Canadian Association of Radiologists
L'Association canadienne des radiologistes

CAR RESIDENTS' REPORT

American College of Radiology
ACR 2015 Annual Meeting

Dr. Stephanie Lam (PGY-4) and Dr. Kari Visscher (PGY-3)
Washington, D.C., May 16-21, 2015

OVERVIEW

We were privileged to have the opportunity to attend the Resident and Fellow Section (RFS) Meeting held in conjunction with the American College of Radiology (ACR) 2015 Annual Meeting (formerly the Annual Meeting and Chapter Leadership Conference – AMCLC), as the CAR resident delegates. Organized under the theme *The Crossroads of Radiology 2015*, ACR 2015 is the first annual meeting of the ACR to include all ACR members, residents, fellows, industry partners and radiology professionals from across the speciality. This historic event thus marked the first time that all radiologists – members and non-members alike – as well as other professionals connected to the field were invited to participate in the College's Annual Governance Meeting and the College Convocation conducted by the ACR Council.

The meeting was organized around topic areas called ACR Knowledge Pathways, aimed at focusing learning and promoting skill-building in:

- ACR Governance
- Advocacy, Economics, and Health Policy
- Clinical Education
- Clinical Research
- Informatics and Innovations
- Leadership
- Medical Physics
- Quality and Safety
- Radiation Oncology
- Areas pertinent to residents, fellows and young physicians

BACKGROUND

WHAT IS THE AMERICAN COLLEGE OF RADIOLOGY?

The ACR, founded in 1924, is a professional medical society dedicated to serving patients and society by empowering radiology professionals to advance the practice, science and professions of radiological care. It represents more than 37,000 diagnostic radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians and medical physicists. In addition to the ACR's core areas of advocacy, economics, education, quality and safety, research, and membership value, its Imaging 3.0 initiative is leading the transition to value-based radiologic treatment and care. Furthermore, the ACR oversees facility accreditation, publishes the Journal of the American College of Radiology (JACR) and the ACR Appropriateness Criteria, promotes the Image Wisely and Image Gently campaigns, and administers the American Institute for Radiologic Pathology (AIRP), the Radiology Leadership Institute (RLI), and other Continuing Medical Education activities.

WHAT IS THE RESIDENT AND FELLOWS SECTION?

All residents and fellows training in the United States and Canada receive complimentary membership in the ACR and are considered members-in-training. The RFS is composed of over 5,000 members, making it the largest and most active trainee section among radiology organizations. The ACR-RFS represents radiology and radiation oncology residents within the ACR and other specialty organizations including the American Medical Association (AMA), the American Alliance of Academic Chief Residents in Radiology (A3CR2) and the American Board of Radiology (ABR). Its focus is on education and resources for residents. The RFS is led by the RFS Executive Committee, comprised of six members, who hold office for one year. Elections for the positions of the RFS Executive Committee are held during the ACR Annual Meeting. This year represents the 23rd annual RFS meeting to be held the weekend before the ACR 2015 annual meeting (formerly AMCLC).

RFS SESSIONS/ SPEAKERS

IMAGING 3.0

GERALDINE MCGINTY, MD, FACR; NATE MARGOLIS, MD

Dr. McGinty outlined the Medicare fee for service journey including the Physician Quality Reporting System (PQRS); the Volume Based Modifier (VBM); the bundling codes to reduce payment; the bundling payment demos; the Shared Savings Program and Accountable Care Organizations (ACOs); and US Secretary of Health and Human Services Sylvia Mathews Burwell's accelerated transition to value-based payments. Dr. McGinty's bottom line was that we need to do better with less and Imaging 3.0 is the blueprint for integrating imaging into the healthcare delivery system.

