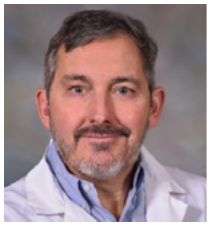
American College of Radiology™
Radiology Leadership Institute

RLI Impact in Leadership Award: Past Recipients

2024



Archie R. McGowan, MD, MBA, FACR

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2023

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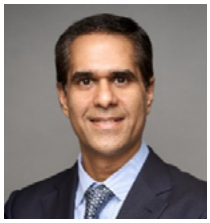

Vivek Masson, MD, DABR

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Andrew Moriarity, MD, MBA

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2024 RLI Impact in Leadership Award

Archie R. McGowan, MD, MBA, FACR
Co-Director Portsmouth Regional Hospital Comprehensive Stroke Center
Portsmouth Regional Hospital

Project Description

From my first clinical exposure to the morbidity and disability caused by ischemic stroke, I became interested in the diagnosis, treatment, and prevention of acute ischemic stroke (AIS). Thankfully, over the course of my career all three elements have undergone a rapid period of scientific and clinical advancement. However, medical care has historically been delivered locally and this creates challenges and limitations in providing quick effective care in less geographically dense regions like my practice, Atlantic Radiology of New Hampshire, in Northern New England. The structural, economic, and technical challenges within our healthcare system are additional complications to the delivery of care.

After early supportive clinical trials in 2008 and the three positive stroke intervention trials of 2015 the community needs for AIS care in New Hampshire required that this care be available. The initial stated goal of our team was “providing necessary AIS care to a population that would otherwise have limited access.” The actual goal was decreasing the morbidity and mortality of AIS and this is highly dependent on early competent coordinated intervention. Ischemic stroke care shares these requirements with acute coronary syndromes, trauma and to a lesser degree hemorrhagic stroke secondary to subarachnoid hemorrhage. Utilizing models of rapid coordinated care delivery is necessary.

According to the CDC, stroke is the number five cause of death in the US with 163,000 deaths per year in the US and a nationwide average of 49 deaths per 100,000 people per year. 795,000 strokes occur per year in the US with 87% being ischemic and approximately 20-25% of those being potentially treatable with interventional care. Northern New England has a relative low penetration of disease relative to other parts of the country with New Hampshire having a mortality rate of only 30.3 deaths per 100,000 per year which is good but further decreases the density of disease in our geographic area making subspecialty care even more challenging.

Starting in 2010 my private practice took the lead in Southern New Hampshire offering subspecialty dedicated interventional radiology care in our 220-bed facility as well as referral from five other local facilities which were without dedicated interventional services. These services included trauma, stroke, vascular emobilization, GI work, urologic work, women's health, pain and interventional oncology. The provision of the services was asymmetrically burdensome on the IR members of the private practice and considered by some partners to be disruptive, divisive and economically unwise. Nonetheless, the clinical benefit to patients and the community was clear and the economic benefit to the hospital also clear.

Solving or minimizing the problem of asymmetric professional burden and the disconnect between the benefit to the group and the hospital was obviously complex and required far more than the ability to perform a thrombectomy. All signs pointed to "managing" the integration of the related pieces to solve the delivery

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puzzle. At the same time the **Radiology Leadership Institute** was developing courses on how to address the non-clinical functions leaders needed to perform in order to provide care and help their practices succeed.

Specifically, topics at the 2017 summit became highly relevant. Scott Taylor's symposia on sustainable change outlined the steps of aligning incentives for the decision makers in way that was more broadly applicable and allowed a redefinition of the "asks" necessary to acquire resource for clinical support and was relevant to our organization working with a for profit hospital. Using this methodology, we were able reframe the request. Instead of asking for call pay and a biplane we asked to be partners in a new service line. The topics addressed in the "customer insight" sessions clearly allowed one to consider the proposal/request for hospital financial and clinical capital spending to be considered from the perspective of return on investment and other metrics known to the C suite team but not in the radiology vernacular. This perspective aided in our team's ability to listen and ultimately was the key to the project's success.

