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Bulletin

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

QUESTIONS? COMMENTS?
Contact us at bulletin@acr.org. Digital edition and archives of past issues are available at ACR.ORG/BULLETIN.

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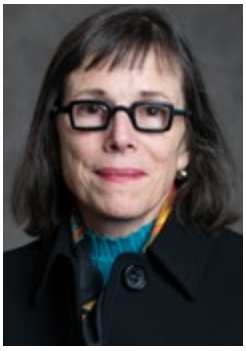
Jacqueline A. Bello, MD, FACR



The Pathway to Practice Excellence

The in-person gathering of the 2022 ACR Annual Conference on Quality and Safety presented a robust and interactive learning program to help attendees breathe new life into their quality improvement efforts.

The 2022 ACR Annual Conference on Quality and Safety, held Oct. 20–22, took place in person for the first time since 2019. The meeting brought together more than 250 quality improvement professionals who participated in sessions and discussions about aligning their practice operations with the latest trends in medical imaging, explored new informatics and decision support solutions for optimal reporting and patient outcomes, and connected with like-minded colleagues across the quality community. A diverse range of speakers — from physicians to patient advocates to technologists and more — covered critical quality topics, including the patient experience in operational improvement, the use of video radiology reports to improve patient-centered radiology, and the impact of AI on clinical decision support, to name just a few.

Here are a few highlights from the 2022 ACR Q&S Conference that I want to call out:

The opening keynote address, "Harmonizing the Drivers of Value-based Care Transformation: Professionalism, Provider-Led Performance Improvement, Payers and Policy Makers," was delivered by Pamela T. Johnson, MD, FACR. The vice-chair of quality and safety at Johns Hopkins Medicine's Department of Radiology challenged attendees to broaden their perspectives to all outcomes and realize that radiologists, through their work, can improve longitudinal outcomes and save downstream costs. Dr. Johnson's keynote urged attendees to discover high-value operational improvement strategies, such as making a business case for health equity and operationalizing quality improvement.

The "Lessons Learned From the National Contrast Shortage" workshop session challenged attendees to ask the critical question, "Are we better prepared for the next supply chain disruption?" While the contrast shortage emergency of the summer seems to have abated, the lessons may be applied to the next major shortage, whatever it may be and whenever it may occur.

COVID-19 has taught us that supply chains are very fragile, and while just-in-time inventory for healthcare-related items may make some business sense, it may have unintended consequences. The session was expertly conducted by Pranay Krishnan, MD, vice chair for operations, quality, and safety and director of CT at MedStar Georgetown University Hospital, and Helise R. Coopersmith, MD, vice chair of quality for Northwell Health Radiology. The doctors urged attendees to ask the questions, "What data was required for real-time monitoring? Did new dashboards/databases need to be created to facilitate this monitoring? How were all decisions regarding management of the shortage communicated? Will we do better with the next crisis?"

COVID-19 has taught us that supply chains are very fragile, and while just-in-time inventory for healthcare-related items may make some business sense, it may have unintended consequences.

While planning is already underway for the 2023 ACR Annual Conference on Quality and Safety, I would be remiss if I didn't thank the ACR Q&S staff and program co-chairs Ben Wandtke, MD, MS, MMM, vice chair of quality and safety at University of Rochester Medical Center, and Shlomit A. Goldberg-Stein, MD, associate professor of radiology with the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell Health, as well as David B. Larson, MD, MBA, FACR, chair of the ACR Commission on Quality and Safety and vice chair for education and clinical operations at Stanford University. The team planned a spectacular conference centered on quality improvement in radiology, at a time when value cannot be overemphasized!

Keep Up With News From ACR Quality and Safety

To receive quarterly updates on ACR activities and issues related to quality and safety in radiology, sign up at bit.ly/QSnewsletter.

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New Patient-Friendly Animations Released

The ACR Commission on Patient- and Family-Centered Care (PFCC) has developed a series of animated videos to help patients better understand their imaging. The videos are connected to the patient-friendly summaries of the ACR Appropriateness Criteria®. The PFCC Patient Engagement Committee, under the direction of Nina S. Vincoff, MD, has released several videos, covering topics like:

- Headache
- Acute Onset Flank Pain
- Acute Nonlocalized Abdominal Pain
- Ovarian Cancer Screening
- Thyroid Disease
- Right Upper Quadrant Pain
- Sinonasal Disease
- Prostate Cancer — Pretreatment, Detection
- Breast Cancer Screening
- Breast Imaging During Pregnancy and Lactation
- Jaundice

ACR members are encouraged to share these videos with referring providers, as well as patients. To access the videos, visit the *JACR*® YouTube channel at bit.ly/PFCC_PFA.

Submit Your Resolutions Today

At ACR 2023, the Council will consider resolutions to establish policy and adopt parameters and standards that support the practice of radiology. If you believe the College should take a particular position on an issue, write a draft resolution and secure sponsorship from one or more of the following: a Councilor, a chapter, the CSC, the BOC, the RFS, or the YPS. Before drafting a resolution, members should search the ACR Digest of Council Actions for relevant or related policies, and it may also be helpful to determine whether other organizations have policies or have acted on the issue. According to ACR Vice Speaker Timothy A. Crummy, MD, FACR, MHA, "submitting a resolution to the ACR Council is how members can help to guide the actions and policy positions of the organization and have a voice in our College."

Resolutions must be submitted to ACR staff no later than 90 days prior to the start of ACR 2023 to be considered by the Council. For ACR 2023, the deadline to submit resolutions is Feb. 6, 2023.

Directions and the format for resolutions can be found online at bit.ly/ACR_GOV. Questions? Contact ACR CSC staff at tbehbahani@acr.org.

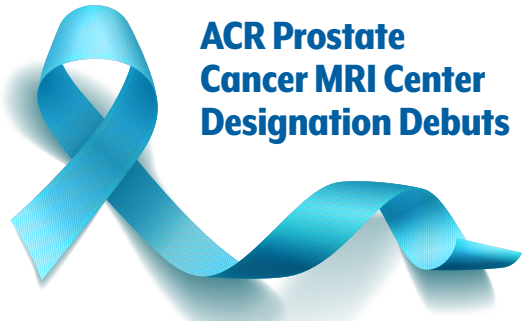

Kurt A. Schoppe, MD

Get to Know a Next-Generation Leader

In a new Radiology Leadership Institute® (RLI) Taking the Lead podcast episode, Kurt A. Schoppe, MD, president-elect of Radiology Associates of North Texas and radiology department chair at John Peter Smith Hospital, discusses how he has spent much of his career working on state and national payment policy through the ACR and has distinguished himself at the national level as an ACR advisor to the AMA/Specialty Society RVS Update Committee (RUC) and as chair of the ACR Commission on Economics' Reimbursement and Practice Expense Committee.

A vocal proponent for the importance of leadership training, Schoppe teaches younger physicians not to wait for a title to seek training, but to leverage leadership knowledge and tools early on to prepare to become a future leader.

Listen to the RLI podcast episode at bit.ly/RLI_Podcast.



ACR Prostate Cancer MRI Center Designation Debuts

The new ACR Prostate Cancer MRI Center Designation launched in November. Developed as part of the ACR Accreditation program, the designation will recognize sites notable for providing safe, effective diagnostic care for prostate cancer patients.

A facility is eligible to receive the ACR Prostate Cancer MRI Center designation if it meets the following basic criteria:

- ACR MR accreditation in the body module
- Imaging protocol that meets minimum technical specifications and includes the use of an external (surface) pelvis phased-array coil
- Use of Prostate Imaging Reporting and Data Systems (PI-RADS)
- Coordination of prostate biopsy (fusion/in-bore referral)
- Radiology/pathology follow-up
- MR scanner used for MR prostate studies at 1.5T–3T

Learn more about the designation and how to apply at bit.ly/Prostate_MRI_Center.

> **Providing truly patient-centered care demands more than just listening to patients. It requires providing the resources and opportunities for patients to actively partner in their care.**
>
> NINA S. VINCOFF, MD

Register for SPR 2023 Fetal Imaging Course

The Society for Pediatric Radiology (SPR) is conducting the SPR 2023 Fetal Imaging Course, Jan. 20–21, 2023. This live online course will feature two days of didactic lectures and interactive presentations designed to update your knowledge of prenatal imaging modalities, with a particular focus on MR imaging of the fetus.

