

# AI is for people and processes

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## The reality in imaging today



Imaging volumes  
continue to rise



Case complexity  
is increasing



Staffing  
shortages persist



Experience levels  
are more variable

## The risk of 'efficiency-only' AI

- Faster workflows  $\neq$  lower stress
- Automation without reliability increases verification burden
- Poor outputs shift work downstream
- Burnout risk increases when variability persists
- Alert vs clinical context



## AI as a quality and consistency multiplier

### Strategic Shift



Task enablement



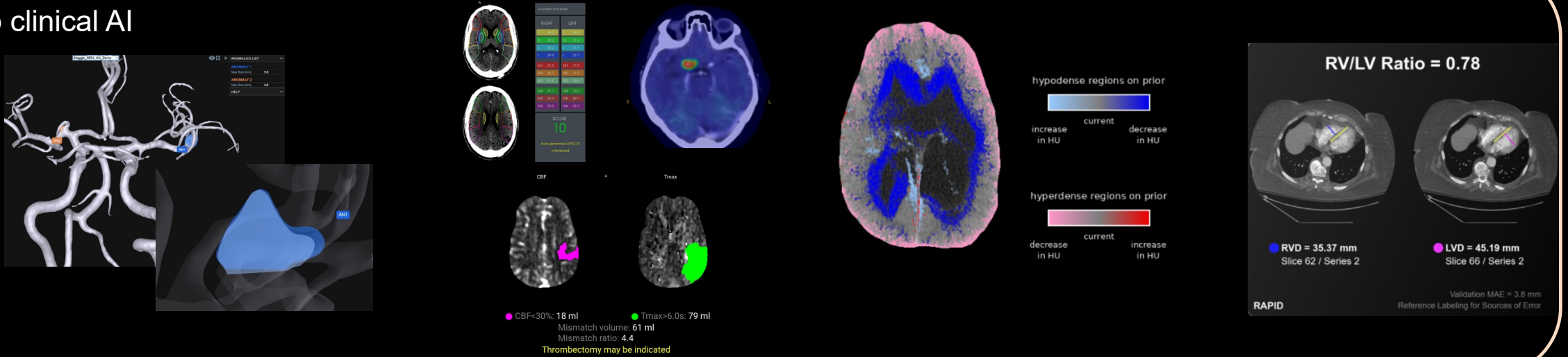
**Decision enablement**

### The most impactful AI:

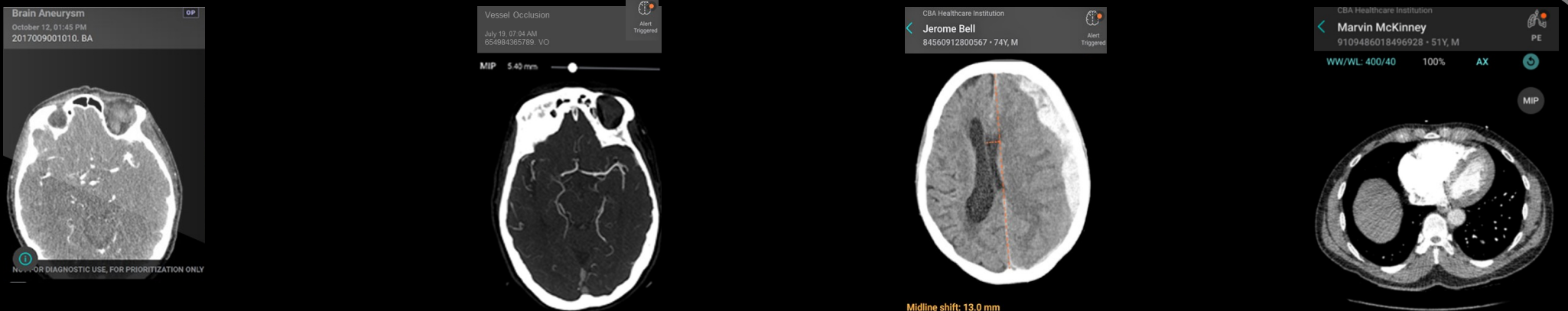
- Reduces variability before it reaches the reader
- Creates a consistent baseline across experience levels
- Minimizes repeated manual correction, measurements, + calculations
- Builds confidence that drives sustained adoption

