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Thomas C. Ricketts III, PhD, MPH, Managing Director of the American College of Surgeons (ACS) Health Policy Research Institute, Washington, DC, recently brought to my attention a report from the Healthcare Cost and Utilization Project of the Agency for Healthcare Research and Quality. “Trends in Operating Room Procedures in U.S. Hospitals, 2001–2011,” indicates that although the overall number of procedures remained relatively stable over that time, the volume of some procedures grew while the number of other types of operations declined.* I thought many of you, particularly surgical educators, would be interested in reviewing some highlights from the report and in considering the implications on the surgical workforce and training.

Findings
The report indicates that some operating room (OR) procedures have become more prevalent, whereas other operations are being performed less frequently. Some examples are as follows:*

• In 2001, musculoskeletal procedures constituted 17.9 percent of all procedures, but in 2011, this number rose to 24.2 percent, representing a 38 percent increase. Knee arthroplasty nearly doubled from 371,600 procedures in 2001 to 718,500 procedures in 2011, and hip replacement procedures increased by 40 percent, from 332,500 operations to 466,500. Spinal fusion increased by 70 percent, from 287,600 in 2001 to 488,300 in 2011.

• OR procedures involving the digestive system accounted for 18 percent of the operations performed in 2001 versus 18.5 percent of the procedures in 2011, representing a 5 percent increase in volume. The volume of appendectomies decreased by 13 percent, from approximately 376,700 procedures in 2001 to 327,100 in 2011. Colorectal resection and cholecystectomy remained relatively stable during this time.

• OR procedures involving the cardiovascular system decreased from 15.5 percent in 2001 to 13.6 percent in 2011, an 11 percent decrease in volume. Coronary artery bypass graft operations decreased by 46 percent, from approximately 395,100 procedures in 2001 to 213,700 procedures in 2011. Percutaneous coronary angioplasty decreased by 28 percent and pacemaker or cardioverter/defibrillator procedures increased by 42 percent, while heart valve procedures remained fairly stable. Both endarterectomy and peripheral vascular bypass decreased by approximately one-third.

• OR procedures involving the female and male genital organs each constituted more than 8 percent of all OR procedures in 2011, and both decreased in volume from 2001 (33 percent for female genital organs and 10 percent for male genital organs).

• Obstetrical operations represented slightly more than 8 percent of all OR procedures in 2011—a 23 percent increase in volume since 2001, with a 28 percent increase in the volume of cesarean sections.

The trends uncovered in the study likely are the result of several factors, including an aging patient population combined with advances in technology and pharmaceuticals. Older individuals are more likely to suffer from musculoskeletal disease, such as osteoarthritis and rheumatoid arthritis and disc deterioration, and to require hip replacements, spinal fusion, knee operations, and so on. Meanwhile, advances in noninvasive procedures, technology, and medication are likely spurring the decline in cardiovascular operations and certain gastrointestinal conditions.

Implications for the future
These trends will likely have profound implications for the surgical workforce of the future. "The reduced demand in community hospitals for selected procedures combined with growth in others can change the structure of the surgical community," said Dr. Ricketts, professor of health policy and management and social medicine at the University of North Carolina (UNC) Gillings School of Global Public Health and the UNC School of Medicine-Chapel Hill. “The drop in the total

number of procedures such as appendectomy, combined with the lack of growth in colorectal resection and cholecystectomy—procedures performed most often by general surgeons—has implications for whom we train, as well as how we train surgeons.”

The conventional wisdom for many years has been that the aging baby boom patient population combined with a larger number of surgical residents opting to enter the subspecialties will lead to an access to care crisis for general surgery patients. Furthermore, as more patients obtain health insurance coverage under the Affordable Care Act, we may see a gradual growth in the demand for elective general surgery procedures as patients and insurers seek out the most cost-effective methods for curing diseases and achieving long-term relief from health care conditions. Therefore, it is imperative that the surgical community provide incentives for young physicians to pursue general surgery as a career path.

On a surface level, the data presented in this study would seem to negate this hypothesis. After all, if fewer general surgery procedures are being performed, why would the nation need more general surgeons? However, a more reasonable and realistic conclusion is that we need to provide general surgeons with a broader skills set that extends well beyond performing surgical procedures, so that they are better able to provide the full range of services that their patients will need. The ACS and other members of the surgical community have been making this claim for some time, and this study, if anything, should demonstrate that the need to move in this direction is increasingly urgent.

With regard to surgical training specifically, “These broader trends mean that teaching programs for some specialties, especially general and thoracic surgery, may find it difficult to give surgeons the volume of work they need to develop excellent surgical skills,” added Dr. Ricketts, who is also deputy director of the Cecil G. Sheps Center for Health Services Research at UNC. As a result, we may need to expand the use of simulation and other innovations in surgical training to ensure that residents do have ample opportunity to hone their operative skills.