Learn more at bit.ly/SPR_Meetings.

Renew Your ACR Membership

An ACR membership has numerous benefits! Did you know it comes with all this?

1. Up to 65 CME per year just from the daily Case in Point®
2. At least 12 CME per year from the CME-bearing articles in the *JACR*®
3. Podcasts to listen to while you work or drive including:
   - *Bulletin* Podcast
   - RLI Taking the Lead Podcast
   - Lung Cancer Screening Podcast
   - Value-Based Imaging Podcast Series
4. Webinars on topics ranging from practice quality improvement to population health management and more
5. Opportunities for volunteering, mentoring, and providing input, including the ability to provide comments on the annual Practice Parameters and Technical Standards field reviews

Renew today at acr.org/renew.

Study Finds Racial Disparities in Access to New, Advanced Mammography Technology

Among the Medicare population from 2005 to 2020, Black women were less likely to have their breast screening exams performed with more advanced mammography technology. This is according to a study of over 4 million claims published in *Radiology*. The results found that Black women were 20% more likely than White women to receive digital mammography in 2005 and 16% less likely than White women to receive DBT from 2015 to 2020. The research was the work of the Harvey L. Neiman Health Policy Institute®, in collaboration with the Radiology Health Equity Coalition.

Read the summary at bit.ly/Mammo_Access.

New CPI Ultrasound SA-CME

ACR continuous™ professional improvement

The Continuous Professional Improvement (CPI) program has released its Ultrasound Module 2022. The self-assessment module features casework from CPI's expert sonographers featuring more than 230 imaging examples in grayscale, color Doppler, and spectral Doppler, among others. Claim your print copy or complete the online exam and earn 8 SA-CME.

Access the module at bit.ly/CPI_Ultrasound_Module.

ACR Presents at September RUC Meeting

The ACR presented time and value recommendations for a procedure code relating to ultrasound guidance for vascular access during the recent AMA/Specialty Society Relative Value Scale Update Committee (RUC) meeting Sept. 22–24. This was a multispecialty effort in collaboration with the Society of Interventional Radiology and the Society for Vascular Surgery.

The ACR also submitted more than 10 multispecialty action plans for review during this meeting. Several of the code families in the action plans will be forwarded on to the AMA's CPT® Editorial Panel for further review and potential bundling before being revalued by the RUC at a future date.

The AMA will relay the RUC's time and value recommendations to CMS, which has the authority to refine the RUC's proposal and implement its own recommendations based on its internal review. The final recommendations will be included in the 2024 Medicare Physician Fee Schedule.

For more information, contact Stephanie Le, ACR's director of economic policy, at sle@acr.org. Read more at bit.ly/ACR_RUC_Meeting.

Gregory N. Nicola, MD, FACR

Yogi, Britney, and the No Surprises Act

The government should institute the law as it was intended — to protect patients and not favor either insurance companies or doctors.

Richard E. Heller III, MD, MBA

Vice Chair of the ACR Commission on Economics' Committee on MACRA and Co-Chair of the ACR Commission on Economics' Committee on Pediatric Radiology

Guest Columnist

According to legend, after watching Mickey Mantle and Roger Maris hit back-to-back home runs during the 1961 season, Yogi Berra, the late Hall of Fame baseball player, said, "It's like déjà vu all over again." Four decades later, Britney Spears sang "Oops!... I Did It Again." Both expressions seem applicable to the federal government's approach to the arbitration process in the No Surprises Act.

The 2020 No Surprises Act was passed to end the problem of surprise medical billing.[1] This issue, which is more accurately described as a surprise gap in insurance coverage, occurs when someone with private health insurance receives care unexpectedly from a physician or hospital not in their health plan's network. This is meaningful since out-of-network care may mean a higher out-of-pocket expense for the patient. The No Surprises Act was welcomed by the medical community as a reasonable solution.

Laws addressing surprise medical billing can do two things. The first is obvious; they reduce surprise medical billing. Less intuitive is that laws to address surprise medical billing may disrupt good-faith network negotiations between medical practices (or hospitals) and insurance companies. In a sense, surprise medical billing legislation can be a Trojan horse, with insurers claiming it's about protecting patients from out-of-network bills, when their real interest is in disrupting good-faith negotiations to their benefit.

The No Surprises Act is intended to protect patients from unexpected out-of-network bills in a manner that does not favor physicians or insurers. Under the law, when receiving unexpected out-of-network care, patients pay their normal in-network cost-sharing amount, and insurers reimburse physicians the rest. To settle disputes when insurance companies and doctors cannot agree on a rate, the law created an arbitration process using a third party.

The Departments of Health and Human Services, Labor, and Treasury were tasked with rulemaking, detailing how the law would function. In September 2021, the government issued a rule instructing arbiters on how to decide cases.[2] While the law detailed a list of criteria for the arbiter to consider, balancing the concerns of both physicians and insurance companies, the rule stated the arbiter should instead begin with the presumption that one of the listed factors, an insurance company-determined amount (termed the "qualifying payment amount," or QPA) was appropriate and select the offer closest to it. While physicians could appeal the insurer's payment offer to an arbiter, the burden of proof was on doctors to demonstrate why the QPA was inappropriate.

The rule prompted numerous lawsuits, including from the ACR. In February 2022, the judge in a lawsuit filed by the Texas Medical Association (TMA) issued his verdict, agreeing with the TMA and writing that nothing in the law instructs arbiters "to weigh any one factor or circumstance more heavily than the others."[3]

The federal government subsequently retracted this part of the rule and vowed to issue a new rule, which it did in August 2022. This updated rule states that the arbiter must first look at the QPA and then consider additional information.[4] Further, if the arbiter does not select the QPA, it must explain in writing the rationale and why the insurer-determined QPA does not already take the additional information into account. The new version of the rule (again) makes the QPA the primary factor in arbitration. As a result, the TMA filed a second lawsuit, which the ACR is supporting through a "friend of the court" brief.

To quote Yogi, it's like déjà vu all over again.

The No Surprises Act was intended to protect patients from unexpected out-of-network bills, not help insurance companies profit. Shortly after the government's initial rule establishing the QPA as a rebuttable presumption, insurers in North Carolina and elsewhere began sending letters to in-network practices, specifically referencing the law and rule.[5] Practices could accept a substantial rate reduction or risk being kicked out of network.

Recall that the law was intended to stop unexpected *out-of-network* billing (it is literally named the No Surprises Act), but these letters were exclusively being sent to *in-network* practices. These letters demonstrate that insurers were using the law to disrupt good-faith negotiations to their advantage.

The government should implement the No Surprises Act as Congress wrote it. It should acknowledge the mistake and issue rules that reflect balance, not favoring insurance companies *or* physicians. Or, as Britney sang, "Oops!... I Did It Again." B

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

Read more about the No Surprises Act and the ACR's response to it in the feature article on page 8.

NO SURPRISES

The ACR advocates for patients and radiologists as it pushes back against unfair policies.

The College backed passage of the 2020 No Surprises Act (NSA), a law intended to address the billing of unexpected out-of-network care, and continues to support its strong patient protections. However, the ACR has serious concerns about the way the law is being operationalized. Specifically, the College is concerned the law is being altered in a way that threatens medical practices and the patients they serve.

The debate has intensified since Aug. 19, when final revisions to the No Surprises Act were issued jointly by the U.S. Departments of Health and Human Services (HHS), Labor, and Treasury in the form of a final rule.[1] The latest document finalizes and clarifies requirements that were proposed under an interim rule released in July 2021.

"For radiologists and other specialists, it means insurance companies, inappropriately, are ratcheting down in-network rates — using the NSA as a lever to do so," says Richard E. Heller III, MD, MBA, associate chief medical officer for health policy at Radiology Partners, vice chair of the ACR Commission on Economics' Committee on MACRA and co-chair of the ACR Commission on Economics' Committee on Pediatric Radiology. "This was never the intent of the law."

The NSA holds patients harmless, which means it removes them from reimbursement disputes between insurers and providers. To resolve these disputes, the law created an equitable provider-insurer arbitration process, termed independent dispute resolution (IDR). The IDR process is used by providers who believe the amount of reimbursement they received from the payer for applicable services was incorrect or not sufficient. If the provider and insurer are unable to come to an agreement during an open negotiation period, the situation may move to arbitration.

