

Bulletin

No Bullying

Addressing bad
behavior in the workplace



New Venue!

Sept. 29–Oct. 1, 2023
Seaport Hotel | Boston, MA

2023 RLI Summit

The RLI Summit only happens once a year. Don't miss this chance to learn from radiology thought leaders and Babson business school experts.

SAVE THE DATE

Join us for the annual RLI Summit, Sept. 29–Oct. 1, 2023, to learn, network and find new inspiration for your leadership journey.

New Venue | Same Great Content

The 2023 RLI Summit will be held at a new venue — the Boston Seaport Hotel, located just minutes from Logan Airport on the historic waterfront.

Although the venue has changed, this year's program will deliver the same compelling leadership training and networking opportunities you've come to expect from the RLI Summit.

acr.org/RLIsummit



THE SEAPORT HOTEL

Authentic New England feel on the historic waterfront. Restaurants, parks and museums within walking distance.



Bulletin

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QUESTIONS? COMMENTS?

Contact us at bulletin@acr.org. Digital edition and archives of past issues are available at acr.org/Bulletin.

OUR MISSION: The *ACR Bulletin* supports the American College of Radiology's Core Purpose by covering topics relevant to the practice of radiology and by connecting the College with members, the wider specialty, and others. By empowering members to advance the practice, science, and professions of radiological care, the *Bulletin* aims to support high-quality patient-centered healthcare.



**American College
of Radiology™**



On Our Members' Minds

You've spoken and we are listening. Our latest survey shows you're looking toward the future while coping with the challenges of today.

The College's Centennial celebration at the 2023 ACR Annual Meeting last month provided a wealth of information and opportunities to exchange ideas with members from every walk of the field. Ahead of the event, with the goal of uncovering what our members think the future of radiology may hold, our ACR Centennial Committee worked in tandem with ACR staff to develop and disseminate two short surveys. The responses were thoughtful and enlightening — providing us invaluable insight into how the specialty may evolve in the coming years.

The surveys posed a variety of questions around healthcare policy, AI, quality and safety, physician wellness, physician shortages, COVID-19 and more. One survey focused on practicing physicians and the other on medical students. There were close to 200 respondents combined — though the vast majority were practicing radiologists — sharing their concerns, lessons learned and what excites them about radiology and its constantly evolving landscape.

Among practicing radiologists, most agree that the COVID-19 pandemic significantly altered working environment dynamics and changed communication patterns between themselves and referring physicians. About half think COVID-19 changed referrers' ordering patterns and accelerated changes to technology. It was interesting to see the data support what we've all been feeling.

The survey showed there is near-unanimous agreement on the importance of health policy and economics as radiology moves forward. Our members are also highly interested in AI and machine learning, watching it very closely, along with the commoditization of the specialty. Survey respondents believe quality and safety policies present the most opportunities for positive change while commoditization is seen as the biggest threat — especially as we see venture capitalists buying more and more radiology practices.

The survey identified burnout within radiology as a major concern, with the majority of respondents worried about wellness within their own practice group or department. However, fewer expressed personal concern. Among the potential causes of burnout listed in the survey, physician and staff shortages were most commonly cited. We all

seem to be feeling the pinch of doing more with less.

The survey identified reimbursement and practice creep, or encroachment, as areas of concern now and into the future. In contrast, AI and machine learning will catalyze some of the most exciting changes in radiology over the next five to 15 years, respondents say. These are two topics that seem to come up in sessions and discussions no matter where we go these days.

There was a wide range of responses to the question, What advice would you offer your former self? Maintaining a better work-life balance and slowing down was a popular answer. Other responses included getting involved sooner with local and national medical societies, being more of a self-advocate with management, remembering that there are patients behind the images, making more time for direct patient contact and never assuming it is too late to change work environments if you are unhappy. Most respondents, however, say radiology was a great medical path and that they plan to stay in their current work setting. That is good news.

The makeup of our membership was a consideration when the Centennial Committee was garnering information. A combined 57% of respondents work at an independent private practice or academic practice. Radiologists working at a hospital or within a hospital system account for 14% of respondents. Most of the physicians surveyed have been in practice for at least 10 years, and 14% identified as retired. Nearly 90% of respondents reported living in an urban or suburban area of the country, with only 10% living and working in rural areas. Most practicing physician respondents were male and an average age of 55 years old. For medical students, respondents were also mostly male, with an average age of 30.

It should be noted that a very small percentage of medical students responded to their survey. As a result, we have little data about what may guide their future career paths. Based on the answers of those who chose to participate, most are likely to pursue radiology as a career.

As we continue to celebrate the College's 100-year anniversary, we rely on members to inform us about what the future of radiology means to them and how current events may impact outcomes. Most interesting will be seeing how factors we haven't even thought of today will impact our specialty in the future.

Feedback from these surveys has given us a unique snapshot of what members expect from our College. We hear you and will continue listening so that we may serve you and our collective patients with the high level of care and commitment you exemplify. **B**



SEE THE RESULTS

The infographic on page 20 shows more details about what we uncovered in the ACR Centennial Survey.



A CENTURY OF QUALITY, INTEGRITY,
LEADERSHIP AND INNOVATION

ACR Representatives Head to GO₂ for Lung Cancer Voices Summit

ACR Director for the Commission on Patient- and Family-Centered Care (PFCC) Tiffany Gowen, MHA, and ACR Project Manager Beverlee Carlisle, PMP, attended the GO₂ for Lung Cancer Voices Summit March 19–21 in Washington, D.C., on behalf of the PFCC Commission and the ACR Lung Cancer Screening 2.0 Steering Committee. The premise of the summit was to secure a requested \$60 million in research funding for the Lung Cancer Research Program (LCRP), the only dedicated program of its type for early detection and treatment for members of the military and the public who have a higher risk for lung cancer (learn more at cdmrp.health.mil/lcrp).

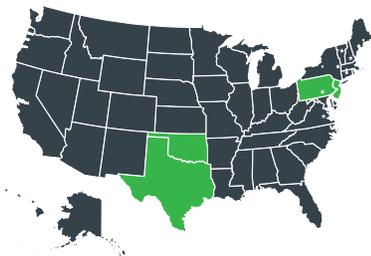
Patients shared their stories related to lung cancer with congressional leaders on Capitol Hill, including Sen. Tim Kaine (D-Va.), Sen. Mark Warner (D-Va.) and Rep. Jennifer Wexton (D-Va.). ACR PFCC staff explained the importance of early detection and the need for continued outreach, research and education in the lung cancer community.

The ACR encourages practices around the country to participate in Lung Cancer Screening Day on Saturday, Nov. 11, 2023, to continue to spread screening awareness.

Learn more about the ACR's LCS resources at bit.ly/LCS_Resources.



Left to right: Beverlee Carlisle, PMP, ACR advocate; Lia Ridout, patient advocate; Tiffany Gowen, MHA, ACR advocate; Amelia Faraco-Hadlock, senior legislative assistant for Rep. Jennifer Wexton (D-Va.); Frank McKenna, patient advocate; and Debby McKenna, caregiver advocate



4 State Societies Receive 2023 ACRA SOP Grants

Four state radiological societies have been awarded 2023 grants from the ACR Association® (ACRA®) Scope of Practice (SOP) Fund. Societies receiving funds are New Jersey, Oklahoma, Pennsylvania and Texas.

The SOP fund was established in 2021 by the ACRA to safeguard patients and patient access to radiologist expertise by fighting state and federal non-physician SOP expansion legislation. Non-physician provider groups continually seek expanded authority by introducing legislation that would, for example, reduce radiologist oversight and enable direct billing. So far in 2023, the ACR has tracked non-physician scope-of-practice expansion legislation in 38 states.

For information about applying for an ACRA SOP grant, visit bit.ly/Scope-of-Practice.

For questions, email Eugenia Brandt, ACR senior government affairs director, at ebrandt@acr.org, or Dillon Harp, ACR senior state government relations specialist, at dharp@acr.org.

ACR Achieves Highest CME Accreditation Status

The ACR was reviewed by the ACCME® and was awarded Accreditation with Commendation for providing continuing medical education (CME) for physicians, a status that will be in effect for six years. This is the highest accreditation status and longest accreditation term offered by the ACCME.

“Achieving the highest level of CME accreditation is a testament to the medical community and our members that the ACR is dedicated to providing radiologists with the best possible CME opportunities to promote quality improvement,” says ACR CEO William T. Thorwarth Jr., MD, FACR.

The ACR was awarded this designation because the ACCME recognized the achievements of the College to progress inter-professional collaborative practice, address public health priorities, initiate behavioral change, show leadership, leverage educational technology and show the importance of healthcare education.

Read the full story at bit.ly/ACR_ACCME.

Pricing Update Takes Effect July 1

The College is set to continue to improve and modernize its ACR accreditation value and customer experience by strengthening security, usability and efficiency. The result of these upgrades will be a pricing update on July 1, the first fee change in a decade.

The ACR continues to stay ahead of the evolving security landscape as the College works to get its Health Information Trust Alliance certification, making sure to protect its sensitive data with a more secure login process with multi-factor authentication. Fees are expected to increase by about 9% for all modalities except mammography and radiation oncology. Breast MRI accreditation will become a module under the larger MRI accreditation program, lowering the costs to sites.

