Bulletin *FALL 2017*

The Pennsylvania Radiological Society

A Chapter of the American College of Radiology

www.paradsoc.org

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Remember, the ***Bulletin*** is available to members online at
http://www.paradsoc.org/

MESSAGE FROM THE PRESIDENT:

Following an engaging 102nd meeting at the Bellevue Hyatt in Philadelphia, I thank Dr. Julie Gubernick for her strong leadership as President during the Society's 102nd year, and John Kline, our Executive Director and Legislative Counsel for smoothly running our Society's day to day operation and constantly moving our Society forward. Under Julie's guidance, the Society has formed a strong Communication and Member Engagement Committee under the capable leadership of Drs. Josh Tice and Sonia Gupta. The committee has been very active, setting up PRS communication platforms on Facebook and Twitter and exploring ways to conduct Society business on the ACR Engage platform and the PRS website.

Our 102nd meeting featured an excellent lineup of speakers including David Levin MD FACR, Richard Duszak Jr. MD FACR, Mary Magee MSN representing the PA Patient Safety Authority, Erin Simon Schwartz MD FACR, Elliot Fishman MD FACR, Ted Burnes, Director of ACR RADPAC, Eliot Siegel MD FACR, Sanj Katyal MD, and Residents Stacey White MD (Einstein), Akash Patel MD (Penn), and Ravi Kagali MD (Geisinger) under the moderation of Mary Scanlon MD FACR. Topics included radiology pricing and the need for price transparency in the current era of high deductible health plans, preparing for MACRA and MIPS, safety in the radiology suite, imaging of the pediatric spine, use of social media in radiology education, body imaging protocols and use of the web, machine learning and artificial intelligence, and radiologist well-being.

Congratulations to Dr. Beverly Hershey for organizing another informative and inspirational meeting. Also, congratulations to Dr. Rickhesvar Mahraj for another record year of excellent scientific exhibits and Dr. Mary Scanlon for an enlightening resident panel discussion. More information from the Educational Program and the Scientific Exhibits can be found on the PRS website.

Our Gold Medal honoree for the 102nd meeting was William Herring MD FACR. Dr. Herring has lead an exemplary career in radiology education as Residency Program Director and Vice Chairman of the Einstein Medical Center Department of Radiology, President and Webmaster of the Philadelphia Roentgen Ray Society, and creator of the Learning Radiology website currently with 750,000 Facebook and 15,000 Twitter followers. Mindy Horrow MD FACR gave an excellent and informative lecture in his honor on first trimester ultrasound.

My thanks and appreciation to our meeting sponsors this year including Bracco and Phillips at the Silver level and Bayer, Foundation Radiology, General Electric, Genentech, Medicus, TeraRecon and MBMS at the Bronze level.

As we enter our 103rd year, our Society is well positioned to continue moving forward on several strategic initiatives including communication technology, member engagement, maximizing the benefit of ACR membership, and resident, fellow, and young physician participation. These topics are all included in the current ACR Strategic Plan for membership and member engagement. Currently, Society committees are expanding the use of our current Facebook and Twitter sites, evaluating our state use of the ACR Engage platform and addressing functionality of the PRS website.

In legislative matters, we are working with the PA Medical Society and hospital based specialty societies including Emergency Physicians, Anesthesiology, and Pathology to craft balanced billing legislation that is fair to Radiologists who are not members of narrow insurance networks. We are also writing letters to move bills forward on medical imaging and radiation therapy licensure and insurance coverage for supplemental ultrasound and MRI screening of women with dense breasts.

Following Dr. Richard Duszak's discussion of the value of ACR services at our annual meeting, Eric Rubin MD has crafted a proposed ACR 2018 Council resolution to maximize financial impact of essential benefits for ACR members. We hope the resolution will gain support from the Council Steering Committee and other states leading to discussion by the ACR Council in the spring.

This year our chapter is very well represented on the national level with the following PA members serving the ACR:

Board of Chancellors
Beverly Coleman MD FACR - Chair, Commission on Ultrasound
Andre Konski MD MBA MA FACR – ARS Representative
Frank Lexa MD MBA – Chair, Commission on Leadership and Practice Development
Robert Pyatt Jr. MD FACR – Chair, Commission on General, Small, Emergency and/or Rural Practices
Mitchell Schnall MD Phd FACR – Chair, Commission on Research
Richard Duszak Jr. MD FACR – Council Vice Speaker (formerly from Reading, PA)

ACR Council Steering Committee
Elaine Lewis MD FACR
Richard Duszak Jr. MD FACR – Council Vice Speaker (formerly from Reading, PA)

ACR Nominating Committee
Robert Pyatt Jr. MD FACR – Chair, Commission on General, Small, Emergency and/or Rural Practices
Sonia Gupta MD

YPS Executive Committee
Sonia Gupta MD

RFS Executive Committee
Michele Retrouvey MD (Pediatric Radiology Fellow CHOP)

Our Society is a volunteer organization and we are very fortunate to have so many talented Radiologists committing their time and effort to move our Society forward. I look forward to working with all of you this coming year.