The interim final rule called for arbiters to begin with the presumption that an insurer-determined rate, termed the qualifying payment amount (QPA), is appropriate and select that rate unless there was evidence to the contrary. This rule created a "rebuttable presumption," ignoring the law's intent that the QPA be among equally weighted factors considered in these disputes, says Josh Cooper, ACR vice president of government relations and economics health policy.

The interim rule made the QPA the primary factor, creating a benchmark payment set by insurers — a situation radiologists say could result in narrower provider networks, drastic imaging reimbursement cuts regardless of network status, and potentially reduced access to care for patients. The final rule issued in August does not correct that situation.

"The surprise billing issue was generated from reports that patients were getting medical bills from out-of-network providers for the non-insured costs of providing their service," Cooper says. The most common incidents were associated with patients going to an in-network facility but unknowingly receiving care provided by an out-of-network physician.

"Insurers might only cover a small portion of the out-of-network charge, if any at all," Cooper points out. "Some of these patients have been left on the hook for many thousands of dollars. The College supported legislation that would protect patients from these types of medical bills, while also preserving good-faith contract negotiations between insurers and medical practices."

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SURPRISE BILLING:

What You Need to Know

As passed by Congress, the No Surprises Act held patients harmless and created an equitable provider-insurer independent dispute resolution process. The surprise billing interim final rules that took effect Jan. 1, however, ignored the law's intent that a qualifying payment amount (QPA) be among equally weighted factors considered in these disputes. The rules made the QPA the primary factor over others, creating a benchmark payment that is set by insurers. The radiology community is concerned this could result in narrower provider networks, drastic imaging reimbursement cuts regardless of network status, and reduced patient access to care.

What You Can Do

- Review ACR advocacy regarding the new law and its implementation.
- Take action by letting the ACR know what your payers are doing about surprise billing.

Learn more at acr.org/surprise-billing.

Learn About the Surprise Billing Implementation Suit

In a video released earlier this year, ACR legal and congressional leaders discussed the College's lawsuit against the federal government's implementation of the No Surprises Act. The lawsuit maintains the public's best interest by protecting patients' access to care in their own communities. The ACR No Surprises Act implementation lawsuit seeks to do the following:

- Preserve the new law's patient protections. It does not raise costs for patients and would affect solely the insurer-provider payment dispute process.
- Protect patient access to care by stopping insurers from using the legislation to narrow provider networks.
- Maintain the public's best interest by protecting access to care in their communities.

Watch the video at wi.st/3WIn5Iz.

Understanding the Details

The details of the law and associated rulemaking are complex but consequential, Heller says. For example, the calculation methodology and integrity of the QPA can have meaningful consequences for medical practices. The QPA is defined as the median in-network rate for a service for a particular insurer based on contracted rates with physicians of the same specialty and geographic region from Jan. 31, 2019, adjusted annually for inflation. The ACR has concerns about the QPA calculation methodology and provided comments to the government on this topic in September 2021.[2]

In response to the NSA, the ACR has focused its efforts on the IDR process, which directly impacts provider reimbursement, says Kathryn Keysor, ACR senior director of economic policy. "The IDR process does not impact the amount that patients must pay," she says. "We fully and completely support the patient protections provided by the NSA."

The primary issue with the calculation methodology, Keysor says, is the treatment of a contract as a data point in the median calculation, rather than individual claims representing data points. There is no weight given to the number of claims or services provided under a contract. As a result, the QPA, which is calculated by the insurer, may include so-called "ghost rates." These are contracted rates that are never or rarely billed by a practice.

Providers are more likely to negotiate the rates on services they perform frequently. Providers who never or rarely perform a given service are more likely to accept lower rates, Keysor says. "As a result, there is potential downward skewing of the QPA calculation. For this reason, the ACR urged the government to adhere to the law and not make the QPA the primary determining factor in the IDR process," she says. In August, the administration seemed to acknowledge this problem.[3] However since the QPA calculations are not transparent, it is not yet clear whether this will be addressed, and if so then how.

Another substantial in-the-weeds issue is batching. With batching, medical groups submit multiple claims together for IDR. The goal is to maximize efficiency. Unfortunately, the government's rulemaking has severely limited batching. To qualify for batching, the claims must be within the same limited time period, for the same exam, from the same practice, and for the exact same health insurance plan. By limiting the number of exams that can be batched together, the government is increasing the overall number of cases in IDR — and increasing the expenses associated with arbitrating them.

In August, it was reported that there is a tremendous backlog of cases with more than 97% of submitted cases awaiting arbitration.[4] Further, restrictions on batching are also limiting some from accessing IDR altogether. Since the administrative fee of $50 per IDR submission is higher than many individual radiology claims, it is frequently not cost-effective to go to IDR without batching.

No-Surprise Litigation

The interim rule's establishment of the QPA as a rebuttable presumption is what Keysor says led the ACR, the American College of Emergency Physicians (ACEP), the American Society of Anesthesiologists (ASA), and other groups to file lawsuits against the government to block parts of the rule, while leaving patient protections intact. The Texas Medical Association (TMA) was the first to file a lawsuit.

In February 2022, a federal court ruled in favor of TMA, saying the QPA is not more important than the other criteria in arbitration and that nothing in the law instructs arbiters "to weigh any one factor or circumstance more heavily than the others."[5] That part of the rule was vacated, and the government stated its intention to comply with the ruling and issue final guidance at a later date.

In August 2022, the administration released the long-anticipated new rule.[6] In the final rule, the government removed the language indicating that IDR entities should begin with the presumption that the QPA is the most accurate payment rate. "That is the good news," Keysor says. "The bad news is that if the IDR

entity chooses an amount that is not the QPA, it is required to provide a detailed explanation as to what factors were considered and why the factors are not already considered in the QPA." In other words, the QPA is again the primary factor in IDR — and there is more work involved for an IDR entity that chooses an amount higher than the QPA, she says.

As a result, the TMA filed a second lawsuit in September 2022. That lawsuit, like the first, states that the law does not establish the QPA as the primary factor in IDR determination. The TMA is arguing that the challenged provisions of the final rule deprive physicians and providers of the fair arbitration process the law intended.[7] The new TMA suit is filed in the same Texas federal court that ruled in favor of the TMA prior to this suit. The ACR, ACEP, and ASA filed a joint amicus brief with the Texas court in support of TMA in October 2022.[8] Additionally, the three organizations have dismissed a joint lawsuit in the U.S. Court for the Northern District of Illinois challenging the interim final IDR rule because that rule is no longer in effect. However, the organizations have preserved their legal right to re-file the Illinois lawsuit if the Texas court rules against TMA and its supporters.

"These changes in the proposed implementation guidelines are going to end up punishing medical practices, including radiologists, who have never been bad actors in presenting surprise bills," says Lauren P. Nicola, MD, chair of the ACR Reimbursement Committee. That does not match up with the intent of the original legislation, she says, and that's why the TMA filed its lawsuits.

CONTRACT RATES

"Many radiologists are unaware of the significant changes in reimbursement occurring in the background at their practices," says Daniel G. Gridley, MD, FACR, chair of the ACR Payer Relations Committee and Network. "We encourage you to reach out to your managed care/payer contracting team and your billing team to garner feedback and information about what may be happening due to NSA implementation." This includes cancellation of in-network contracts, re-contracting with payers at lower rates (often due to payer demand), and receiving no reimbursement or markedly decreased reimbursement for services from non-contracted payer entities.

