Bulletin *FALL 2018*

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:

The 103rd meeting of the Pennsylvania Radiological Society was another outstanding success. I want to thank Dr. Keith Haidet for his leadership this past year as President of the Society for its 103rd year. His efforts and guidance have continued to promote the success of the Society and radiology in the state of Pennsylvania. I also want to thank John Kline, our Executive Director, for keeping the Society under his watchful eye this past year. The development of the Engage platform under John's direction for the members of the Pennsylvania Radiological Society will help us to communicate more easily and address the important issues that arise during the year.

I want to thank Dr. Beverly Hershey for developing another exceptional program for the 103rd meeting. It was inspiring to hear an update on the ACR from Dr. Geraldine McGinty, the Chair of the Board of Chancellors. Quality and Safety Issues in Radiology were addressed in lectures by Dr. Kimberly Applegate. Excellent neuroradiology lectures were given by Dr. Tanya Rath and Dr. Marion Hughes, as well as additional exceptional lectures on Remembering the Me in Medicine by Andy DeLao, MRI Safety by Kristan Harrington, Computer Enhancement of Radiology by Benjamin Strong. The resident panel of Dr. Ravi Kagali, Dr. Jamaal Benjamin, Dr. Jean Kimberly Rongo and Dr. Ryan Cobb under the continued direction of Dr. Mary Scanlon gave insight into issues facing radiology today.

I want to congratulate Dr. Rickhesvar Mahraj for organizing another very successful year with a record 39 scientific exhibits. The exhibits have offered an opportunity for the residents and radiologists of Pennsylvania to actively share their achievements with the membership.

Dr. Elaine Lewis, the Gold Medal honoree for the 103rd meeting was honored at the evening celebration for her commitment to the Pennsylvania Radiological Society and service to the ACR. In honor of Dr. Lewis, Dr. Brent Wagner spoke about how the maintenance of the board of certification serves the radiology profession.

I am excited about the coming year for our society. We have many enthusiastic members in our society and have shared many exciting ideas at our meeting on ways to move our society forward. There are many radiology residents and young radiologists in the state of Pennsylvania that we need to engage to help take our society to the next level. I hope that each of us takes time to think about how we might mentor another radiologist or resident to encourage them to reach their potential in the field of radiology. Through the success of building these new relationships, we will bring new ideas and energy to our society.

Michael Spearman, MD, FACR
Pittsburgh

EDITOR'S NOTE

The Fall 2018 issue of the Bulletin will provide you a legislative review of 2018 and preview of 2019. In addition, this issue includes updates from the ACR BOC and CSC. Dr. Hublall continues our focus on physician wellness. Dr. Pyatt presents a report from the PRS Quality and Patient Safety Committee. Dr. Biggs updates us on breast cancer screening. Finally, Drs Cobb, Kagali, Magnetta, and Vincenti from our resident section highlight content from the PRS Fall Meeting's Resident Forum and from recent RLI events

Thank you to all the contributors.

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

The Legislative Committee has been active this past summer and fall with several bills that have seen House and Senate Committee activity prior to the end of the legislative session this fall. The following is a summary or our positions and actions on several bills and summary of our strategy for several bills for the 2018-2019 legislative session.

1. **Senate Bill 678 / House Bill 1553** – Surprise Balance Billing – a popular matter in several states where an out of network provider is restricted in billing for a hospital service in addition to the health system bill. Whitney Cross, Secretary for the House Health Committee held a hearing which I attended with Josh Tice and John. She proposed a flat out of network rate of 150% of Medicare for all out of network bills and frankly did not want to discuss it. While a 150% Medicare rate is generally good for many Radiology services, there is concern that the flat rate would potentially set the fee schedule for all Radiology services across the board in the future, while tying reimbursement to the federal budget.
   The bill is not moving this term and will likely be reintroduced next year.
2. **House Bill 1884** - Patient notification of test results – This bill passed the House and was in front of the Senate Health and Human Services Committee, chaired by Lisa Baker. Representative Quinn, the bill's sponsor in the House, is running for a Senate seat this year, that the Republicans desperately need to win. They are willing to support Representative Quinn and her causes to ultimately win the Senate seat. For this reason, Senator Baker, a Republican, was willing to move 1884 to a Senate vote just before our fall meeting. Fortunately, the bill has been diluted over several years by our diligent efforts and the wide spread use of electronic patient portals by state health systems. Mike Cortez, Senator Baker's assistant, incorporated all of our significant changes to the bill in the final amendment process. The bill moved unanimously out of committee the week before our meeting without us supporting or contesting it. As it currently stands, current Radiology practice should not change in any significant way for a facility that has an electronic portal and/or follows ACR communication standards.
3. **Senate Bill 780** – establishes the Telemedicine Act to license health care providers who use telemedicine in PA and requires insurers to provide coverage and reimbursement for its use. This bill passed the Senate unanimously and a 5-hour hearing for the bill (which John and I attended) was held recently by the House Professional Licensure Committee. The majority of the testimony was in support of the bill and given by HAP, PMS, and other medical societies. As you may guess, the insurance industry was against the bill and had tried behind the scenes to maneuver the bill in front of the House Insurance Committee where they felt they could have stopped it. The bill is currently undergoing consideration for passage out of committee at the end of the legislative session.
4. **House Bill 1545** – would formally establish a statewide Medical imaging and Radiologic Therapy Board of Examiners. This bill is strongly supported by Representative Cutler, the incoming House Majority Leader and strong friend of Radiology. In testifying for this bill, we uncovered several weaknesses in the Department of Environmental Protection