Read the full article at bit.ly/ACR_Strengthens.



Leadership training is an essential component of professional development for radiologists of all levels.

KURT A. SCHOPPE, MD



Still Time to Join the New RLI Bootcamp

For anyone interested in honing the skills it takes to successfully run a radiology department, the new virtual ACR Radiology Leadership Institute® (RLI) Learning to Lead Bootcamp is open for registration. The program is designed for leaders at every career stage, providing resources, tips and strategies to build skills needed to overcome common challenges. The bootcamp takes place from 6–8:15 p.m. on June 22.

Participants will:

- Gain confidence in their ability to build trust and earn respect among their fellow leaders.
- Learn how to balance clinical and administrative duties.
- Effectively interpret and advise based on financial reports.
- Develop a strategic plan to support leadership.
- Explore many other leadership topics.

Visit bit.ly/RLI_Bootcamp to learn more and to register.

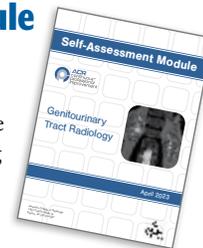
RLI Power Hour Webinar Series

The Radiology Leadership Institute® (RLI) Power Hour Webinar Series continues with the topic of “Wellness in the Workplace.” A panel of experts talking about their projects aimed at reducing physical burnout will include Cheri L. Canon, MD, FACR; Ivan M. DeQuesada II, MD;Carolynn M. DeBenedictis, MD; and Gloria L. Hwang, MD. During this free webinar taking place from 7–8:15 p.m. EDT on Tuesday, June 27, panelists will share their experiences, lessons learned, signs to watch for within your team and proactive tools to use to achieve and maintain a mentally healthy staff.

Visit acr.org/powerhour to register.

Introducing Genitourinary Tract Module

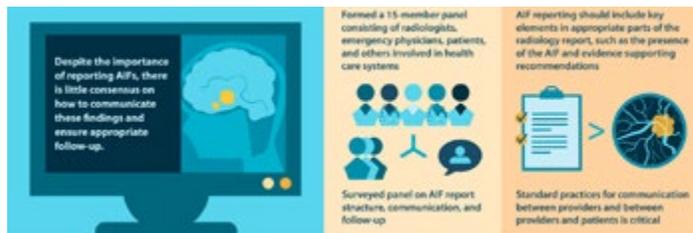
A new self-assessment module from the ACR Continuous Professional Improvement (CPI) program allows you to assess your genitourinary imaging knowledge and earn eight CME. The module features over 170 multimodality high-resolution imaging examples including CT, MRI, US and radiography.



This CPI module also features:

- Case topics relevant to community and academic settings and for all levels of expertise, ranging from commonly encountered genitourinary imaging entities to emerging state-of-the-art imaging techniques and procedures.
- Entities involving the urinary tract, adrenals, prostate and female pelvis.
- Practical questions discussing the nuances of PI-RADS®, O-RADS™ US, O-RADS MRI and Bosniak classification v2019 to keep you updated on the latest guidelines and best practices.
- Discussion of cutting-edge issues in genitourinary imaging.
- Choice of print or online format. Each format includes a complimentary digital download version — the perfect on-the-go reference.

Print supplies are limited, so order your copy today at bit.ly/CPI_Module.



Landmark Paper on Incidental Findings

The ACR and the American College of Emergency Physicians (ACEP) have unveiled new landmark recommendations to aid health systems, physicians and other clinicians in improving patient outcomes by addressing actionable incidental findings (AIFs) in emergency department (ED) imaging.

The recommendations were published in a white paper in the *JACR*® titled “Best Practices in the Communication and Management of Actionable Incidental Findings in Emergency Department Imaging.”

Over 150 million ED visits were recorded in the U.S. in 2019, and radiologic imaging was used in more than half of them.¹ AIFs are defined as masses or lesions detected by an imaging examination performed for something else.

“Strong communication and collaboration between clinicians when addressing actionable incidental findings is key to providing optimal patient care and preventing adverse outcomes,” says ACR CEO William T. Thorwarth Jr., MD, FACR. “The recommendations created by ACR and ACEP highlight a multispecialty effort between radiology and emergency medicine that aims to improve the reporting and communication of AIFs, which will ultimately benefit the patient.”

Read the full white paper at bit.ly/AIF-white-paper.

ENDNOTE:

1. Rui P & Kang K. National Hospital Ambulatory Medical Care Survey: 2017 emergency department summary tables. 37 (2017).

SOS: Save Our Screening

A provision that helps patients receive lifesaving preventive care without co-pays is in jeopardy following a Texas judge's ruling, which is being appealed.

Research shows that cost-sharing, even in small amounts, reduces the likelihood that people will use preventive services. As a result, the Affordable Care Act (ACA) contains a provision that mandates group health plans and health insurer coverage of certain essential health benefits and preventive services without cost-sharing by patients. The ACA's list of preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) includes several radiology exams, like breast, lung and colon cancer screenings, that have received a rating of "A" or "B" from the USPSTF.

However, this widely popular provision is in jeopardy. A federal judge for the U.S. District Court for the Northern District of Texas ruled on March 30 that the ACA provision requiring health plans to cover care and treatments recommended by the USPSTF is unconstitutional. According to Judge Reed O'Connor, this provision of the ACA violates the U.S. Constitution's appointments clause since members of the USPSTF are not Senate-confirmed. Instead, the 16 members of the USPSTF, who are primarily physicians and scientists, are chosen by U.S. Department of Health and Human Services leaders.

The decision builds upon a prior ruling from September in which O'Connor concluded that coverage of an HIV prevention treatment violated the Religious Freedom Restoration Act and, separately, that the USPSTF was unconstitutional. At that time, O'Connor requested supplemental briefings addressing whether the government should be entirely blocked from requiring health plans to cover services identified by the USPSTF, or whether the decision should apply only to the plaintiff in this case.

The latest ruling, which went into effect immediately, now applies nationwide. However, most insurance plans run on the calendar year, so preventive services are expected to be covered through the end of the enrollment year.

As a result of this ruling, health plans are no longer required to cover any of the recommendations for preventive services made by USPSTF since 2010, when the ACA was first signed into law.

Recommendations made by USPSTF prior to 2010, including screening mammography, will not be affected. However, private insurers could rescind coverage of CT colonography and lung cancer screening CT. Insurers may now choose to charge a co-pay for preventive services or cover only select services, which would tragically erase recent progress in improving access to screening for these high-mortality diseases.

In 2016, USPSTF designated CT colonography as a recommended screening test for colorectal cancer starting at age 50 and continuing until age 75. In May of 2021, USPSTF expanded the age range recommended for colon cancer screening to patients ages 45 to 49, granting millions more Americans private insurance coverage for this vital screening test. This coverage provided hope on the heels of American Cancer Society data showing that the proportion of colorectal cancer occurring in people under age 55 doubled between 1995 and 2019.¹

While we continue to advocate for Medicare coverage of CT colonography, mandated private payer coverage was a huge step in the right direction. Simply, this coverage saves lives.

In March 2014, the USPSTF recommended annual lung cancer screening in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. The USPSTF expanded the eligible age range to 45 to 80 and reduced the pack-year requirement to 20 in March 2021.

Early detection of lung cancer through screening has been shown to reduce mortality by 20%.^{2,3} Providing insurance coverage for lung cancer screening CT saves lives. Yet, lung cancer screening rates remain abysmally low with 5.8% of eligible patients receiving the recommended screening nationwide.⁴

We can make every effort to improve our screening tools, provide education on their benefits and build programs that navigate patients through the system. But without coverage, our patients will never have access to these lifesaving services in the first place.

Following the March 30 decision, the U.S. Department of Justice quickly filed an appeal. Multiple physician groups and patient advocacy groups, including the ACR, voiced concern and expressed support for the appeals process. The federal government is also expected to pursue a stay of the ruling, which would prevent it from going into effect during the appeals process.

The ACR will continue to advocate for access to evidence-based screening services, especially for our most vulnerable patients with the lowest ability to pay out-of-pocket health expenses. **B**



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

No Bullying

Underreported bad behavior puts radiologists' well-being and performance at risk.

Bullying in the workplace occurs in every sector of industry. The healthcare landscape, including radiology, is not exempt from a problem that can have devastating effects for talented physicians who feel they have nowhere to turn. Unprofessional behavior that amounts to bullying is often difficult to identify, prevent and stop — and who does it, what they do and why they do it may surprise you.

Bullying behavior may involve abuse, humiliation, intimidation or insults. Victims are often on the receiving end of this behavior repeatedly, at the cost of great distress that may impact their mental and physical health. Workplace bullying is more common in healthcare than in other industries and can prove detrimental to the delivery of quality patient care.¹

People find it difficult to talk about bullying. When you hear the word, there tends to be a focus on the physical aspect, says Aine M. Kelly, MD, FACR, professor and clinical educator of radiology at Emory University. But there are many forms of bullying that go unrecognized and are underreported.