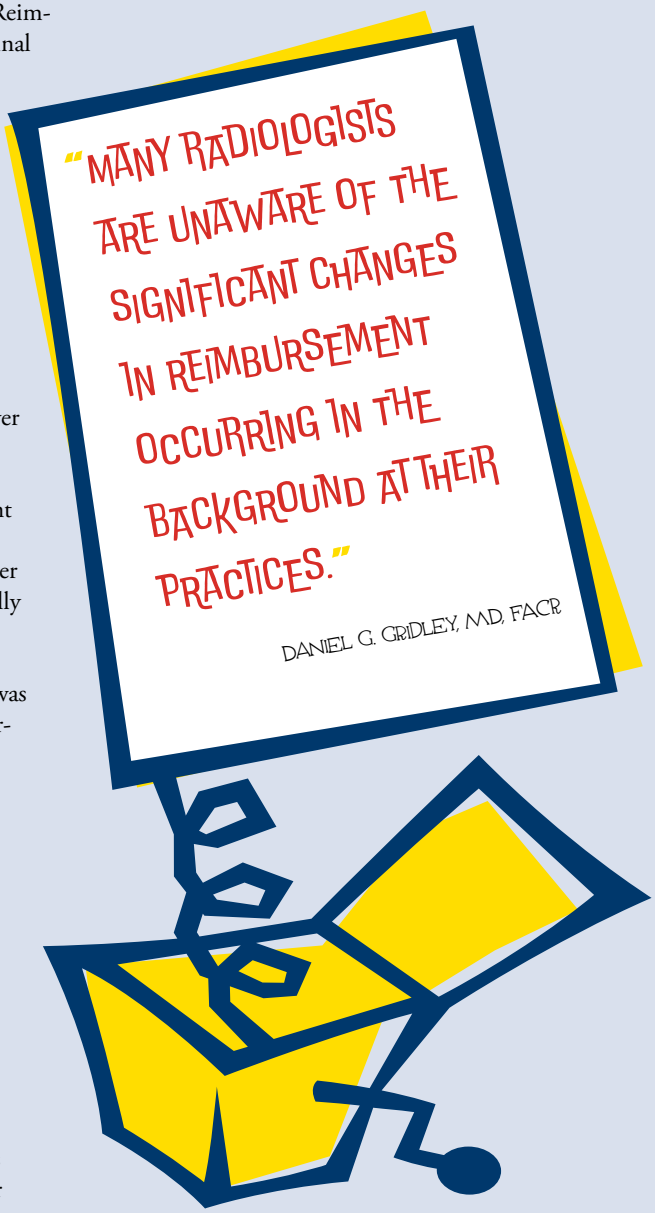
The QPA is tied to the median in-network reimbursement for the service rendered as determined by the insurance company, a non-transparent calculation with potential for manipulation. Gridley also expresses concern about "ghost rates" being used in QPA calculations. "Inclusion of these lower reimbursement levels could be leveraged by the insurance payers to artificially lower the QPA," he says.

Establishing the QPA as a benchmark, especially if it is artificially depressed, can have significant consequences. Weeks after the interim rule was released in late 2021, establishing the QPA as a benchmark rate, some insurance companies issued letters to healthcare systems and physician groups noting that if they refused to re-contract at a lower reimbursement level, then the payer would move to remove them from the network. The letters specifically referenced the NSA and the rule granting them this authority.

"This Trojan horse effort by payers to morph the NSA into wide-sweeping reimbursement reduction has the potential to result in lack of contracting and an out-of-network status for multiple groups — thereby steering patients away from those entities and limiting networks in geographic areas," Gridley says.

UPHILL BATTLE

"Every time I talk about this, a lot of people tune me out on the radiology side of things," Nicola says. "Radiologists tend to think it is not a problem for them because most are in-network with their contracts." The problem is that once the QPA is set, the insurance companies have the option of either



PROVIDE YOUR FEEDBACK

If you have any information regarding issues related to the No Surprises Act implementation, including challenges with the IDR website or payer reimbursement, please email Katie Keysor at kkeysor@acr.org.

forcing practices to take those lower in-network rates or kicking the practices out of network altogether — knowing that they'll be able to get something near the QPA in arbitration, she says.

The ACR is aware of practices in multiple states that received letters stating that because of this legislation, the insurer has the authority to demand a rate reduction or move to terminate their contract, Nicola says. The threats are being made to in-network practices, although the law was intended to address out-of-network billing. Paradoxically, the law could actually increase out-of-network billing. In this scenario, if the contract is canceled, the practice will be considered out-of-network.

"Then they have to go through this arbitration process, which will undoubtedly will be cumbersome, labor-intensive, and expensive," Nicola says. "So, for some radiology practices, it is hardly worth the cost to try to fight it out."

Radiology professionals need to stay on top of the issue, says Gregory N. Nicola, MD, FACR, chair of ACR's Commission on Economics. "The fact is that this law ensures the patient is protected," he says. "The negotiations now are between clinicians and insurance companies."

The law intended this to be a balanced process, doctors say, and the implementation process should reflect that intent. "What we are hoping to gain by supporting the TMA's second suit is that the government further revises its language on what the QPA means," and its relative weight in an IDR process, he says. This is about preserving good-faith network contract negotiations and protecting patients' access to care, he says.

> "THE FACT IS THAT THIS LAW ENSURES THE PATIENT IS PROTECTED. THE NEGOTIATIONS NOW ARE BETWEEN CLINICIANS AND INSURANCE COMPANIES."
>
> GREGORY N. NICOLA, MD, FACR

Heller echoes that sentiment: "The administration should implement the NSA as Congress wrote it and issue rules that reflect balance — not favor insurance companies or physicians."

The challenge now is getting the word out about what's happening so radiology professionals can take a proactive stance, Heller says. "One of my concerns is that the first time groups find out about this is when they realize their reimbursement has gone down dramatically," he says.

"With proper implementation, legislation to end surprise medical billing can be used as a tool to benefit insurers at the expense of patients and physicians — that is what I want people to know," Heller says. "I would like to see our members be proactive. The ACR's members should be reaching out to the College. The ACR can be a repository of evidence. If your radiology group sees evidence of inappropriate, abusive payer behavior, you should convey this information, in a compliant manner, so the ACR can use this for advocacy purposes.

"The College is doing important work on behalf of radiologists and the patients we care for, but they need our help," Heller says. "I encourage people to get involved." B

By Chad E. Hudnall, senior writer, ACR Press

ENDNOTES

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Hone Your Data Science Skills

Here's how you can brush up and keep up with changes in AI in radiology, both on your own and through organized activities.

You're a full-time radiologist working a day job. A few years ago, you heard about big data and AI and decided to learn all you could. A good thing you did, too: Radiology AI is real and here today, and your practice looks to you as the local expert.

The challenge, then, is keeping up.

Just as all AI performance degrades with time, your data skills will also need upkeep. If your goals are similar to mine, these suggestions might help. These are not ways to become the world's leading expert in AI but suggestions for brushing up.

Engage in a Data Project

While images are the most apparent source of rich data, you regularly run across a lot of text data as a radiologist. Finding a project in data analytics can take your work to the next level. Maybe the project is predicting future volume based on this year's data to justify hiring new radiologists. Perhaps it's predicting demand for radiologists and RTs by day and hour using a combination of exam volume and turnaround time by modality. Maybe it's building a computer vision model for a disease entity you've spent your career studying.

Working on a project that will impact your daily practice is probably the single best way to keep your skills current because there is a real incentive to do things well. There is the pressure of eventually displaying your work. What's more, it's an opportunity to improve the way your co-workers do their work. As long as you are willing to accept the challenge, both intrinsic and extrinsic rewards can be well worth the effort.

Make Your Data Better

If taking on a truly tangible project sounds too involved for your professional life right now, that's OK! There are plenty of other ways to keep your data skills current.

The best data science projects start with high-quality data. Sometimes this means better data: A structured format for diagnostic findings, standardized recommendations, and fine-tuned, practice-level reporting templates are all meaningful engagements. These can be highly worthwhile projects to refine the input to machine learning models.

Sometimes high-quality data means better use of data. What is the volume trend in your practice? What is the average turnaround time? Make a request to your data center for a spreadsheet of last month's radiology reports by modality, anatomy, and timestamps. In particular, timestamps are extremely helpful for calculating turnaround time and identifying outliers.

Take a moment to learn how data is populated. How is your practice's turnaround time calculated? Do your radiologists and ED physicians agree on the definition? Are there manual components in the time calculations — for instance, does the scanner automatically fill in exam start time, or is there another button an RT has to click? If a data field is manually populated, what are your options to improve the quality of that data?