Keith R. Haidet, MD, FACR
Lancaster

EDITOR'S NOTE

The Fall 2017 issue of the Bulletin will provide you a legislative update on a potentially busy and important legislative fall session. In addition, this issue will highlight content from our Fall meeting held at the Hyatt at the Bellevue in Philadelphia on September 9 with articles from Dr. Ellen Deutsch and Mary Magee of the Pennsylvania Patient Safety Authority, Dr. Sanj Katyal, and Dr. Ravi Kagali. Dr. Hardy continues his thought provoking contributions to the Economic Forum. Drs Tucker and Rozenberg discuss their experience at the 2017 RLI Leadership Summit. Finally, Dr. Pyatt presents a report from the PRS Quality and Patient Safety Committee.

I hope you enjoy this Fall issue of the PRS Bulletin. Please feel free to contact me with any concerns. I continue to welcome your ideas and suggestions for future topics.

Joshua G. Tice, MD
West Reading

Legislative Updates

2017-2018 Session

We are at the halfway point of an eighteen-month legislative session. Despite their largest majorities in 50 years it seems the republicans cannot agree to get much done. This is a microcosm of what is happening in Washington. In general, leadership is so lacking in the capitol I expect someone to come along soon to take charge. PRS continues to be very active in Harrisburg matters. The Legislative Affairs Committee, headed by Dr. Keith Haidet, is very supportive of John's efforts in the capitol.

Budget

A 'spending plan' was approved by the legislature last month. It was sent to the governor. The governor did not sign it or veto it. When that happens the bill automatically becomes law after 10 days. Only one problem…… how do we pay for it? Can't make this stuff up folks. I don't even know why we call it a budget process because it does not resemble anything of the sort.

House republicans are trying to close a gap that would create new funds. This would be done by increasing certain fees but not raising taxes. Democrats insist that tax increases are needed. If this sounds like a broken record, it is. As predicted, this scenario seems to be the new norm. Once the Supreme Court decided that state workers would be paid even during a budget stalemate, there seems to be little pressure to pass an on-time budget.

Legislation

The legislature resumed session on September 11th (House) and September 18th (Senate). We have summarized some bills that are important to radiology and the status of each effort.

Senate Bill 678 – Balance Billing**/House Bill 1553 –** Surprise Balance Bill Protection Act. These are 'companion' bills. Each has nearly identical language. The bills have been introduced in each chamber. Whichever one advances first will likely be the vehicle to pass. This is a common legislative tactic. Both bills have been crafted to ensure patients do not receive a balance bill for an out-of-network service. Hospital based specialties are expected to be the most impacted and include: emergency medicine, pathology, anesthesiology, and of course, radiology.

SB 678 was introduced by Senators Judy Schwank (D-Berks) and Don White (R-Indiana). HB 1553 was introduced by Representatives Matt Baker (R-Tioga) and Tina Pickett (R-Bradford/Susquehanna). These legislators hold committee chair positions and it is likely that we will see a bill move.

Drs. Tice and York have been serving on a coalition of specialties from the Specialties Leadership Cabinet of the Pennsylvania Medical Society to address the issue. This coalition has had numerous meetings and conference calls to map out a strategy for dealing with these bills. PRS has also acted swiftly and independently to meet with legislators and their senior staff. The sub-committee has

made its concerns known to both Senate and House Legislators regarding fair payment for services in an environment of ever narrowing insurance networks.

The latest meeting was held August 29th in the state capitol. Dr. Tice and John Kline represented the PRS along with representatives from emergency medicine and anesthesia. The meeting was convened by senior House staff, specifically the Executive Director (ED) of the House Health Committee, who works directly for the prime sponsor of the House bill. The meeting was a listening session for comments from key interested parties. Radiology was well represented by Dr. Tice who addressed the most pressing issues including arbitration, a 'floor' for payments, and general discussion on narrow network realities. Members of the insurance federation were also present but physician's interests seemed to be the most prevalent topic.

These bills will most likely be re-drafted by staff following this round of comments. We expect to be contacted soon regarding movement of the bills. The House bill is being addressed by the Health Committee and the Senate bill is being addressed by the Banking and Insurance Committee.