“In medicine, including radiology, it can be embedded in social interactions,” Kelly says. “Some examples of bullying that I have seen, and sometimes unfortunately experienced in a previous academic workplace and other radiology settings such as national societies, encompass a great many things. There may be a denial of privileges, like the amount of time allocated to academic pursuits. Some radiologists with qualifications equal to their colleagues may be prohibited from performing the same tasks they are trained and able to do.”

Undesirable shifts or duties are sometimes given only to certain staff. Denying or delaying promotions for an extended period with insufficient explanation or justification can also qualify as bullying.

Other examples include repeatedly declining to put someone's name forward for a leadership position or preventing certain radiologists from sitting on or chairing committees. Radiologists with extensive experience may be told to answer phones or complete other tasks that traditionally are not part of their job. “These assignments may be regarded as demeaning and could make staff feel small,” she says.

Women, people of color, trainees, residents and younger radiologists tend to be the most frequent targets for bullying, Kelly says. Trainees need a degree to qualify as doctors, and residents need someone at a higher level to sign off on their certificate, for example. A person in a position of power can affect whether someone gets that degree or certificate. Younger radiologists who are not familiar with a working group's culture may have fewer support options or allies than more seasoned colleagues. They may have no one to champion for them, Kelly says.

Powers Shift

A huge obstacle to coming forward as a victim of or a witness to bullying is that the issue must be raised by someone in a perceived position of power — or at least in a stable position that doesn't make them feel vulnerable, Kelly says. “Anyone should be able to put their hands up and say, ‘Wait, something is not

right here,’ and leaders must lead by example with a zero-tolerance policy,” she says. “Unfortunately, in a previous workplace, I saw leadership move perpetrators sideways into a similar or equal position to get them out of the limelight. In some cases, they promoted them to create distance from a victim.”

This way of dealing with bullying is not uncommon. “That is sometimes referred to as ‘passing the trash,’” says Carolyn C. Meltzer, MD, FACR, dean of the Keck School of Medicine of the University of Southern California (USC). “Someone exhibiting unprofessional behavior is simply moved from one workplace environment to another. Once there, that person is likely to exhibit the same unacceptable behavior and have the same impact on staff. It is vital that this practice is taken seriously and investigated.

“I have witnessed intimidation in the workplace,” Meltzer says. “I have seen radiologists use their influence to promote some people and marginalize others. We see a lot of gender segregation, especially in academia, when women are not given the same opportunities for mentoring or teaching. They are frequently passed over for more powerful committee appointments and may be excluded from other staff support roles.

“Many forms of intimidation go unreported,” she says. “If you are junior to the person, you may feel that you don't have a voice. I have so much more opportunity to speak out — to be an active bystander or upstander — if I see someone being intimidated because I am senior and have more perceived power.”

Bullying of radiology residents goes largely underreported by victims and witnesses. A significant percentage of radiology residents are unaware of zero-tolerance harassment and bullying policies in their workplaces, for instance, or rules protecting people from retaliation.² Building camaraderie can help residents share their experiences with trusted colleagues who may offer encouragement and support — or speak up on a victim's behalf.

“When I was early in my career, it was very hard to speak out,” Meltzer says. “There was always the fear of retaliation and being labeled as ‘difficult’ or someone who ‘can't take it.’ In medicine, we have this drive to not show weakness. We are there to serve patients, so we are told to toughen up and not complain.

“I had an experience years ago in a new position with someone who was quite a bully,” Meltzer recalls. “He repeatedly intimidated others from a leadership role. I asked him to step out of that position, and I received a lot of flak for it. Regardless, it set the tone for what was acceptable behavior and what was not right — and that it didn't matter who it was.

“In an environment where everybody on the team is respected for what they bring to the table, regardless of their identity or seniority, they are more likely to speak up and prevent an error,” Meltzer says. This includes radiation oncologists, RTs

and support staff who contribute to the radiology value chain. “That fair and just culture needs to be part of everything we do and actively promoted.”

Consequences Manifest

The consequences of bullying should not be taken lightly. “Sadly, I have seen victims of bullying resign and move on to another institution or practice,” Kelly says. They can suffer exhaustion and burnout, develop health problems, struggle with substance abuse, and see relationships with colleagues, partners and family deteriorate.

“Then there is the issue of diminished patient care and the reputation of the radiology group or practice when word gets out about workplace bullying,” Kelly says. It is also costly and time-consuming to replace a radiologist who abruptly leaves because of bullying. “You may be losing a talented radiologist with valuable skills,” she points out.

Today it's important to keep in mind that not all bullying happens in person. “Outside of the workplace, one thing we don't talk enough about is cyberbullying,” Meltzer says. “In social media around radiology, we see anonymous Twitter handles, for instance, used to engage another through demeaning posts.”

Malicious responses to someone's tweets can be especially painful for victims because they don't know who is making the belittling statements. “It is nearly impossible to undo these things,” Meltzer says. “We have seen terrible outcomes from this type of bullying in education among younger people, and physicians are just as at risk.

“If your health and performance are compromised as a result of bullying, there can be a direct impact on the quality of patient care you deliver,” Meltzer says. “It is incumbent upon leadership to ensure the safety of patients. Those in positions of power need to set the tone for professionalism, inclusion and flattening the hierarchy. As leaders, we should strive to create a welcoming and less formal environment. Ultimately, that will better serve our patients.”

Causes Differ

Tracey H. O'Connell, MD, a musculoskeletal radiologist who left private practice five years ago and now does teleradiology, says she coaches physicians, including radiologists, who are being gaslighted and bullied. Gaslighting is a form of psychological manipulation that involves abusers seeking control over other individuals by making them question their own judgment and intuition.

“Bullying is more overt — behavior or actions that people can see from the outside,” O'Connell says. “For instance, most people in a meeting can witness bullying behavior and recognize that something isn't right. Gaslighting is more subversive, but still

“Those in positions of power need to set the tone for professionalism, inclusion and flattening the hierarchy. As leaders, we should strive to create a welcoming and less formal environment. Ultimately, that will better serve our patients.”

Carolyn C. Meltzer, MD, FACR

WORDS MATTER

A late-career radiologist from New Jersey tells her story:

It is probably easier to pick on someone who is less experienced and less likely to speak up. I have mostly worked in smaller private practice groups where a fear of retaliation was prevalent. Reporting bullying was especially difficult if your superior was the one doing it. Victims were reluctant to exacerbate an already unpleasant or uncomfortable work environment. No one wanted to be labeled a complainer, and I have seen many people just suck it up as a result.

Things I would consider bullying include criticizing or questioning someone's work ethic in front of others, repeatedly threatening to fire someone or reminding them that they are replaceable, or repeatedly giving a subordinate more difficult assignments in a rotation — resulting in that person staying past her or his scheduled work time. Other examples could be responding to a radiologist who is asking for help on a case with unhelpful and negative comments or speaking poorly about a radiologist to technologists and other support staff.

Most of my experiences with bullying come from my last job — a position I held for 11 years. The partner in charge would regularly inform me that I was paid too much for what I did and that she could replace me with someone less expensive. She once walked in during a procedure with a patient and asked, out loud, why it was taking me so long. The patient was wide awake and aware of what was happening. She made so many negative comments over the years that it just became part of my day — something I expected.

When the practice was sold, we were encouraged by new management to document any complaints. When we did, no action was taken toward a solution. In fact, after filing a complaint, I was written up with a final reprimand. In my mind, it was clear retaliation. I responded to the reprimand with proof that allegations against me were false — and again, no one followed up. I was told the reprimand was part of my permanent file and that any future mistake on my part meant I could be fired. With that, I'd had enough and quit. Luckily, I had no trouble finding another job. It has been a year now in the new position and so far, no bullies.

I think leadership within any radiology group should have established protocol to allow those who feel bullied to report it anonymously. There should also be protocols in place to facilitate an open conversation between the bully and the victim. Many people do not know how to initiate these things on their own without support from leadership. That makes it tough to thwart the problem.

a type of bullying. It dismisses a person's reality, making them feel like they are making things up or being too sensitive. It depends on having a gaslighter, who needs to be right, and a gaslightee, who needs the gaslighter's approval."

Bullying can take the form of spreading rumors and planting seeds of doubt. Trainees and early-career radiologists are vulnerable to anyone trying to undermine their expertise. Often, bullying or gaslighting is done subconsciously as a response to feeling 'not enough' — not smart enough, not fast enough, not skilled enough. Ironically, shame is often what causes bullying and gaslighting, and shame is also the result of such behaviors, O'Connell says.

"When someone needs to feel more secure, they bully or gaslight. They feel threatened and want to maintain their position in the hierarchy," she explains.

"They may be afraid of anyone who is in a position of power over them," O'Connell says. "Medical students may be afraid of residents and everyone above them. Residents may be afraid of fellows and attendings, and those people afraid of the chair, and the chair afraid of the administration. This vertical power structure limits an individual's ability to speak out about what's OK and what's not OK."

The competition never ends in radiology, with partners competing with each other for RVUs, number of cases read and perceived dedication — or competing for referrals with another radiology group in town.

"Sometimes all it takes, for example, is someone commenting offhandedly to others, 'I hope this person doesn't come in late tonight, because they were late yesterday.' Then others in the group may say, 'Oh yeah, I noticed that, too. They are often late.' Little comments like this can put that person in the crosshairs," O'Connell says. A similar result may happen if someone tells residents they aren't going to pass boards.

