radiologists, in particular, based on what we do are really extremely well-positioned to inform those discussions

[01:24:22.549]
Geoff: That is an important and terrific insight. Yeah. And look forward to progress in that direction. I want to just ask you a little bit about your life outside of medicine, your family life, for example, what do you do to assure that you're able to commit time to nurturing relationships with family and friends?

[01:24:40.154]
Ezequiel: Yeah, I'm pretty meticulous with my schedule. Like most people are, and I'm just, I have the good fortune of being part of a practice where if I can sort of plan in advance, then in general, I can get, you know, a half-day off or a vacation day here and there. And as I looked through what my responsibilities commitments are, the very top of that list is family is, you know, moving my daughter to college or my son's baseball games or, you know, something that my wife's interested in where she expects me to be there. And I prioritize that pretty highly. I had the good fortune as I was growing up that every time I looked into the stands when I was playing a game or every time I was involved in our performance or the equivalent of that, that I always knew that my parents were in the audience and it meant a lot. And I've always said to myself, as best as I can, I'm going to provide the same. And I've been fortunate again to be part of a practice that with some overthinking, I can enable that. Now, I mentioned earlier, you know, my daughter is in Los Angeles and she's been gone for a few months. I'm sort of a half-empty nester if you will. I'm not sure what I'm going to do when my son goes to college in a couple of years, but I predict I'll probably find something to keep me busy.

[01:25:52.977]
Geoff: Yeah. I was going to ask, you know, in between those moments, when the kids are busy and your engagement is not necessarily requested and your wife's occupied too. What do you do to unwind? Do you have any activities that you're pursuing that reenergizes you?

[01:26:09.191]
Ezequiel: I appreciate your asking. So for most of my, since I've been part of the group, I was, I did a lot of triathlon. I used to cycle a lot. I used to run a lot. I actually did an iron man in 2012, which was an interesting day. And I really enjoyed that. And it's funny, you know, I think about when I leave the house in the morning for a run, I don't run as much as I used to, but when I used to run a lot, I always made sure that when I came in from the run that I had a notepad there, because when I was running, I used to give lectures in my head or I

would think about ideas or I would think about a paper I was writing or some type of activity of that nature. Or I would just get these ideas.

[01:26:46.426]
And the first thing I'd do, I'd walk in the door and I would just get that pad of paper and start writing them down. And then I would look back on it later and then sort of reflect, was that a great idea or not? I've been running as much in recent years. I'm actually been playing a little golf hereand there, Geoff. I'm not very good. But what I do love about the game is that it's such a combination of your sort of mental acuity and your mental focus. It's very academic, as far as how the proper golf swing is carry forth. And I think it has a sort of physical aspect to it, but I just liked that it kind of gets me off the grid for a little bit, gets me outside a little bit. My son plays, that's always a nice combination when I can spend time with him or my dad or my brother or nephews, you know, doing something just to kind of get out and enjoy it.

[01:27:33.034]
Geoff: Yeah. That's beautiful. Looking ahead, what excites you most about radiology?

[01:27:38.686]
Ezequiel: Well, a lot of what we've talked about already know. I think that one of the things we've always been able to do in radiology is sort of redefine ourselves. And you think about what we were doing. The story I always tell was one of my faculty, whenever I was at Baylor was over at MD Anderson. It was Dr. Dodd. And he would show us these cases. He was sort of our barium expert. He would show us these cases and he would be putting all of these great barium cases up and we'd be looking at him and doing board review and, you know, we'd kind of stumbled through him and then he would take a CT and he wasn't really experienced in CT. It just wasn't part of his academic makeup. He'd put the CT up and we'd be like, Oh, well there'll be a boom, boom.

[01:28:22.083]
We nailed the diagnosis. And it just shows how our specialty from a technology perspective has evolved, you know, very unplanned films, cross-sectional imaging. And as I think about kind of the next chapter, and I think about what I tell residents coming into it is I think our specialty is on the verge of building on its foundation and building on its strengths, but really redefining itself again. And I tell the residents, I say, you know, mid-career maybe, you know, maybe a little on the other side of that. And I said, I mean, I think it is so exciting to be walking into a specialty and have the opportunity and have frankly the responsibility to sort of define what that specialty will become. And I think to your point, Geoff, I think some of it's technology, some of it's new technology,

but I think some of it is some things we haven't really necessarily talked about, but as you know, it's changing our presence with patients and with physicians, you know, it's sort of being a little bit more and being more involved in the clinical care team, but it's also the digital side of things.

[01:29:23.759]
It's, you know, what is augmented intelligence going to do to us? What about the evolution of digital therapeutics? What about the telemedicine evolution that I've already described? You know, what about sort of new practice models, if you will. And what about collaboration with other specialties? Imagine we talk about radiology and we talk about diagnosis, but what if diagnosis also included pathology? What if we went back to our AFIP roots and said no longer are we just going to interpret the image, but we're also going to be involved in commenting on and interpreting the histology when you combine that? We bring a molecular platform in and we inform it with augmented intelligence, we can define our outcomes. And that's a continuously learning system that provides constant feedback to what we're doing.

[01:30:06.762]
I mean, it's staggering to me how much there is to know out there. But it's the same thing I've always said about the college and I've always said about what we do within our specialties, we've always had this gift within radiology to acknowledge that there's no way that any one of us can know everything and that's true across all professions, but let's stay within radiology. So, what we've always said is we can't know everything, but what we can do is we can put people in position to become the expert on this or the expert on that and to become the person that's sort of charged with forward-thinking complimenting the person that has that 20-year history with defining what we do. And we've always done this phenomenal job of bringing those individuals together to decide what we're going to do next, to think that it's going to be those in training now and the residents in training now that are going to walk into our specialty and define that I'm almost jealous of that opportunity.

[01:31:05.944]
Geoff: Wow. That is a very inspiring vision for the future and encompassing of so many opportunities that we face. Dr. Zeke Silva, you have provided us with many phenomenal leadership lessons, your journey, and the way you have approached it is inspirational. And I've learned a lot. I've really appreciated your perspective. And I can't thank you enough for joining us today on "Taking the Lead."

[01:31:35.485]
Ezequiel: Geoff, it was a pleasure. Thank you.

[01:31:46.396]
Geoff: Please join me next month. When I speak with Cheri Cannon, the Witten-Stanley Endowed Department, Chair of Radiology at the University of Alabama, President of the Society of Chairs of Academic Radiology Departments and President of the board of directors for the Momentum Women's Executive Leadership program, which for 20 years has empowered, promising women through leadership training and mentorship to positively impact business, culture and politics in the State of Alabama. She founded the Lead Program, which brings women chairs of radiology departments together with leaders from GE Healthcare to sponsor women's leadership in the field of radiology. Born and raised in Garland, Texas, Dr. Cannon overcame the strong forces of traditional gender roles to become a champion of women's leadership within radiology and beyond. Her ceiling busting efforts on behalf of women and underrepresented minorities as well as her service to our field have led to her recent recognition as a gold medalist of the American College of Radiology and recipient of the Marie Curie Award from the American Association for Women in Radiology.

[01:32:51.662]
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[music]