Six Sigma/Lean discussions were championed by the RLI and have been utilized by Atlantic Radiology of New Hampshire to circle back and constantly try to improve our delivery of care. Early in the project thrombectomy post case debriefs were performed on every case with an eye towards process improvement and timeliness of care. Morbidity and mortality reviews are part of our process and have aided in learning of potential pitfalls, allowed us to track various manageable metrics as well as celebrate a high TICI 3 success rate.

Starting around 2018 the clinical and administrative teams felt that we were collectively ready to move forward with creating a certified comprehensive stroke center to augment care and address hemorrhagic stroke, subarachnoid hemorrhage, arterial venous malformation and incidental aneurysms in our community. However, the demographics of these diseases were not dense enough for a project to be economically viable for our private practice group. This was a critical point where the RLI tools came into play. Using the RLI toolbox our team was able to develop a relationship with University of Massachusetts aneurysm center on the professional side to provide this type of NIR care separately but within our financial structure. The synergy here was based on the density of disease and the timeliness of intervention. This was possible in part due to the timeline for treatment of subarachnoid which is typically more elongated from diagnosis to therapy than AIS. For subarachnoid hemorrhage early intervention is defined as within 72 hours. Our team delivers care within 24 hours and often sooner. With this model the NIR aneurysm team can be safely based 90 minutes away in Worcester, Massachusetts while the AIS team is onsite within 20 minutes. While the economics of the NIR professional costs could not be sustained by subsidy from Atlantic Radiology's professional income stream they could be supported by the hospital due to the favorable hospital economics of the NIR care.

The combined teams of our certified comprehensive center are now in our fourth year of operation. In our unique model I have served as the co-director on the ischemic side and my partner from University of Massachusetts Ajit Puri, has been the co-director on the ischemic side. Our volumes are growing, our TICI2b and TICI3 outcomes as well as our disability/Rankin score metrics are well above average, and it is now time to evaluate the next steps in widening the care.

I see several opportunities to build on our solid foundation. Personally, I am interested in trying to reach the next level of care delivery by reducing the geographic burden in therapy the way the previous generation of

advancements reduced the role of geography in diagnosis. I am now serving as a consultant for Telos, a stroke robot company to ultimately provide remote stroke therapy in rural areas such as Northern New England and anywhere the population cannot support the needed level of sub specialization.

Restructuring is in the works to organize the regional systems of stroke care. Using the RLI framework, the improved voice of my group has successfully petitioned the state of New Hampshire to improve acute stroke and Interventional Radiology care. During COVID when there was little revenue, I was able to get New Hampshire Governor Chris Sununu to provide a grant of $50,000 to support our clinical AIS and IR services. Additionally, a program is now being developed for improved EMS facility selection based clinical findings predicting likely LVO presence.

Our hospital CEO is also currently restructuring his side as well and looking towards regionalization of care with ambulance services/transport augmentation, a dedicated helicopter service, collaborative relationships with other facilities and off-site emergency rooms.

Technical innovations have removed the geographic component to diagnostic imaging. But geography remains a formidable foe on the therapeutic intervention side. This is where we will continue to use the RLI toolbox of management skills to support patient care and the sustainability of our group.

2023 RLI Impact in Leadership Award

Ian A. Weissman, DO, FACR
Attending Radiologist | Milwaukee VA Medical Center

Project Description

Our radiology practice, as well as the larger radiology community, continues to suffer from increasing rates of radiologist burnout which is increasingly impacting patient care as radiologists resign or cut-back their hours resulting in less radiologists available to provide timely care.

As the current President of the Wisconsin Radiological Society, I used the strategies taught to me by my mentors and colleagues at the Radiology Leadership Institute (RLI) to create a national well-being project in 2022 which presents impactful solutions to mitigate radiologist burnout.