Another common way gaslighting shows up in radiology is through differences of opinion. A different interpretation is not always a "mistake" because it's possible to have many interpretations of the same study, particularly when reading MRIs, O'Connell says. Sometimes even the same radiologist will read the same case differently weeks after rendering an initial interpretation. Yet, such disagreements can be used to "rank" radiologists based on nuanced language around who is "right," which can be arbitrary unless surgically proven.

"People can work in bad situations for a long time, until they can't anymore," O'Connell says. "You can sacrifice your well-being for decades, until it becomes unsustainable. I've seen very qualified people quit after many years of practicing radiology in a psychologically unsafe environment where no one is speaking up or offering support. Some radiologists, when they have had enough, realize they don't need to tolerate bullying — that they can go work somewhere else where they are valued and can have relationships with colleagues based in mutual trust."

Speaking Validates

When radiologists experience bullying, they have to decide how to handle the situation — and that brings up a whole new set of stressors. "Raising concerns in isolation may not always be the best approach because of potential adverse effects," Meltzer says.

Institutional leaders at many places have established multiple lines of reporting, she says. "One way is through trust lines, an online or phone-based resource that allows someone to anonymously draw attention to another person's behavior. The person raising an issue does not have to be the victim — the reporting can be on behalf of an ally who doesn't feel senior enough or comfortable enough to speak up."

There are ombudspersons in many academic environments who can help with resolution. "As a chair and now as dean, I have relied on these ombudspersons to meet with me on a regular basis and make me aware of where there

may be bullying or other professionalism issues that truly warrant an investigation," Meltzer says. It is also important that residents and younger radiologists have mentors who offer guidance about interpersonal situations.

"At my institution, we have processes in place for important milestones — academic promotions or a move to a leadership position. We use search committees, for example, which are comprised of staff trained in anti-bias techniques," Meltzer says. "I don't make decisions about promotions or filling senior leader positions without a search committee reporting to me, collecting feedback from other sources and compiling that information in an objective manner."

When it comes to leadership's role in preventing and eradicating bullying in the radiology workplace, first and foremost they must have the desire to do so, says Daniel B. Chonde, MD, PhD, a radiology resident at Massachusetts General Hospital. "If a leader does not see an issue with the bad behavior, nothing will change. Despite there being more momentum in efforts to stop bullying, some leaders will still tolerate it — especially if the perpetrator provides a great deal of value to a program.

"Assuming leadership is committed to reducing and eliminating bullying, they need to be involved in the goings-on of their department," he says. "If they rely on intermediaries, they increase the likelihood of bias distorting the information they are given."

Fortunately, there are some promising changes on the horizon, Meltzer says. With more women than men now in medical school, for example, there is a stronger and more diverse pipeline to the specialty. Diversity has become top of mind for many radiology groups, she says.

"When there are more of you, and diversity becomes more normalized, these situations are less likely to occur," Meltzer says. "But when you feel different or isolated in your position — when

people don't look like you or they see things from a different professional and cultural perspective — unfair treatment and discrimination can become commonplace. Scrutinizing or singling out one individual or a like-minded group is less acceptable under diverse leadership."

As workplaces grow more diverse, things are starting to change — but it will take conscious effort, Meltzer says. "I think we are moving in the right direction. The last thing you want is a monolithic leadership team who have similar cultural interpretations and who view all staff performance and behavior through a singular lens.

"It is critical to know what's going on with your people at the ground level in any organization," Meltzer says. "There is nothing that keeps me up at night more than not knowing someone is suffering. If they are not reporting a case of bullying or another form of harassment, they are living and working in isolation — sacrificing their own well-being and potentially the safety of patients." **B**

By Chad E. Hudnall, senior writer, ACR Press

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RECOGNIZE WORKPLACE STRESS

Radiology professionals speak out in a new ACR report, "Doing More With Less: Investigating the State of Well-Being in Radiology and Crowdsourcing Ideas to Reduce Burnout." Bullying is one of the stressors that can lead to burnout as well as anxiety, physical and mental deterioration and resignation. Ultimately, these stressors erode patient care. Read the report at www.acr.org/WB.

CIRCUMSTANCES APPLY

A former military radiologist who now practices teleradiology tells her story:

As doctors, our job is to take care of one another, as well as our patients. When that is the case, bullying is less of an issue. Radiologists are people, too. They have children and family, they get sick, they experience stress and anxiety. Those things don't make them bad doctors. We still want to take care of our patients.

I think a large problem in addressing bullying in radiology and elsewhere is that the bad behavior is completely individualistic. What might trouble one person may not be a problem for someone else.

I remember a resident I worked with in the military who was very smart but sometimes had trouble. The resident seemed to have a target on her back and the "sharks smelled

blood," if you will. Rather than offering her more support or additional training, she was put under a magnifying glass and was constantly stressed out.

It seemed like everyone was watching her and constantly looking for mistakes. She ended up leaving halfway through her fourth year of residency. She told me she couldn't fight anymore and would rather move on with nothing on her permanent record. From my perspective, she was bullied and it shattered her confidence.

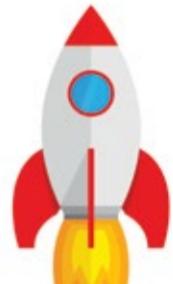
I also think misogyny is a big part of bullying in situations similar to what this resident experienced. I never remember seeing a male radiologist get bullied while in the military. It seemed like the ones who got singled out during my residency and after were women. The ones who had children and no support at home were put under the microscope more than the men who could come in early and

project a workaholic image as they frequently had a spouse who had a more forgiving career.

While I was stationed abroad with two young children, the director of the radiology program told me I would never make it in the military. He said I had a family and clearly couldn't do what needed to be done to get ahead. He and everyone else in the department was single with no children. I felt like he was trying to make me feel stupid and inefficient — when looking back, in reality those traits applied to him.

Practicing with a teleradiology group part-time from home has been great for balancing my work and family commitments. Ironically enough, this all started because a fellow resident had had enough as well and she introduced me to the practice. I then brought in another residency colleague. We all understand how things should run. Bullying is not a part of our work.

Patient Care Among the Stars



Researchers at the University of Southern California are working to provide patients with the best imaging care possible — even in space.

Caring for patients is the goal of all physicians. With technological advancements sending humans to the moon and beyond, patient care must adapt as well, and radiologists must be able to provide imaging care — even in a spaceship.

But how will this be accomplished? Researchers from the Keck School of Medicine at the University of Southern California (USC) are planning an experiment to determine the best way to use radiation to help provide imaging care during spaceflight.

The *Bulletin* talked to the leader of the USC research team, John Choi, MD, PhD, an integrated IR/DR resident physician at the Keck School of Medicine, to find out more.

What sparked the idea for this experiment?

Prior to joining the program at the Keck School of Medicine at USC, I was fortunate to have worked at NASA's Jet Propulsion Laboratory, and through an aerospace industry colleague I was introduced to an emergency medicine physician, who is now a NASA astronaut candidate, Anil Menon, MD. Through our conversations, the idea of radiology using ambient radiation came up, but I did not follow up further. Much later, while looking for a research project to pursue as a resident, I remembered the idea and was introduced to an anesthesiologist and PhD working in the field of space medicine. Together, we proposed the experiment for a launch opportunity, and we are very grateful to have been selected to potentially fly! Looking back, it was helpful to have those conversations with people from outside of my own field who motivated a new line of thought.

How long has X-ray imaging in space been a concern for astronauts?

According to one source, it was considered during the 1980s for a predecessor design of the International Space Station

(ISS), but the idea was ultimately abandoned.¹ Since then, X-ray imaging in space has not been a reality, due to the size, weight and power limitations aboard a spacecraft. Current space radiology is limited to the use of ultrasound, first implemented on the ISS in 2001 (a Philips ATL HDI-5000 weighing approximately 480 pounds).^{2,3} That system was upgraded in 2011 to a GE Vivid Q, weighing approximately 11 pounds, and there was a demonstration in 2021 of a handheld device, the Butterfly iQ, weighing less than 5 pounds.^{4,5,6} By comparison, a “portable” CT scanner, a CereTom, is advertised as weighing approximately 1,000 pounds and requiring 1.3 kilowatts (kW) of peak power.⁷ For perspective, the ISS is characterized as providing up to 30 kW of power for use by all payloads, and a typical CT scanner alone might need more than 25 kW.⁸

Can you explain the process of harnessing radiation in space?

Using ambient radiation is a way to simplify our experiment for launch into space, and a starting point to begin the process of making in-flight X-ray imaging a reality. To give an analogy, we want to take photos using outdoor sunlight instead of using a flash or indoor lighting. This has analogous limitations, some of which would be deal-breakers for medical applications. However, just as photography started with extremely limited technologies, like pinhole cameras, our justification is that space radiology needs to start somewhere. The basic idea is to use an intensifying screen, as is used for analog X-ray film, to convert ionizing radiation into visible light, which is then captured by a digital camera, taking advantage of advances in digital camera technology. We want to answer the question of whether there is enough ambient radiation in space to generate a visible light signal and characterize the background noise level for our detection system. The next steps would be to capture an image containing spatial information and continue to iterate toward clinical usefulness.