She then provided 15 practical ways for radiologists to add value in their daily practice, advising that we pick one and do it well. These include:

1. Building rapport with other specialties
2. Providing referring physicians with evidence-based opinions
3. Facilitating patient flow
4. Communicating effectively
5. Educating yourself on the cost of imaging
6. Providing excellent acquisition and interpretations
7. Interacting with patients
8. Remembering radiation safety in everyday practice
9. Avoiding unnecessary repeat examinations
10. Integrating quality into daily practice
11. Crafting meaningful reports
12. Communicating certainty and uncertainty
13. Issuing standardized, actionable recommendations on incidental findings
14. Reducing delays in patient care
15. Showing and telling your unique skill set as a radiologist to multidisciplinary teams

In conclusion she stated that transforming radiology requires trainees to embrace value-added activities, provide examples of translating the concept of Imaging 3.0 into practice, and encourage others to do these activities.

RADIOLOGY ADVOCACY NETWORK (RAN)

ANDREW WU, MD, FACR – RAN MEMBER, NORTH CAROLINA

Dr. Wu provided an update on the accomplishments of the Radiology Advocacy Network (RAN) in the last few years, including advances in social advocacy, social media, and the Sustainable Growth Rate patch (SGR) signed by President Obama. These achievements were made possible because of membership engagement and productive Government Relationship staff. He encouraged residents to stay involved and to stay informed, as it is because of the involvement of its membership that the RAN is able to make a difference.

LEGISLATIVE UPDATE

CHRIS SHERIN – DIRECTOR, CONGRESSIONAL AFFAIRS, ACR

Mr. Sherin described the following recent developments in congressional affairs:

1. With overwhelming bipartisan support, Congress recently passed H.R.2, the Medicare Access and CHIP Reauthorization Act (MARCA), to permanently repeal the flawed SGR formula. This Act establishes the Merit-Based Incentive Payment System (MIPS) and encourages physicians to transition to alternative payment models (APMs). We will gradually be moving away from the current fee-for-service model.
2. In 2012, a 25% Multiple Procedure Payment Reduction (MPPR) was applied to the professional component of diagnostic imaging services, with additional cuts introduced in 2013. The MPPR has now been expanded to include both individual and multiple radiologists interpreting multiple imaging studies from the same patient on the same day. The ACR supports H.R. 2043/S. 1020, the Diagnostic Imaging Services Access Protection Act, which seeks to repeal the MPPR.
3. The US Preventive Services Task Force (USPSTF) recently gave a draft recommendation grade C for mammogram screening in women ages 40-49, and grade B for women ages 50-74. The consequence of the grade C recommendation is that private insurances might no longer cover screening services (only grade B and higher recommended screening is covered). The ACR has secured a bipartisan letter urging Secretary Burwell to

take steps to ensure that women still have insurance coverage for screening mammograms. The ACR notes that this recommendation is a symptom of the greater issue of the lack of transparency of the USPSTF's recommendation process, and states its support of legislation requiring the USPSTF to be more transparent.

THE BUSINESS OF RADIOLOGY

THE NEW HEALTH CARE: INTENDED AND UNINTENDED CONSEQUENCES

LAWRENCE R. MUROFF, MD, FACR

A survey conducted at the 2012 ACR Annual Meeting showed that radiologists believed that radiologists would not change until the pain of the status quo greatly outweighed the potential pain of change. Dr. Muroff described the major challenges (the pain) in the practice of radiology:

1. Declining reimbursements are compensated by increasing productivity, but at the expense of important non-clinical responsibilities, eventually leading to commoditization.
2. Radiology has an image problem: the public thinks that radiologists work little, but get paid a lot; generally speaking, the public does not know what a radiologist is.
3. Increasing demands from hospital administration for increased coverage, better service, and greater subspecialization.
4. Non-traditional competition for radiologists' hospital contracts and outpatient businesses through corporatization and disintermediation.
5. Alternative payment systems to fee-for-service exist, but radiologists have yet to understand how to successfully conduct their practices under these systems.

Dr. Muroff concluded by emphasizing that the shift from volume to value, and from output to outcome, is not optional. Radiologists will have to be significant or become irrelevant.