# Depth that drives clinical impact

## Deep clinical AI

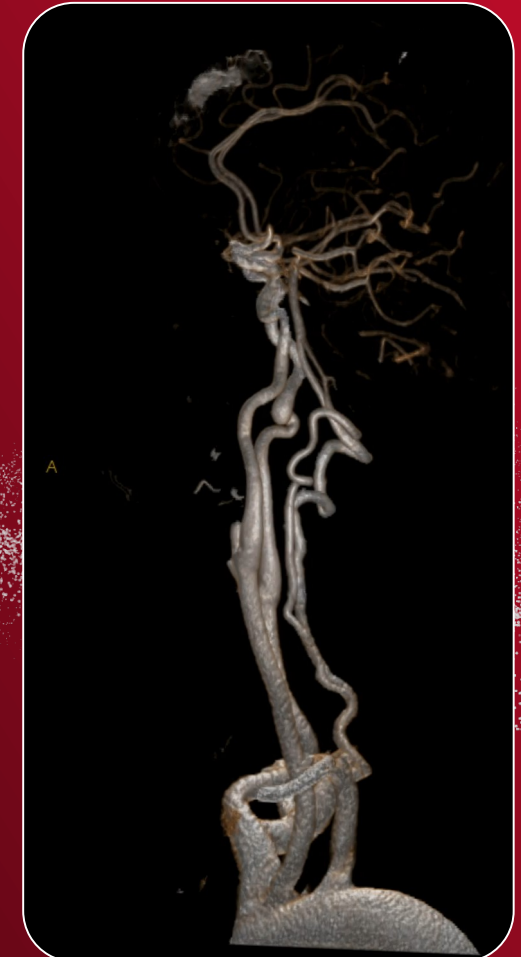
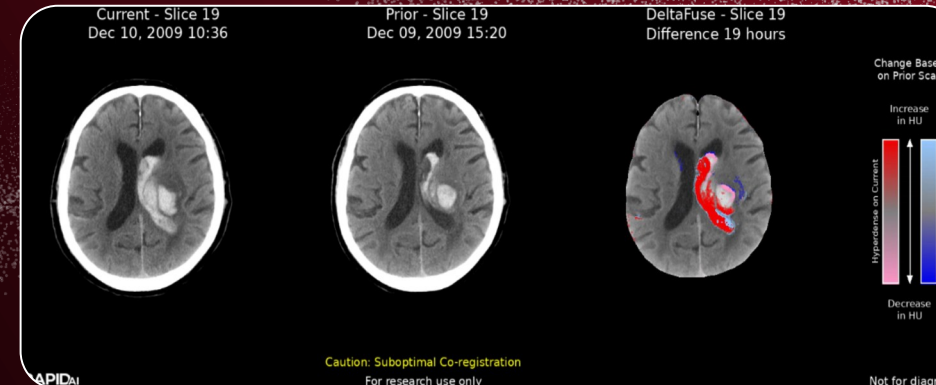
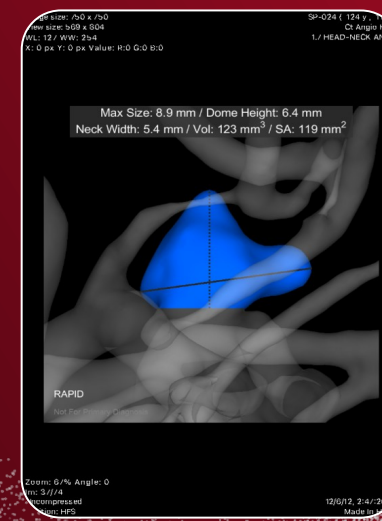
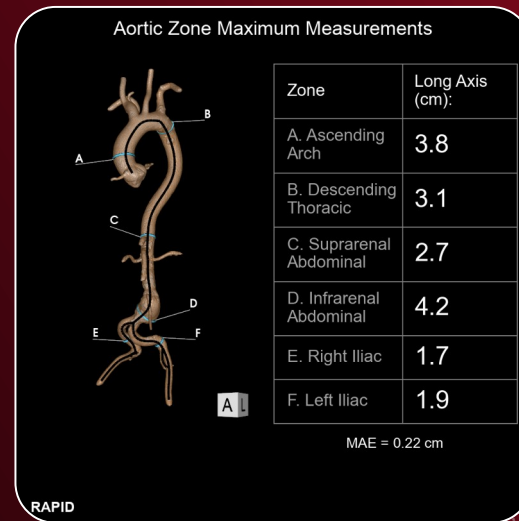


## Standard AI



# How depth changes the workforce

- Less manual constructions
- Fewer downstream corrections
- Reduced variability across shifts
- Improved cognitive capacity for interpretation



# AI must support the imaging team

*Not just the radiologist*

- Technologists benefit from automation of reconstruction
- Radiologists benefit from standardized outputs
- Administrators benefit from performance consistency + improved throughput
- IT benefits from scalable infrastructure