If successful, how will this specific experiment benefit future space missions such as the eventual trip to Mars?

The main motivation is that a human spaceflight mission measured in years, such as to Mars, will require medical capabilities onboard the spacecraft. To us, that includes diagnostic radiology, which we believe is an essential step of modern medicine for proper diagnosis. Although ultrasound is important, X-ray modalities would still be necessary for certain conditions that might occur in space. As an example, a case of left internal jugular venous thrombosis was reported aboard the ISS.⁹ This was diagnosed with an ultrasound scan and treated with anticoagulation, all aboard the ISS, an example of space radiology and in-flight medicine. However, if the thrombus had been within the pulmonary arteries, a pulmonary embolism, a CT would have been the proper exam for diagnosis rather than ultrasound.

What have been the biggest challenges in this experiment? Has anything surprised you during the preparation?

The biggest challenge has been the process of launching an experiment into space. This is not unique to our experiment, but universal for all space-related endeavors. The playing field was significantly changed by the advent of private commercial space entities, and the field will continue to evolve. I think the most surprising thing is the positive reception this project has received so far. In particular, I would like to thank the radiology department at USC, which has been extremely supportive — especially the chair at the time, Robert K.W. Ryu, MD, and my team of co-residents and collaborators. This project wouldn't have been possible without all of them. I hope that means there are more radiologists who believe improving space radiology is a worthy goal and are willing to help make it a reality. Overcoming the challenges of patient care in space will require a community and not just one person, group or institution.

How will this endeavor benefit patient care on Earth?

As necessity is a driver of invention, the limitation of resources in space will likely result in X-ray-based medical technologies that consume less power and, consequently, use lower levels of ionizing radiation. This would likely reduce the carbon footprint of radiology equipment and reduce patient exposure to ionizing radiation. In addition, I am sure there will be other unintended benefits. One of the reasons I personally enjoy research is because of the joy that comes from a surprising result or discovery — and, as a physician, figuring out how it might be used to help my patients. I hope that will be the case for space radiology as well. **B**

Interview by Alexander Utano, editorial assistant, ACR Press

ENDNOTES

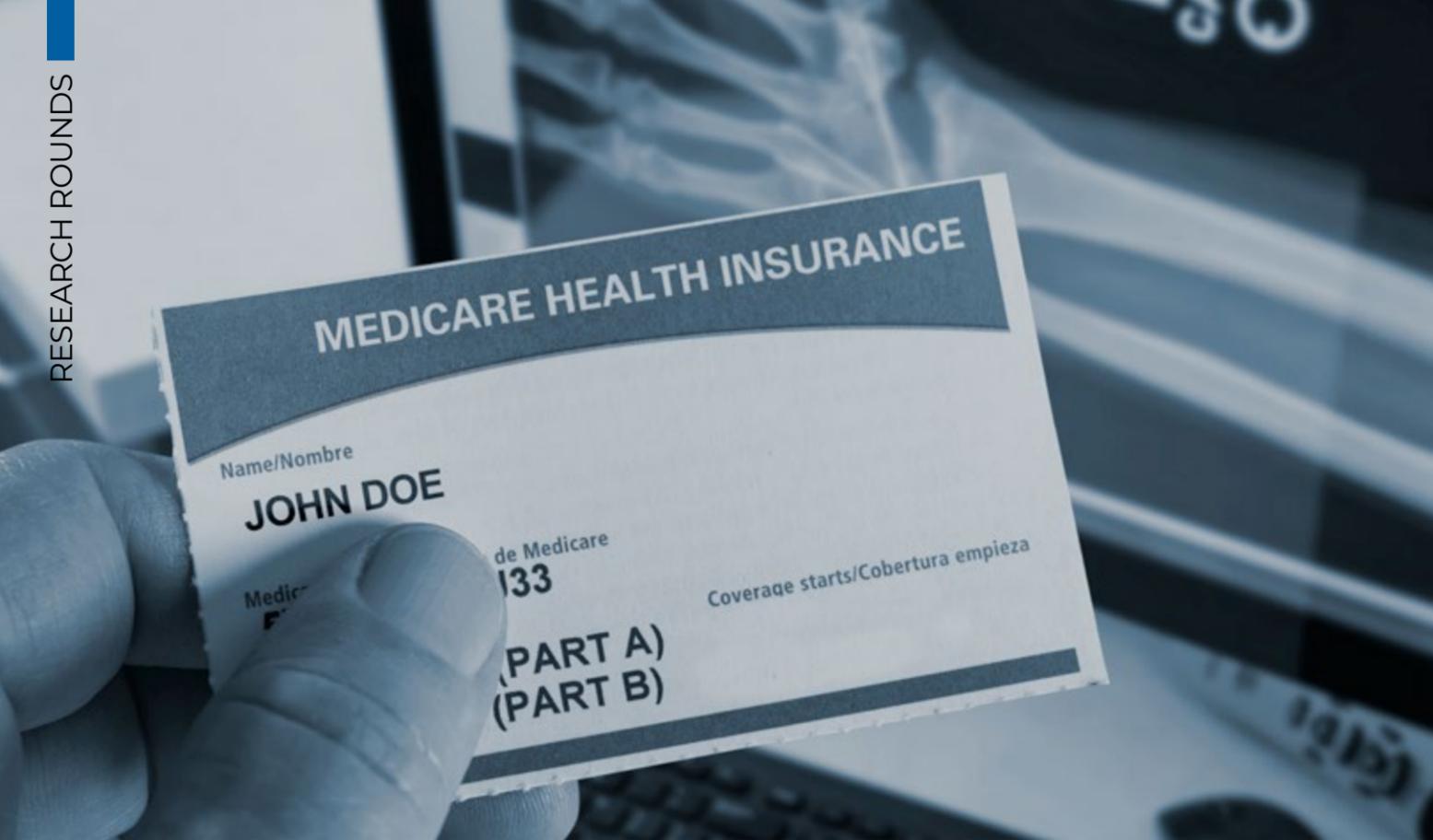
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Left to right: USC radiology residents Benjamin P. Sugar, MD, Adam T. Miller, MD, and Matthew Hartman, MD, make adjustments to the experiment that will go to space.



At the University of Southern California Keck School of Medicine, preparing the radiology space payload has been a team effort. Pictured left to right: integrated IR/DR resident Benjamin P. Sugar, MD; DR resident Adam T. Miller, MD; former USC radiology department chair Robert K.W. Ryu, MD; integrated IR/DR resident John Choi, MD, PhD; DR resident Saif Azam, MD; and integrated IR/DR resident Matthew Hartman, MD. Not pictured: integrated IR/DR resident Max W. Raynor, DO; and DR resident Dane Weinert, MD.



Medicaid Reimbursement Is Not Keeping Pace With Medicare

New data from the Harvey L. Neiman Health Policy Institute® offers insight into the differences between reimbursement rates for the two programs — bringing to light striking variations.

While Medicare reimbursement rates are consistent nationally, differing only by a geographic cost index, Medicaid reimbursement rates are determined by each individual state and are based on one of three factors: 1) a percentage of Medicare, 2) a market assessment structured by the state or 3) a relative value scale. In general, Medicaid reimbursement rates tend to be much lower — usually equaling only about 78% of Medicare reimbursement.¹ Further, the rates vary substantially across states and for specific procedures.

The lower reimbursement rate has contributed to reductions in provider participation in Medicaid, as reported by the Medicaid and CHIP Payment and Access Commission (MACPAC) in 2017. Specifically, 96% of providers said they were accepting new privately insured patients, 88% were accepting new Medicare patients and only 74% were accepting new Medicaid patients.

Among some specialty groups, only 70% were accepting new Medicaid patients.²

Lower provider participation in Medicaid means that having insurance does not equate to having equal access to care. Continued degradation of Medicaid reimbursement will further diminish the already limited access to care that low-income patients in the United States currently face.

Knowing the Numbers

Given the importance of imaging reimbursement deficiencies in ACR advocacy, the ACR Government Relations team collected the past 10 years of state-level Medicaid and Medicare reimbursement rates for 10 common procedures of varying complexity. The Harvey L. Neiman Health Policy Institute® analyzed these data and created heat maps, now available on [NeimanHPI.org](https://www.neimanhpi.org).

The analyses served to verify the dire situation. Many states are severely deficient in their Medicaid reimbursement rates for professional fees. This was seen even among states with the highest rates of Medicaid enrollment, which means more than 25% of the state population, including Alaska, California, New Mexico, Arkansas, Louisiana, Kentucky, West Virginia, New York, Vermont and Washington, D.C.³

For instance, in Rhode Island, where 32% of the population uses Medicaid, the professional rates for Medicaid are only about

MEDICAID VS. MEDICARE DEFINED

Medicaid and Medicare both help people access healthcare, but these programs are vastly different. Medicare provides federal health insurance for people age 65 or older and those with certain disabilities, while Medicaid assists people with low incomes in covering their healthcare. Medicare is both federally funded and federally run, while Medicaid is state-run — and to the degree that a state adheres to federal requirements for eligibility and benefits, the federal government jointly funds the state's Medicaid programs. Consequently, the two programs differ significantly in provider reimbursement.

two-thirds (64%) of the Medicare rates, whereas Medicaid rates in Wyoming are almost double Medicare rates (194%) in a state with only 12% Medicaid enrollment.