The ACS Health Policy Research Institute and the College’s leadership intend to study these data and their potential effects on the surgical profession and training in greater detail. We will work with the surgical education community to ensure that this and future generations of surgeons have the technical skills and knowledge necessary to provide high-quality care in our evolving practice environment. ♦

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
H  urricane Katrina, which the Federal Emergency Management Agency (FEMA) has described as the “single most catastrophic natural disaster in U.S. history,” hit the Gulf Coast on August 29, 2005, causing severe damage to Louisiana, Mississippi, and surrounding areas. A total of 1,833 people in five states lost their lives as a result of the hurricane and subsequent floods; approximately 1,600 of those deaths occurred in Louisiana. More than 1 million people in the Gulf region were displaced by the storm. Over President George W. Bush declared a state of major disaster in Alabama, Louisiana, Mississippi, and Florida. Kathleen Blanco, Governor of Louisiana at the time, declared a public health emergency on September 2, 2005. The Secretary of the U.S. Department of Health and Human Services (HHS), Michael O. Leavitt, declared a state of emergency in Mississippi, Florida, and Alabama initially and later extended emergency status to nine additional states, including those that received the displaced victims.

In the chaos that ensued in flood-ravaged areas, hospitals became shelters for patients, hospital workers and their families, visitors, and other individuals seeking refuge. Physicians and other health care professionals found themselves overseeing triage and evacuation efforts in addition to delivering medical care to sick patients with limited staff and resources. Power failure in hospitals in the affected areas added to the challenges. Health care providers worked

HIGHLIGHTS

- Describes the need for uniform license recognition and liability protection laws for volunteer health professionals
- Provides an update on UEVHPA
- Discusses the Good Samaritan Health Professionals Act
- Explains why surgeons need to continue to advocate for trauma and emergency care liability reform
- Lists useful resources for grassroots advocacy

by Naveen F. Sangji, MD, MPH; Jon Sutton, MBA; Kristin McDonald; and Leonard J. Weireter, Jr., MD, FACS
More than 33,000 VHPs responded to the call for assistance through various state-based or private emergency response programs, while others arrived on-site spontaneously. However, legal issues, such as licensing and credentialing, civil liability, and reparations for harm to volunteers, delayed or prevented these volunteers from providing care.

tirelessly in 100-degree heat without air conditioning or even light for days while evacuation efforts slowly progressed.5-6

As federal, state, and county officials worked to address the public health needs of disaster-stricken areas, they relied extensively on volunteer health professionals (VHPs) to provide health care services. More than 33,000 VHPs responded to the call for assistance through various state-based or private emergency response programs, while others arrived on-site spontaneously.7 However, legal issues, such as licensing and credentialing, civil liability, and reparations for harm to volunteers, delayed or prevented these volunteers from providing care. For example, left with no opportunity to provide medical care, a Louisiana physician and his staff mopped the floors at the New Orleans airport while sick people died around them. FEMA prohibited the team from administering care due to liability concerns.8

In a poignant letter to the American College of Surgeons (ACS), Melanie Korndorffer, MD, FACS, and James Korndorffer, MD, FACS, who were in Mississippi when Katrina struck, described their efforts to serve as volunteers in a hospital in Gulfport. (This letter, which is unavailable to the general public, was provided to the College as testimony for the Connecticut state legislature Joint Committee on Public Safety and Security hearing.) Dr. James Korndorffer is a practicing general surgeon at Tulane University in New Orleans; Dr. Melanie Korndorffer had until two years prior to Katrina practiced in Montgomery, AL. In the early stages of disaster relief, both physicians attempted to provide help in New Orleans, but due to evacuations, they were directed to the only functioning hospital located in Gulfport, on the coast of Mississippi. They arrived at the facility with proper identification; however, despite extensive efforts, the hospital administrators were unable to obtain approval for the Korndorffers to relieve the sole surgeon who had been working in the hospital for 96 hours without a break.

The Korndorffers shared their story with the College in an effort to convey to the physician community the necessity of devising a better system to facilitate volunteer health professionals in times of emergency or disaster. Specifically, they requested support for the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA).

In the last 60 years, an average of 36 disasters and six states of emergency have been declared annually in the U.S.9 Physicians and other medical professionals have consistently met the health care challenges associated with these events by volunteering their services. For example, within hours of the 9/11 attacks, a hotline set up to register physician volunteers in New York received more than 8,000 offers of help from across the nation. A group of 110 physicians, nurses, and paramedics attending an emergency and critical care conference across from the World Trade Center left the conference center en masse and set up a field hospital eight blocks from the fallen buildings.10

Unfortunately, inconsistent federal and state laws providing liability protections for volunteers prevent trained health care professionals from putting their skills to use in these times of emergency and disaster.11 Glenn Cambre, JD—the attorney supervisor for the Louisiana Department of Health and Hospitals during the period following Hurricane Katrina—stated the following with regard to disaster relief efforts after Hurricane Katrina: “The main thing we worked on was allowing out-of-state medical professionals who wanted to volunteer and come help, to waive the requirement of having them licensed in our state if they could show they were validly licensed in the state that they were coming from…. We had to keep renewing that executive order because we had so much need for help.”12 The time and resources expended on these efforts could be used more effectively elsewhere during such disasters. The obstacles that prevented volunteer health care professionals from assisting in the aftermath of Hurricane Katrina were also reported after the 9/11 attacks, Hurricane Rita in 2005, and Hurricanes Gustav and Ike in 2008. In a Council of State Governments publication, one of the five major lessons learned in the aftermath of Katrina was the necessity of defining liability and workers compensation coverage for volunteer health professionals.12
LIABILITY AND DISASTER RESPONSE

MAP OF THE ENACTMENT STATUS OF THE UEVHPA

Adapted from The Uniform Law Commission.