COMMODITIZATION IN RADIOLOGY: WHY IT IS NOT INEVITABLE, EVEN WHEN IT HAS ALREADY HAPPENED

FRANK J. LEXA, MD, MBA

A commodity was defined as a product that is uniform in quality, and traded solely on price. The principle of de-commoditization lies therefore in providing additional value to a product, and thereby justifying its higher price. By understanding that commoditization is a failure of imagination, innovation, and understanding of the market, it is possible to prevent it from occurring. It was emphasized that commoditization was not inevitable, and could be remedied by shifting from a volume-based practice to a value-based practice, which can be accomplished through greater involvement in decision-making, service metrics, process and cost improvements, customer satisfaction, and quality improvement initiatives – activities that are actually unrelated to the clinical work of reading studies. Radiologists should be prepared to work with Accountable Care Organizations (ACOs), their related programs, and other health care providers, while always prioritizing patients and their needs.

INTERNATIONAL OUTREACH SUBCOMMITTEE

MARY HUFF, MD; ADAM PRATER, MD, MPH

Various international outreach opportunities available in radiology and radiation-oncology were presented. Residents and fellows were encouraged to get involved in humanitarian projects. Their involvement could be facilitated through a number of scholarships that are available.

HOT TOPICS: QUALITY AND SAFETY AND INFORMATICS

IMPORTANCE OF CHANGE MANAGEMENT IN INFORMATICS

SAFWAN HALABI, MD – HENRY FORD HEALTH SYSTEM

Physicians should be spearheading informatics initiatives, as they are the ones who know what best fits their needs and the environment they work in. Cost is only one of many important considerations

and should not be the driving factor when determining which IT system to choose. The decision-making process that should be undertaken was explained, as well as which factors to consider, how to implement a new IT system, and how to manage downtime.

BUILDING A SYSTEM AND CULTURE FOR QUALITY IMPROVEMENT

JASON N. ITRI, MD – UNIVERSITY OF CINCINNATI MEDICAL CENTRE

The steps involved in building a quality improvement program were outlined. Time, high-quality data and people are the necessary resources for building a successful quality improvement program. It is important to promote a culture of quality within the department, as well as transparency, open communications, and accountability. Having the appropriate mindset and culture promotes trust, which ensures the success of the project.

IMPROVING THE AVAILABILITY OF CLINICAL HISTORY USING INFORMATICS AND TECHNOLOGICAL AUTOMATION: THE "WHAT, WHEN, WHERE" QUALITY IMPROVEMENT PROJECT

MATT HAWKINS, MD – EMORY UNIVERSITY

Dr. Hawkins discussed an example of a clinical audit performed at his institution, aimed at gathering additional clinical information from the patients through the technologists. The additional information was found to moderately-to-markedly improve image interpretation by the radiologists. As well, the technologists take pride in participating in improving the quality of the interpretation. The project relied on good relationships with the technologists and ultimately proved to be a success. It has now been maintained for more than two years.

CAREER DEVELOPMENT: YOUNG AND EARLY-CAREER PHYSICIAN SECTION PANEL

TESSA COOK, MD; LOUISE MILNER, MD; SEAN HIGGINSON, MD; MADELENE C. LEWIS, MD

This was a Q&A session on job hunting, private practice versus academic setting, education versus research versus clinical tracks, and how to choose and weigh job opportunities.

How do you deal with a new hire having to do the ABR Part 2 during the first few months of a new job?
Answer: It does not seem to be an issue. Studying is done on their own time.

Do you have any advice about networking?
Answer: It is important to build your network before you need it. Keep your interview face on every day at work during your residency, as you never know who your future employer will call as a reference.

Regarding going from private practice to academics or vice versa, how final is the decision, and which is harder to do?
Answer: There are several issues to consider. Going from private to academics may be easier in terms of comfort level for reading certain kinds of studies. However, when considering academics, it is important to start early, in order to build your CV. The academic ladder is harder to climb when you have been in private practice for many years.