## SITUATION

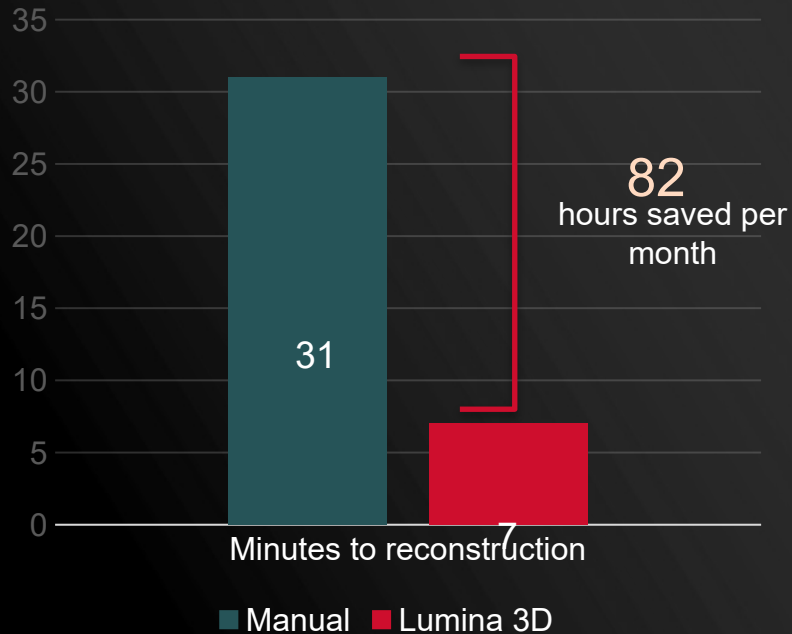
### Nebraska Methodist

- 700+ bed system
- 3,800 head + neck CTAs per year
- Overburdened techs

Review of 30-day usage of Lumina 3D™

## TRANSFORMATION

### 100% H+N recon transfer to Lumina



## IMPACT

### Incremental CT scans

**108** ↑  
*Added per month*

### Incremental revenue

**\$43k**  
*\$405 per scan*

## VALIDATION

"Lumina 3D improved our CT imaging efficiency by reducing post-processing time, leading to faster turnaround and quicker results."

**Leslie Cattau, MHA**  
*Executive Director of Imaging*

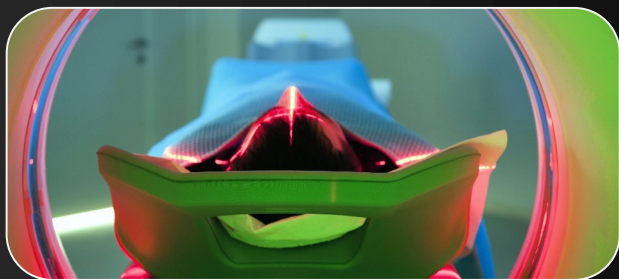
# Cognitive burden

The background features a smooth gradient from a vibrant red on the right to a deep black on the left. A trail of fine white particles, resembling a comet's tail or a spray of dust, curves across the lower half of the image, starting from the right and moving towards the left.

# Cognitive burden is a performance limiter

## Drives fatigue

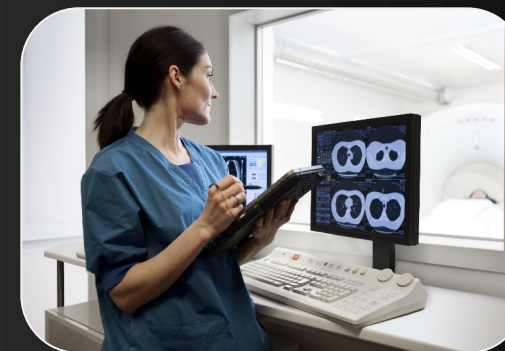
Contributes to inconsistency, diagnostic error, + lower productivity