Current protections
Congress passed the Volunteer Protection Act (VPA), P.L. 105-19, in 1997. The VPA provides immunity to volunteers serving in both emergency and nonemergency situations, as long as they are licensed in the state in which harm occurred and no evidence of gross negligence emerges. However, an organization may be sued for the actions of its volunteers or itself sue its volunteers. This law falls short of specifically protecting health care professionals, such as physicians, nurses, and emergency medical technicians (EMTs). It also offers no protection to volunteers serving in any state other than the one in which they are licensed. Therefore, each individual state is free to determine the protections it will offer to out-of-state volunteers in times of crisis.

All 50 states and the District of Columbia have their own laws protecting VHPs, but because they are developed and implemented at the state level, the laws lack uniformity. For example, Mississippi protects VHPs who are licensed in the state but requires that out-of-state volunteers receive special volunteer licenses to receive those protections. Alabama protects VHPs licensed in any state as long as they are working with an “established free medical clinic” in Alabama during a disaster or emergency. Kansas law offers regional medical emergency response team members the same liability protections as state employees. Some states grant liability protections to VHPs during declared public health emergencies, and governors may declare volunteers to be state employees for liability purposes during public health emergencies.

States also have Good Samaritan laws that protect volunteers who act in good faith, without expectation of compensation, but those laws also lack uniformity. Some apply only to care provided to “accident” victims, whereas others apply to patients who receive care due to an “emergency.” The definition of “emergency” varies from state to state, as do the exact clauses and protections of each of these volunteer protection laws. A survey of state laws relating to VHPs and public health emergencies found that approximately 40 percent of states either lack statutes that provide immunity to volunteers during declared emergencies or have ambiguous statutes that require clarification. The lack of uniformity often causes confusion and uncertainty during emergencies and disasters when timely volunteer services are most needed.

UEVHPA initiatives
The UEVHPA is model legislation adopted by the Uniform Law Commission in 2006 in the aftermath of the Gulf Coast hurricane disasters. Laws that follow this
model allow health care professionals credentialed in any state to volunteer in a state that is experiencing a declared disaster. Health professionals may register to provide volunteer services either before or during an emergency in a state that has adopted the UEVHPA. Volunteers may register with federal programs, such as the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), local Medical Reserves Corps (MRC), or with private relief organizations, which confirm appropriate licensure. Volunteers are limited to the scope of practice for those health care professionals licensed by the state in which the disaster occurs and the scope-of-practice limits of the state in which they are licensed. The legislation obviates the need for time-consuming license-verification processes during disasters, when the infrastructure of the affected state may be unable to support registration and temporary licensing, and timely services can mean the difference between life and death. Civil liability protections and worker compensation also are offered. States may choose between two options for civil liability protections, both of which offer the same patient protections against willful misconduct and gross negligence. Alternative “A” offers protections for vicarious liability (that is, an organization is protected from liability for the actions of its volunteers), whereas alternative “B” does not. Alternative “B” also caps the compensation a volunteer may receive at $500 per year.

Kentucky became the first state to adopt the UEVHPA in 2007, followed by Colorado and Tennessee. In 2007, the College’s Board of Governors directed ACS Division of Advocacy and Health Policy State Affairs staff to advocate for passage of the UEVHPA in all 50 states and the District of Columbia, and in 2008, the Board of Regents adopted a formal statement in support of the model legislation. The Committee on Trauma (COT) has also endorsed the legislation. Since then, the ACS has been lobbying for passage of the UEVHPA in state legislatures, and Fellows have provided testimony in support of the model bill. Thus far, 14 states, one territory, and the District of Columbia have passed the legislation (see figure, page 12). Most recently, the model bill was introduced in the Pennsylvania State Senate (S.B. 1235/H.B. 512/S.B. 35).

**Good Samaritan Health Professionals Act**

Efforts are under way at the federal level to secure liability protections for professional health care volunteers who provide services in a declared emergency. The Good Samaritan Health Professionals Act, H.R. 3586, was introduced by Reps. Cliff Stearns (R-FL) and Jim Matheson (D-UT) in 2011 but died in committee. The language in this bill was subsequently included as an amendment to H.R. 5 in the 112th Congress, which passed in the House; however, because it was coupled with a repeal of the Independent Payment Advisory Board and a $250,000 cap on noneconomic damages, H.R. 5 died in the Senate. A total of 224 Republicans and 27 Democrats voted in favor of this amendment in the House.

Rep. Marsha Blackburn (R-TN) and Matheson reintroduced the bill as H.R. 1733 in 2013 along with 16 cosponsors. H.R. 1733 has been referred to the House Energy and Commerce Subcommittee on Health and the House Judiciary Subcommittee on the Constitution and Civil Justice. The Good Samaritan Act would afford volunteer health professionals the same level of civil immunity provided to all volunteers under the federal VPA. More specifically, H.R. 1733 would provide licensed health care professionals with civil immunity when they serve as volunteers during declared emergencies. To be covered under the legislation, VHPs must be “licensed, certified, or authorized” in one or more state(s).