House Bill 1545 – Medical Imaging and Radiation Therapy Health and Safety Act. Introduced by House Majority Whip Bryan Cutler. This bill would formally establish a statewide Medical Imaging and Radiologic Therapy Board of Examiners. The board would be responsible for requiring appropriate education, training, examination, and certification for individuals operating medical imaging or radiation therapy equipment and performing medical imaging or radiation therapy procedures. (including radiologic technologists, radiation therapy technologists, PA's, NP's and RA's in radiology and radiation therapy departments). Patient protection from excessive and improper use of radiation in medicine is a prime reason for the bill. The ACR traditionally has been a strong advocate for state licensure of medical personnel. Past ACR Council actions reflect the following: "The American College of Radiology supports licensure, certification, or other appropriate methods designed to assure the qualifications of all persons operating equipment emitting ionizing radiation." (adopted 1986,1996,2006) This bill is in the House Professional Licensure Committee. We are currently drafting a letter to Representatives Mustio and Readshaw, the Republican and Democratic Chairs of the Committee, to encourage a hearing on the bill.

House Bill 1648 – Legislation establishing a telemedicine law for PA. Introduced by Representative Marguerite Quinn. This bill would set specific licensure requirements for physicians involved in telemedicine services. The bill also provides for insurance coverage of telemedicine services and for Medicaid program reimbursement for telemedicine services. This type bill has been supported by radiology in the past. The bill is in the House Insurance Committee.

House Bill 1293 - Prior Authorization of Medical Services in PA. Also introduced by Representative Quinn. This bill regulates and standardizes the preauthorization process conducted by utilization review companies relating to health care services. Radiology has collaborated with Cardiology and worked through the Pennsylvania Medical Society to support this bill which calls for transparency of the preauthorization process and standardization of the process to match national guidelines. The bill in in the House Insurance Committee.

House Bill 1344 – Licensing Medical Physicists in PA. Introduced by Representative Harry Readshaw, Democratic Chair of the Professional Licensure Committee. This bill establishes the State Board of Medical Physicists, which licenses and establishes standards for licensure of medical

physicists in the state. Representation on the Board includes Diagnostic Radiology, Radiation Oncology, and Nuclear Medicine. Dr. Geise, Chair of the ACR Commission on Medical Physics has reviewed this bill and feels that it is reasonable and should not place an undue burden on imaging facilities, especially small and rural practices. The ACR traditionally has been a strong advocate for state licensure of medical personnel because state licensure "encourages better adherence to safety protocols, urges dissemination of best practices, and directly promotes continuous quality improvement of medical care." The bill is in the House Professional Licensure Committee.

Senate Bill 869 – Breast Density Screening Insurance Coverage. Introduced by Senator Bob Mensch, a member of the Senate Health and Human Services Committee. This bill would mandate that insurance companies pay for screening of women with the two higher categories of breast density with additional imaging including breast ultrasound and MRI. This bill moved slightly last session. We support the effort and have met with Mensch's staff to provide advice on bill language that would make economic sense to the insurance lobby, who opposes the bill. The bill is in the Senate Banking and Insurance Committee. We are currently drafting a letter for Senator Mensch to encourage a hearing on the bill.

Patient Test Results. Representative Marguerite Quinn is circulating a memo for support of her patient test results legislation. Though not introduced yet, we expect it to happen this fall. With the conversion of the majority of health systems to electronic medical records and the widespread use of electronic portals for patients, the arguments for having legislation mandating a simplified version of every radiology result sent to patients have progressively weakened.

John Kline
Executive Director
Pennsylvania Radiological Society

Keith Haidet, MD, FACR
President, Chair Committee on
Legislative Affairs

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Our state goal is for 20% of our members to give to RADPAC.

- In 2016 we made it to 15%
- We are currently at 11% – we need at least another 100 donations
- Rhode Island, Utah, Tennessee, Iowa, Wyoming, North Carolina have more than surpassed the 20% goal
- Indiana, South Carolina, Minnesota, Texas, Virginia, Vermont, South Dakoda, Alabama are close
- The Great State of Pennsylvania has got to step it up

Every dollar you give reaps enormous returns on Investment:

- Preserved mammography screening coverage for women aged 40-49 until 2019
- Blocked the VA from allowing Advanced Practice Nurses to perform and interpret images
- Prevented further reductions in reimbursements for Low Dose Lung Cancer CT screening
- Successfully introduced House Bill 1298 that would require Medicare to cover CT colonography as a colorectal screening test.
- Lowered professional component imaging cuts from MPPR from 25% to 5%
- Total repeal of SGR

Why is this important?

Only 6% of the Members of Congress have a healthcare background. This means most Members of Congress don't understand healthcare issues. Organized radiology needs to have a voice on Capitol Hill to educate lawmakers on the essential role radiology plays in the delivery of quality healthcare to patients.