## 39%

of radiologists want to leave their job

**Burnout** + retention issues have clinical + financial consequences



## Impaired quality of life

+ functional capacity

# Understanding cognitive burden

01



Mental energy is finite, complex reads are exhausting

02



Workflow friction is cumulative, clicks add up shift over shift

03

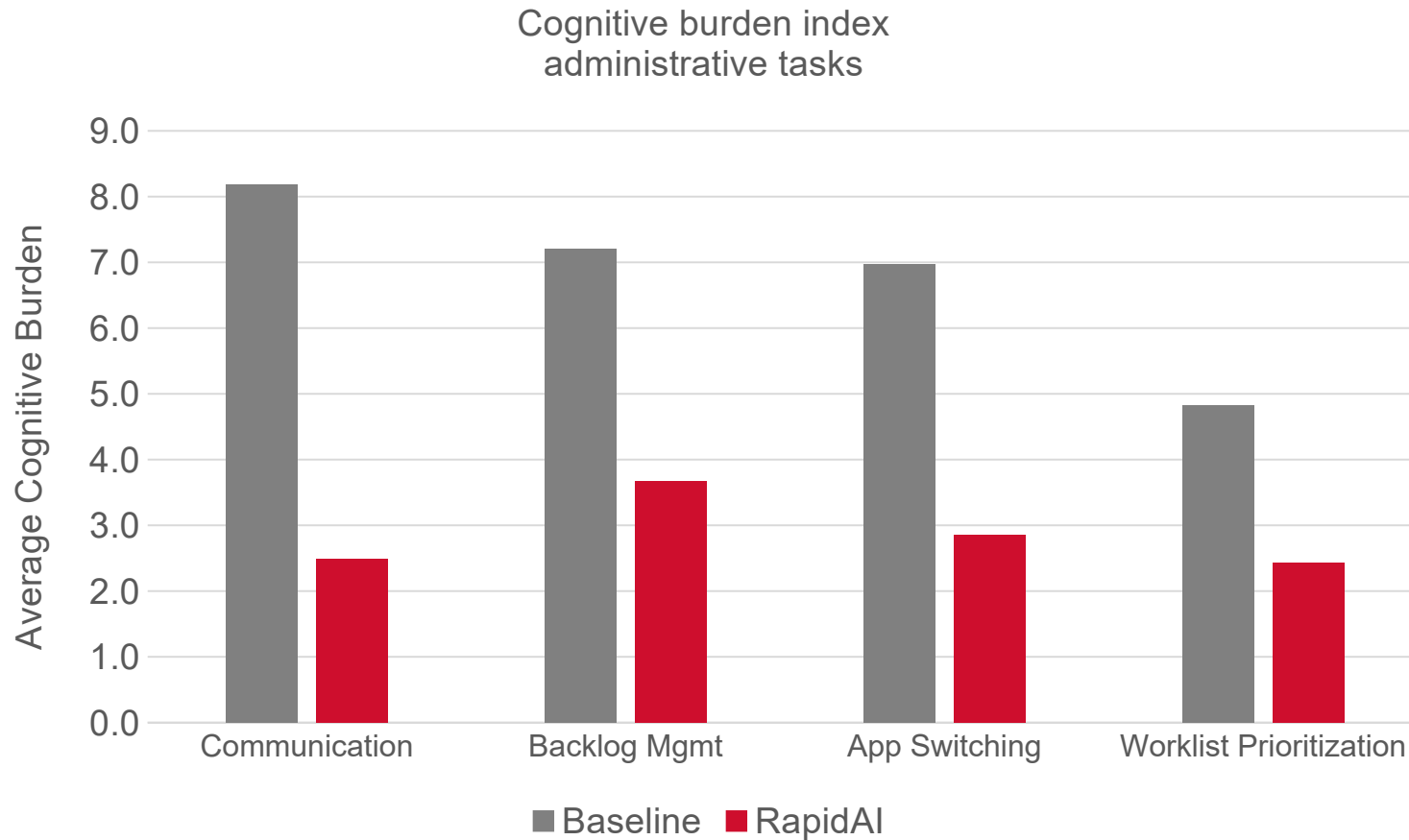


When fatigue meets friction, errors and variability increase

Reduce friction → protect mental energy → improve clinical clarity

# What the data show

Mental energy x workflow friction = Cognitive Burden



Anonymous survey

- **40** radiologists
- Various specialties
- Various tenure

**60%** Reduction of cognitive burden

# Radiology's unified workspace

Patient Name	MRN	Study Date	Description	Modality	Accession #	Instances
Veronica, Vict...	38KXC3D0K	Jul-25-2025	06:05 PM	CT Head w/ w/o C...	CT	ZP81TCY4DF 213
Tony, Treat	7ca83cf4-84...	Jun-08-2020		XA		469
Tara, Brian Col...	UQV9L8D0X5	Feb-22-90	07:59 PM	CT Head w/ Contr...	CT	WA694VBRFW 306
Stroke_Demo...	840619583	Jan-31-2024	04:00 PM	CT Head w/o Contr...	CT	354120 45
Stroke_Demo...	8847440223	Jan-31-2024	09:00 AM	MR Head (Stroke)	MR	800675 965
Stroke_Demo...	4070419526	Jan-31-2024	07:30 PM	CT Head w/ w/o C...	CT	444082 213
Stroke_Demo...	883370907	Jan-31-2024	07:45 PM	CT Head w/ Contr...	CT	337034 305
Sheri, John L.o...	IBATZ780H5	Sep-21-1950	08:26 PM	CT Head w/ Contr...	CT	MU263EGOZ 460
PE_Demo, Pen...	707130559	Jan-31-2024	01:00 PM	CT Chest Pulmonary...	CT	514868 267
Paulita, Poom	64bd5e48-d...	Nov-02-2017	01:14 PM	CT	CT	552
Paulita, Poom	64bd5e48-d...	May-15-2018	01:23 PM	CT	CT	428
Mason, Middle	0878cd0-5e...	May-19-2023		CTA		711
Mason, Middle	0878cd0-5e...	Jan-21-2021		CTA		693
Mary, Middle	c380995c-8...	Nov-21-2022		MR		312
Mary, Middle	c380995c-8...	Nov-21-2022		MR		278
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Mary, Middle	c380995c-8...	Oct-08-2021		MR		278

LVO on NCCT Series 1 Suspected

Vessel Occlusion + Suspected

VO+ Occlusion Suspected

CT Brain VO+

DOEY / F18MM Series Description...

MRN: 1234567

1234 - A.MT\_ANEURYSM\_AORTIC\_DEMO - CT Chest

CLINICAL DATA: Chest pain, left upper quadrant pain and shortness of breath since this morning.

EXAM: CT ANGIOGRAPHY CHEST, ABDOMEN AND PELVIS

TECHNIQUE: Non-contrast CT of the Chest was initially obtained.

Multidetector CT imaging through the chest, abdomen and pelvis was performed using the standard protocol during bolus administration of intravenous contrast. Multiphase reconstructed images and MIPs were obtained and reviewed to evaluate the vascular anatomy.

CONTRAST: 100ml OMNIPaque (CHEXOL 350 MG/ML SOLN)

COMPARISON: CT scan [DATE]

FINDINGS: CTA CHEST FINDINGS

Dissection: The precostal CT of the chest does not show any definite intimal hematomata. Mild enlargement of the descending thoracic aorta with maximum diameter of 39.5 mm. The ascending thoracic aorta is normal in caliber with maximum diameter of 37 mm. After contrast administration there is evidence of a type B aortic dissection beginning just past the left subclavian artery origin and extending all the way down the thoracic and abdominal aorta. Well demarcated intimal flap with a smaller true lumen and a larger false lumen with typical beak sign.