Importantly, the legislation closes the gap in the VPA by allowing professional health care volunteers who are licensed in one or more states to cross into the state that is experiencing a declared emergency. This law also preempts any state statutes that are inconsistent with the Act, unless the state law provides “greater protection from liability.” Therefore, volunteers cross-
In 2007, the College’s Board of Governors directed ACS Division of Advocacy and Health Policy State Affairs staff to advocate for passage of the UEVHPA in all 50 states and the District of Columbia, and in 2008, the Board of Regents adopted a formal statement in support of the model legislation.

REFERENCES


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You can help

Volunteer health professionals are a key component of emergency and disaster response. Currently, lack of uniformity for licensure recognition and protection from civil liability remain major stumbling blocks to appropriate and timely involvement of physicians, nurses, EMTs, and other health professionals in times of disaster. The UEVHPA model legislation addresses those issues at the state level, and the Good Samaritan Act provides liability protection to VHPs at the federal level. Had the laws been in place before
This Good Samaritan Health Professionals Act would afford volunteer health professionals the same level of civil immunity provided to all volunteers under the federal VPA.

Hurricane Katrina struck the Gulf Coast, surgeons such as Drs. Melanie and James Korndorffer and countless other volunteer medical professionals could have served the victims of the disaster and, undoubtedly, saved lives.

To help avert these situations in the future, surgeons and other health care professionals are encouraged to advocate in their home states for the adoption of the UEVHPA and to urge their members of Congress to support the Good Samaritan Health Professionals Act of 2013. The ACS offers a new platform called SurgeonsVoice (www.surgeonsvoice.com), which allows members to quickly and easily send personalized electronic letters to their representatives and senators requesting that they support this legislation. A form letter in support of H.R. 1733 is available on the website. SurgeonsVoice also includes contact information for the district offices of legislators so that surgeons can request meetings with their elected officials to discuss these issues in person and share personal stories, which often have the greatest impact. SurgeonsVoice also includes contact information for each individual ACS member’s state legislators.

In addition, the ACS State Affairs staff can offer guidance and support to surgeons interested in advocating for this legislation in states that have yet to adopt the UEVHPA. Surgeons can play a vital role by offering testimony in support of the UEVHPA to state legislatures. The model legislation and educational materials are available on the ACS Advocacy and Health Policy Web page (http://www.facs.org/ahp/uevhpa.html), and State Affairs staff can be reached for further questions at state_affairs@facs.org.

Through grassroots advocacy, surgeons have the power to shape emergency and disaster care for the entire nation. ✪

REFERENCES (CONTINUED)

International Guest Scholarships:

An investment in surgical training around the globe

by Tony Peregrin
For nearly half a century, young surgeons have traveled to the U.S. from as far as Bangladesh, Sri Lanka, Uruguay, and New Zealand with a common purpose—an international exchange of surgical practice and research information. International Guest Scholarships (IGS) provide surgeons from around the globe the opportunity to visit clinical, teaching, and research facilities in North America with the goal of enhancing the scholars' patient care practices when they return home. The scholarships, in the amount of $10,000 each, also provide scholars with the opportunity to participate in the American College of Surgeons (ACS) annual Clinical Congress.

Most of these scholarship awards are funded through past and current contributions to the ACS Foundation. Some awards—like the Murray F. Brennan, MD, FACS, International Guest Scholarship—have been established in honor of surgical leaders. Since the IGS program was established in 1968, more than 250 surgeons have been selected to receive the awards.

In this article, three previous International Guest Scholars—Pawanindra Lal, MB, BS, MS, FRCS, FACS, a laparoscopic bariatric and general surgeon from New Delhi, India; Alvaro Sanabria, MD, MSc, PhD, FACS, a head and neck surgeon from Medellin, Colombia; and Rauf Shahbazov, MD, PhD, MRCS, Ed, FEBS, a general and transplant surgeon from Baku, Azerbaijan—describe their experiences at U.S. health care facilities and how this exposure to advanced operative techniques has resulted in improved patient outcomes and safer patient care management in their counties of origin.

Dr. Lal brings safer surgery to India

“There are several different kinds of challenges working in India,” said Dr. Lal, the 2012 recipient of the Elias Hanna Scholarship. “The sheer number of patients, combined with the strenuous, time-consuming process of requesting equipment, can be daunting. There are also limitations regarding
time available for operations and, specifically, a lack of available operating rooms for bariatric patients—
which is in contrast to what I saw in the U.S.,” he noted.

Dr. Lal visited five facilities in the U.S. in 2012, including Mount Sinai Hospital, New York, NY; Univer-
sity of Southern California (USC) Hospital, Los Angeles; Alta Bates Summit Medical Center, Oakland, CA; Barnes-Jewish Hospital, St. Louis, MO; and the University of Illinois at Chicago (UIC).

“Visiting high-volume centers such as these, I
learned how to make procedures more safe and reli-
able,” explained Dr. Lal. “Since I returned to India
from the U.S., we have literally doubled our number
of bariatric cases. I learned some new tips and tricks
generally related to modifications of standard pro-
cedures. For example, depending on surgeon prefer-
ence, there are differences in the stapling device that
can be used or the size of the bougie—some go really
tight, some very loose. I kept noting these variances in
a small diary as I observed them so that I could apply
them when I returned home,” added Dr. Lal, refer-
ing to a small spiral notebook he kept in a pocket.