regulations which govern the training of personnel involved in the use of radiation producing equipment in the outpatient setting. The bill, which proposes a new licensing bureau and added expense, does not have much chance of passing. We are hoping to tighten up the DEP regulations by testifying in front of their oversight committee with a proposal for new, stricter regulations for personnel training and certification including ARRT registry and ARRT ongoing CME requirements as an interim safeguard.

5. **Senate Bill 869** – this bill mandates insurance coverage for additional MRI and US screening in women with the 2 higher categories of breast density as defined by BIRADS. Introduced by Senator Mensch, friendly to Radiology, the bill is in front of the Senate Insurance and Banking Committee, where it is going nowhere. We have recently met with the PA Breast Cancer Coalition, a powerful patient advocacy group, and agreed to join forces to try to achieve movement for this bill in the next legislative session. This would involve more Senators as sponsors and a push for a new hearing on the bill by both organizations. We have compelling economic and scientific arguments for passage of the bill, compiled by Marcela Bohm-Velez MD FACR, Breast Imaging Committee Chair, and Mitchell Schnall MD PhD FACR, MRI Committee Chair. We would also help find potential patients who could be recruited with their consent by PABCC to give compelling stories in support of the bill (an area at which PABCC excels).

We have been active in Legislator support this summer and fall. Eric Walker and John attended a recent fundraiser for Bryan Cutler, incoming House Majority Leader, a former Rad Tech, and our biggest supporter in the House. Ricky Mahraj, Terry York, and John attended a recent fundraiser for Lisa Baker, Chair of the Senate Health and Human Services Committee, where many bills important to us are referred. This committee tends to give a more favorable assessment than the Banking and Insurance Committee. John and I had the opportunity to attend the Harrisburg Press Club luncheons for Governor candidates Scott Wagner and Tom Wolfe on separate occasions to hear their respective platforms for office and watch them field questions from the audience on a wide range of topics.

Our fall meeting also generates an annual reminder/ask for you to support our lobbying efforts in Harrisburg by contributing to our political action committee, PARADPAC. You can contribute by personal check mailed to the Society Office; by credit card via our website at www.paradsoc.org/page-1623583; or by credit card by calling the Society Office at (717) 230-8050. You have been very generous with donations in the past which have significantly helped our name recognition and effectiveness in Harrisburg.

John Kline
Executive Director
Pennsylvania Radiological Society

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

Physician Wellness

Creating Resiliency through Team Building

The thought for this contribution came to me as I was driving home after attending another lecture on burnout.

As usual, the presenter reviewed the list of items off their slides and mentioned all the current buzzwords. It was a good overview of the problems associated with physician burnout.

But I was thinking, "We know the problem. What we need are action plans and tools."

In last year's newsletter, the contributions by Drs.' Katyal, Kagali and Rosenberg discussed effective tools that an individual can use in preventing burnout. I would like to build upon their contributions.

Rather than combatting "burnout", I would like to encourage you to create "resiliency". To create resiliency is to instill within us the capacity to withstand the many negative forces that can lead to burnout.

The first step in creating resiliency is to develop a supportive environment to foster a culture of well-being in our departments.

It all starts with teams. The strength of a well-functioning team is greater than that of each of the individuals.

The foundation of an established and well performing team is having the same focus on the outcome. Think about the offence of a football team. Each player knows their roles and responsibilities and may share the same responsibilities at various times. For example, the tight end may block before running his route. But the actions of each player serve a single goal: to move the ball down the field toward the goal line.