The heart is normal in size. No pericardial effusion. No pericardial homotoma. The aortic branch vessels are otherwise appear normal.

Mediastinum/Lymph: No mediastinal or hilar mass or adenopathy. The esophagus is grossly normal.

Lungs/Pleura: Patchy bibasilar atelectasis but no infiltrates or effusions. No worrisome pulmonary lesions. Musculoskeletal: No significant bony findings.

Review of the MIP images confirms the above findings.

CTA ABDOMEN AND PELVIS FINDINGS

VASCULAR

Aorta: The aortic dissection continues down and involves the abdominal aorta. No aneurysmal dilatation. Collar: Originates from the true lumen. No stenosis or atherosclerotic calcifications. The collar arch branch vessels are patent.

SMA: Originates from the true lumen. No stenosis or atherosclerotic calcifications. The branch vessels are patent.

Renals: The right renal artery is originating from the true lumen. The left renal artery is involved with the dissection but demonstrates normal perfusion. Both kidneys are normally perfused.

IMA: Originates from the false lumen but normal appearing perfusion.

Follow: The dissection continues down the left common iliac artery. I do not see it on the right side for certain. It goes down to the left low-artery bifurcation and continues down to the left common femoral artery bifurcation.

Veins: Grossly normal.

Review of the MIP images confirms the above findings.

NON VASCULAR

Hepatobiliary: No hepatic lesions or intrahepatic biliary dilatation. The gallbladder appears normal. No common bile duct dilatation.

Pancreas: No mass, inflammation or ductal dilatation.

Worklist Prioritization

Rad Assistant

Auto reporting

# Process & performance

Outcomes depend on **workflow fit**, not on algorithms alone.



