



Canadian Association of Radiologists  
L'Association canadienne des radiologistes

---

**CAR RESIDENTS' REPORT**  
**American College of Radiology**  
**Annual Meeting and Chapter Leadership Conference**

---

Olivier Clerk-Lamalice, PGY3  
Washington, D.C.  
April 26-30<sup>th</sup>, 2014

## OVERVIEW

I was privileged to have the opportunity to attend the 2014 American College of Radiology Annual Meeting and Chapter Leadership Conference (AMCLC) as the CAR resident delegate to the Resident and Fellow Section (RFS). The AMCLC is held each spring in Washington, D.C. and took place this year from April 26-30. The meeting includes advocacy, economics and socioeconomics conferences and a policymaking portion where representatives vote on matters of interest for the American College of Radiology (ACR) members. This report briefly resumes some of the most relevant points and talks of the 2014 AMCLC-RFS.

## BACKGROUND

### WHAT IS THE AMERICAN COLLEGE OF RADIOLOGY?

The ACR is an organization representing more than 36,605 members including diagnostic radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians and medical physicists. The goals of the ACR is to advance the sciences of radiology, improve the quality of patient care, positively influence the socioeconomics of the practice of radiology, provide continuing education for radiology and conduct research for the future of radiology. To support this mission, the ACR is organized according to its five pillars: advocacy, clinical research, economics, education, and quality & safety.

### WHAT IS THE RESIDENT AND FELLOW SECTION (RFS)?

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. 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). 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 AMCLC. This year, approximately 320 members-in-training have participated in the RFS Section program while attending the AMCLC.

## RFS SESSION/SPEAKERS

### IMAGING 3.0

Geraldine McGinty, MD, FACR - Chair, ACR Commission on Economics

Imaging 3.0 is a change initiative led by the ACR for the profession of radiology. It recognizes the changes facing all of radiology and understands what radiologists need to know to manage their practice, patient care and their own future. It is a multi-phase, multiyear initiative that requires input and involvement. 'Our goal is to deliver all the imaging care that is beneficial and necessary and none that is not'<sup>1</sup>.

---

<sup>1</sup> <http://www.acr.org/FAQs/Imaging-3-FAQ>

### Goals of Imaging 3.0:

- Position radiologists as expert consultants to referring physicians and health systems
- Coordinate service and technology tools to support radiologists as diagnosticians and consultants in new health care models
- Empower and inform patients and providers in order to improve efficiency and quality of care
- Help sensibly align payment incentives as medicine shifts from volume to value-based care

### **What are the differences between Imaging 1.0, 2.0 and 3.0?**

**Imaging 1.0 (1920-1990)** – Era of image acquisition. The use of X-rays for diagnostic imaging was popularized in the 1930s. Ultrasound was developed in the 1950s and popularized in the 1960s. CT scans and magnetic resonance imaging technology were developed in the 1970s and 1980s.

**Imaging 2.0 (1990 to present)** – Improved image acquisition and digital image management caused the exponential growth of productivity, but also, defensive medicine, financial incentives and difficulty sharing images. This period was characterised by a significant increase of the radiation dose delivered to patients. From 1990 to the present time, because of the high demand of radiology exams and the implantation of the PACS, some radiologists unfortunately became less implicated in patient care.

**Imaging 3.0 (The future)** – Incorporate imaging in healthcare. Approximately 20% of radiology exams are duplicates. Improving our imaging system will not only be beneficial for our patients but also financially since the potential cost savings in the United States from reduced imaging utilization is close to 6.3 billion dollars/year.

### **LEGISLATIVE UPDATE & RADIOLOGY NETWORK (RAN)**

Andrew Wu, MD, FACR - RAN Member, North Carolina

This talk explained the Protecting Access to Medicare Act of 2014 (H.R. 4302; 113-93). A formula, called the Sustainable Growth Rate (SGR) formula, was established in 1997 to make planned cuts to Medicare reimbursement rates. Congress has regularly avoided making these cuts by passing legislation (called the “doc fix”). The goal of these laws was to delay the cuts. Congress has been making these temporary changes for over a decade. Last year, H.R. 4302 averted a 24% cut in Medicare reimbursement with calculation of the SGR formula. This law delays until March 2015 the pending cut. Also, in this presentation Dr. Wu explained the goals of the Radiology Advocacy Network (RAN)<sup>2</sup>.