A more complex procedure with higher reimbursement, CT of the abdomen and pelvis, showed similar variance. In 2022, the Medicaid rate for this procedure in New York State (which has a 28% Medicaid enrollment) was 59% of Medicare's rate, while Nebraska's Medicaid program paid doctors 159% of the Medicare rate but had only about half the rate of Medicaid enrollment (15%).

Closing the Gap

For some procedures, the Medicaid-to-Medicare reimbursement gap seems to have grown wider over the last 10 years. In 2012, for instance, these rates were nearly equal for a single-view chest X-ray in Rhode Island, a ratio one-third higher than it would be in 2022 (0.64). For a more complex procedure, an esophagram with upper gastrointestinal imaging, states such as New York, Connecticut and Rhode Island are even seeing Medicaid professional reimbursement at less than half of what was paid by Medicare in 2022, while the same ratio for these states in 2012 was 0.54, 0.98 and 0.99, respectively.

In general, the majority of states are seeing shifts toward Medicaid-to-Medicare ratios of less than 1.00 for professional charges reimbursed for common imaging procedures, regardless of procedure complexity or cost.

Together, state and federal governments need to find a way to narrow the massive gap between Medicare and Medicaid reimbursement to improve access to care rather than just access to insurance. Although states do receive funding from the federal government to cover a majority of their Medicaid expenditures — and particularly so after the Medicaid expansion under the Affordable Care Act — Medicaid is ultimately a state-run program, and states determine reimbursement for specific services.

Medicaid expansion has resulted in increases in access to care, including higher rates of early-stage cancer diagnoses, which have led to fewer premature deaths in the U.S.⁴ Hence, while Medicaid expansion has been helpful, its potential impact is limited by its relatively lower reimbursement that may hinder access to care and create disparities across the states.

Although Medicaid oftentimes reimburses at a mere fraction of Medicare rates, it does provide a necessary lifeline for much of the U.S. population, allowing people to receive medical care when they otherwise would not be able to if Medicaid did not

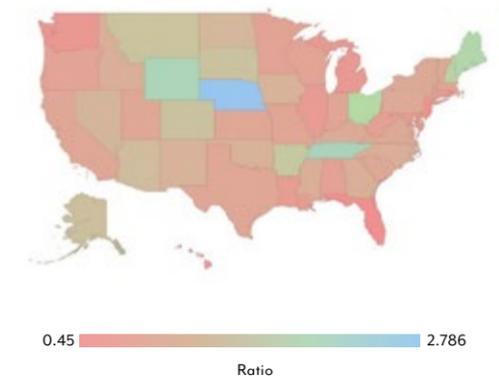
exist, even if the access to care it provides is more limited than for Medicare or commercially insured individuals. During the COVID-19 pandemic, for example, Medicaid served as a safety net for patients, when so many people who were laid off from their jobs lost their private or employer-sponsored health insurance and relied on Medicaid to access the care they needed. Medicaid enrollment rose 29% in the first 22 months of the pandemic, while employer-sponsored health insurance and other private plan enrollment dropped.⁵

It is time to level the playing field for providers who treat Medicaid patients and for patients who do not meet the eligibility criteria or cannot afford other healthcare coverage options. Not only will this ensure providers are being paid appropriately, but it will also facilitate access to preventive care, like cancer screening, for patients who so desperately need it. **B**

By Casey E. Pelzl, senior economics and health services research analyst, Harvey L. Neiman Health Policy Institute®. Eugenia K. Brandt, Neil C. Davey, MD, FACR, Elizabeth Y. Rula, PhD, and Eric Christensen, PhD, contributed to this column.

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

State-Level Ratios of Medicaid to Medicare Professional Charges for Single-View Chest X-Ray, 2022



This heat map demonstrates the ratio of Medicaid to Medicare charges for professional services rendered, serving as a proxy for reimbursement, for a single-view chest X-ray in each state in 2022. Ratios below 1 indicate lower rates of Medicaid reimbursement when compared to Medicare for that state in 2022. Ratios above 1 indicate a Medicaid reimbursement rate greater than Medicare for that state in 2022.

COMPARE THE DATA YOURSELF



The Harvey L. Neiman Health Policy Institute® has made the map presented here and other state-level interactive maps available online to provide objective data for advocacy. Please visit the Neiman Almanac at [neimanhpi.org/heat-maps-2022](https://www.neimanhpi.org/heat-maps-2022).

Building a Community of Problem-Solvers



ACR Learning Network Physician Director David B. Larson, MD, MBA, FACR, discusses tackling some of radiology's toughest challenges.

With his passion for quality improvement, David B. Larson, MD, MBA, FACR, who serves as chair of the ACR Commission on Quality and Safety, shares the origins of the ACR Learning Network, its purpose and what participants can expect from the program.

Larson is a professor of radiology at Stanford University, where he also serves as the senior vice chair for education and clinical operations in the radiology department. He is the associate chief quality officer for improvement for Stanford Health Care and physician co-leader of the Stanford Medicine Center for Improvement. He is also the founder of the Realizing Improvement through Team Empowerment (RITE) program, co-founder of the Clinical Effectiveness Leadership Training program and founder of the Advanced Course for Improvement Science, all at Stanford.

What is the ACR Learning Network?

It's a program that is designed to help local teams make improvements in specific patient care areas by growing skill sets in problem-solving and enabling sharing of ideas between organizations.

The ACR Learning Network is made up of separate improvement collaboratives, each of which uses this same general approach to address different challenges. We have started with four improvement collaboratives: lung cancer screening, mammography positioning, prostate MR image quality and recommendations follow-up. Any radiology practice, hospital or imaging center can apply to enroll a team in any of the four areas through participation in the Learning Network.

What kind of time commitment is required?

On average, team members spend a few hours a week during the four-and-a-half-month improvement program, though it varies by participant role.

How is the time broken up? Is it protected time?

When an organization signs up, the leaders commit to organize and protect the time for a team of four to six people to work on

one of the collaboratives' topics. Team members participate in the 10 two-hour improvement training sessions held every two weeks. We also hold a review session every other week where project leaders present an update and receive guidance. Then there's the time they spend working on the project, which is where we want the teams to put most of their focus. This generally takes a couple of additional hours each week.

Can an institution solve these kinds of challenges on its own?

In theory, any organization could make these types of improvements without help from a program like the Learning Network, but in reality, we find that that rarely happens for a variety of reasons. These types of improvement initiatives are much more likely to be successful in a structured program like this one.

The ACR Learning Network is made up of separate improvement collaboratives, each of which uses this same general approach to address different challenges.

Whose idea was the ACR Learning Network?

The idea of the ACR Learning Network was an outgrowth of my work in developing a number of improvement training and project-support programs at Stanford, which were built on my experience at Cincinnati Children's Hospital. The quality improvement (QI) training portion of the Learning Network, ImPower, was patterned after the RITE program at Stanford, which was initially supported by an RSNA Research and Education grant. I was fortunate to be able to hire Kandice Garcia Tomkins, MS, RN, who now serves as the QI director for the Learning Network. We now have eight years of experience at Stanford, with 40 cohorts of more than 2,000 graduates completing around 250 team-based projects.

As I came into my role as the chair of the ACR Commission on Quality and Safety, I was fortunate to have an incredible partnership with ACR Executive Vice President Mythreyi B. Chatfield, PhD, generous support from ACR executive leadership and amazing contributions from the talented and dedicated ACR Q&S staff. We worked together to submit a proposal to the Gordon and Betty Moore Foundation, which generously provided funding support for the program. So while I contributed the idea

and the vision, this program has quickly become a labor of love for many passionate people who have made it a success.

Did the pandemic influence this project, given the timing of its beginnings?

In retrospect, it turned out the changes that came about from the pandemic probably contributed to the success of the program in that the pandemic enabled virtual meetings to be widely adopted as an acceptable and productive way of conducting business across long distances. For example, our training programs we have here at Stanford had all been in person up until that point; along with everything else, we converted the in-person sessions to virtual meetings. We were also sponsoring similar training programs at other institutions as a trial, and we converted those into virtual formats. We've just recently published our experience with that and found it actually worked really well. That gave us the confidence that this could succeed in a virtual environment at scale.

Why did you choose the topics you chose for the four improvement collaboratives?

The best candidate topic for an improvement collaborative is one that has an outcome which is difficult but possible to achieve through effective coordination of processes, systems and people. It also needs to be important to a variety of stakeholders and have at least a strong theoretical link to patient outcomes. The topic should be amenable to measuring performance, though there does not necessarily need to already be a fully developed measure in place. Each of the four topics we ended up selecting meets these criteria.

Will other improvement collaboratives be added?

One of our long-term goals is to expand the scope of the program. In fact, that's why we launched four collaboratives in the beginning. The Gordon and Betty Moore Foundation was cautious about starting with that many collaboratives right out of the gate, but we felt it was very much in the spirit of what we were trying to accomplish with the Learning Network. In other words, just as each site should learn from each other within their respective improvement collaboratives, each improvement collaborative should also be learning from each other within the overall Learning Network.