Just like in football, your team needs to work together. No individual is more important than any other with respect to the team's success. There are different roles and responsibilities. With this philosophy the whole team is rewarded with the success, not just an individual. The team may celebrate individual successes amongst themselves, but people who are external to the team must celebrate the success of the whole team rather than the individual to foster the long-term success of the team.

"How do I start?" you may ask.

First, your team must get to know one another. Encourage people to have lunch together. Not just the radiologist, but also everyone in your office or department. Ask questions and listen and ask

questions again. Get to know your staff personally. They have significant life experiences and insights that they enjoy sharing. Invest personally with your staff; it does pay dividends. When your teammates know that you respect them and value them GENUINELY, you will see performance improve. This is your first step to diminishing depersonalization.

If you have learned mindfulness exercises, use them. Be in the moment when you walk in. Greet your team members warmly and if the opportunity exists to genuinely complement them, do it. We all appreciate positive interactions. It may just be that positive bump that turns someone's day around from a negative interaction that they had previously.

"Who is my team?" you may ask.

Your team is everyone that you depend upon to get your job done well. It is everyone from the first step to the last: the operator, billing staff, front desk tornado fixers, technologists, film library, environmental services, pharmacy, etc.

Everyone needs and wants a sense of purpose for what they do. So, go ahead and acknowledge them and genuinely thank them for their job.

"How does it help me to put effort into having a better team?" you may ask, "I'm already tired."

The power of giving and the personal fulfillment that you internally receive from aligned selfless giving has been proven and established by organizational behaviorists. This effect replenishes the currency in your well-being bank account. By working to build a better team, you build resiliency within yourself to withstand the effects of burnout.

So here are your action steps:

Take the group of people you work with the most.
Join them for lunch or a break.
Occasionally, take them for coffee.
Sit and discuss things with them.
Give genuine positive feedback generously. Do it often and don't forget to spread it around.

Repeat.
Take a group of people that you work with a little less often.
Repeat the action steps.

Practice is important.
Repeat often!

Ronald V. Hublall, MD, FACR **W. Ross Stevens, MD, FACR**
Sayre

Guidelines

New Breast Cancer Screening Guidelines for High Risk Women

The American College of Radiology recently released new guidelines for breast cancer screening. All women should be evaluated by age 30 to determine if they are at increased risk for developing breast cancer. This is particularly important for black women and those of Ashkenazi Jewish descent, as these groups are at greater risk compared to other women.

In general, women with a strong family history of breast cancer or known gene mutation associated with breast cancer should begin yearly screening mammography at age 30. The same women should begin annual breast screening MRI between ages 25 and 30. Women who have been treated with chest radiation therapy (treatment for lymphoma, for example) should begin screening mammography at either age 25 or 8 years after treatment, whichever is later. They should also undergo supplemental screening with MRI. For women who have been diagnosed with breast cancer and have dense breasts, or who were diagnosed with breast cancer before age 50, annual breast MRI is recommended in addition to annual screening mammography.

A detailed discussion of the new guidelines is available at the Mammography Saves Lives website, https://www.mammographysaveslives.org/Facts/Guidelines.

Guidelines - Mammography Saves Lives
www.mammographysaveslives.org

> The American College of Radiology (ACR) and Society of Breast Imaging (SBI) recommend that women start getting annual mammograms at age 40. The American Cancer Society (ACS), US Preventive Services Task Force (USPSTF), ACR and SBI agree that this approach saves the most lives.

The College continues to recommend that women without additional risk factors begin annual screening mammography at age 40, as 75 percent of breast cancers occur in women of average risk.

Kelly Biggs, MD
Tyrone

ACR Updates

BOC Fall 2018 Summary

The Fall Board of Chancellors (BOC) meeting focused on many topics, some familiar and some new. The following report discusses the major themes of the meeting.

Dr. Geraldine McGinty, as part of her Board Chair report, noted that one of the ACR's challenges is **how to expand the ability of our members to participate.** She posed the question: How well does our model of volunteer engagement align with and support our mission? She spoke of a need to have a balance in our ACR structure and should look for areas where we can open the ACR to more participatory group decision making. To explore this topic in more detail, members of the BOC and CSC were asked to read an article from the Harvard Business Review: Understanding "New Power". The focus was on the ACR's Membership Strategic Goal with a point/counterpoint approach presented by Drs. Bill Herrington and Sonia Gupta on ways to expand meaningful opportunities for Member participation in the ACR. Small workgroups discussed what we do well with 3 big "keep it" ideas and what we could do with 3 big "change it" ideas. The article stated that "new power gains its force from people's growing capacity and desire to go far beyond passive consumption of ideas and goods". New power favors informal, networked approaches to governance and decision making and places a special emphasis on collaboration. Discussion points concluded that new power has value in its transparency, however there needs to be a balance. You may be so committed to participation you never get anything done.