RADPAC Background

Created in 1999, RADPAC is the political action committee (PAC) for the American College of Radiology Association and serves as the "political voice of radiology" on Capitol Hill.

There are more than 145 healthcare provider PACs in Washington, D.C., and RADPAC routinely ranks as one of the top 3 in both contributions raised and made each year. Each year RADPAC raises roughly $1.3 million from more than 3,000 radiologists across the country (only 15% of all ACRA members).

RADPAC's sole focus is supporting Members of Congress and federal candidates who are radiology-friendly, regardless of their political party.

Mary H. Scanlon, MD FACR
Philadelphia

2017 Annual Meeting: Highlights

Physician Wellness

"It is not a daily increase, but a daily decrease. Hack away at the inessentials."
– Bruce Lee

What if you learned that only few of the activities that you do are responsible for most of your happiness? What if someone told you that performing a couple of key tasks at work will cause most of your success? What if you realized that spending time with just a handful of people provides the

greatest amount of happiness? To put it another, more depressing way; what if most of the things you do provide the least amount of success, pleasure and satisfaction? What if most of the people with whom you spend the majority of time provide you with only a small amount of happiness? This is the 80/20 rule or sometimes called Pareto's principle named after an Italian economist Vilfredo Pareto who studied the distribution of wealth among landowners and found that 80% of the land was owned by 20% of landowners. Simply put, it states that 80% of results flow from 20% of causes. For example, we wear 20% of our clothes 80% of the time. We send 80% of emails to 20% of our contacts. We spend 80% of our time with people giving us 20% of our happiness. In business, 20% of customers provide 80% of the profits. 20% of your growth initiatives will result in 80% of extra future value. Only 20% of high performers are responsible for 80% of the organization's success. This is a powerful rule and is described in great detail in Richard Koch's great book *The 80/20 Principle* (1998).

The 80/20 principle describes an imbalance between input and output. To put it another way, there are some inputs – thoughts, actions, goals – that can drive much greater outputs – money, success, happiness. Understanding and exploiting this inequity is the key to optimizing and directing effort toward desired outcomes. Life is better lived if we can maximize the return on our most precious investment (time) for the things that really matter. This is where the movement of Essentialism is really useful. This concept or way of life is skillfully articulated by Greg Mckeown in his great book *Essentialism: The Disciplined Pursuit of Less* (2014). Essentialism is (essentially) the 80/20 rule on steroids. Where the 80/20 rule states that a minority of activities provide the majority of benefit, Essentialism states that we should actively eliminate everything that is not important and focus only those few areas that are vital. Essentialism is not a time management system designed to get more things done – it is a way of life to get the *right* things done. Essentialism is about doing less but better. It implores us to ask ourselves what is truly essential and to eliminate everything else. It is about having the self-awareness to focus only on the things that truly make a difference – for our work, for our family, and for our soul.

Living the way of the Essentialist is also about having the courage and discipline to cut out the noise in our lives. We live in a world with an almost constant barrage of information, opportunities, and other mind-numbing stimuli. It is easy to become overwhelmed and float thru life allowing others and society to define how to spend your life. I mean "spend" in the literal sense because once we have made a withdrawal in the currency of time; we cannot replenish our bank account. We need to proactively invest our resources to figure out what values we hold dear, what exactly we want to be doing with our limited time on earth, and what provides us with meaning and happiness. Once we have figured out our "essentials" then we have to relentlessly and ruthlessly protect them and eliminate everything else. By embracing Essentialism, we can distinguish between the trivial many from the vital few, eliminate the non-essentials, and remove any obstacles that stand in our way on the path toward the good life.

Reading, journaling, and meditating have really helped me to figure out what few activities and pursuits are most meaningful to me. Studying and teaching principles of well-being has become one of my "essentials". Raising a close-knit family unit filled with love, optimism, gratitude and service is another non-negotiable pursuit. Spending more time having real conversations with people I care about is crucial. Having complete congruence between what I think, say and do (a definition of integrity) has become a clear focus for me. Staying mentally and physically fit thru nutrition, yoga, meditation and sports is a top priority. Contributing to the success and well-being of others is one of my daily goals. By clearly defining all my true "essentials", I can easily (or at least confidently) say no

to the many non-essential requests for my time. I can choose to go to yoga over my lunch hour rather than eat at my desk mindlessly surfing the internet. I can choose to write rather than going golfing for 4 hours. I can choose to play catch with the kids rather than checking email for the 100th time that day. I can choose to block regular time in my schedule to meet with two of my best friends.