RLI educational background

Active participant in the Radiology Leadership Institute (RLI) since its creation in 2012 completing:

- All 4 leadership levels of the RLI.
  - First radiologist in the country to achieve the designation of Leadership Mastery in 2014.
- All RLI/Harvard Emerging Leaders Seminars.
- RLI Maximize Your Influence and Impact Program (twice).
  - At initial rollout of the course.
  - Several years later to hear ideas from new faculty.
- Nearly every RLI Summit.
- Many RLI Power Hour Webinars.
- Many RLI Taking the Lead Podcasts.

Examples of lessons learned from the RLI pertaining to completion of well-being project:

Overall: After over a decade of participating in the RLI, all these programs/seminars/summits have led to a cultural transformation in the way I see our world and profession, and have allowed me develop solutions to better navigate our complex changing healthcare environment.

Specifically:

- Dr. Alex Norbash: First lecture I attended from RLI faculty over 10 years ago.
  - He stressed not hiring someone just to fill a vacancy. The wrong person will create more problems for the department than one can imagine.
    - I have experienced this in my career, and is a contributing factor to burnout in many radiology practices.

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●Dr. Frank Lexa and Dr. Lawrence Muroff: Emphasize proposing solutions to solve challenges in our collective radiology community. As they underscore, if we don't step up to take on challenges, who will?

Tackling radiologist burnout is a large challenge, but one that we can solve collaboratively with thoughtful leaders to guide our way.

●Dr. Geoff Rubin and Dr. Harprit Bedi: Stress thinking outside the box, and the importance of learning the language of our colleagues in professions different than our own whether that be in finance, or in other areas such as well-being.

To develop solutions to mitigate burnout, I read the well-being literature by pioneers in this area such as Tait Shanafelt, MD to learn to speak the language and have followed for many years, evolving work on improving well-being from organizations such as the National Academy of Medicine and the U.S. Surgeon General who both recently published seminal resources to mitigate burnout in October, 2022.

●Dr. Richard Duszak and Dr. Geraldine McGinty: Underline the importance of social media which is just another tool in our leadership toolbox.

I have leveraged social media over the past 8 years @DrIanWeissman to share articles and exchange ideas and solutions with patients and colleagues on critical issues such as improving well-being.

Detailed description of national well-being project/RLI strategies used/Outcomes:

On December 12, 2022 I launched the first part of a 2-part seminar on improving Well-Being directed first toward residents/fellows through a national webinar (www.wi-rad.org/Webinars) where I presented the problem and the expert panel provided solutions. The second part, for all practicing radiologists, will occur in person on April 1, 2023 at the annual conference of the Wisconsin Radiological Society (WRS) and will be simulcast live through a national webinar. To increase accessibility and interest both of these webinars are free for all radiologists and provide CME credit. There is a landing site on the WRS webpage for radiologists to access these recorded well-being seminars which provides solutions for their respective organizations.

To make this project a reality took many steps over many years. The strategies necessary were facilitated by multifactorial discussions through the RLI in areas such as defining a problem, addressing one's audience, getting buy-in from stakeholders, building one's brand, marketing one's product.

The inspiration for this project occurred around 5 years ago in 2018 when I became aware of the increasing rate of burnout in our radiology colleagues. In 2019 the American College of Radiology created a Well-being Committee, which I serve on, and I immediately hosted a Tweet Chat through the #JACR in May of 2019 on the *Importance of Clinician Well-Being: Why it Matters to Your Patients* (wakelet.com/wake/c702c04d-fd08-4adb-9763-39b17bf07c2e). This was followed by a series of invited

lectures in 2021 and 2022 through multiple radiology and non-radiology organizations where I built my brand, and I began to speak the language of improving well-being.

In 2019, I was appointed the Chair of the ACR Patient and Family-Centered (PFCC) Outreach Committee and as radiologist burnout worsened during the COVID pandemic, I expanded the mission of our committee to address clinician well-being since radiologists need to be well to provide effective patient care. I have expanded these ideas through a grand rounds I developed and lecture on called the *Joyful Triad of Healthcare Success: PFCC, Health Equity and Clinician Well-Being* since they are all interconnected and are critical to ensuring excellent patient care.