An ACR Task force was created in February 2018 to study **Corporatization and its impact on radiologists** led by Drs. Howard Fleishon and Bob Pyatt. The task force held an ACR Thought Leaders' Summit which found the need to understand the ACR's value proposition for various stakeholders other than members (corporatized entities, payers, providers, patients, large employers, private equity), to expand & communicate the role radiologists play in impacting healthcare delivery, and to continue strong advocacy for the profession of radiology and radiologists. The task force is working with Frost and Sullivan (a consulting firm hired by the ACR). A preliminary report was presented including a balanced look at factors favoring and constraining consolidation. A final report will be submitted to the JACR as a whitepaper in 2019.

Burnout and physician well-being were another focus of the BOC meeting. The 2018 Intersociety Conference focused on **Strategies for Managing Stress to Mitigate Burnout.** At that Intersociety meeting, 4 high level strategies emerged to mitigate the impacts of stress in our workplaces. The four strategies that could be used by leaders in radiology were:

1. You cannot manage what you cannot measure
2. Effective Leadership
3. High functioning teams and organizations
4. Raise our voices for advocacy.

Led by Drs. Claire Bender and Johnny Kruskal, small break-out groups were tasked with identifying action items in each strategy for possible implementation. There was a consensus that we need to find ways to obtain "hard data' and develop a toolkit to implement solutions.

Dr. Alex Norbash presented information on **next generation sequencing (NGS) and digital pathology** with an emphasis on the potential for radiology to collaborate with other specialties around integrated diagnostics. As the cost of NGS has decreased, DNA and RNA sequencing can be harnessed for personalized treatment of oncology patients with the ability to predict therapeutic response and to improve the assessment of prognosis. NGS will generate huge amounts of data which will need to be interpreted and integrated with other patient information including imaging. Dr. McGinty reported on ongoing discussions between the leadership of the ACR and the College of American Pathologists seeking to improve outcomes for our patients. She reported that while radiology's digital practice environment is mature compared to pathology's, we can learn from other disciplines about the effective adoption of structured reporting.

A session on **Ethics in AI-Driven Autonomous and Intelligent Agents in Radiology** was presented by Dr. Raym Geis. He pointed out that we "need to earn the trust from all parties who rely on radiologists and the ACR that we are doing the right thing for them". As artificial intelligence (AI) evolves, we are becoming aware of ethical issues related to data collection and security, algorithms, practice, and research. Ethical issues related to data include determining when is there a need for informed consent, privacy of patient data and data protection including recurrent use of data for applications the original data collection were not intended. Who owns the data, who gets paid for the data and who sets rules for its use? Regarding algorithms, how is safety determined and what should be the standards for transparency? AI algorithms try to optimize whatever they are built to do. Should this be the best outcome for each patient, the best outcome for population health given finite resources, or for the benefit of the owner? One of the goals of the ACR's Data Science Institute (DSI) is to work with other societies to produce a code of ethics for data scientists and AI developers that radiologists can refer to and implement.

Dr. Keith Dreyer presented an update on other ACR DSI activities including the challenges of moving AI concepts to clinical practice. The AI development cycle begins with an AI concept which is studied by Data Engineering to produce AI models that are eventually sent to market as AI applications. ACR DSI is currently in the Use Case Creation Process for multiple clinical scenarios. Approximately 50 Use Cases are near completion and are currently undergoing preliminary industry review. ACR DSI has become well known in the medical developer, research and regulatory communities and is becoming the "go to" organization for use case validation.

CSC Fall Meeting Summary

Sunset Policy Review

The CSC has begun its annual sunset policy review. Every year the Vice Speaker recommends action on policies due for sunset. There is a total of 24 policies up for review in 2019. The 24 policies were sent to the ACR Commission chairs for comments and recommendations for action (renew, renew as amended or sunset). Dr. Duszak then reviewed all comments and recommendations from each Commission prior to the CSC Fall Meeting. At the meeting, we had robust discussion and look

forward to continuing these at our November meeting. In November, we will vote and finalize recommendations for action to present before the ACR Council at the 2019 Annual Meeting.