For private practice, what role did buy-ins and time-to-partnership play in choosing which group to join?
Answer: Fit is generally considered more important than buy-in and time-to-partnership. However, it is important to ensure that time-to-partnership is reasonable (average is three years) and has been attained by recent hires. Other issues to consider are buy-out and if the practice has any debt.

What is it important to look for in a contract? Are there any deal breakers?
Answer: It is strongly recommended and worthwhile to have an attorney look at the contract.

Do you have any advice for a junior resident picking a fellowship?
Answer: Do what you love, unless you have a very specific plan, like a city or a hospital you would like to work at. In that case, you should ask what they need, and gear your fellowship towards their needs.

NOMINATING COMMITTEE REPORT AND CANDIDATE SPEECHES

Various resolutions were presented and adopted. Subsequently, candidates were presented and Nominating Committee elections took place.

DEBATE: IS HOSPITAL EMPLOYMENT GOOD FOR RADIOLOGISTS?

Two teams presented the pros and cons of hospital employment for radiologists. The pros of hospital employment included secure employment, comprehensive compensation, a built-in referral network, and access to hospital resources. The major con was loss of autonomy. In addition, there are administrative benefits to being part of a smaller, more flexible, organization.

WORKFORCE UPDATE

EDWARD BLUTH, MD, FACR

This is a review of the ACR Commission on Human Resources Annual Workforce Survey. Highlights included:

- 39% of individuals spend over 50% of their time working in their area of subspecialty. This was marginally higher for those working in academic centers. 90% of residents complete fellowships.
- Most common subspecialties included Abdominal, General and Interventional Radiology.
- Most common subspecialties for part-time work included General, Breast and Abdominal.
- Most hired subspecialties in 2015 were Interventional, Breast, Body, Neuroradiology, MSK, Emergency Trauma and General. Projected most-hired subspecialties for 2018 are General, Breast, Body, MSK, Interventional, Neuroradiology and MRI.
- When radiologists were asked who they would prefer to hire, most (68%) answered a single speciality radiologist with general capabilities. The least desirable candidate would be a single specialty radiologist.
- Trends show increasing hire with an increased percentage of female radiologists in younger age groups.

AMERICAN BOARD OF RADIOLOGY UPDATE

MILTON GUIBERTEAU, MD, FACR; KAY VYDARENY, MD, FACR

The core quality and safety guide for the ABR exam was updated on February 20, 2015. As well, residents were encouraged to get the most up-to-date copies of the following guides: The Value in Healthcare, Quality Measures and Key Performance Indicators, The Skill, Rule and Knowledge-Based Classifications and High-Reliability Organization.

The remainder of the talk described the certifying exam including the Maintenance of Certification component (MOC).

EFFECTIVE NETWORKING

JONATHAN FLUG, MD

Networking was defined as an exchange of information or services among individuals, groups, and institutions. Within this definition, there is no mention of shaking hands, business cards or schmoozing. Relationship-driven careers aid in professional success and satisfaction.

Reference was made to the book "Never Eat Alone: And Other Secrets to Success, One Relationships at a Time" by Keith Ferrazzi and Tahl Raz. The emphasis here was on the fact that success is about working with people. Dr. Flug feels that social networks are more influential than traditional medical journals. He stressed the importance of being a part of an organization's formal network because it improves success when bridging disconnected groups and individuals,

especially with 'fence-sitters'. The thought is to not waste time trying to win over people against an idea or organization, but to spend effort engaging 'fence-sitters' who can swing the pendulum in favor of the idea or organization. Social networking tools mentioned included LinkedIn, Doximity, Instagram, QuantiaMD, and Sermo.

The importance for an individual of developing a mission was discussed. This includes defining the individual's goals as well as 1-, 5-, and 10-year plans. A 3-step plan was proposed as follows: (1) find your passion (a dream with a deadline); (2) put your goal to paper making it specific and believable; and (3) create a personal 'board of advisors'.