In radiology, we can use this approach to understand and optimize the few key drivers for success in our practices. Embracing the role of imaging consultants rather than passive consumers of imaging revenue is vital to our future. Developing and prioritizing relationships with hospital administrators and referring physicians is as (or more) important as churning out our reports. Identifying and eliminating waste (inappropriate exams, inefficient workflows) rather than accepting that "this is the way it's always been done" is critical as we approach new payment models that require us to do more non-interpretive tasks.

By doing the hard work of identifying your "vital few", you can distinguish and eliminate the "trivial many". So constantly ask yourself "what is the most important thing I could be doing right now?" and go do it. Life is too short to waste it on things that don't matter. I will end this discussion with two quotes that really bring this point home:

"You cannot overestimate the unimportance of practically everything."
– John Maxwell

"I do believe in simplicity. It is astonishing as well as sad, how many trivial affairs even the wisest thinks he must attend to in a day…so simplify the problem of life, distinguish the necessary and the real."
– Henry David Thoreau

Sanj Katyal, MD
Pittsburgh

SAFETY IN THE RADIOLOGY SUITE: HOW CAN THE PENNSYLVANIA PATIENT SAFETY AUTHORITY HELP?

Do you know how the Pennsylvania Patient Safety Authority helps prevent patient harm and improve patient safety? Many physicians in Pennsylvania are not aware of the work we do or the resources we provide; I appreciate this opportunity to provide information. **Our mission** is to improve the quality of healthcare in Pennsylvania by collecting and analyzing patient safety information, developing solutions to patient safety issues, and sharing this information through education and collaboration. **Our vision** is safe healthcare for all patients.

We work toward these goals in several ways, including analysis of incidents and serious events reported through the Pennsylvania Patient Safety Reporting System (PA-PSRS). Pennsylvania has one of the oldest and broadest state safety event reporting systems in the US. Many unique, important and insightful aspects of our reporting system make it exceptionally valuable. First, reporting of patient care events is based on **unanticipated patient harm**, rather than error. While error may contribute to some events of harm, there are circumstances in which harm occurs which are not the result of error.

Second, reporting includes events in which harm could have occurred, but did not. These could be events which reached the patient, but did not cause harm; events in which chance or an active intervention prevented the event from reaching the patient; and even **unsafe conditions**, which could potentially impact many patients. This allows analysis of hazardous conditions or latent patient safety threats even before harm occurs.

Finally, our state-wide perspective allows us to identify events and patterns of harm that are not necessarily apparent within single facilities or single healthcare systems.

We analyze the incident and serious event reports submitted to the PA-PSRS and provide information and education in a variety of formats, including a peer-reviewed quarterly journal, the Pennsylvania Patient Safety Advisory, freely available online at http://patientsafety.pa.gov (select "Advisories and Events"). CME can be obtained for selected articles through PA Med. We also participate in collaboratives and provide in-person presentations, webinars, and online learning opportunities.

Here are examples of information obtained through analysis of PA-PSRS reports from radiology:

- There were 4,065 reports that involved IV, oral, and enteral routes of contrast administration reported through PA-PSRS from January 2014 through December 2015 in hospitals with ≥ 300 beds. The majority involved near miss events or events that reached the patient and did NOT result in harm or require additional healthcare services. Almost two-thirds were related to IV infiltrations or extravasations. Allergic reactions were reported in 897 events. http://patientsafety.pa.gov/ADVISORIES/Pages/201706_76.aspx
- There were 35 reports describing adverse events related to implanted IVC filters reported through PA-PSRS from June 2004 through November 2010. Nineteen were events similar to FDA events types including filter migration and perforation of the vena cava. However, the Authority also received 13 reports of filter deployment problems and filters dislodging after implantation. http://patientsafety.pa.gov/ADVISORIES/Pages/201103_08.aspx
- There were 3,173 reports related to discrepancies between the ED physician interpretation of a radiograph and the final reading by a radiologist reported through PA-PSRS between June 2004 and December 2008. In 2008 alone, 35% of the reports indicated the discrepancy involved a potentially significant clinical finding such as fracture, pneumonia, and appendicitis. http://patientsafety.pa.gov/ADVISORIES/Pages/201003_18.aspx
- In 2009 50% of the 652 radiology events reported through PA-PSRS were wrong procedure or test. Thirty percent were related to wrong patient, 15% wrong side, and 5% wrong site radiology errors. http://patientsafety.pa.gov/ADVISORIES/Pages/201106_63.aspx

Information is available about many other conditions and circumstances that may affect our patients, such as falls is radiology, intoxication, adverse drug reactions, drug-drug interactions, simulation, and much more. *Advisory* articles include data analysis along with evidence-based and expertise-based risk reduction strategies.