During this period, other projects that I was involved in on improving well-being began unfolding such as an invited in-depth interview that I co-authored on improving well-being in the December 2022 ACR Bulletin www.acr.org/Practice-Management-Quality-Informatics/ACR-Bulletin/Articles/December-2022/Being-Well-Together and an invited review article on strategies to improve well-being that I first authored for a planned special focus issue on well-being to be published in the Journal of the American College of Radiology.

All of these steps were necessary to get buy-in from the WRS Executive Committee for a two-part seminar on Well-Being that I proposed in April of 2022 to be the keynote session at our April 2023 annual WRS meeting.

The critical importance of mitigating burnout in radiologists necessitated expanding the message to a national audience so I reached out to the ACR Well-Being Committee and the RLI to ask if they would be interested in collaborating on this project, and we formed a partnership.

Defining the audience was important so I designed the first session on well-being to address the concerns of residents and fellows and the second session toward all practicing radiologists. Both sessions are interactive, the second session with a 45 minute question and answer session, allowing an exchange of ideas among the participants to facilitate engagement and buy-in, all strategies learned from the RLI.

Lastly, to make radiologists aware of this well-being seminar I leveraged my social media platform on Twitter which has 36,000+ followers to make clinicians aware. This was effective in increasing the number of participants by 10-fold after I marketed this well-being seminar on Twitter for one week.

I have brought these well-being strategies back into my own radiology practice. As a result, I was appointed by the VA Undersecretary of Health to serve on a new national taskforce designed to improve well-being across our healthcare network called REBOOT (Reduce Employee Burnout Optimize Organizational Thriving) where we have developed well-being strategies that have recently been rolled

out nationally. I have also been recently accepted into a new national leadership program in 2023 through our health network where I will continue to develop and share these well-being initiatives with my colleagues at our institution and across the nation.

Conclusion/Strategies learned from RLI:

The RLI teaches us to be forward-thinking and to be change leaders. Because of the strategies taught to me by the RLI, I was successful in developing and rolling out a national webinar designed to reduce burnout in radiologists in December of 2022.

This work also led to a high-level national committee appointment through my healthcare network to develop national well-being initiatives, and recent acceptance into a new national leadership program to allow me to further develop and roll-out these well-being strategies to mitigate burnout in our colleagues.

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2023 RLI Impact in Leadership Award

Syed F. Zaidi, MD, MBA, FACR
Office of the Chief Medical Officer, Operations and Integration | Radiology Partners

Project Description

I have been attending the ACR Practice Leaders meetings since 2010, and the RLI Annual Summit since 2012 from the inaugural meeting. I have attended multiple sessions of these meetings, and also have participated in presentations at these meetings, and the RLI Power Hour, most recently in 2022. The RLI meetings in particular were very inspirational to me and propelled my leadership career in my group, Radiology Associates of Canton (RAC) and subsequently also lead to my leadership role in Radiology Partners (RP). I also was inspired to obtain an MBA from the business curriculum of the RLI, which I completed at the Wharton School of Business in 2019.

The RLI experience exposed me to the use of business strategies generally in healthcare and how radiology could be helped by use of modern business strategies, particularly in private practice, along with other clinical strategies that could be applied in radiology. The following concepts were largely introduced to me at RLI meetings:

- Value = Outcomes/Cost
- Value of Hospital-based Radiologists
  - Better IP Coordination
  - Decreased Length of Stay
  - Shifting Inpatient to Outpatient Care
  - Role of IR in High Value Care
- Co-Management of Radiology Service Line
- Population Health Management/Utilization Management
- Imaging 3.0

I learned these concepts from multiple radiologist presentations but particularly from a few rad leaders, namely Frank Lexa, Jonathan Berlin and Rich Duszak along with others. These mentors were liberal in their sharing of ideas to inspire the audience, and as a young rad leader, I was hungry for actionable ideas. I could write many essays on how I implemented each of these concepts but I'll focus on one of the key parts of the foundation for me which is Co-Management.