> **The right platform can make all the difference when you go from analyzing a spreadsheet with 300 rows to one with 30 million.**

It might be easy and tempting to do the analysis straight on a spreadsheet, but instead, try using an analytic platform. Is R your cup of tea? Do you prefer Python? The benefit of approaching analytics this way is that you can scale your analysis quickly. The right platform can make all the difference when you go from analyzing a spreadsheet with 300 rows to one with 30 million.

Enter Machine Learning Competitions

Many machine learning competitions allow you to solve discrete problems in "practice mode" (or in actual competition mode with penalties for wrong answers). For example, national societies such as RSNA and the Society for Imaging Informatics in Medicine (SIIM) routinely produce radiology-relevant competitions on a timely topic. ML competitions provide optimized data and encapsulate the problem. While real-life data science is messy and often

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Improving Care for Prostate Cancer Patients

Several initiatives are helping ensure early diagnosis and treatment, including PI-RADS® standards, a new ACR Prostate Cancer MRI Center™ designation, and the Prostate MR Image Quality Improvement Collaborative.

With prostate cancer the second-most-common cancer in American men, behind skin cancer, according to the American Cancer Society, it's important to stay on top of technology that can improve early diagnosis and treatment.[1] In this Q&A, Andrei S. Purysko, MD, discusses the importance of continuous quality improvement in prostate MR. Purysko is a clinical assistant professor of radiology at the Cleveland Clinic Lerner College of Medicine, physician lead for the ACR Learning Network Prostate MR Image Quality Improvement Collaborative, and a faculty member for the ACR Education Center prostate MR course.

What is the importance of prostate MRI in the delivery of better patient care?

Prostate MRI has changed the paradigm of prostate cancer diagnosis. We've been steadily increasing the use of prostate MRI over the last couple of decades, and it has become integral to diagnosing and managing patients with suspected or confirmed prostate cancer. We're now using MRI from the initial cancer detection to define the most appropriate treatment for patients and evaluate disease recurrence.

In this context, one of the most important benefits of MRI is to help triage patients for biopsy. Until recently, we used to perform biopsies taking random samples of the prostate in reflex to an abnormal PSA or digital rectal exam. The problem with random biopsy is twofold. First, it fails to detect aggressive forms of cancer in many patients, leading to a delay in diagnosis. Secondly, it detects many indolent cancers that are unlikely to progress and would not require any treatment.

MRI has been proven to be a more accurate method for detecting clinically significant cancers and can direct the location where the biopsy samples should be taken. Additionally, MRI can rule out the presence of clinically significant prostate cancers, preventing many men from having an unnecessary invasive biopsy procedure and mitigating the overdiagnosis and overtreatment of insignificant cancers.

Can you give examples of how quality process improvements can enhance patient care?

Better patient care relies on high-quality prostate MRI exams, which include using adequate equipment, correct imaging acquisition protocols, and accurate interpretation of MRI findings — and appropriately communicating that information to the referring physicians taking care of patients. With greater utilization of prostate MRI, however, there are concerns about variability in the quality of the MRI examination across different sites.

Toward that end, participating in ACR body MR accreditation and implementing the standards defined by the ACR Prostate Imaging Reporting and Data System (PI-RADS®) (bit.ly/pi-rads) are good examples of processes that can reduce variation in the quality of exams and significantly enhance communication with referring physicians.

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What is the ACR Prostate Cancer MRI Center designation, and why is it an indispensable part of every quality and safety program?

The new ACR Prostate Cancer MRI Center designation (bit.ly/prostate-mri-designation) is the next step in the evolution of quality improvement, ensuring that sites use best practices beyond the technical standards PI-RADS has defined. Using the ACR Mammography and Breast MR Accreditation programs and the Lung Cancer Screening Center Designation as references, a workgroup — led by Jeffrey C. Weinreb, MD, FACR, and Anthony J. Scuderi, MD, FACR, in collaboration with ACR staff member Dina Hernandez, BSRS, RT — developed a set of requirements specific for the Prostate Cancer MRI Center designation.

Two noteworthy requirements for the designation involve coordination of prostate biopsy and radiology-pathology follow-up to ensure that radiologists are engaged throughout the spectrum of patient care. This requires that the facilities forge a relationship with referral groups that perform the biopsy and receive feedback from the biopsy results. The radiology-pathology feedback mechanism provides an extra safety net to ensure that discrepant results between pathology and radiology are routinely reviewed and flagged. This mechanism is essential for radiologists to continuously learn and improve from every experience. As part of the evaluation process, each facility receives a comprehensive, confidential report from the ACR highlighting areas for improvement and recommendations for that facility.

What are the benefits?

In achieving the designation, facilities distinguish themselves as safe and effective diagnostic care providers. Facilities show patients, referring physicians, administrators, and payers that they meet high-quality MR prostate imaging standards and are committed to patient safety and quality care beyond the accreditation norm. Facilities meeting the designation requirements will be identified as an ACR-Designated Prostate Cancer MRI Center by a symbol on the ACR Accredited Facility Search page (bit.ly/accredited-facilities).

What are some of the other requirements?

In addition to ACR Accreditation in body MR, there are some prostate-specific requirements. For example, physicians will have to demonstrate they have experience with prostate MRI interpretation, either by showing they have independently interpreted and reported at least 150 prostate MRIs in the last three years or performed 100 MR prostate examinations in a supervised situation.

If sites want to apply for designation but do not have a high enough volume of prostate MRIs or if physicians have not had enough previous experience with prostate MRIs, they can take advantage of the ACR Education Center (bit.ly/ACR-education). There's a workshop dedicated to prostate MRI directed by Katarzyna J. Macura, MD, PhD, FACR, where physicians will have a chance to read enough cases to meet and exceed that requirement and learn from leaders in the field of prostate MRI who are current or past members of the ACR PI-RADS Steering Committee, such as Baris Turkbey, MD, Daniel Margolis, MD, Sadhna M. Verma, MD, and Clare M. Tempany, MD, FACR.

There's also a requirement for demonstrated RT expertise in prostate MRI. Additionally, sites will need to submit examples of their images to be reviewed by the ACR, which is an excellent opportunity for the ACR to provide feedback to the site to help them improve their image quality.

Where can you learn more and apply for the designation?

Applications for the ACR Prostate Cancer MRI Center Designation will be accepted beginning with the launch of the new ACRedit Plus system (bit.ly/ACRedit-Plus) in the coming months. For more information, including requirements and how to apply, visit acr.org/MRIprostate.

MRI has been proven to be a more accurate method for detecting clinically significant cancers and can direct the location where the biopsy samples should be taken.

ANDREI S. PURYSKO, MD

Tell us about the ACR Learning Network Prostate MR Image Quality Improvement Collaborative.

Inadequate prostate MR image quality is associated with an increased chance of equivocal MRI results and can lead to diagnostic errors. For example, researchers have found that as many as 40% of the abbreviated prostate exams using just the two key pulse sequences — T2-weighted and diffusion-weighted images — have inadequate image quality for various reasons.

The Prostate MR Image Quality Improvement Collaborative (bit.ly/prostate-MR-collaborative) is one of four improvement collaboratives in the ACR Learning Network, which is led by David B. Larson, MD, MBA, FACR, chair of the ACR Commission on Quality and Safety, and funded by a generous grant from the Gordon and Betty Moore Foundation.

The collaborative is centered around a robust didactic program on improvement sciences led by Kandice Garcia, MS, RN. It provides a framework to help participating institutions identify the root causes of poor image quality and define the key drivers and interventions that can lead to sustainable improvement. Participants in the first collaborative cohort, which convened in spring 2022 and concluded in November, came together to learn and share ways to develop image quality metrics, standardize protocols, and ensure appropriate patient preparation to deliver high-quality prostate MR images consistently.

In 2023, the ACR Learning Network will convene two other prostate MR quality improvement cohorts comprised of four to six sites each. To apply, visit the Prostate MR Image Quality Improvement Collaborative (bit.ly/prostate-MR-collaborative). B

Interview by Linda Sowers, freelance writer, ACR Press

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

Shining a Light on Scope-of-Practice Battles

The government relations chair of the Wisconsin Radiological Society speaks about the importance of radiologist-led advocacy.