Three forms of workplace networking discussed include: (1) operational – to help with day-to-day factors; (2) personal – to help with personal development; and (3) strategic – to help with professional development. General principles for developing these networks included: never saying "no" (or at least trying to not say "no"); showing up early and often; creating casual encounters; and doing favors with nothing expected in return.

Seven key habits of super networkers include: (1) asking insightful questions (so do your homework!); (2) adding value; (3) learning the personal and professional story of the person you are networking with; (4) sharing a memorable fact; (5) making small promises and keeping them; (6) rewarding your 'power contacts'; and (7) sharing your needs and desires.

Ways to maintain your network include: (1) reaching out and staying in touch even when you do not need something; (2) persistence – practice makes perfect and you might learn to enjoy networking; (3) doing activities that engage your passion; and (4) identifying super-connectors.

Network assessment is important for maintaining effective networks. You want a network that is diverse but selective, and among which about 35% should be people who think differently than yourself.

LEADING FROM THE START

KATIE LOZANO, MD

Early-career physicians are the longest-term stakeholders in any practice and should be included in practice leadership and decisions. Success should not be judged by rank or position, but by the contribution you are making. Suggestions for how to make a positive influence include:

1. Understand your practice. Know what your practice requires or expects and make sure you fulfill those requirements and more.
2. Understand your partners, referring physicians and employees. Engage patients before they become your patients.
3. Understand yourself. Know your talents and what you can create to fill the needs of your practice.

The principles of tribal leadership were contrasted to that of selfless leadership. With tribal leadership, the premise is that we are great and the other person/group is not. Whereas, with selfless leadership, the premise is that you serve a purpose greater than yourself. The question posed then becomes: how do you get members of a team who are driven by the quest for individual glory to give themselves to the betterment of the group? The talk then went on to discuss how a real legacy is not what we accomplish individually but what we do for others and how we motivate them to work together for a greater goal. The optimal leader is a coach who role models the type of culture the group wants and who motivates through encouragement, not retribution.

The session concluded with the thought that, if we were all to use selfless leadership for the betterment of our practice and groups, then radiology could be the crossroads of medicine – the place where all medical specialities intersect for optimal patient management.

PERSONAL FINANCE PRIMER

KURT SCHOPPE, MD – CHASE DETERS (RAFFA WEALTH MANAGEMENT)

Savings rates are much more important than investment rates of return. We were encouraged to be weary of the financial entertainment industry and the behavior gap. The behavior gap is between those people who put money in and out of investment vehicles versus those who put money in one investment vehicle and leave it. Those who leave it make more money in the long term. Reference was made to the book 'The White Coat Investor: A Doctor's Guide to Personal Finance and Investing' by James Dahle. The point was that the ideal portfolio is one that can be created in retrospect.

Ways to plan for investing include: (1) investing in 401/403b up to the match; (2) paying off short-term, non-tax deductible debt; (3) saving for an emergency fund; (4) using tax diversification; (5) maximizing 401k contributions; (6) using the health savings account if you have one; and (7) paying down debt.

It is generally felt that doctors have an irrational fear about taxes, but we need to relax. The bottom line is to automate what you can (bills, debt payments, savings, investing, retirement) and leave your money where you put it and not keep moving it around.

CONCLUSION

We are grateful for the opportunity to attend the ACR and RFS Annual Meetings this year. The meeting focused on radiology being at a crossroads, with many changes on the horizon. Radiologists need to be leaders – and need to be seen as being leaders – in these times, becoming advocates for value-based practice, quality improvement, cost-reduction initiatives, and patient satisfaction, in order to avoid the commoditization of our specialty. These are values that we can learn, and activities that we can undertake now, as residents and young radiologists. Attending the RFS Conference has shown us how the ACR empowers its members to effect positive change in their own work environments, and how by keeping value as a priority, we can build a stronger specialty. While the issues are not identical in the Canadian landscape, we have learned valuable lessons that can only serve to enrich our specialty in Canada.

Dr. Stephanie Lam, PGY-4, McGill University
Dr. Kari Visscher, PGY-3, University of Western Ontario