Co-management was being discussed at the ACR/RLI meetings in 2011-2012 in the context of its use in Orthopedics and it was an open question of whether this could be adopted in radiology. I first heard about it at a lecture by Dr Brant-Zawadzki. There are multiple strategic benefits to implement this concept in radiology. It allows a private practice to showcase its clinical quality, for increased financial support for clinical services by investing and risk-sharing on important clinical initiatives, and ultimately

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bolstering a group's position with their health system as a strategic partner rather than a vendor. It also allows a radiology group to face the pressures of payer and health system consolidation, manage internal cultural and governance issues, and how to make the practice of radiology more sustainable with the newer generation of rads. This was all new to me about its potential in radiology.

I went back from the meeting in 2012 and developed the model to partner with Aultman Hospital on co-management of the radiology service line. The model was developed collaboratively with the health system on shared strategic goals, and with incentives to achieve clinical performance metrics. These were not TAT goals, they went beyond that to encompass true clinical quality metrics, such as improvement in mammography recall rate, improved IVC filter retrieval rate, improved length of stay by optimizing inpatient utilization, care coordination, IR oncology growth etc. We developed formal shared governance of the service line with the hospital including joint strategic planning, approval of capital equipment purchases, and tech staffing decisions. For the hospital, they obtained alignment with the rads without high cost of employment, and the rads became advocates for hospital clinical initiatives in collaboration with other service lines. For the radiologists, we strengthened our relationship, were able to recruit for IR and other subspecialties more reliably, and grow market share while maintaining our independence and dept leadership. There were many clinical improved outcomes from this model, along with financial benefits where we received additional $400,000 support to our practice which was used to align our practice's governance to support this strategic initiative. This was very successful since it was instituted in 2012 at RAC and has continued all these years to the present through the group's partnership with Radiology Partners, which is a testament to the strength of the model. The model was published in JACR in 2015 and I have talked about it at multiple ACR/RLI presentations over the years.

This model of co-management allowed our group to develop another key RLI concept of radiology's role in population health management which was most inspired by Jonathan Berlin's ACR/RLI presentations along with others. The concept included use of CDS, use of ACR Recommendations for Incidentalomas, about how data mining could be used to evaluate outcomes, and about how hospital-based radiologists can manage utilization across the spectrum of inpatient/outpatient/ER. I took this concept and implemented it within the governance model of co-management at RAC. The hospital had purchased a data mining software called Montage, which could track keywords in our reports. Under co-management, RAC hired a radiology clinical coordinator who used Montage to review imaging results of inpatients being admitted for suspicious new neoplastic findings who may need a biopsy. The coordinator worked with the hospital admitting team to ensure whether a biopsy was needed, and if so, was able to expedite it rather than waiting for the usual process of a consult leading to a biopsy request to IR days later. We were able to reduce length of stay by 3 days in the inpatient biopsy population by using this strategy. This led to multiple other successful projects of population health management such as decreasing utilization of Chest CTA in the ER for pulmonary embolism by 15% over one year (won an ACR Gold Medal for Abstracts in 2016). These projects were formulated into a

consulting group called RadHelp, which lead to the partnership between RAC and Radiology Partners (RP) in 2015, and is the foundation of the clinical value team in RP.

So, in summary, as you can see, the ACR Practice Leaders meetings and RLI have been essential in my personal career growth as well as the success of RAC and RP, and has led to lasting clinical quality improvement as well as sustainable value-based radiology practice models. I couldn't have instituted these strategies without the guidance provided by the RLI as well as key associated RLI mentors including but not limited to Frank Lexa, Jonathan Berlin, Rich Duszak, Larry Muroff and others. The human capital and leadership of the RLI is a key institution guiding the future of the radiology specialty and I am honored to have been a small part of it and its impact in radiology practice leadership.