Notably, Dr. Lal, a professor of surgery at Maulana
Azad Medical College (MAMC), New Delhi, had not
performed a gastric bypass procedure before visit-
ing the U.S. “There can be a kind of inherent fear
about doing gastric bypass [procedures]. In India, we
perform sleeve gastrectomies 90 percent of the time
because they are seen as a more simple procedure
compared with a gastric bypass due to the reduced
number of joints involved,” said Dr. Lal.

After meeting with Namir Katkhouda, MD, FACS,
director, USC metabolic and bariatric surgery program,
Dr. Lal said he began to seriously consider the possi-
bility of performing a gastric bypass procedure before visiting the U.S. “There can be a kind of inherent fear about doing gastric bypass [procedures]. In India, we perform sleeve gastrectomies 90 percent of the time because they are seen as a more simple procedure compared with a gastric bypass due to the reduced number of joints involved,” said Dr. Lal.

Although his interaction with Dr. Katkhouda
inspired Dr. Lal to pursue gastric bypass surgery, it
was his introduction to Ajay Upadhyay, MD, FACS,
FRCS, medical director of the bariatric program at Alta
Bates Summit Medical Center, that ultimately led to
Dr. Lal’s inaugural gastric bypass.

As part of the site visit at Dr. Upadhyay’s facility,
Dr. Lal observed a robot-assisted laparoscopic Roux-
en-Y gastric bypass, followed by laparoscopic removal
of a gastrointestinal stromal tumor. “Dr. Upadhyay
agreed to my offer to visit India in the winter of 2012
as an international faculty member and mentor. After
his arrival, he performed a laparoscopic gastric bypass
while more than 200 surgeons observed the procedure.
He also mentored me, allowing me to perform my
first bypass on the fourth of December 2012—a date I
cannot forget.”

During his site visit to UIC, Dr. Lal observed anoth-
er robot-assisted procedure—a renal transplant per-
fomed by Enrico Benedetti, MD, FACS, co-director of
the UIC transplant center. Dr. Lal called the experience
a “high point of his visit to the U.S.,” especially consid-
ering the entire procedure was completed robotically,
including all three anastomoses.

“You see the organ go from cold slush and placed
into the body, and then you see a robotic hand instru-
ment that is used to join the vein of the kidney to the
vein of the body, which is when the circulation starts,”
explained Dr. Lal. “This is a very critical procedure, and
something that is challenging for surgeons to accom-
plish in open surgery, let alone to accomplish roboti-
cally. Having seen this, I could visualize that, with hard
work and diligence, it was possible to perform techni-
cally demanding robotic-assisted surgery, and that is
why I mention this was a high point of my visit to the
U.S. It was a grand conclusion [to my site visits], before
attending the Clinical Congress.

“The exposure to such a scientific wealth of knowl-
edge was incredible,” added Dr. Lal, regarding his first
Clinical Congress in 2012. “Clinical Congress is a great
forum for exchanging views and for learning from one
another. In addition to learning about advances taking
place in the West, it was a very enriching experience
to see what is happening all over the world.”

At the Clinical Congress, Dr. Lal established some
key contacts, including Subhash Kini, MB, BS, FACS,
a general surgeon and associate professor at Mount
Sinai Hospital. Dr. Kini offered Dr. Lal advice on a
case involving a rare complication—an unexpected
esophageal perforation caused by a drainage tube in
a 35-year-old female who underwent a laparoscopic sleeve gastrectomy. According to Dr. Lal, this complication was so unusual that it had not been reported anywhere in the literature. “We initially thought it was a leak but it turned out to be a perforation caused by a drainage tube. I had to contact Dr. Kini because it was so rare, and we ended up presenting the case at the International Federation for the Surgery of Obesity and Metabolic Disorders annual meeting in 2012.”

Dr. Lal’s visit to the U.S. also inspired him to conduct original research in the area of bariatric surgery. He presented these findings at the 2014 Society of American Gastrointestinal and Endoscopic Surgeons annual meeting in April, in a presentation titled Early Postoperative Weight Loss after Laparoscopic Sleeve Gastrectomy Correlates with the Volume of the Stomach Excised and Not With That of the Sleeve! Preliminary Data from a Prospective MDCT-Based Study.

Of all the experiences he had during the three-week visit to the U.S., observing the systematic training and mentoring of students seemed to have the greatest impact on Dr. Lal. “At all five centers of excellence—this was consistent at each facility—I saw the intense and focused hands-on training of fellows. In India, we do a lot of hands-on training of residents, but the post-residency fellows in the U.S. really have the opportunity to learn in a very direct manner,” noted Dr. Lal. “Each institution knew I was visiting on that particular day, and yet the chief surgeon still allowed the fellow to operate, standing by only to help him when necessary. Now, if I was receiving a fellow from another country, I would take over and show what we do. I would do the case very quickly, in a short amount of time, and reveal all the tips and tricks to the visiting fellow myself,” explained Dr. Lal.

He noted that the chief surgeons “were not at all perturbed that I was visiting,” and he quickly realized this atmosphere was because of the confidence senior surgeons had in their residents. “The fellow would perform the procedure and the chief would step in only to do certain steps—allowing the fellow to resume the operation. This really changed me,” said Dr. Lal.