ACR Fellowship

State Chapters are the most important assessors of candidates. The ACR Fellowship Committee looks closely at chapter endorsement versus concur and use it frequently for final decisions. State Chapters need to use the criteria sheet and ensure candidates meet the qualifications for the length of membership in the category for which they are applying and being supported by the State Chapter. There is no limit to the number of candidates per chapter. Endorsement letters are important, and one must be from outside the candidate's practice.

Pathway to ACR Fellowship
Nomination Criteria
Military Nomination Criteria

Interim Workgroup Reports

Annual Meeting Workgroup
Members: Amy Kotsenas, MD, FACR (Chair); Mark Alson, MD, FACR; Sonia Gupta, MD; Kevin Smith, MD, FACR; Aradhana Venkatesan, MD.

This group was tasked with reviewing the feedback provided on the ACR 2018 post-meeting survey to identify the meeting's strengths and areas of improvement. They were also asked to provide recommendations for consideration for planning ACR 2019. Some positive aspects of ACR 2018 were return to governance-centric AMCLC-like meeting format, praise for chapter leader's workshop, advocacy and economics session content, and networking and discussion opportunities. Some identified areas of improvement for ACR 2019 included increased CME programming that doesn't conflict with governance, improving accessibility and distribution of annual meeting agenda materials, and dedicating less Council time to proofreading and editorial review of the Practice Parameters and Technical Standards and resolutions thereby allowing more substantive discussion of policy issues. There was feedback from respondents indicating they would prefer to change the meeting venue. The ACR has entered into a contract with the Marriott Wardman Park through 2023 under very favorable terms (as compared with other venues including the Hilton). The ACR will revisit this suggestion as the end of the contract nears. Recommendations for ACR 2019 included continuing to offer Open Microphone, Economics Forum sessions as part of annual meeting programing, adding more CME programming options on Saturday (pre-meeting), or Thursday after Capitol Hill Day or at 7am time slots, not to conflict with governance sessions, utilizing Engage platform for pre-meeting discussion and increasing the frequency of pre-meeting communications to registrants.

Open Microphone Workgroup
Members: Colin Segovis, MD, PhD (Chair); Elizabeth Hawk, MD, MS, PhD; Elaine Lewis, MD, FACR; Madelene Lewis, MD; Darlene Metter, MD, FACR.

This workgroup was tasked with analyzing the discussion and feedback from the Open Microphone session at ACR 2018 to determine next actionable steps. Two specific areas were identified from the Open Microphone Session: Engagement between CSC and Council and Operations of the CSC. During the Open Microphone Session, the sentiment expressed was the CSC was not

communicating effectively with the Council and the mechanisms of communication currently in place are not effective. The workgroup recommended periodic as needed Virtual Town Hall Meetings with the Speaker and Vice Speaker for ACR Council and Chapter Leaders and periodic CSC liaison conference calls with chapter councilors. Survey of councilors, state chapter leaders and members-at-large was also suggested to determine interest in communications from the CSC, appropriate frequency and preference for modes of communication. Per the ACR bylaws, the CSC represents the Council between Council meetings and provides Council liaison with the BOC, subspecialty societies represented in the ACR Council, and chapters; and resolution management.

Elaine Lewis, MD, FACR
ACR, Council Steering Committee
Reading

Quality and Patient Safety Committee Report

To increase utilization of ACR Quality & Safety Resources, this report will highlight and capture some important sections of the Quality & Safety sections of the ACR website(www.acr.org). This is part of the PRS effort to increase knowledge and utilization of the ACR Quality & Safety Resources, a PRS Board Approved Program for 2018-2019.

QCDR Deadlines Approaching for 2018 MIPS Participation

If you or your group will participate in the 2018 Merit-based Incentive Payment System (MIPS) using the ACR National Radiology Data Registry (NRDR) ACR Qualified Clinical Data Registry (QCDR), the deadlines for setting up your account and submitting your quality measure data are fast approaching.

Participants must submit some data for each registry they intend to use for MIPS reporting by **Oct. 31, 2018.** This includes submitting data to all relevant registries within the National Radiology Data Registry (NRDR®) as well as submitting MIPS measure data through the MIPS Participation Portal . Facilities also must have their physician list finalized and have all TINs and NPIs added to their NRDR account by **Nov. 30, 2018.**

All data for the Dose Index Registry (DIR) must be submitted by **Dec. 31, 2018**, and all data for other NRDR registries and MIPS measures must be submitted by **Jan. 31, 2019.**

Adherence to these deadlines will allow you to identify any problems with your data early, before it's too late to correct any account or data issues.