## **Seamless fit**

Integrates with existing process



## **Precision timing**

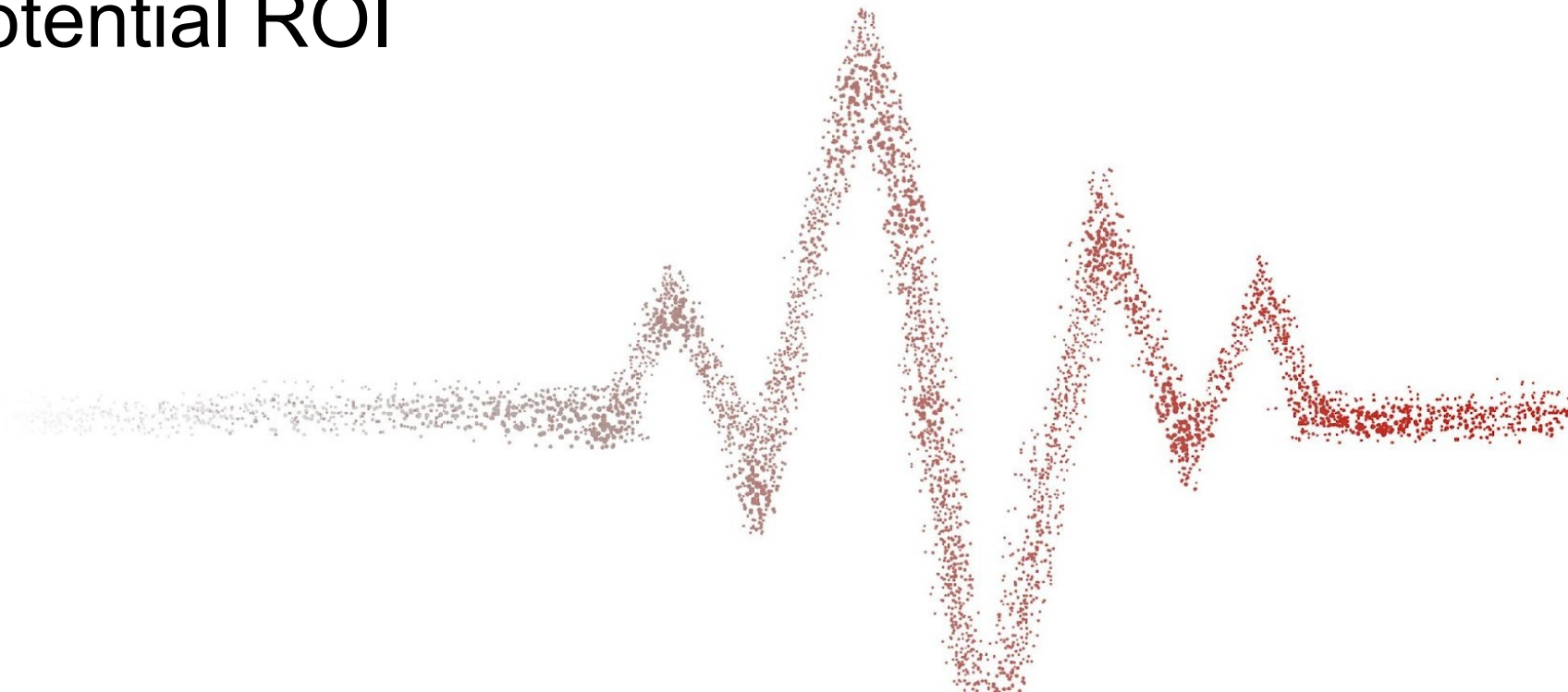
Right moment delivery



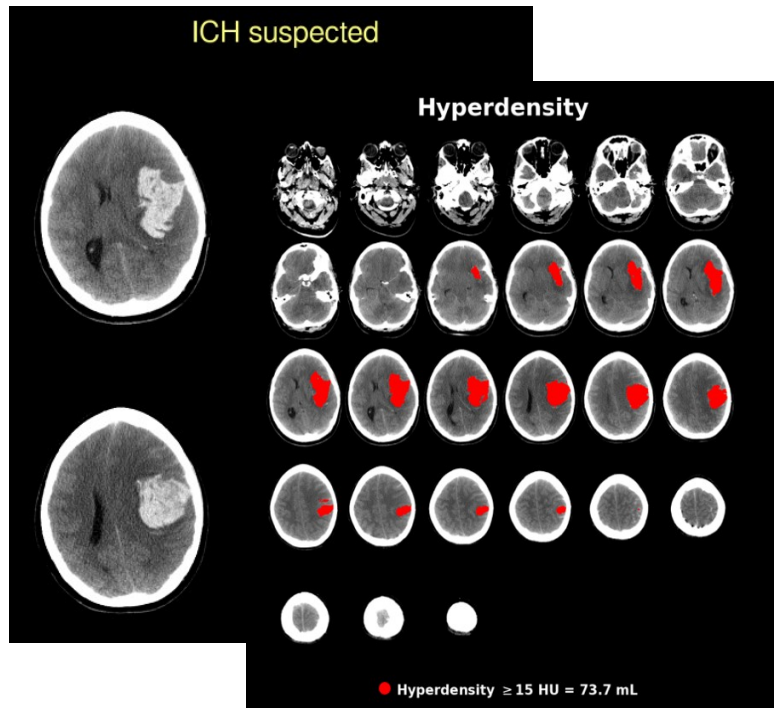
## **Actionable insights + collaboration**

Reduce decision fatigue

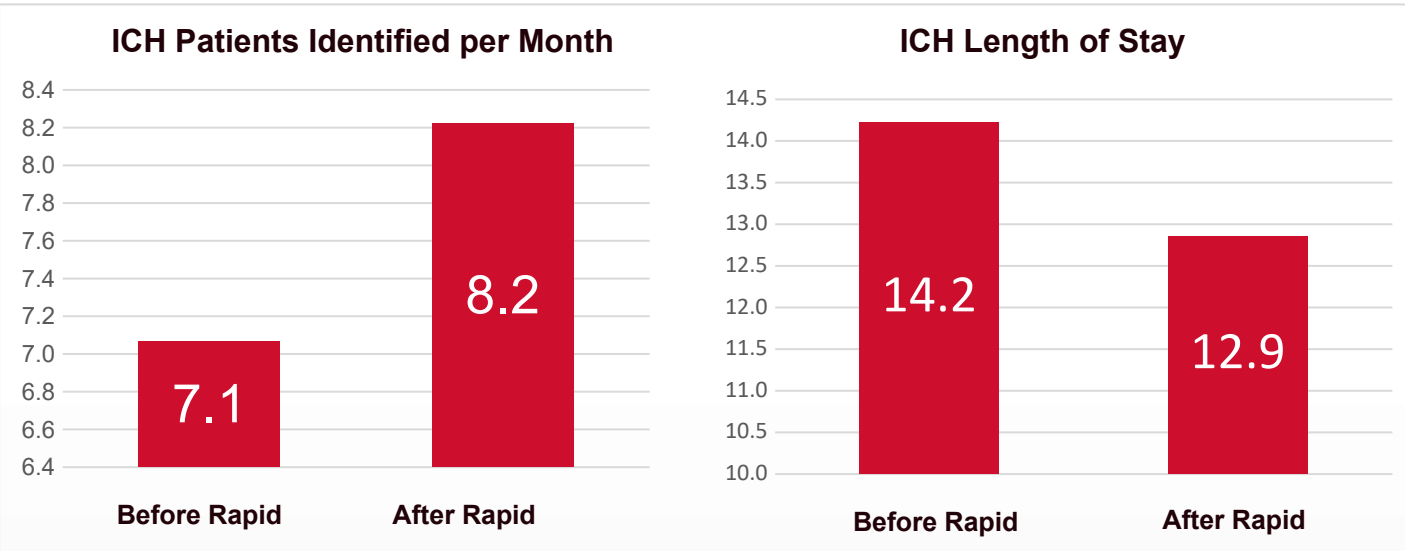
# Recognizing the potential ROI




# Increased ICH identification // Reduced LOS



Analysis of 36 months of data pre- and post- rapid installation at **Corewell Health's Dearborn Campus**.



**TAKEAWAY** >>> Rapid can enhance ICH detection, improve ICH score reporting, boost throughput, and support incremental reimbursement.