Over time, we hope the program can be streamlined and expanded in a predictable way. For example, we will soon be able

to give a reasonable estimate of both the costs and likely benefits of standing up another improvement collaborative within the Learning Network — then it becomes a relatively straightforward cost-benefit assessment.

Why should a program participate?

We recognize that joining the Learning Network requires a real investment. But we are confident it is just that — not a cost, but rather a worthwhile investment into the individuals in your organization and the organization as a whole. It's the kind of investment that turns on its head the conventional wisdom that greater costs more. Once the investment is made, we are convinced it easily pays for itself in financial and other ways. For example, we find that when participating sites develop a program for organizational development, such as a coaching model to support their frontline staff, those staff members feel supported and tend to stay at their organization. This becomes a powerful recruiting and retention tool that positions your organization favorably and also decreases problems associated with high turnover. In other words, it requires a bit of a leap of faith to get started. But once they do it, we've found that participants consistently say, "Yes, it was a lot of work. Yes, it was humbling. And yes, it was hard. Would I do it again? Absolutely."

This is a big project. How and why do you do it and still have a full-time job (or two)?

I think my motives are the same as anyone else who volunteers for the ACR and other radiology societies — for the love of the profession we have inherited and the desire to meaningfully contribute by helping to make it better.

I don't think we should underestimate our ability in radiology to impact the entire medical field for the better. In fact, the Gordon and Betty Moore Foundation has told us they view this as a showcase model for learning networks in general. If we do it right, our efforts can not only improve radiological care but can also improve healthcare more broadly. And this is just one of many examples of how radiology leads the field in important ways.

With that type of opportunity, you make time — especially given the wonderful staff and colleagues we have throughout the ACR. The opportunity to work with such amazing people to create something that can be self-sustaining for decades to come is incredibly rewarding. Come join us and we'll build it together — and have a lot of fun on the way. **B**

Interview by Raina Keefer, contributing writer, ACR Press



EXPLORE THE ACR LEARNING NETWORK

In this commemorative brochure, read what participants from cohort 1 of the ACR Learning Network program are saying about their experience at bit.ly/ACR-LN-Cohort-1. Interested in participating? Read about how to apply for the next cohort at bit.ly/Cohort-application.

GET INVOLVED IN THE ACR LEARNING NETWORK

To learn more about the ACR Learning Network or to sign up to participate, visit bit.ly/ACR-learning-network.





Making an Impact in Leadership

Meet two recipients of an annual award recognizing radiologists for noteworthy contributions that improve organizations and lift communities.

In 2022, the Radiology Leadership Institute® (RLI) celebrated 10 years of delivering leadership and professional development training to radiologists at all career stages. Each year, the RLI recognizes the work and achievements of current leaders and provides scholarship opportunities for new leaders through its RLI Leadership Awards and Scholarship program (learn more at bit.ly/ACR_RLI). One of those honors is the RLI Impact in Leadership Award (read more at bit.ly/Impact_Leadership_Award), which recognizes individuals whose participation in an RLI course or program was integral to the successful completion of a specific project or initiative at their practice or institution.

The 2022 Impact in Leadership recipients were Andrew K. Moriarity, MD, vice president of clinical operations and quality chair at Advanced Radiology Services (ARS), and Vivek Masson, MD system chair of radiology at CarePoint Health. Here are their stories of leadership initiatives and impact.

Optimizing the Organizational Structure

At ARS, Moriarity faced the challenge of integrating two disparate reading environments, where 200 radiologists were reading more than

2 million exams each year. Over the course of a year, he led a project to merge the practice's largest hospital partner into the ARS teleradiology platform, creating a cohesive reading solution. As a result, the practice was able to achieve its goals of enhancing patient care, standardizing systems and improving overall clinical operations.

"At the beginning, we were effectively operating in two parallel environments, with limited ability for radiologists in one area to assist others," Moriarity says. "Creating a cohesive reading workflow not only helped us optimize case distribution, but we were also able to expand the reach and impact of our subspecialists, while improving overall scheduling flexibility and radiologist work-life balance."

As chair of the Clinical Leadership Committee, Moriarity was tasked with coordinating this project while working with radiology practice section chiefs, the distributed radiology information technology department, the clinical decision support analytics team and hospital partners. According to Moriarity, participating in the RLI Maximize Your Influence and Impact Course (learn more at bit.ly/RLI_Maximize) provided the crucial foundational leadership knowledge and the skills to lead this project to fruition.

STORIES OF IMPACT

In a recent RLI Power Hour webinar, the two recipients of the 2022 Impact in Leadership Awards shared the stories of their leadership projects and the impact they made on their communities. Watch this on-demand webinar to learn pointers that could help you implement your own leadership project at bit.ly/2022-Impact-Webinar.

"Throughout the project, I was able to draw on lessons learned from the many hands-on discussions and real-world case examples," Moriarity said. "The course highlighted how to build effective teams, manage change and develop operational efficiencies, as well as underscored the importance of both formal and informal communication in building relationships and enhancing the success of major initiatives."



"The RLI is a great resource to supplement the clinical training we get as radiologists."

ANDREW K. MORIARITY, MD

Among the successes, Moriarity's project:

- **Created the right organizational structure** to navigate change in radiology and hospital operations. The team mapped out the practice volume across 14 different hospitals, according to detailed historical data, and used a robust capacity analysis tool to optimize scheduling on a per-hour basis, which gets patient exams to the right radiologist faster.
- **Addressed team challenges** by aligning members with diverse perspectives and backgrounds around performance goals. The project tackled "turf" concerns and created equity across different jobs, which was vital to program implementation and success.
- **Focused on enhancing work-life balance.** Optimizing subspecialty workload distribution for on-site staff and increasing in-home workstation deployment by 100% resulted in enhanced job satisfaction and greater ability to recruit new staff, especially for second and third shifts.
- **Recognized the critical relationship** between radiology and clinical operations to improve outpatient turnaround times (TAT). By combining a robust remote reading solution and optimizing clinical staffing, the practice was able to improve outpatient TATs by more than 35% within just three weeks.
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"The RLI is a great resource to supplement the clinical training we get as radiologists," Moriarity says. "In training, we learn a lot about disease pathology, but not about healthcare delivery and economics or change management and gaining buy-in. The RLI gives you a new lens to determine the best way to improve

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VIVEK MASSON, MD

One example of Masson's efforts to enhance patient care in this underserved community was the development of a Woman's Health Pavilion in 2022, which aimed to address access-to-care issues for local communities.

"Over the past few years, I have worked hard to address access to care and systemic bias issues in my local system and community at large," Masson says. "A significant aspect of the woman's center is offering affordable care to populations who would otherwise be unjustly deprived of access. Beyond that, we're providing state-of-the-art technology, top-quality facilities and exceptional care in underserved communities — we didn't sacrifice anything. Quite

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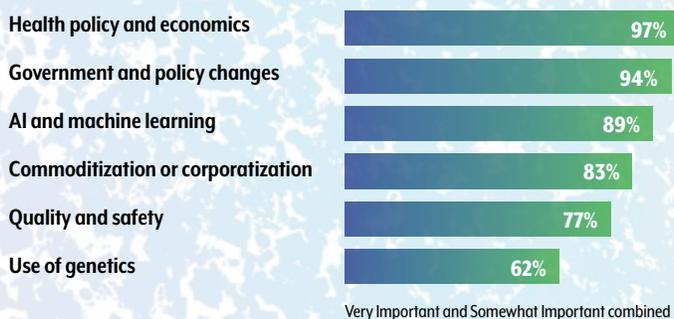
Insights from the ACR

centennial survey

The ACR is celebrating a major milestone this year: a century of leadership, integrity, quality and innovation. Our 100th anniversary gives us an opportunity to recognize and celebrate the world-changing achievements and contributions of our members.

In August 2022, the ACR Centennial Steering Committee, in concert with the ACR Environmental Intelligence team, sent out a brief survey asking members for their thoughts on what the future of radiology might look like and how current events might impact those outcomes.

The Future: What we're watching



Future Factors: Opportunity vs. Threat



Health policy/economics, while viewed as mostly a threat, was also viewed by one-third as an opportunity



Lingering Effects of the COVID-19 Pandemic



Nearly 7 out of 10 respondents agree the pandemic has modified communication patterns between radiologists/referring clinicians, **significantly more** than it has:

- Accelerated changes in technology
- Impacted referring physician ordering patterns

The Future:

What we're most excited about in the next 5 to 15 years

AI, machine learning and new technology



Burnout:

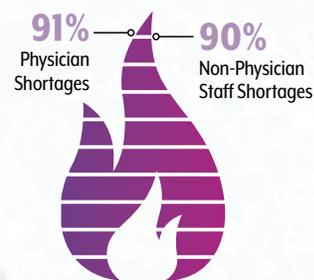
Where we're worried about it

While the majority of respondents are concerned about burnout in general, respondents are **significantly more** concerned about burnout across the radiology profession and in their workplaces. They are **least** concerned about suffering from personal burnout themselves.

Burnout:

What's causing it

Respondents pointed to **physician and staff shortages** as the top areas of concern related to burnout.