Gregg A. Bogost, MD, FACR, government relations chair of the Wisconsin Radiological Society (WRS), recently shared insights into the WRS scope-of-practice advocacy success achieved during the 2022 legislative cycle. During his conversation with the ACR, Bogost shared how an American College of Radiology Association® (ACRA®) Scope of Practice Grant helped in Wisconsin's scope fight. During the legislative session, the WRS was engaged in combating a well-funded effort by multiple non-physician provider groups to drastically expand the scope of practice in Wisconsin for advanced-practice nurses. Multiple state and national physician specialty groups advocated against the scope expansion legislation, which was ultimately vetoed by the governor. The ACR's conversation with Bogost touched on this advocacy victory and the importance of radiologist-led advocacy.

Why and when did you get involved in advocacy?

As an eager young radiologist, I was asked to assist in defeating a harmful licensure bill at a time when cross-state turf battles were more of an issue. I found the entire political process to be an interesting new opportunity for professional diversification. The process brought new positive professional relationships and fun and interesting challenges, and it was professionally rewarding to be productive beyond the view box. I've been involved in advocacy ever since. Because most proposed legislative actions have an impact on patient care in one way or another, political advocacy is another route we can use to improve patient care while advancing our profession.

Why do you think it is important for other radiologists to be involved in advocacy?

Our expertise is badly needed to educate and guide our legislators. Our point of view is critically important for legislators to understand since they are generally unaware of the issues' nuances and may not even know why a particular proposal is bad or good for patients.

The key point is that these various legislative issues can have profound impact on your practice's success and the care you deliver. So having your voice heard is important, and it is very doable. Even if you don't have the time, interest, or comfort level to directly meet with legislators, radiologists can have a huge influence by responding to calls to action and communicating their position electronically to the offices of lawmakers. We have received specific feedback over the years from legislators' offices commenting on the volume of support coming from our doctors on issues we have been successful with.

Another way is to attend political fundraisers and try to get to know your legislators. A familiar face goes a long way the next time you need to communicate.

Keep in mind, the next legislative fight is not if, but when, so be ready. Being ready means building your internal structure and outside relationships ahead of time instead of being simply reactive.

What advice would you give to other state radiological chapters that are engaged in scope-of-practice battles?

My first piece of advice is if you don't have one already, retain a lobbyist who is well-established and has good connections in your state capitol and experience in healthcare issues.

Next, it's important to build relationships with other state and local medical organizations. This includes not only other physician groups, but other potentially impacted stakeholders, whether they are hospital systems, patients, and even in some cases, the insurance industry. Such coalitions are more powerful than a single specialty group's voice and are proven to increase the chance of legislative success.

Regarding scope issues specifically, it's important to emphasize the critical importance of the role we play at the top of the healthcare team, directing care for best outcomes at a lower cost, and not defaulting that care to lesser-trained providers. To help lawmakers understand that, it's important to emphasize the differences in our education and training as radiologists compared to mid-level providers. Legislators are generally unaware of these nuances, which are obvious to us. Also, compared to other specialty physicians, we understand the overuse of imaging and subsequent increased costs resulting from lesser-trained mid-level providers practicing independently. These arguments resonated with our governor in his decision to veto the Advanced Practice Nurse Practitioner scope expansion.

How did the ACRA's Scope of Practice Grant help WRS during its recent legislative fight?

The WRS was very grateful to the ACR for establishing this grant as it greatly impacted our advocacy efforts. This scope-of-practice fight took much more time, money, and effort than originally thought. The money the WRS received from this grant allowed our chapter to develop much more extensive and far-reaching coordination and collaboration with other stakeholders. We used it mostly for lobbying, but other chapters have used the funds to appeal directly to patients, voters, and legislators through social media and advertising that define the radiologists as the best-trained leaders of the necessary team approach. This type of funding was needed and will be needed again as we anticipate future battles with non-physician groups that are well-organized and well-funded and aren't going away anytime soon. B

Interview by Dillon Harp, ACR's senior state government relations specialist

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Dive Into the ACR Workforce Survey

The number of women in radiology is on the rise, especially among professionals under 40 — an age group that also accounts for increases in people of color.

Since 2012, the ACR has deployed an annual survey to U.S. practice managers and leaders to assess employment and hiring patterns of radiology professionals. The 2021 ACR Commission on Human Resources survey fielded responses from more than 1,700 radiology decision-making, "rank and file," and retired radiologists. Here are some of the key takeaways from the 2021 survey:

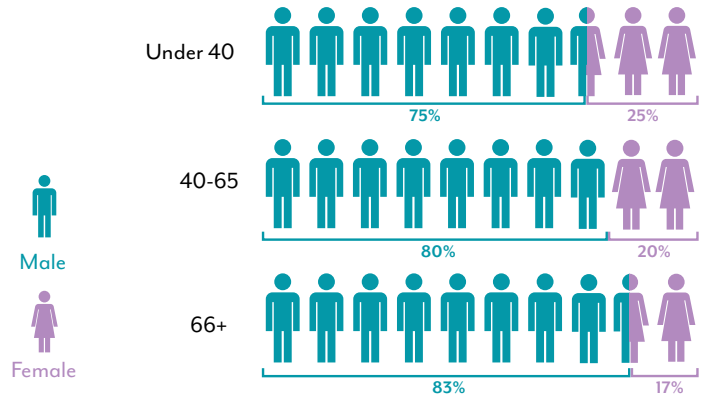
- **There is an upward trend in the number of female radiologists and radiologists of color in radiology practice, particularly in the younger cohorts.** The percentage of female radiologists is greater among the youngest cohort (Figure 1), and more than half of radiologists of color are under age 46.
- **Private practice is the dominant practice type across regions.** Academic practices congregate in urban centers, while national practices operate primarily in the South, where their many locations and large practice sizes attenuate the strains of distance in low-population areas.
- **Work-life flexibility is a common theme.** When asked about whether they have worked remotely or would like to, and to click all answers that apply, most said their practices allow telework, while nearly 44% said they would like theirs to endorse it (Figure 2).
- **Academic and national practices tend to be larger practice types.** They are more well-resourced when it comes to staff and locations, and they provide work-life flexibility at greater rates than other practice types.
- **Non-physician radiology provider (NPRP) incidence in radiology is low overall.** Radiology practices at the median employ zero NPRPs, and practices of more than 100 employ the most non-radiologists in radiology practices. RTs make up most non-radiologists in radiology practices (Figure 3). B

To learn more, contact the ACR Environmental Intelligence team at survey@acr.org.

By David Markovich, MS, MHA, business program analyst; Mary Jo Tarrant, MBA, director, environmental intelligence; and Dominick J. Parris, senior environmental intelligence analyst, all with ACR Strategy Management & Foresight

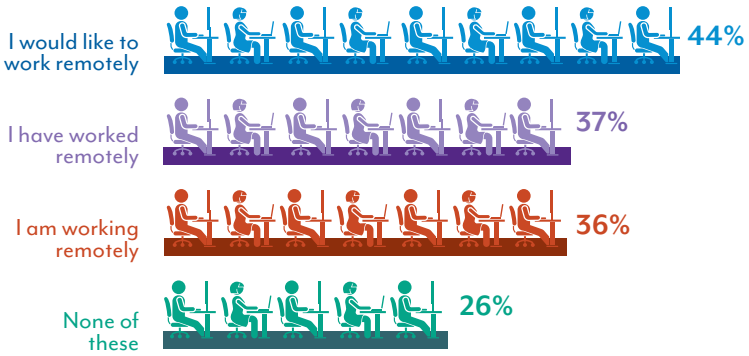
MALE–FEMALE SPLIT BY AGE

FIGURE 1



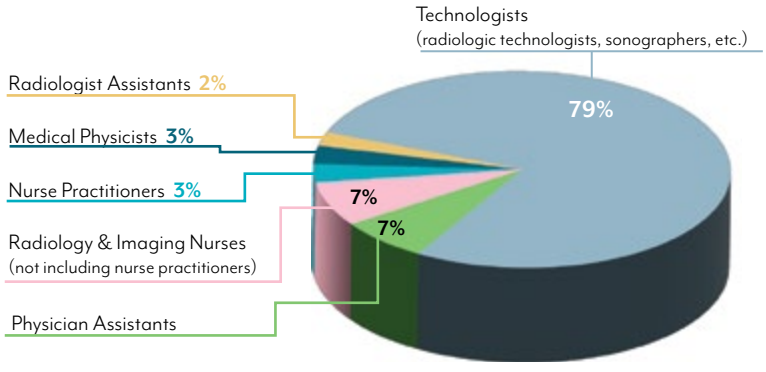
RELATIONSHIP WITH TELEWORK

FIGURE 2



NON-PHYSICIAN RADIOLOGY PROVIDERS IN RADIOLOGY PRACTICE

FIGURE 3



Being Well Together

A new webinar will provide radiology residents and fellows with strategies to improve wellness and mitigate burnout.