“These surgeons can do this because they are confident in the fact that the fellow can replicate the procedure in the same manner as the chief has taught him—in a step-by-step, protocol-based manner,” added Dr. Lal. “This confidence shows me the strength of the system, because it says that this fellow, who I am mentoring, will perform this case as I would myself. It speaks volumes of the strength of the training at these centers.”

Dr. Sanabria brings integration therapy to Colombia

One of the main challenges health care professionals face in Colombia, according to Dr. Sanabria, a 2012 International Guest Scholar, is convincing physicians to adhere to guidelines and standards. “Latin people can
be resistant to following strict protocols. It is important to encourage health care providers to be more disciplined,” said Dr. Sanabria, a head and neck surgeon at the Universidad de Antioquia-Hospital Pablo Tobon Uribe, Medellin, Colombia. In fact, Dr. Sanabria is currently developing a protocol to validate an MD Anderson Cancer Center (Houston, TX) symptom inventory for head and neck patients in Colombia.

MD Anderson is one of three facilities Dr. Sanabria visited as a recipient of the 2012 ACS IGS. The other two institutions were the Georgia Health Sciences University, Augusta, and Memorial Sloan-Kettering Cancer Center, New York.

“The most important thing I saw at MD Anderson—something I have never quite seen before—is an integration of other therapies and alternate medicines that support standard treatment and help get better results,” said Dr. Sanabria. “There aren’t a lot of people trained in alternative therapies in my country,” he added. “Before going to [MD Anderson] I was afraid of using them—but now that I have seen them in practice I have a more open mind to the integration of other therapies that can improve a patient’s quality of life.”

Specifically, Dr. Sanabria now recommends acupuncture for patients suffering from xerostomia (dry mouth) – a debilitating side-effect caused by head and neck cancer radiation treatment. Some studies suggest that acupuncture helps treat xerostomia, which can impact a patient’s ability to eat, speak, and sleep.

At Georgia Health Sciences University, Dr. Sanabria had the opportunity to assist in a robotic thyroidectomy. Although one or two pieces of such equipment are available in his homeland, according to Dr. Sanabria, he found it incredibly useful to observe and learn the advantages and challenges of this evolving technology. “If you ask a hospital administrator to buy this equipment, they always ask you how useful it will be— which is understandable because we have a different kind of patient here than you do in the U.S. Here, patients tend to have very advanced tumors,” he said.

Dr. Sanabria said he learned a great deal about clinical and laboratory testing during his visit to Georgia Health Sciences University—techniques that he has since adopted at his current institution. As a result, today Dr. Sanabria’s facility has the largest cohort of outpatient thyroidectomies in the city.

What impressed Dr. Sanabria the most about his visit to Memorial Sloan-Kettering was the “rational use of technological resources” combined with charismatic physicians who exhibited a strong commitment to quality patient care. “My experience here showed me that good oncological care is possible with interdisciplinary and coordinated work and is not exclusively dependent on technology,” explained Dr. Sanabria. For example, the head and neck surgeons at Memorial Sloan-Kettering do not use neuromonitoring of recurrent laryngeal nerve routinely, according to Dr. Sanabria. “After I came back, I worked on a meta-analysis about this subject, demonstrating that its use does not offer much of an advantage in comparison with the classical method of searching the nerve,” he said. “We used to think that you need a lot of technology to make things better here, but in fact, more than technology or money, discipline and a commitment to the patients are what get results.”

Dr. Sanabria said his experience at the 2012 ACS Clinical Congress was memorable, largely due to the format of many of the sessions. “For me, it was a novelty to attend lectures where people are debating a topic. We usually don’t have these kinds of lectures at our meetings, where people show different points of view. In the end, the session chair was able to offer a more balanced view about the topic at hand.”

Dr. Sanabria’s advice for future IGS awardees is to keep an open mind. “I was really impressed to see very famous people sitting at your side and talking
to you as if you were their partner, rather than a student. They speak to you as a friend, and you share ideas. So, my advice is to lose your fear of talking to famous people and do not hesitate to discuss a new approach or idea.”

Dr. Shahbazov applies expanded skills and confidence in Azerbaijan

“Although there have been some significant changes and improvements to the health care system in Azerbaijan over the past 20 years, there are still issues in need of a solution,” said Dr. Shahbazov, a consultant transplant surgeon for the country’s Ministry of Health and a 2011 International Guest Scholar. “Not everyone has access to high-quality surgical care due to the lack of an insurance system.” Additionally, new fields of surgery, such as organ transplantation using deceased donors, do not receive enough funding, he said, and are still waiting for approval from the government.

Before Azerbaijan won independence from the Soviet Union in the 1990s, education and medical and surgical services were centralized in Moscow, Russia, according to Dr. Shahbazov. “Whatever Moscow implemented, we were supposed to follow. Unfortunately, the Soviet Union was isolated from the rest of the world and had a health care system that was defective. We didn’t have the opportunity to travel to the west and to be exposed to new advances in medicine and surgery. There are still so many challenges in this independent country, but today, young surgeons have the opportunity to get advanced surgical training in western countries, bring new innovations to their home institutions, and improve overall surgical care for their patients,” explained Dr. Shahbazov.