Learn more about using the NRDR QCDR for MIPS participation, and direct any questions to nrdrsupport@acr.org or create a helpdesk ticket .

Jason Itri, MD, FACR is a former PRS member who has become a National Leader in Radiology Quality & Safety. Here is an FAQ Section from the ACR Quality & Safety website:

Q&A With Jason N. Itri, MD, PhD

In this Spotlight, we talk with **Jason N. Itri, MD, PhD**, Vice Chair of Quality and Patient Safety and Associate Professor, Wake Forest Baptist Health, about how the General Radiology Improvement Database (GRID) Committee is working to make quality measures more meaningful for radiologists.

What is the GRID Registry and how does it help improve quality and safety?
The General Radiology Improvement Database collects information about imaging facilities to establish benchmarks for performance and quality improvement. It allows facilities and physicians to compare turnaround times (TATs), patient wait times, incident rates and many other types of measures with other facilities and practices of similar size and type.

The GRID was formed in 2008 as the brain-child of the late Harvey L. Neiman, MD, FACR, who had considerable foresight about the importance of performance and quality measurement within the specialty. Currently, GRID comprises structure, process and outcome measures. Many of the approximately 20 process measures are related to turnaround time (TAT). The GRID outcome measures span several topics that cover a broad array of measures for quality and performance in the practice of radiology. GRID allows participants to benchmark themselves relative to other similarly sized practices and identify opportunities for improvement.

What is changing in GRID?
A lot has changed in radiology over the last 10 years since GRID was initiated. The GRID Committee is taking another look at the quality measures collected in the registry, especially as they relate to MACRA and the increasing impact of quality and safety on reimbursement. At the same time, GRID participation has increased dramatically over the last 10 years. The majority of the 150 participating practices are submitting process measures to the registry, primarily because TATs are reported to CMS as part of the Quality Payment Program. Fewer practices currently participate in the outcome measures, because it can be a burden to report those measures and they aren't always tied to reimbursement.

On the GRID Committee, we are working to include more meaningful quality measures, especially related to diagnostic accuracy. Another area we're interested in is access and capturing the intervals between the initial reporting of symptoms or screening results to diagnostic exam, and from diagnostic exam to image-guided biopsy. There is data that shows if you're waiting more than a few months with some types of cancers, the prognoses are worse. Equally important is the anxiety patients experience when they are waiting weeks or months to get a diagnosis and begin treatment.

We're also focusing on identifying and including measures related to patient-centered care (for example, radiology consultation clinics where you can measure patient satisfaction). In short, we're

working to make the GRID measures more contemporary and meaningful to radiologists and other stakeholders today. And if we can do that in a way that doesn't create too much of a burden to report, then we believe can get more practices to participate.

What steps are you taking to make GRID outcomes measures easier to report?
We're looking at how tools like ACR Assist™ and structured reporting techniques can help. ACR Assist is a clinical decision support framework for radiologists to automatically provide structured clinical guidance, including classification and reporting taxonomies in the form of the ACR "RADS" such as BI-RADS®, LI-RADS® and PI-RADS®. Creating a structured reporting framework can significantly reduce the burden of reporting radiology measures.

Why should radiology practices participate in GRID?
Quality is often hard to measure, so practices end up competing on measures like turnaround time and cost. And that is a commodity-based practice. Unfortunately, it is difficult for stakeholders — payers, patients and government agencies — to separate radiology practices in terms of quality. So far, radiology practices are frequently differentiated in terms of turnaround time and cost of services. Unless we find better ways to measure our quality, we will be commoditized.

Participation in GRID will help us shift the focus to quality and value. And it will ultimately lead to quality improvement and better patient care. That's the main goal: being able to compare yourself to other similar practices, to see how you're performing and to identify areas for improvement.

What is on the horizon for GRID?
We're going to look at the current measures to see where we can breathe new life into GRID and make it more relevant and more robust than it is today. Right now, there are 11 quality measures that have been proposed by the ACR Quality Metrics Technical Expert Panel that are going through feasibility testing. We hope GRID can serve as a proof of concept for those new measures to see how they're received and what kind of data we can get. We are also evaluating other measures in areas like diagnostic accuracy, access, patient-centered care and appropriateness. If your practice is interested in participating in our upcoming testing project, please fill out an interest survey or contact Karen Orozco at korozco@acr.org.

What are three actions you would recommend for fellow radiologists related to GRID and quality improvement?
One, for every radiologist, it's important to understand where we're going with quality in the field. I'm not saying everyone needs to be a quality expert; but take some time to understand quality measurement and its importance to our specialty, so that we're not just judged solely on cost and turnaround times.