---

<sup>2</sup> <http://www.acr.org/Advocacy/Grassroots/Radiology-Advocacy-Network>

### A.J. Lewis, MD - Resident RADPAC Board Member

RADPAC is the bipartisan political action committee of the ACR Association (ACRA). Its goal is to support the campaigns of pro-radiology candidates at the federal level through voluntary monetary contributions of ACRA members. RADPAC uses contributions to attend events for members of Congress who are directly involved in the legislative process on healthcare issues. The return on RADPAC investment is excellent. Unfortunately, only 8% of the ACR members contribute to RADPAC. The goal of this presentation was to make the association known to residents. One of the many issues that RADPAC will be focussing on within the next years is the self-referral of exams by subspecialties<sup>3</sup>.

### LEADERSHIP

#### Richard B. Gunderman, MD, PhD, FACR

In this original talk, Dr. Gunderman described how Mary Shelley talked about leadership in her book *Frankenstein*. Victor Frankenstein is a classical leader with all the wrong characteristics. Dr. Gunderman eloquently demonstrated how it is possible to learn about leadership from this story. He also described different leadership types: commercial, academic, moral and imaginative. From his perspective, a good leader needs many qualities but the most important asset is imagination.

### RSNA RESIDENT AND FELLOW COMMITTEE UPDATE

#### Richard Sharpe, MD

This committee has established a panel discussion at the RSNA and developed courses such as: Career 101, 201 and Money talks. A career symposium will also be available online at the 100<sup>th</sup> RSNA meeting. The committee has developed an online resource to learn about available fellowship: *RSNA Fellowship Connect*<sup>4</sup>.

### Q&A WITH ACR LEADERSHIP

#### Albert L. Blumberg, MD, FACR - President, ACR

#### Paul H. Ellenbogen, MD, FACR - Chair, ACR Board of Chancellors

#### Bibb Allen, Jr., MD, FACR - Vice Chair, ACR Board of Chancellors

The purpose of this session was to discuss topics chosen by residents with leaders of the ACR. The conversation was mainly about job availability in the next years, salary and implication of residents in the ACR.

*With the present job market, there are fewer jobs opportunities but companies doing teleradiology are offering jobs. Should residents accept these jobs?*

<sup>3</sup> <http://www.acr.org/Membership/Young-Physician-Section/Advocacy-and-RADPAC>

<sup>4</sup> <http://www2.rsna.org/timssnet/About/committee.cfm?c=00521716>

**Answer:** When possible, no. The ACR position is moving from a volume-based work model to a value-based. Residents should look forward to being an integral part of the medical field. Teleradiology delivers a service but does not give the extra edge that the ACR is trying to move forward to with Imaging 3.0.

*How do you currently view the job market for new radiologists?*

**Answer:** The jobs in radiology are more difficult to find than a few years ago but radiology is still in a favorable position within the health care system. Also, the salary of radiologists is still in the top 3 most paid specialities.

## Non-Clinical Careers in Radiology

Sanjay K. Shetty, MD, MBA - President, Steward Health Care Network

Alex Misono, MD, MBA

The different options available for radiologists interested in non-clinical careers were presented in this talk: management consulting, pharmaceutical devices, biotechnologies, venture capital, entrepreneurship, technology & IT, healthcare administration, medical writing, insurance & disease management, research & CRO and expert witness. Online resources are available to help radiologists interested by non-clinical careers: ACR Radiology Leadership Institute (RLI), American College of Physician Executives (ACPE) and Society of Physician Entrepreneurs (SoPE). These resources can also be a good way to network and develop contacts.

It is still debated if radiologists benefit from an MBA in non-clinical careers.

**Pros of an MBA:** formal training, networking, recruiting & exploration of opportunities, timelines & structure, credentials.

**Cons of an MBA:** expensive, time consuming, give 'Book knowledge' and not experience in the field, broad knowledge and but not deep, the MBA is not a guarantee of a particular job or salary.