As a member of the ACR Well-Being Committee, Ian A. Weissman, DO, FACR, knows how important it is to focus attention on clinician burnout. "The COVID-19 pandemic has exacerbated burnout in our healthcare colleagues, and the data coming out about increasing rates of burnout is extremely worrisome," he says.

Weissman, who also serves as president of the Wisconsin Radiological Society (WRS), chair of the ACR Commission on Patient- and Family-Centered Care's Outreach Committee, and chair of the ACR Veterans Affairs Committee, has worked with the WRS to put together a free Dec. 12 webinar on well-being geared specifically to residents and fellows. He spoke with the *Bulletin* about the current state of radiologist burnout, the need for leaders to prioritize well-being, and what attendees can expect to learn from the Dec. 12 event.

How did the idea for this webinar come about?

The increasing incidence of burnout in our colleagues has been very concerning to me since before the COVID-19 outbreak, but the pandemic has exacerbated the problem. According to the 2022 *Medscape* Radiologist Lifestyle, Happiness & Burnout Report, nearly 47% of radiologists reported that they were burned out, increased from 42% in 2021.[1] In addition, more than 5 million workers have quit their jobs — and careers, for some — since February 2021. Healthcare is the second-largest industry hit, reporting losses of 20% of the workforce over the past two years.

Overall, healthcare employment is down by an estimated 500,000 workers.[2] It is estimated that up to 47% of U.S. healthcare workers plan to leave their positions by 2025.[3] This threatens to destabilize the healthcare system in the United States. As we all know, radiology is experiencing widespread shortages in staffing across multiple modalities and is struggling to maintain and recruit staff.[4]

It made sense to make burnout and well-being one of the main topics during the WRS annual meeting in April 2023. As a prelude to that comprehensive discussion, we decided to hold a webinar on well-being directed toward residents and fellows on Dec. 12, 2022, at 7 p.m. CT, and it's free for all to attend (bit.ly/wrs-event).

What can attendees expect from the December event?

I have known Frank J. Lexa, MD, MBA, FACR, and David P. Fessell, MD, for many years. Both are thought leaders in the radiology profession. Dr. Lexa is the chief medical officer for the Radiology Leadership Institute® (RLI). Dr. Fessell is a radiologist and certified executive coach who has recently shifted his focus to improving well-being among his colleagues.

Some of the greatest advice I have learned throughout my career has come directly from radiology colleagues like Drs. Lexa and Fessell, who have walked in our shoes, and some of the most powerful strategies I've incorporated into my practice have come from listening to our radiology colleagues who continuously mentor us through organizations like the RLI.

BE WELL WITH THE ACR

Each month, the ACR will feature an activity or initiative you can use in your daily life to support your well-being. Participants can win prizes for sharing their activities with friends and colleagues on social media. Be sure to follow #BeWellWithACR and @RadiologyACR on Twitter to be the first to hear about the monthly wellness challenge. Share a photo or video of yourself completing the activity and be sure to include #BeWellWithACR in your post. The ACR will randomly select a winner.

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Dr. Lexa's presentation, "Leadership Strategies to Succeed Despite Work-Work Imbalance, Burnout and Other Challenges in Radiology," will discuss the impact of rising clinical demands on burnout, the definition of work-work balance and why fixing it is critical to our future, and how leaders and leadership have contributed to rising rates of burnout and short-term thinking in radiology. Attendees will learn how to develop personal and institutional strategies for mitigating imbalance and burnout and will be able to consider changes in workflow and work structure with concomitant implementation of leadership, mentorship, and professional development programs.

Dr. Fessell's presentation, "Thriving Under Stress: Leading Yourself and Influencing Others," will examine evidence-based strategies that individuals can access to decrease burnout, including mindfulness, support groups, and coaching. Dr. Fessell will talk about how health and wellness can spread via social networks, norms, and behavior change, also known as "positive contagion," and post-traumatic growth and how it helps us benefit from challenges.

What is the importance of leadership in well-being?

Leaders define the culture of the organization. We are all leaders, and we each have the power and responsibility to contribute to a culture of well-being at our workplace.

Using categories named in the popular book *Good to Great* by Jim Collins, the most effective leaders are servant leaders or Level 5 leaders — those who live for the health and success of the organization and its people. While it takes dedication, emotional intelligence, and personal humility to be a Level 5 leader, if this ability is not innate, leaders can be trained to become more effective. Simply demonstrating care for one's employees goes a long way toward decreasing burnout. Leaders should routinely ask their employees questions such as, "What do you look forward to every day about your job?" and "How can I help you be more satisfied at work?"

Why should leaders prioritize well-being?

The ongoing Great Resignation has demonstrated to us that being committed to a culture of well-being is no longer optional. We must substantially improve our well-being strategies to encourage our colleagues to stay in the profession. We can look to our neighbors in other countries as well as to the rural areas of our country to learn what we will start to experience in our larger cities if we do not prioritize well-being. For example, EDs are closing due to critical work staff shortages.[5] In radiology, our patients are experiencing delays in receiving the critical results of their imaging studies, as well as much-needed diagnostic and therapeutic radiologic procedures.

What do you do to help reduce the stress of burnout?

Our daily lives are filled with complexities, so I try to keep my strategies simple and attainable. Effective communication is one of our most powerful strategies to achieving a culture of well-being, so I try to do this effectively at work and at home. Food and exercise have a tremendous impact on well-being, so I make daily healthy food choices, and I walk every day — being close to nature restores me. As a weekly energizer, I sail or snow ski. Salsa dancing is one of my passions, and I am a violinist. Being connected to my family, friends, and community has helped me stay centered during the pandemic. Each evening, I learn and exchange knowledge with my friends and colleagues around the world through social media @DrIanWeissman.

BRAINSTORM ON BURNOUT

Although overwhelming volume and poor work-life balance are major contributors to burnout, well-being needs differ across subspecialty, career stage, and practice type. Tailored solutions can help improve well-being.

How would you address burnout at your practice or institution?

The ACR has started Well-Being 360, an initiative to identify the range of ideas, real and imagined, about how to improve well-being. Has voluntary moonlighting helped? Are employer-sponsored lunches or coffee breaks worth it? The goal is to find ways to better serve you — our members — and to share ideas.

If you have time to participate in a 15-minute interview, please send an email to coplstaff@acr.org. Each participant will be entered to win a HidrateSpark PRO, a smart water tumbler.

What well-being resources are available for ACR members?

The ACR offers numerous resources through the Radiology Well-Being Program (acr.org/wbi). Additionally, the National Academy of Medicine just released its National Plan for Health Workforce Well-Being that proposes impactful solutions (bit.ly/nam-well-being). The U.S. Surgeon General just released two seminal resources on Addressing Health Worker Burnout (bit.ly/health-worker-burnout) and Addressing Workplace Mental Health and Well-Being (bit.ly/workplace-well-being) that propose strategies organizations can adopt.

Importantly, if you or a colleague you know is experiencing a crisis, please reach out for help. One powerful resource is the Physician Support Line 1-(888)-409-0141 staffed by physicians for physicians (physiciansupportline.com). I would like each of my colleagues to know how critical you are to our profession and how the hard work you do daily has had such a profound impact on improving the health of our collective community. B

Interview by Raina Keefer, contributing writer, ACR Press

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10 Years of Building Bridges for Research

The Harvey L. Neiman Health Policy Institute® has built relationships throughout the College and among ACR members to move forward the ACR Strategic Plan.

In 2012, the ACR and the late Harvey L. Neiman, MD, FACR, made a bold move to impact the national health policy debate by forming a health policy organization now known as the Harvey L. Neiman Health Policy Institute® (HPI). The HPI has played a crucial role in helping patients, practices, and policymakers make the best decisions possible to improve patient care.