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How do you foster patient- and family-centered care in your organization?



“As breast imagers, we are intimately involved in a patient’s breast journey from conducting preventive care with screening mammograms, and addressing concerns with diagnostic imaging, to helping a patient with a breast cancer diagnosis and surveillance afterward. We have an incredible opportunity to involve the patient and selected family members in their care and decision-making along each step. Viewing the mammogram alongside the patient is a great way to provide education on breast density and supplemental screening options. In our ambulatory center, every patient is offered a patient liaison to address any needs, allowing a consistent point of contact. Promoting shared decision-making empowers patients to be their own advocates, which not only contributes to the best patient experience and outcomes but also leads to greater job satisfaction for the healthcare team.”

Sonya Bhole, MD, director and physician lead of ambulatory breast radiology and assistant professor of radiology, Northwestern University, Feinberg School of Medicine, and member of the ACR Commission on Patient- and Family-Centered Care’s Outreach Committee



“We have really been working on our scheduling process. We have developed a self-scheduling process through Epic MyChart for many types of imaging exams — mammograms, most CTs and we are now adding MRI and dual X-ray absorptiometry (DEXA) scans. Patients can schedule as soon as the order is placed by their provider. We’ve also made it easier for provider offices to schedule imaging exams directly into our software while the patient is checking out so patients have an appointment before they leave. These shifts have resulted in a lower wait time and abandonment rate at our call center. No more waiting on endless hold!”

Jennifer A. Harvey, MD, FACR, chair of imaging sciences and professor at the University of Rochester, and member of the ACR Commission on Patient- and Family-Centered Care’s Outreach Committee

LEADERSHIP

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simply, this center has saved lives by providing one-stop screening, diagnosing and treatment for women who have breast cancer, as well as a host of other gynecological malignancies and diseases.”

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Masson’s lessons learned from various RLI courses include:

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This seminar laid the foundation for Masson’s project. Getting buy-in from all parties involved was instrumental in selling his vision, and truly building a connection with the president of the medical staff as well as the system CEO was crucial to the success of the program.
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Masson gained a solid foundation to understand the business side of radiology, where he could sit down with relevant stakeholders from the finance and business development teams and speak their language with confidence so everyone was aligned to the same goal for the Woman’s Health Pavilion: being self-sufficient and sustainable, while providing additional downstream sources of revenue.
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“Without the RLI, I would not have had the tools to be able to lead my radiology team for the past decade,” Masson says. “The skills learned from the RLI and ACR have been by far the most important part of my transformation into a practice and system leader. If not for the RLI, this project, which will help save the lives of thousands of underserved people in northern New Jersey, would not have happened. The RLI has empowered me to make a positive impact in my local community that I hope will lead to bigger and more impactful initiatives in the future.

“For radiologists at every level, it’s more important than ever to develop leadership skills,” Masson adds. “With the advent of AI, our workflows are going to change. And those people who can lead reorganization of processes and navigate management changes will be the ones who come out ahead. My advice: Keep building your leadership skills and it will pay off in the end. The RLI is an incredible organization, and the people behind it are extraordinary. We’re fortunate to have their wisdom and the ability to network with one another and bounce ideas off other people who are solving the same challenges we have. That’s a remarkable advantage.”

Read more about Masson’s award-winning Impact in Leadership project at bit.ly/Masson_Project. 

By Linda Sowers, freelance writer, ACR Press

2023 RLI SUMMIT | NEW VENUE

The 2023 RLI Summit will be held Sept. 29–Oct. 1, 2023, at the Boston Seaport Hotel, just minutes from Logan Airport. Located in the Seaport District, one of Boston’s most exciting neighborhoods, the award-winning Seaport Hotel offers an authentic New England feel on the historic waterfront with dozens of restaurants, parks and museums within walking distance.

Although the venue has changed, this year’s program will have the same compelling content and networking opportunities you’ve come to expect from the RLI Summit. As always, we’ll have our renowned Babson faculty

covering topics important to your journey as a leader, including strategy, finance and negotiations. Radiology experts will share case studies designed to help you apply what you learn.

The 2023 RLI Awards recipients will be honored during the RLI Summit Awards Dinner being held on Friday, Sept. 29. You won’t want to miss it!

The RLI Summit happens only once a year. Don’t miss this unique opportunity to learn, network with radiology’s best and brightest, and find new inspiration for your leadership journey.

Register today at acr.org/RLISummit.

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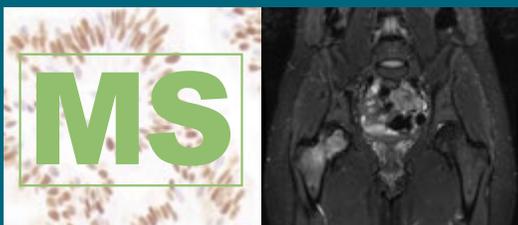
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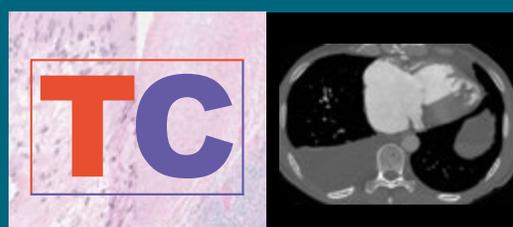
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Sept. 22–23, 2023 | In person



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Making an Impact in Leadership

Meet two recipients of an annual award recognizing radiologists for noteworthy contributions that improve organizations and lift communities.

In 2022, the Radiology Leadership Institute® (RLI) celebrated 10 years of delivering leadership and professional development training to radiologists at all career stages. Each year, the RLI recognizes the work and achievements of current leaders and provides scholarship opportunities for new leaders through its RLI Leadership Awards and Scholarship program (learn more at bit.ly/ACR_RLI). One of those honors is the RLI Impact in Leadership Award (read more at bit.ly/Impact_Leadership_Award), which recognizes individuals whose participation in an RLI course or program was integral to the successful completion of a specific project or initiative at their practice or institution.

The 2022 Impact in Leadership recipients were Andrew K. Moriarity, MD, vice president of clinical operations and quality chair at Advanced Radiology Services (ARS), and Vivek Masson, MD, system chair of radiology at CarePoint Health. Here are their stories of leadership initiatives and impact.

Optimizing the Organizational Structure

At ARS, Moriarity faced the challenge of integrating two disparate reading environments, where 200 radiologists were reading more than 2 million exams each year. Over the course of a year, he led a project to merge the practice's largest hospital partner into the ARS teleradiology platform, creating a cohesive reading solution. As a result, the practice was able to achieve its goals of enhancing patient care, standardizing systems and improving overall clinical operations.



“The RLI is a great resource to supplement the clinical training we get as radiologists.”

ANDREW K. MORIARITY, MD

“At the beginning, we were effectively operating in two parallel environments, with limited ability for radiologists in one area to assist others,” Moriarity says. “Creating a cohesive reading workflow not only helped us optimize case distribution, but we were also able to expand the reach and impact of our subspecialists, while improving overall scheduling flexibility and radiologist work-life balance.”

As chair of the Clinical Leadership Committee, Moriarity was tasked with coordinating this project while working with radiology

practice section chiefs, the distributed radiology information technology department, the decision support clinical analytics team and hospital partners. According to Moriarity, participating in the RLI Maximize Your Influence and Impact Course (learn more at bit.ly/RLI_Maximize) provided the crucial foundational leadership knowledge and the skills to lead this project to fruition.

“Throughout the project, I was able to draw on lessons learned from the many hands-on discussions and real-world case examples,” Moriarity said. “The course highlighted how to build effective teams, manage change and develop operational efficiencies, as well as underscored the importance of both formal and informal communication in building relationships and enhancing the success of major initiatives.”

Among the successes, Moriarity's project:

- **Created the right organizational structure** to navigate change in radiology and hospital operations. The team mapped out the practice volume across 14 different hospitals, according to detailed historical data, and used a robust capacity analysis tool to optimize scheduling on a per-hour basis, which gets patient exams to the right radiologist faster.
- **Addressed team challenges** by aligning members with diverse perspectives and backgrounds around performance goals. The project tackled “turf” concerns and created equity across different jobs, which was vital to program implementation and success.
- **Focused on enhancing work-life balance.** Optimizing subspecialty workload distribution for on-site staff and increasing in-home workstation deployment by 100% resulted in enhanced job satisfaction and greater ability to recruit new staff, especially for second and third shifts.
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LEARNING STORIES OF LEADERSHIP INITIATIVES AND IMPACT

In a recent RLI Power Hour webinar, the two recipients of the 2022 Impact in Leadership Awards shared the stories of their leadership projects and the impact they made on their communities. Watch this on-demand webinar to learn pointers that could help you implement your own leadership project at bit.ly/2022-Impact-Webinar.

“The RLI is a great resource to supplement the clinical training we get as radiologists,” Moriarity says. “In training, we learn a lot about disease pathology, but not about healthcare delivery and economics or change management and gaining buy-in. The RLI gives you a new lens to determine the best way to improve your local practice. Beyond that, it gives you access to a network of people who are highly engaged and motivated who can become very influential in your career.”

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By Linda Sowers, freelance writer, ACR Press

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