Two, if you have an interest in quality, there's no shortage of need for quality champions in radiology practices across the U.S. There are tons of resources available, people to talk to, workshops and opportunities to learn more about quality. So, if you have an interest, please get involved. Reach out to someone at the ACR, volunteer for a committee or apply for an Amis Fellowship, which is how I first got involved.

Three, be a willing participant in the quality measurement process. I can't overstate how happy it would make me if people just randomly emailed me and said, "Hey, I have this idea for a quality measure." Or "What do you think about this?" Let's harness everyone's interests and experiences.

There are tens of thousands of radiologists out there, so if you have an idea about a quality measure, make your voice heard.

Improve Your Mammography Performance

In the battle against breast cancer, mammography facilities have a powerful tool — the National Mammography Database (NMD) — to help compare and benchmark performance. As part of the National Radiology Data Registry (NRDR®), NMD allows participants to receive quarterly feedback reports providing comparisons to peer facilities along with benchmarks of measures such as cancer detection rates, positive predictive values and recall rates.

In the drive to improve care for cancer patients, one of the challenges radiologists face is the lack of data to determine outcomes related to screening findings. For mammographers to improve their performance, it is critical for them to get biopsy results and clinical pathology data back from providers and labs.

Now, participants in NMD are eligible to gain recognition and a financial incentive for achieving high-quality data submission.

NEW! NMD Star Status Program

The NMD Star Status Program rewards NMD participants based on three tiers of completeness of their screening exam data. Each facility that achieves gold, silver or bronze status will receive an award that is applied toward its NRDR annual participation fee:

Gold: $500
Silver: $300
Bronze: $100

Beginning in Nov. 2018, NMD quarterly feedback reports will include evaluation of participants' completeness of screening exam data and identify their NMD Star Status level (if applicable).

As part of the NMD marketing toolkit, those who achieve NMD Star Status will also receive a certificate that indicates their NMD Star Status, which they can use in their marketing programs to highlight their screening quality.

Shoot for the Stars

Watch for your Q3 NMD feedback report to see if you qualify for NMD Star Status. Your feedback report will help you assess how your site is performing in terms of screening data completeness and your ability to assess patient status based on outcomes data.

Here are three actions your mammography center can take to improve your performance:

1. Understand where your facility stands in achieving completeness of screening data.
2. Compare your site to other participants in the NMD registry to determine quality improvement goals and priorities.

3. Develop a plan to take actionable steps to make improvements where needed to obtain more complete outcomes data.

Star Status Metrics Level — Year 1

Data Element*	Gold	Silver	Bronze	NMD Percent Reported *8/1/2017 – 7/31/2018*
Date of previous exam	60%	50%	40%	64.1
Indication for exam	80%	70%	60%	96.1
Personal history of breast cancer	80%	70%	60%	75.2
Breast cancer in first-degree relative	80%	70%	60%	65.2
Breast density	80%	70%	60%	92.8
Assessment — patient level	80%	70%	60%	100.0
Date of biopsy	80%	70%	60%	53.3
Classification of lesion	80%	70%	60%	56.2
Malignancy type	80%	70%	60%	91.8
Tumor size	40%	30%	n/a	52.3
Tumor stage	40%	30%	n/a	19.0
Nodal status	40%	30%	n/a	28.7

**To achieve NMD Star Status, participants must meet the completeness metrics across ALL data elements for each level.*

These first-year completeness metrics were developed by analyzing data across all NMD participants and identifying the levels of top performers. The metrics for each level will be adjusted annually to drive better performance.

Learn more about participating in the NMD and achieving NMD Star Status. For questions, contact:

Email: nrdrsupport@acr.org
Phone: 1·800·227·5463, ext. 3535

If you have questions or comments for the PRS Quality & Safety Committee, please contact the Chair of the committee:

Bob Pyatt, MD, FACR
Chair, General, Small, Emergency, and/or Rural Practice Commission
Board of Chancellors, ACR
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RESIDENT AND FELLOW SECTION:

Highlight from the Annual Meeting:

Gender and diversity in radiology

Gender and ethnic diversity are hot topics in business today and radiology is not immune to the pressure. Studies show that having a diverse workforce generates increased return on investment for businesses. In medicine, studies reflect similar results. Patients feel more comfortable talking to people from similar backgrounds and are more compliant with medications.