 **\$500** Confirmed Average Payment on Outpatient NCCT scans billed with 0722T (Rapid Hyperdensity)<sup>1</sup>

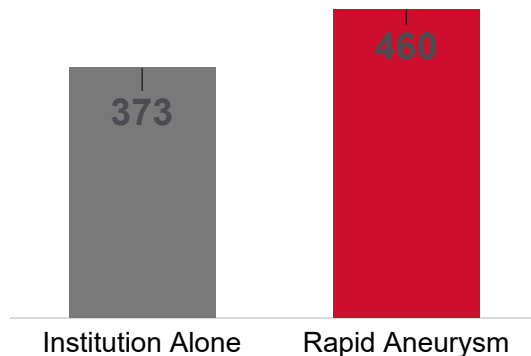
<sup>1</sup> When 0722T was applied to outpatient NCCT scans, where no subsequent CT scan was performed, Corewell received payment with an average payment rate of \$500 per case. For more information, please contact [reimbursement@rapidai.com](mailto:reimbursement@rapidai.com)

# Proven gains in incidental aneurysm detection<sup>1</sup>

Largest ever – 4-year retrospective consecutive real-world study of **11,694** CTAs  
Full neurovasculature: ICA, MCA, ACA, ACOM, PCA, BA, VA  
5% aneurysm prevalence  
93%/96% Sensitivity/Specificity for ≥3mm aneurysms  
3.9 mm average size of Rapid-detected aneurysms missed by radiology

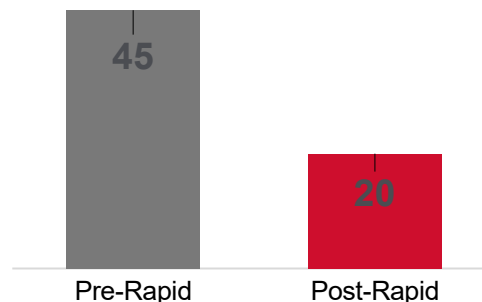
**23%** ↑

More aneurysms detected with Rapid



**55%** ↓

Fewer patients lost to follow up<sup>2</sup>



Stony Brook Medicine

Estimated financial gain

**\$1.7M**

from increased detections<sup>1</sup>

**\$676k**

from reduction in lost patients<sup>2</sup>

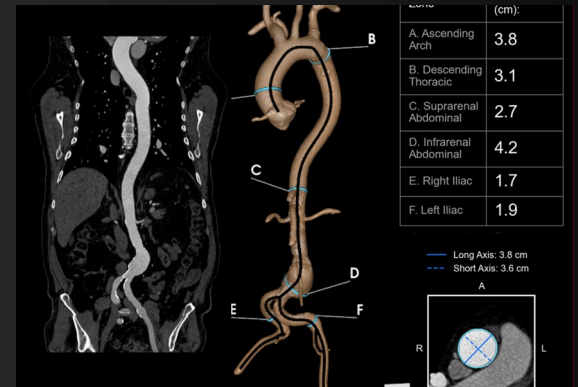
1. [Dashti R, et al. 2025 AANS Annual Scientific Meeting; 2025 Apr 25-28; Boston, MA.](#)  
2. [Secondary analysis of the original dataset. Pending publication.](#)