In addition, the *Advisory* contains commentaries addressing patient safety concepts such as complex adaptive systems, work-as-imagined versus work-as-done, "data data everywhere," and Safety-II (understanding what goes well in healthcare delivery).

The **MCARE Act** (Act 13 of 2002) established the Authority as well as other reporting and patient safety requirements for facilities including hospitals and ambulatory surgical facilities in Pennsylvania. Reports are confidential and non-discoverable. Reporting by faculty and trainees can contribute to fulfilling the ACGME CLER requirements.

The Authority estimates the combined efforts of Pennsylvania healthcare facilities, statewide quality improvement entities, and the Authority have contributed to saving more than 2,600 lives and more than $147 million dollars since the Authority was created by the MCARE Act.

After healthcare providers submit reports within their internal reporting systems, Patient Safety Officers (or designees) in each facility assign harm scores and submit patient safety event reports through PA-PSRS. The Patient Safety Authority receives reports of incidents and serious events, which it analyzes to develop and disseminate aggregate information and education. Our function is distinct from the regulatory responsibilities of the Pennsylvania Department of Health, which receives reports of serious events, infrastructure failures, and a specific category of "other" but does not receive reports of incidents. In 2016, the Authority received more than 250,000 reports from acute healthcare facilities; 97% of these were incidents (rather than serious events), bringing the total number of reports received to 2.76 million since data collection began in June 2014.

Each hospital and ambulatory care facility in Pennsylvania has a Patient Safety Officer, and the Authority has Patient Safety Liaisons (PSL) geographically distributed throughout the state. Your facility's PSL, the Authority's Patient Safety Analysts and I would be happy to respond to informational inquiries; provide presentations based on analysis derived from PA-PSRS or general concepts of safety to your facilities, your departments or your trainees; and discuss how we might collaborate on safety projects. Please send inquiries to https://www.surveymonkey.com/r/PSASpeakerRequest and reference this Pennsylvania Radiological Society Fall 2016 Bulletin article.

By Ellen S Deutsch, MD, MS, FACS, FAAP1
Medical Director, Pennsylvania Patient Safety Authority

Mary C. Magee, MSN, RN, CPHQ, CPPS
Senior Patient Safety / Quality Analyst, Pennsylvania Patient Safety Authority

Economic Forum

During the 2017 annual meeting of the Pennsylvania Radiological Society there were outstanding presentations on machine learning from Dr. Eliot Siegel, innovative models of early detection and improved staging in pancreatic cancer by Dr. Elliot Fishman, and discussion of value by Dr. Richard Duszak. Yet despite the potentially transformational jumps in technology, we should examine the economic viability of this technology with two questions.

1. Who are the customers?
2. Is there a willingness to pay?

Healthcare may be one of the few industries where customers are not the same stakeholders as payers. Assuming these technologies deliver on the promises of improved detection of cancer and more appropriate imaging for customers (i.e. patients); are hospitals going to trade cash, or net income, for this technology?

This economic question is where the concept of value becomes critical. Value is a wedge, a simple machine, used to split costs of the technology from hospitals' willingness to pay. More value packed into the technology makes the transaction easier. There are a few possible outcomes.

Hospitals that are financially stressed simply will not have the ability to acquire this new technology. They will choose the status quo, which has no impact on their financial statements, and continue outsourcing the interpretation to a group of radiologists.

However, hospitals that are in better financial shape may decide that the new technology gives them a competitive advantage in areas of marketing, quality, or throughput. This competitive advantage will have to add more value than the cost of acquiring the technology PLUS the loss of revenue through less testing and therapy. This business proposition may be difficult for some C-suites.

Finally, if a hospital is taking long term risk on the lives covered such as our Veterans Health Administration, then the cost side of the value equation becomes much more compelling. A risk-based organization will have an added incentive to adopt new technologies not only to improve quality and utilization, but also reduce the costs of caring for the covered lives. By aligning the customers' desire for biological sustainability with the hospitals' need for financial sustainability, these new technologies are likely to thrive in select environments.

Seth M. Hardy, MD MBA FACR
https://healthyinnovation.co
Lititz

Quality and Patient Safety Committee Report

The Quality & Safety Committee continues with their collaborative efforts with the Pennsylvania Patient Safety Authority (PSA) and their HIIN project. The focus is on Incidental Findings (IFs) in the Emergency Department, and the follow-up of these findings. Mike Bruno (Penn State Hershey) has been very helpful in leading the thoughts and design of the project, in part from his experiences with Failsafe. Several other practices have joined the project, including Kelly Biggs (Tyrone, PA) and our practice (Chambersburg Imaging Associates) with Summit Health. There are other sites as well, with PRS members.