With this in mind, the American Medical Association commissioned research on diversity. The AMA research demonstrated dwindling numbers of females and minorities from medical school into residency in comparison to census information. Radiology is unfortunately one of the least diverse residencies/specialties where the typical radiologist is a Caucasian male. Potential contributing factors to radiology's lack of diversity include a lack of early exposure to radiology, poor outreach, and a dearth of female and minority mentors. A subtler factor is our own unconscious bias. Since the typical radiologist is a Caucasian male, we subconsciously associate the Caucasian male stereotype as better for the job.

We can do better! We must recognize and face these issues! We can begin by celebrating the contributions from our female and minority colleagues, while expanding initiatives and incentives to recruit a more diverse workforce. The American College of Radiology has made strides to correct these deficiencies, but more can and should be done within our field. Progress may be slow, but the benefits are worth the effort.

Ravi Kagali, MD
PGY-5, Diagnostic Radiology
Geisinger Medical Center

International Volunteerism and RAD-AID

In high-income countries, imaging plays an integral role in a majority of critical diagnoses. Unfortunately, these vital imaging resources are not available in many medium and low-income countries. There is a clear and present need not only for the imaging technology but also the knowledge and expertise required for a sustainable healthcare system. The educational and infrastructural needs for a sustainable healthcare system can be met through the volunteer efforts of radiologists, radiology technicians, information technologists, and donations and guidance from the private sector. A group unifying these efforts with tried and true methodology is RAD-AID. From its inception as a grassroots effort at Johns Hopkins University, it has grown to involve chapters in almost every US state covering volunteer efforts on every continent, except Antarctica. The use of their trademarked Radiology Readiness tool helps diagnosis the inherent issues in the delivery of radiology services within a local system. Identification of the delivery issues allows the volunteers to

optimize their impact, as well as, creates an environment for success for the local healthcare providers. Efforts like these take a tremendous amount of human-power to accomplish. Regardless of level of training, everyone in the radiology pipeline has something positive to offer and is encouraged to answer the call.

www.rad-aid.org

Ryan Cobb, MD,
PGY-5, Lewis Katz School of Medicine at Temple University

RLI Experience

I would like to thank the Pennsylvania Radiology Society for funding my tuition to the 2018 ACR Radiology Leadership Institute (RLI). This was a conference and experience unlike any other. I would highly recommend it to any Pennsylvania radiologist in leadership or interested in learning about struggles and solutions facing radiology practices.

The RLI is an excellent opportunity to learn from others in the radiology community and network. The conference participants ranged from trainees to group CEOs, academic department chairmen and ACR thought-leaders. I went to the RLI alone but, through interactive sessions, dinner and drinks, left with many friends and colleagues from all over the country. Everyone was approachable, willing to listen and to share their institutional insights and struggles. The Babson College faculty were engaging and clearly understood the pressures facing practicing radiologists in many arenas – academic, employed and private practice.

In sum, I learned a great deal from the RLI and feel privileged to spend this time with likeminded radiologists who share a passion for improving patient care and leadership in radiology. I look forward to the opportunity to return to RLI in the future and am incredibly grateful for this experience. Thank you PRS!

Michael Magnetta, MD
PGY-6 Abdominal Imaging Fellow
University of Pittsburgh

Attending the Radiology Leadership Institute was an experience I will never forget. The spirit of the conference was one of collaboration and forward-thinking. As a resident, I have focused the majority of my studies on the knowledge-base that I must acquire to be a proficient and practical radiologist. The RLI really gave me a glimpse into the softer side of the field, one which I will continue to embrace going forward. I met countless individuals who clearly care about the future of the specialty and how we as radiologists can continue to impact patient care. I not only walked away with take home points for implementing tangible changes in my practice, but I also developed several new relationships that I will continue to foster. I am grateful to have shared the experience

with so many like-minded individuals and to learn from those whose viewpoints were different than mine. The scholarship to attend the RLI as a resident is an honor I am truly grateful for, and I hope to return in years to come to further strengthen my skills and connections.

Kerri Vincenti, MD
PY5, Pennsylvania Hospital

ANNUAL MEETING: ELECTRONIC EXHIBITS

The exhibits will soon be 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:	"Magnetic Resonance Imaging Features of the Normal Placenta and Myometrium: Trends Across Gestational Age." Sloan, J, Woodfield, C, Lim, P.
2nd Place Exhibit:	"Incidental Colon Cancer On Routine CT: A Pictorial Review." Tong, N, Tucker, MW, McGillen, K.
3rd Place Exhibit:	"Complicated Inflammatory TMJ Arthropathy with Intracranial Manifestations." Zhang, J, Miller, A.