There is a very good chance that throughout your career you will have to do at some point non-clinical work. It is then important to keep opportunities open in order to try to gain knowledge in those fields.

## Young Physician Panel - Transitioning to Life After Training

Moderator - Peter Van Geertruyden, MD - YPS Executive Committee

The purpose of this session was to give advice for transitioning from residency training to practice.

*What are the common mistakes in job search?*

**Answer:** Some residents are reluctant to pick up the phone and call for a position. In the current job market, you need to start your job search early. The ACR Young and Early Career Physician Section (YPS) network is a good platform for residents to find a job. Also, always keep in mind that the best jobs are often not advertised.

*What type of practice should you be looking for in the current job market?*

**Answer:** It depends on your job expectations. For private practice, it is recommended to choose wisely and to take your time. Don't be afraid to ask questions to the staff. Asking good questions will look professional and will demonstrate your interest in the business, i.e.: Are employees staying here to work? For how long do they stay? Do women have children? What is the business plan of the company?

*When should you seriously start looking for a job in academics?*

**Answer:** For academic radiology, most trainees start looking seriously for a job one year before the end of the fellowship.

*What skills are employers searching for in a good candidate?*

**Answer:** Accuracy and availability. Demonstrate that you are interested in the business expansion or optimisation and demonstrate that you are proactive. Good communication skill is a must since many groups will ask you to market for the company.

### **Achieving Competency in the Health Care Economics Milestones: An RLI Primer**

The Radiology Leadership Institute (RLI) hosted a mini-session for the RFS section entitled, "Achieving Competency in Healthcare Economics Milestones: An RLI Primer". This session was moderated by Dr. Geraldine McGinty, M.D. and provided for residents and fellows with content to address the healthcare economics.

### **From clinical research Concept to coding:**

The Current Procedural Terminology (CPT) code set is a medical code maintained by the American Medical Association. The CPT code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations and payers for administrative, financial, and analytical purposes. Getting a CPT code for a procedure does not necessarily mean that the procedure will be reimburse, i.e., Magnetic Resonance Spectroscopy has a CPT but is not reimbursed (CPT code 76390). The editorial CPT panel is composed of 17 members responsible for the clarity and unambiguity of the new CPT.

### **How a dictation become a dollar - What is the Resource Based Relative Value Scale (RBRVS)**

To understand how dictations are transformed to money in the United States, the resource-based relative value scale (RBRVS) needs to be defined. The RBRVS is a schema used to determine how much money medical providers should be paid for a medical procedure. It is used by Medicare and nearly all health maintenance organizations (HMOs).

RBRVS assigns a relative value to procedures performed by a physician or other medical providers (measured in Relative Value Units (RVU)) which is adjusted by

geographic region. The same procedure in Boston or Los Angeles does not have the same RVU value. Also, different procedures have different RVU values, i.e. Chest x-Ray = 0.2 RVU and Brain MR = 2 RVU. Exams with contrast pay more than exams without contrast. This value is then multiplied by a fixed conversion factor (CF), which changes annually, to determine the amount of payment for a procedure (RVU x CF = Money).

The CF depends on the Sustainable Growth Rate (SGR). The SGR is a statutory formula designed to ensure the sustainability of the Medicare program by aligning spending with specific expenditure targets that prospectively reduce fees whenever aggregate spending exceeds those targets. The SGR is discussed every year by Congress.

### **Physician Performance Metrics: Balancing volume and value:**

One of the main topics discussed this year at the AMCLC was the transition from a volume driven to a value driven care approach. The performance metrics of a radiologist in a value-based system is unfortunately hard to assess adds complexity to this approach. Two articles published recently in the JACR discussed the performance metrics radiology<sup>5,6</sup>.

In the past, the volume was considered value: the performance of a radiologist was attributed to the number of studies read. In the future, the ACR believes that the performance of the radiologist should focus on the patient (Imaging 3.0). Since the current system is based on RVU, some solutions suggest developing a system that improves patient care while promoting teaching and administrative contribution of the radiologist. To support Imaging 3.0 different metrics could eventually be developed such as academic RVU (aRVU) or administrative RVU (adRVU).