Data is being collected on these measures:

1. The patient was verbally informed about the incidental findings
2. The patient was provided with printed material about the incidental finding
3. The patient demonstrated an understanding of the incidental finding

With each of these measures there are a subset of additional measures. Numerator and denominator have definitions as well.

A toolkit is in development, with release expected soon.

I am hoping that this can be published in JACR.

It is also hoped that what is learned from this project can go statewide, or even nationally, as a collaborative Patient Safety Authority and PRS Quality/Safety Initiative.

Bob Pyatt, MD, FACR
Chair, General, Small, Emergency, and/or Rural Practice Commission
Board of Chancellors, ACR
Chambersburg

RESIDENT AND FELLOW SECTION:

Highlight from the Annual Meeting:

Physician Burnout

Physicians are selected and groomed from those who are overachievers and perfectionists. We spend over a decade in higher education to be competent at helping people and the selection process weeds out many characters. Only the dedicated make it to the "finish line". However, there are times when it is better not to be the best. Physicians are number one in burnout and suicide, females greater than males. Given the physician shortages, you would think the system would be keener on ensuring physician happiness to maximize retention.

What is this alarming word, burnout, you might ask? Burnout is a relatively new word, coined in the 1970s by Dr. Maslach while doing research on excessive work-related stress and the psychological ramifications. The syndrome is described as a pathologic process that forms in response to dysfunctional relationships between employees and their workplaces. The three main factors in burnout are physical exhaustion, depersonalization and lack of efficiency. Studies have demonstrated that practically half of all physicians have symptoms of burnout, implying that the problem may be rooted in the environment rather than in the personal characteristics of a few individuals.

Some of the problem undoubtedly lies within ourselves. However, medicine is rife with the stigma that those who are weak or sick are not deserving. From medical school on, we are always told to tough out any personal circumstances for the good of the patient. As medicine attempts to cut costs and perform more with less, physician burnout has been gaining momentum as an important issue to address. Numerous studies have shown that a happy physician leads to better patient outcomes through less medical errors and better patient satisfaction. In the world of MACRA/QPP where patient satisfaction leads to cash in the bucket, it is no wonder that administrators are getting more proactive in combating burnout.

The most common cause of burnout is an abnormal work-life balance, typically thanks to long hours and self-sacrifice. In radiology, an increasing demand for volume production has driven a decreased connection to

fellow radiologists, ordering providers and patients, resulting in increasing isolation and depersonalization. With increasing volume, radiologists fear increasing error rates and the associated potential legal litigation risk. Increasing managerial and non-clinical related tasks required by the system can further stress the radiologist's efficiency and stamina. As a resident, the shadow of financial debt from medical school also looms large. What is the cost of this work-life balance and how long can it be sustained? Is it any wonder so many in the field experience burnout?

All is not lost. There are ways to recover, improve and learn to overcome burnout. In addition, physicians are not alone. Administrators are becoming keenly aware of the systemic cost of burnout with decreased quality of care, lost productivity, and higher attrition.

Broken down, burnout is an abnormal relationship between the workplace and ourselves. However, an individual cannot just fix themselves only to be thrown right back into the same place and expect a different outcome. Work place changes should be prioritized. Daily staffing and call schedules should be optimized to ensure smooth workflow while still maintaining personal time. Physicians should be encouraged to maintain their hobbies and relationships outside of the job to promote self-healing. Schedules can be developed to allow for or protect time to complete non-RVU generating tasks, such as teaching and research. While these tasks do not directly generate monetary returns, they often enrich the work place and reduce stress by allowing individual development and autonomy.

From a personal standpoint, we need to value our own self-worth. You and I are as deserving of happiness and joy as much as a patient. Take time off from work to enjoy yourself. Spend time with family and loved ones, volunteer and expose yourself to new ideas and creativity. Ultimately, stay in the moment and appreciate what you have. Cognitive behavior therapy is rife with ideas to do this as well. In the end, you need to acknowledge that you have one of the most amazing jobs in the world and you should be proud of it.

The tide of burnout can be reversed and lead to wellness not only for physicians, but for systems and ultimately patients.

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RLI Experience

Burned Out and Overexposed

First, I would like to thank the Pennsylvania Radiology Society for allowing me to attend the Radiology Leadership Institute this fall. By attending this interactive course as a resident, I gained a perspective beyond my residency education, and learned the importance team-work in the modern-day practice of radiology.

One of the most common themes at the summit this year was the issue of burnout in our field. While burnout leads to undesirable effects on ourselves and our patients, the summit explored its causes and techniques to prevent it.