# Consistency in a variable world

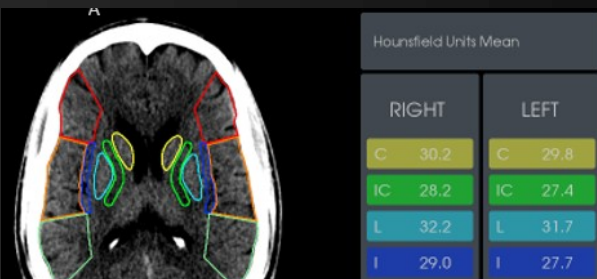
1. Staffing shortages are real

2. Turnover impacts experience levels

3. Training environments vary

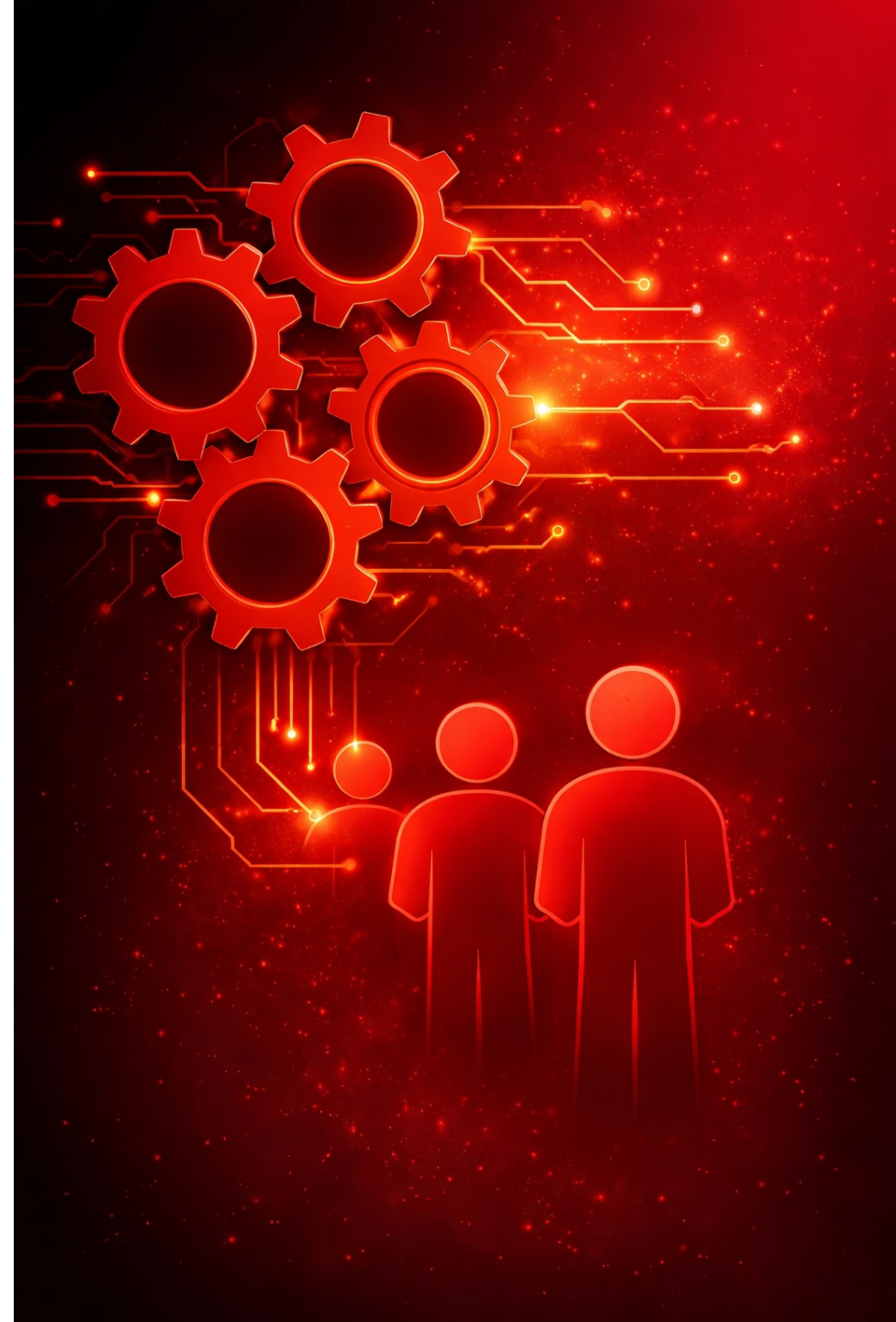


Deep clinical AI can stabilize performance



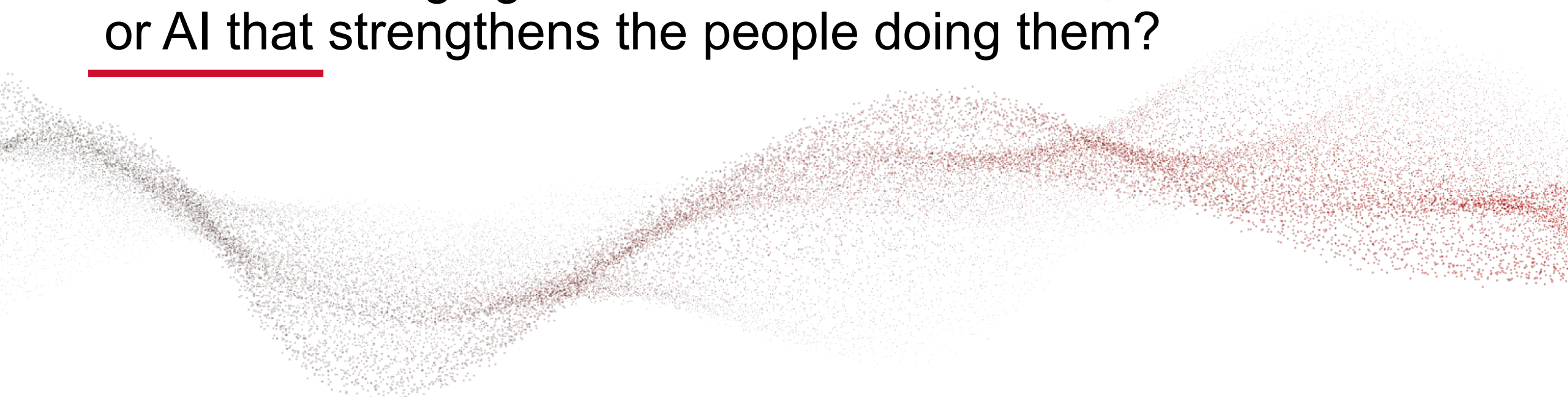
## AI is for people **and** processes

- AI must:
  - Stabilize workflows
  - Protect cognitive capacity
  - Support the entire imaging team
  - Deliver quality, meaningful support
  - Become part of the infrastructure



Are we leveraging AI that accelerates tasks,  
or AI that strengthens the people doing them?

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# Q&A session