### **Ensuring your practice future: applying all the tools**

The ability to provide high quality care to our patients is contingent upon the ability to guide the appropriate use of services and perform those services in a patient centric way. Imaging 3.0 provides tools for our future practice. A proposed lecture was the Imaging 3.0 toolkit available on the ACR website.<sup>7</sup>

---

<sup>5</sup> Duszak R, Muroff LR. Measuring and Managing Radiologist Productivity, Part 1: Clinical Metrics and Benchmarks. *JACR*. 2010;7(6):452–458.

<sup>6</sup> Duszak R, Muroff LR. Measuring and Managing Radiologist Productivity, Part 2: Beyond the Clinical Numbers. *JACR*. 2010;7(7):482–489.

<sup>7</sup> <http://www.acr.org/Advocacy/Economics-Health-Policy/Imaging-3>

## Point-Counterpoint Debate: Should Radiology Residency Spots be Drastically and Immediately Reduced?

Moderator - Saurabh Jha, MD, University of Pennsylvania

### For a reduction of residency spots

Neil Lall, MD and Mark Sharafinski, MD

Too many residents are in training right now for the number of available positions. In the 2000s, imaging modalities exploded and a shortage of radiologist was anticipated. This favourable job market for trainees caused an increased of residency spots.

Currently, approximately 1200 residents are graduating every year and only 1069 jobs were available last year in the US. Recent data showed that the number of applicants for radiology is decreasing. Also, with the current unappealing job market, radiology became unfortunately a second career choice for many medical students. To keep the good candidates interested in radiology a balance between job demand and opportunities should be established. So for that reason radiology residency spots should be drastically and immediately reduced.

### Against a reduction of residency spots

Adam Kaye, MD and Colin Segovis, MD

In the years to come there will be an increase of radiology exam requests with the aging population. In fact, an increase of 85% in imaging demand was assessed between 2000 and 2009. If the number of residents is decreased, the number of radiologists in the system will eventually also decrease. A real shortage of radiologists could be seen, and if the required radiology services cannot be delivered, other specialities will start to read their own exams, as we have already seen in some disciplines. With the aging population and the expected increase of workload, a decrease in the radiology residency spots could be deleterious for our speciality.

## ACR COUNCIL CONVENES

### 2013-2014 was a breakthrough year:

- JACR 10<sup>th</sup> anniversary
- Imaging 3.0 gains wide acceptance
- First Global Summit on Radiological Quality and Safety (GSRQS) summit
- Lung cancer Screening wins support from U.S. Preventive Services Task Force (USPSTF)
- BI-RADS Atlas 5<sup>th</sup> Edition
- Congress enacts SGR 'patch' with provisions: the 17<sup>th</sup> 'patch' to the system

The **ACR-AMCLC 2015** moves to the Washington Marriott and will be held **May 17-21**. The organizers are trying to get a wider audience involved by adding clinical education and clinical research talks to the regular curriculum. The theme of the ACR-AMCLC 2015 will be **The Crossroads of Radiology**. Also, the conference will overlap the AIRP, the organizers believe that members and non-members of the ACR will benefit from this educational activity. First look for registration opens in June.



## Radiology Workforce Disaster Planning

Moderator: Alexander M. Norbash, MD, FACR

Panelists: Edward Bluth, MD, FACR, John Cronan, MD, Kristen DeStigter, MD, FACR, and Jonathan Flug, MD, MBA

Panelists provided their perspective on workforce needs and training issues, to include a brief overview of the current job market, challenges associated with the new ABR process, GME funding and RRC considerations.

This talk raised many interesting points that residents and young physicians will have to consider in the next few years such as: should 24/7 coverage be delivered? If the number of residency spots is reduced, will the number of residents in larger programs or smaller programs be affected?

The RFS plays an active role in the assessment of these questions and has an active role of moderator and data collector while opening new career center recourses. The RFS believes that the aging population should correspond to a significant increase of imaging exam demand, so hopefully in an increase of jobs for finishing residents.

In many academic centers, medical students might not be exposed enough to Radiology during their training. Presenting our discipline to trainees and showing how interesting and exciting is our field is essential for the recruitment of excellent and motivated candidates.

The relationship between clinician and radiologist is necessary for the continuity and development of our speciality. The RFS is working on finding new ways to be more visible and involved in the patient care.