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2022 RLI Impact in Leadership Award

Vivek Masson, MD, DABR
System Chairman of Radiology | CarePoint Health

Project Description

I currently serve as System Chairman of Radiology at CarePoint Health which serves a busy network of safety net hospitals and Outpatient Centers in Northern New Jersey, located in one of the most populous and ethnically diverse counties in the greater New York area. Through my role, I have integrated and combined previously separate divisions and hospitals into one combined service line allowing for increased subspecialized care for the local community.

I am particularly proud of my efforts over the past few years to address access to care and systemic bias issues in my local system and community at large. I am deeply fortunate to care and contribute for a community that I was raised in as a child of two immigrants. To that effect, I have actively sought to address issues of racism and access in our system. Through my role I have increased the diversity of historically underrepresented groups in my department. I recently oversaw the development of a Women's Health Pavilion this fall, which was aimed at addressing access to care issues to the local communities including large LatinX, Indian-American, and African American communities.

A significant part of the program is offering affordable care to those populations who would otherwise be unjustly deprived of access. Christ Hospital has always been a cornerstone of our community, a reflection of the vibrant multicultural hub that is Jersey City. Crucial urban centers of care like Christ fight for their survival amidst the forces of systemic bias that loom large in the state creating a two tiered and inequitable system of health care delivery in NJ. In fact, Christ Hospital recently ranked as the top hospital in the country on the Lown Institiute's most Socially Responsible Hospitals in America for 2021. Quite simply this center has saved lives by screening for, diagnosing, and ultimately treating those women afflicted with breast cancer as well as host of other gynecological malignancies and diseases through a collaborative multi department approach to clinical care.

When I entered my position over 9 years ago, I was excited for the opportunity to lead a group of 15 radiologists across 3 hospitals building a unified platform and system for a newly emerging health system. As a busy clinical practitioner, I had little knowledge or formal training in radiology leadership. My time at New York Presbyterian Hospital Cornell (residency) and New York Presbyterian Hospital Columbia (MSK fellowship) prepared me well for my clinical acumen, but there was not much emphasis on the leadership and business side of radiology. Given my limited time, the Radiology Leadership Institute became my primary source for this knowledge. The ability to learn and be shaped by world class leaders who are giants in the healthcare field was instrumental in my success.

My latest endeavor, which I am most proud of given its social impact of those truly in need of the care we deliver, was a culmination of the plethora of skills I obtained during my time in the RLI where I

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reached level 2 certification in the program as well as during my time at the RLI/Harvard Emerging Leaders Seminar and RLI Summit at Babson College. Though all the courses and seminars added to my development, for this specific initiative, a few notable lectures and courses stood out for me:

- Dr. Brent Wagner's seminar on the need to develop strong relationships with the medical staff and administration laid the foundation for my project. Getting buy-in from all parties involved was instrumental in selling my vision, beyond the short-term cost efficiencies of the program, but to truly build a connection with the president of the medical staff as well as the system CEO was crucial to the success of the program.
- Dr. Frank Lexa's engaging and important seminars on Finance provided me with a solid foundation to understand the business side of radiology where I could sit down with the relevant stakeholders from the finance and business development team and speak their language with confidence so that we were all aligned to the same goal.
- Finally, Dr. Thorwarth's seminar on the importance of involvement beyond clinical care allowed me to think outside the box and advocate for the project on a community health level bringing in local city and health care officials who could become vested stakeholders in the importance of the project. In fact, I was interviewed by the mayor of Jersey City about the importance of the project to the local community.

Beyond these foundational seminars, the ability to practice and hone these learned skills at the RLI/Harvard Emerging Leaders Seminar as well as the RLI Summit in Babson was instrumental to my growth as a leader. The keynote lecture given by the late Clay Christenson was a particularly important turning point in my career as his strong stance on the importance of ethical leadership provided me a foundation to base my own decisions on. More recently, I have thoroughly enjoyed the exquisite podcast series Taking the Lead by Dr. Geoffrey Rubin. Through this series, I have gained deep and meaningful insight into management decisions from the greatest radiology minds in the world.