Whether it is regulatory change, administrative burden or implementation of sometimes counterintuitive technology, the common theme is forced change. More specifically, change that is

forced upon radiologists from an outside source. Simply put, when an individual is not involved in decisions that affect their day-to-day work life, a feeling of powerlessness settles in.

After all, radiologists are generally problem-solving people who become physicians to ultimately help patients. During their work, they often see problems that need fixing; however, they often have their hands tied by policies that limit their ability to do so. Furthermore, their training often does not prepare them to tackle the operational challenges of driving change in a large institution. It is even more frustrating for the experienced radiologists, who understand the daily struggles, but often do not feel empowered to implement solutions.

The summit reminded us that the key to help solve this problem is to remember that burnout is not an individual phenomenon, but rather a problem that needs a team solution. More specifically, we should watch for warning signs in our colleagues, build a community, empower individuals and facilitate mutual support. In a more optimistic view, perhaps we can even set limits on individual workloads. The best solution it seems, is seeking out interpersonal interactions and continual personal and professional development.

Burnout may feel insurmountable, but being overwhelmed is a sign, not a diagnosis. By understanding the symptoms, perhaps we can prevent its effects.

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RLI Leadership Summit Reflections

First, I would like to say thank you to the Pennsylvania Radiological Society and the American College of Radiology for the opportunity to attend the Radiology Leadership Institute's 2017 Leadership Summit, specifically Dr. Rickhesvar Mahraj for his words of encouragement and devotion to resident education. I hope as a Society you continue to sponsor radiology residents and fellows to attend this conference as I believe it was a valuable experience.

My expectations for the Leadership Summit were high, although I had no idea what to expect. I found myself pleasantly surprised, motivated and excited for the upcoming curriculum at the conclusion of our first afternoon together with discussions lead by Babson professor, Scott Taylor, MBA, PhD who discussed Leadership Development and Sustainable Change. We were allowed constructed time to daydream about lost passions, vacations, mentors and our ideal self. I rediscovered and voiced my lost love for Ballet and playing the piano through my writings and discussions with an adjacent attendee seated beside me. Why is it that many of us have lost touch with the things that excite and motivate us and help keep our minds and bodies healthy?

A lifetime ago, when I was in grade school, I trained at the Boston Ballet School, having danced since I was 3 years of age. I continued to dance through college, even after I made the choice not to pursue a career as a professional ballerina. I've hardly danced in the last 9 years, since medical school; how could I lose touch with something I held so dear to my heart my whole adolescent life? No wonder I'm so grumpy, tired and losing muscle mass as I sit on my butt all day learning how to interpret a variety of radiological studies on a never-ending list. I bet there are only a handful of my medical colleagues that know I ever danced or considered that

kind of professional career. How can we expect to be leaders if we can't even make positive changes in our own lives? Although admittedly, I have yet to complete the philosophical assigned homework, I now have an acute awareness of things I need to integrate back into my everyday routine, which in turn will make me happier, healthier and set the foundation for a more optimistic, energetic leader to emerge.

As the conference progressed through the weekend, discussions lent themselves to topics such as Burnout, Artificial Intelligence and the Collective Intelligence of Teams. I came out of my shell and found my voice on the last day, encouraging my small group of four to "Race" our temperamental racecar in the days' theoretical car race, risking another engine failure. Many of the other small teams collectively came to the same conclusion, to "Race!" Ultimately, it was the wrong decision and I felt sick to my stomach, uncomfortably retracting my head back into my shell, hiding safely as a turtle might do. Through further discussions, I realized that I was not alone in my misstep and "hiding" wasn't going to change anything. People make mistakes, leaders make mistakes, and the best possible thing to take away from the experience is how to learn from our mistakes.

I encourage you to continue discussions like this with your colleagues, say outside of the reading room on a lunch break, for the sanity of your team. #FightBurnout

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ANNUAL MEETING: ELECTRONIC EXHIBITS

The exhibits are available for review to PRS members on the PRS website (http://www.paradsoc.org). Awards were given for the top three exhibits. The award winners were:

1st Place Exhibit:	"Chronic Lung Allograft Dysfunction. A Review of the Imaging and Clinical Characteristics." Hota, P, Dass, C, Scott S.
2nd Place Exhibit:	"Comparison of the ACR In-Service Exam and WIDI Call-Readiness Exam To On-Call Performance Data from CAPRICORN: An Initial Experience." Huang, J, Loomba, R, Levin, D, Prabhakar, H.
3rd Place Exhibit:	"Optimal Utilization of the Portable Chest Radiograph in the Critical Care Setting at the Penn State Milton S. Hershey Medical Center." Chan, T, Bruno, M, Mosher, T.