Dr. Shahbazov visited three medical institutions during his 2011 sojourn in the U.S., including the David Geffen School of Medicine at the University of California-Los Angeles (UCLA); the Annette C. and Harold C. Simmons Transplantation Institute at Baylor University Medical Center, Dallas, TX; and the Cleveland Clinic, OH.

During his visit to UCLA, he observed a few abdominal organ procurement operations. “I learned many things from UCLA in terms of surgical procedure and policy,” noted Dr. Shahbazov. “I learned from Hasan Yersiz, MD, a liver transplant surgeon, how to split the liver in situ in an emergency situation like organ procurement.”

While at UCLA, Dr. Shahbazov also became acquainted with policies for declaring an individual “brain dead.” “Many countries define brain death differently—each country has its own specifications,” he explained. “I realized that, as a country, we should define brain-dead criteria, rather than base it on local customs and culture.”

After returning to Baku, the capital of Azerbaijan, Dr. Shahbazov organized a special symposium with
a focus on brain death and organ transplantation. “We gathered more support for this issue by involving Ministry of Health officials, members of parliament, and key figures in the health sector,” he said.

Visiting the transplant institute at Baylor University Medical Center gave Dr. Shahbazov the opportunity to learn about pancreatic islet transplantation. “We have so many pancreatitis patients in Baku who suffer from pain. I met with Marlon Levy, MD, FACS [surgical director, transplantation, Baylor All Saints Medical Center, Fort Worth, TX], and Bashoo Naziruddin, PhD [director, cGMP Islet Cell Laboratory, Annette C. and Harold C. Simmons Transplant Institute], and I learned that this growing field of transplantation can change the pancreatitis patient’s quality of life significantly.”

His interest in islet transplantation prompted Dr. Shahbazov’s return to Baylor University Medical Center in June 2012, to learn the procedure in depth. “Currently, I am a postdoctoral fellow in the islet cell transplantation program. I am learning the procedure as well as actively conducting research in this field of surgery.” Dr. Shahbazov anticipates finishing the program in June and soon after returning to Baku.

The hepatopancreato-biliary and transplant department at the Cleveland Clinic was the last surgical facility Dr. Shahbazov visited during his time as an International Guest Scholar. “I had the opportunity to meet John Fung, MD, PhD [chair, Digestive Disease Institute], during a previous Congress of International Liver Transplantation Society in Valencia, Spain. However, visiting the Cleveland Clinic environment gave me the opportunity to experience surgical excellence up close. Beside liver transplantation procedures, I observed a trisegmentectomy conducted by Dr. Fung,” said Dr. Shahbazov. (A trisegmentectomy is the removal of the true right lobe of the liver in continuity with most or all of the medial segment of the left lobe.)

As a result of his visit to the Cleveland Clinic, Dr. Shahbazov learned how to resect large liver tumors effectively. After returning to Baku (before entering the post-residency program at Baylor), Dr. Shahbazov performed several procedures requiring specialized skill sets including live-donor liver transplantations, dissection of difficult hilar tumors of the liver, and major liver and pancreatic resections. “My experience in the U.S. has changed my way of thinking and gave me more confidence in doing surgical procedures in my daily practice,” he said, referring to his combined experiences at all three U.S. medical centers.

While attending the 2011 Clinical Congress in San Francisco, CA, he participated in a Panel Session titled The College’s International Travelers, 2011. Dr. Shahbazov’s presentation, Organ Transplantation Perspectives in Azerbaijan, was his first experience speaking before U.S. surgeons. He also attended several didactic and skills-oriented courses at the Clinical Congress, including hepatobiliary-pancreatic disasters for the gastrointestinal surgeon, management of liver trauma, and management of hepatopancreatobiliary malignancies. “Senior surgeons were available for every fellow for discussion and idea-sharing,” observed Dr. Shahbazov. “Personally, I was impressed by their modesty, and later I was honored to discover that many of these surgeons have authored chapters in surgical texts.”

For more information on the IGS program, visit ACS Member Services at http://www.facs.org/memberservices/igs.html, or contact the International Liaison at Kearly@facs.org.
Implementation of the ACA:

Turning federal law into state-level reality

by Tara Leystra Ackerman and Justin Rosen

HIGHLIGHTS

- Summarizes the provisions in the ACA that are to be implemented at the state level
- Reviews how states are addressing Medicaid expansion
- Describes states’ experiences with establishing health insurance exchanges
- Outlines ACA mandates for the provision of essential services that insurers must offer to patients
- Provides information regarding one insurer’s attempts to drop physicians from its network

The Affordable Care Act (ACA), P.L. 111-148, was signed into law in 2010 with the goal of lowering the number of uninsured Americans while reducing the cost and improving the quality of health care. Before its passage, the ACA was a divisive and partisan-driven piece of legislation, and it became even more so after its enactment. The U.S. Supreme Court upheld the constitutionality of most of the law in 2012 but made Medicaid expansion voluntary for the states. Although it is a federal statute, much of the responsibility for implementing the law rests with the states, including implementation of market reforms, overseeing Medicaid expansion, and creating the state health insurance exchanges. These action items were largely put into motion in 2013.1 This article examines how states have implemented the ACA thus far and the possible implications of these policies for surgeons.
State legislators have wide latitude regarding how much of the law they embrace, with seven states (Connecticut, Hawaii, Maryland, Massachusetts, Minnesota, Oregon, and Vermont) adopting all provisions outlined in the ACA and five states (Alabama, Missouri, Oklahoma, Texas, and Wyoming) adopting none of the provisions in the ACA.