## Value-Based Health Care Delivery

Michael E. Porter – Bishop William Lawrence University Professor  
Harvard Business School

Michael E. Porter, author of the book *Redefining Health Care – Creating Value-based Competition on Results*, gave a lecture on his vision of health care management. Health care is changing rapidly everywhere in the world, even countries with universal coverage are facing rising costs and serious quality problems in the next few years. In the United States, a restructuration of the health care system is required starting with universal coverage. Also, the health care should be structured in a way that physicians and hospitals should compete on value and not on volume<sup>8</sup>. A value-based system takes into consideration health outcomes of patients and costs related to them over a complete care cycle.

In the field of radiology, specific problems exist: declining reimbursements, commoditization as “report producers”, and skepticism of the value of imaging studies. A reorganization of care around the patient medical condition would be the most efficient way to offer a value-based system. The current health care system organizes care by specialties and discrete services. A new model would organize care into

---

<sup>8</sup> Porter ME. A strategy for health care reform - toward a value-based system. *N Engl J Med*. 2009;361(2):109–112.

integrated practice units (IPUs). The care organization should be centered on the medical condition. A way to obtain that perspective would be to migrate patients to specialized disease clinics. Also, a bundled payment (episode-of-care payment) for care cycle could be used to increase efficiency.

According to Michael E. Porter, radiologists should ask themselves 8 questions to assure an active role in a value-based system:

1. What medical conditions are they involved into?
2. What is your role in the cycle of care?
3. What are the outcomes for the conditions treated?
4. Which of these do you influence?
5. How can you perform your role in the care cycle more efficiently?
6. Where do you focus your practice to maximize your value?
7. How can you better embed yourself in the care team and the IPUs?
8. How could you affiliate with other organizations to expand your reach and volume in your area expertise?

### **Economics Forum: Demonstrating the Value of Imaging 3.0**

This year's Economics Forum at AMCLC had refreshed the concept of Imaging 3.0 with success stories from around the country as well as individual reports from the Commission on Economics.

Healthy competition and transparency are needed to improve patient care. For instance, price fluctuation is seen for a same pathology under different payment methods: surgical site infection costs 900\$ under Medicaid, 3,000\$ under Medicare and 39,000\$ for a particular. Transparency in health care economics is required. Also, new online resources are now available to compare the quality of care over 4,000 Medicare certified hospital<sup>9</sup>. *Leapfrog* is another site that distributes data to improve the quality of health care. Its goal is to build transparency by publishing results of over 1,300 hospitals to improve safety, efficiency and their care. Hospitals can be searched and compared by different characteristics including: maternity care, high-risk surgeries, hospital-acquired conditions, resource use and hospital safety score<sup>10</sup>.

---

<sup>9</sup> <https://data.medicare.gov/data/hospital-compare>

<sup>10</sup> <http://www.leapfroggroup.org>

## **CONCLUSION:**

A recurrent theme of this year ACR-AMCLC was to integrate imaging into health care. In brief, with the implantation of Imaging 3.0 the ACR suggests that radiologists provide a significant 'value added' to patient management. Some challenges are driving rapid changes in the US health care system and will need to be addressed in the near future: the health care 'reform', cost limitation in the public and private sectors, rising educational cost and debts, aging population with sicker patients, conversion of acute disease episode into chronic illnesses and ideological bias against specialized care. Even if the Canadian health care system differs from the US system in many ways, Canadian radiologists face many of the issues discussed at the AMCLC.

I believe that the Canadian system will probably absorb more easily some of the changes required by our speciality and proposed by the ACR since we already have universal health care system. Also, the CAR has already promoted, since a few years ago, the need for the radiologist to be more visible and an integral member of the health care team. Some of the suggestions from the ACR are interesting and could also be considered in our health care system. I have personally gained significant knowledge at the RSF-AMCLC. The RFS is a strong and growing voice within the ACR and is reflective of the importance of current actions of all radiology trainees. I strongly encourage Canadian radiology residents to attend this meeting to learn and be part of the discussions about changes in our profession.

Olivier Clerk-Lamalice, PGY3  
CAR 2014 AMCLC-RSF Delegate  
Université de Sherbrooke