To celebrate a decade of accomplishments and progress in 2022, the *Bulletin* has looked back at the highlights the HPI has provided these past 10 years. In this final installment of a three-part series, the *Bulletin* delves into the HPI's expertise, data, and portfolio of publications that have been an invaluable source of information, especially when it comes to the College's strategic priorities. (Read part one at bit.ly/HPI_anniversary and part two at bit.ly/HPI_anniversary_II).

Assembling World-Class Expertise

By building a well-rounded team, the HPI has been able to advance the College's strategic plan with one goal in mind: improving patient care. "An important part of our strategy that has developed over the past couple of years has been to strengthen our core HPI staff's research expertise and capabilities," says Elizabeth Y. Rula, PhD, executive director of the HPI. "We brought in robust health economics expertise to complement the clinical expertise of the radiologists we collaborate with. We want to make sure we have the staff needed to remain responsive, providing ad hoc analytics and accelerated research to inform urgent topics. We also want to maintain our focus on future-looking work that includes robust studies published in peer-reviewed journals that address both pressing issues today and issues on the horizon."

Rula says part of the HPI strategy was to "deepen the bench" when building an effective research team. The HPI needed a versatile staff that could address a range of questions and topics to ensure the Institute achieved its goals. "We hired highly experienced health economists, health services researchers, and an epidemiologist," she says. "Having that expertise in-house allows us to study a range of topics simultaneously and broadly leverage the value within the data."

Translating Evidence Into Action

Communicating research as relatable information to ACR members and staff is important to the HPI's goal of having its research used as broadly as possible to advance the ACR strategy and policy that supports radiology practice advancement. The HPI uses multiple channels for this communication, including its website (neimanhpi.org), press releases, e-newsletter, social media, annual reports, and the *Bulletin*.

"The HPI has worked hard to build visibility of its research for multiple audiences so that the wide array of our stakeholders can readily find, understand, and reference the research they need for their initiatives," Rula says. "A foundational aspect of all those different channels is the goal of translating the research into actionable information. That way our internal and external stakeholders know how to use what we have found to drive forward radiology and health policy."

Partnering Up

Working together with the ACR's many departments is crucial to the HPI's success. "If our work doesn't support the broader ACR strategy and the objectives of other teams, then we've missed opportunities for impact," Rula says.

The ACR Economics team is a regular internal customer for HPI analytics. The team's requests often involve analytics to determine the likely impact of changes in payment policy and the Medicare Physician Fee Schedule, from creating new bundled payment models to creating, revising, or retiring CPT® codes. "We can rely on HPI staff to quickly respond when we need answers to bring to the RUC or CPT Editorial Panel, and to ensure that we have the data to help define and strengthen our coding position," says Maria Tran, ACR director of economic policy.

This partnership can be seen in the HPI's relationship with the ACR Department of Quality and Safety (Q&S), which has worked on a couple of projects with the HPI. Mythreyi B. Chatfield, PhD, ACR's executive vice president of Q&S, says, "We have found synergies where the HPI has collaborated with Q&S, leveraging their complementary data and skills in research design and statistics." She discussed one project where the National Mammography Database had physician data on quality measures and how a particular physician was performing, while the HPI

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CELEBRATING 10 YEARS

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HPI CELEBRATES 10 YEARS OF EXCELLENCE

In 2012, the ACR and the late Harvey L. Neiman, MD, FACR, made a bold move to impact the national health policy debate by forming the Harvey L. Neiman Health Policy Institute® (HPI). To celebrate a decade of accomplishments and progress, the *Bulletin* has looked back at the highlights the HPI has provided these past 10 years. To learn more about the HPI and how it is having an impact, visit neimanhpi.org.

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What are some of your key takeaways from the 2022 Bruce J. Hillman, MD, Fellowship in Scholarly Publishing?

"The Hillman Fellowship is a deep dive into the radiology publishing ecosystem. It gives you a unique opportunity to connect with the *JACR*® and Elsevier staff and learn about the journal's editorial process. In addition to getting an insider look at the logistics of medical publishing, I also gained a better understanding of what goes into a successful journal article."

Randy C. Miles, MD, MPH, chief of breast imaging at Denver Health

"The Hillman Fellowship is an opportunity to step into academic publishing. The publisher and editors provided in-depth discussions on how articles are received, processed, reviewed, and published, which are very useful in understanding the review and publication process. I have a new appreciation for the diligence and organization it takes to be successful in the scholarly publishing process."

Courtney M. Tomblinson, MD, assistant professor of neuroradiology at Vanderbilt University Medical Center

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involves mixed-quality data, competitions abstract out the logistics and focus on model-building. If you got into data science because you enjoyed the rush of creating something out of your own hours of effort, you might enjoy these competitions. Cash or computing resources are common prizes for top performers.

Kaggle (kaggle.com) is a website that allows users to publish anonymized data sets, build machine learning models, and host or participate in data science competitions both in and outside of healthcare. RSNA and SIIM have hosted many of their recent machine learning challenges — and winning solutions — on Kaggle. Outside of the radiology competitions, data science problems on Kaggle range from straightforward to very difficult, and there is something for everyone, from complete novices to experts. It's never just busywork.

Learn a New API or New Language

Like any skill, every element of computer science builds upon itself. While current literature covering radiology data science emphasizes coding in Python, a radiologist with the right data and no access to full-time data scientists can use a low-code or no-code environment like PyCaret to turn ideas into a working prototype.

For those with coding experience, even within one programming language, there are many packages to consider. Python libraries in machine learning alone pose a daunting challenge: Pytorch, Keras, Caffe/Caffe2, and MXNet are just some examples of the many choices you have for computer vision. For natural language processing, popular starting points include nltk, GenSim, SciPy, and others.

Finally, the proper integration of data models into the broad healthcare technology and workflow is critical in the real world. Pragmatic considerations often require knowledge beyond Python or data science. Java (deeplearning4j), C++ (OpenCV, Cuda), and C# (also OpenCV through a .NET wrapper) are useful considerations for data science projects ripe for clinical translation.

One great way to keep yourself current as a data scientist is to keep learning new things because learning new things requires you to review what you already know.

Conclusion

As a radiologist, I am not (and probably never will be) as good as a full-time data scientist, so my goal is to keep abreast of the newest technologies and periodically create something that helps me solve my everyday problems at work.

How do you keep up with your data skills? B

Po-Hao "Howard" Chen, MD, MBA, is chief imaging informatics officer, IT medical director for enterprise radiology, and staff radiologist in musculoskeletal imaging at Cleveland Clinic.

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had data on the physicians in terms of where they practiced and their overall practice volume.

"We were able to pull the two pieces together and identify physician characteristics associated with higher or lower quality in mammography," Chatfield says.[1] The HPI team also performs specific data analytics to help identify opportunities for radiologists in Quality Payment Programs and current participation and success in these programs from Medicare data.

Government relations is another frequent collaborator. "What helps is that the HPI has data that can answer the wide range of imaging questions the federal government and state governments may have," says Josh Cooper, ACR vice president of government relations and economic health policy. "That data is reliable and not only helps us make our case, but also helps lawmakers and other government officials demonstrate to their constituents the evidence behind their positions on issues such as surprise billing and Medicare reimbursement."

Earlier this year, the No Surprises Act, aimed at helping prevent surprise billing, was a focus of the two departments. "The HPI has been very helpful as we monitor and navigate the implementation of the No Surprises Act," Cooper says. "There have been concerns raised by the ACR and other medical specialty societies about the interpretation by insurers on how the Act should move forward. The HPI examined the data that has been produced to help these medical societies make their case and demonstrate to the federal government that our concerns about the insurance companies' interpretations are valid. The HPI has been very instrumental in helping us crunch the data and make sure we're on the right path with our concerns."

The impact of these efforts can be seen in the ACR's ongoing advocacy efforts, such as surprise billing, cancer screening, and other issues. "The HPI is crucial in providing data that makes it much harder for members of Congress and Capitol Hill staff to say no when it comes to issues of patient care and physician reimbursement," Cooper says. "This evidence-driven approach sets us apart from other physician groups in that we back up our positions with reliable data." B

By Alexander Utano, editorial assistant, ACR Press

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