Without the RLI, I would not have the tools to have been able to have led my radiology team for the last 9 years. The skills learned from the RLI and ACR have been by far the most important part of my transformation into a practice and system leader. I can honestly say that if not for the RLI, this project which will help save the lives of thousands of underserved people in northern NJ would not have happened. The RLI has empowered me to make a positive impact in my local community that I hope will lead to bigger and more impactful initiatives in the future.

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2022 RLI Impact in Leadership Award

RADIOLOGY® LEADERSHIP INSTITUTE
AMERICAN COLLEGE OF RADIOLOGY

Andrew Moriarty, MD
Vice President of Clinical Operations and Quality Chair | Advanced Radiology Services

Project Description

Over 12 months, our large, subspecialized practice took on the challenge of integrating our largest hospital partner into our teleradiology platform and creating a cohesive reading solution for the 200+ radiologists and >2 million examinations annually that effectively touched all aspects of their current and future practice. This project brought together two disparate reading environments into a unified workflow for radiologists the goals of enhancing patient care, system standardization, and overall clinical operations.

At the beginning there were effectively two environments that operated in parallel, with one half of the organization relying heavily on local radiologists to provide 24/7 high-quality care in a busy, tertiary-care environment. As the chair of our Clinical Leadership Committee (CLC), I was tasked with coordinating this project while working with the radiology practice section chiefs, our distributed radiology (DR) information technology department, our decision support (DS) clinical analytics team, and our hospital partners.

Participating in the RLI Maximize Your Influence and Impact Course gave me the crucial foundational leadership knowledge and the skills to lead this project. I was able to draw on the many hands-on discussions during various points throughout the project. The course also highlighted for me the importance of both formal and informal communication as critical to the success of such major initiatives and ways that building and strengthening relationships would help the program succeed. A few of the specific details from the project included:

1) **Recognizing the critical relationship between radiology and hospital operations.**
   Prior to the integration, this institution noted that outpatient turnaround times were regularly outside of target despite sufficient local staff to provide timely emergency, inpatient, and urgent care. By combining a robust remote reading solution and optimizing clinical staffing, the practice was able to improve outpatient TATs by over 35% within just 3 weeks. During the first month of the project, several members of hospital leadership called to note how they or a friend or family member had an imaging study that was performed that morning with results ready by the afternoon. Moreover, we have demonstrated sustained improvements despite staffing challenges due to the recent COVID omicron variant that in the past would have been difficult to manage.

2) **Create the right organizational structure to navigate radiology and hospital operations.**
   Our CLC was organized a few years prior to this project, with the purpose of improving clinical operations at the level section chiefs and reporting to the practice board and leadership. This

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project allowed those section leaders to come together and work with IT and DS to map out all the practice volume across 14 different hospitals according to detailed historical data and build future staffing using a robust capacity analysis tool that to optimize scheduling on a per hour basis. The result is improved clinical efficiency, great subspecialized patient care, and enhanced work-life balance for our radiologists. This tool is now adapted to model future growth and hiring needs and can be adapted to provide crucial information for multiple areas of the practice.

3) **Address the challenges physicians face when working in teams and how to align members with diverse perspectives and backgrounds around performance goals.**

   Our project involved major changes to both the daily schedules of all radiologists and the distribution of cases across the entire enterprise. During initial discussions, it became clear that the need to address "turf" concerns and the need to create equity across different jobs would be vital to program implementation and success. Fortunately, these topics were thoroughly discussed during the RLI webinars and in the breakout group sessions, helping me to build a supportive environment for all stakeholders as we debated and agreed on the needed changes.

4) **Using basic financial statements and financial analysis to assess financial health and develop improvement strategies.**

   While improving patient care and clinical operations were always the key goals of the project, the team made sure to pay specific attention to how the changes would also improve operational finances while also supporting radiologist well-being. This involved a deep look at the scale and flexibility our large organization provided, polling members on their career goals and perspective for work-life balance, and analyzing areas of operational support to radiologists. As mentioned earlier, several of the tools and processes developed during this project have been adapted to provide important ongoing business analytics support to the practice leadership and operational committees.

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