States also have the option of developing their own health insurance exchanges, either by working in partnership with the federal government to develop and implement the exchanges, or by allowing the federal government to run the exchanges. So far, 17 states have created and are running their own exchanges, seven states are working in partnership with the federal government, and 27 states have opted to let the federal government operate their exchanges. Many other states also have decided not to participate in Medicaid expansion, and a few have received waivers to implement the expansion differently than outlined in the legislation. Each state also has been granted latitude in establishing a benchmark plan to cover all 10 essential health benefits outlined in the ACA. As each state implements the ACA differently, there are profound implications for the population of each state in how they access health care and what is covered.

**Medicaid expansion**
The ACA originally required every state to allow individuals earning up to 138 percent of the federal poverty level (FPL) ($27,000 for a family of three) to receive health care coverage through an expanded Medicaid program. This Medicaid expansion mandate was expected to expand coverage to an additional 16.2 million of the 27 million people the ACA would cover overall. As noted previously, the Supreme Court ruling made expansion voluntary. Currently, 26 states and the District of Columbia have chosen to expand Medicaid to the newly eligible population. Arkansas was the first state to apply and receive approval for a 1115 waiver to expand Medicaid to the newly eligible population. Arkansas’ plan mandates that all newly eligible enrollees receiving premium assistance purchase insurance from a qualified health plan through the state exchange. Iowa was also approved

Although states continue to debate the expansion of Medicaid, a delayed expansion will have some immediate effects economically and on patient access to care. One of the biggest consequences is the loss of billions of dollars in federal Medicaid expansion funds. Furthermore, an estimated 5 million people will be without affordable access to health care. Individuals earning less than 100 percent of the FPL fall into a “coverage gap,” which means they are ineligible for subsidies because they were expected to be covered by Medicaid, but also earn too much to participate in current Medicaid programs. For example, in Texas, an estimated 687,000 women would be ineligible for coverage due to various program gaps. This leaves few, if any, options for individuals who fall into this category in non-expansion states.

Payments to disproportionate share hospitals (DSH) also were cut to pay for the law, with the expectation that fewer uninsured individuals would be seeking uncompensated care. In those states that opted out of Medicaid expansion, however, many hospitals will likely experience only a minor reduction in uncompensated care and will have to absorb the added DSH cuts without increased revenues. Many hospitals in states that have opted out of Medicaid expansion are deeply concerned about potential access issues. Critical access hospitals in rural areas may be hardest hit, and some may be forced to close their doors as a result.

**HHS waivers**
Political concerns have prompted some states to opt out of expansion, and several are beginning to look at creative ways to expand Medicaid without having to follow the provisions outlined in the ACA. For example, Arkansas, Iowa, and Michigan have received a U.S. Department of Health and Human Services (HHS) 1115 demonstration waiver to implement Medicaid expansion in a manner that is palatable to each state’s population. (Pennsylvania has also applied for a waiver, but it has yet to receive HHS approval.) A 1115 waiver allows the HHS Secretary to waive state compliance with certain federal requirements and may provide budget-neutral federal funding that would otherwise be unmatched. Each waiver must also go through a public comment period, and the process allows for negotiations between the state and HHS.

Arkansas was the first state to apply and receive approval for a 1115 waiver to expand Medicaid to the newly eligible population. Arkansas’ plan mandates that all newly eligible enrollees receiving premium assistance purchase insurance from a qualified health plan through the state exchange. Iowa was also approved
for a waiver and currently is enrolling newly eligible patients who earn 100 percent to 138 percent of the FPL in a premium assistance program, while charging small premiums and providing incentives for healthy lifestyle behaviors.8,9 While Arkansas was the first state to pass an altered version of Medicaid expansion, the program barely survived to see a second year after the state House had to vote multiple times to garner enough votes to pass it, demonstrating how politically volatile the issue still is in that state.

Michigan did not pursue premium assistance for its newly eligible enrollees, but it is charging premiums to those households with annual incomes of 101 percent to 138 percent of FPL and is providing incentives for healthy behaviors.10 Pennsylvania has applied to enroll all newly eligible enrollees in premium assistance and to charge premiums to individuals making 100 percent to 138 percent of FPL, incentivize healthy behaviors, and institute job training and employment-related activities as a requirement to receive benefits.11 HHS has never approved a work requirement and has only allowed premiums to be charged to a limited population (Iowa’s original waiver application sought to charge premiums to those enrollees earning 50 percent to 138 percent of FPL; it was approved only for those making 100 percent to 138 percent of FPL).3 At press time, negotiations between Pennsylvania and HHS are ongoing. These examples demonstrate how 1115 waivers may be used to allow states to test individualized approaches to Medicaid expansion.

Indiana Gov. Mike Pence (R) is working on a different alternative to Medicaid expansion. He is seeking to expand the state’s Healthy Indiana Plan, which is a Medicaid pilot program initiated in 2008 to provide health insurance coverage to individuals and families who earn too much to qualify for traditional Medicaid. It is modeled on a health savings account (HSA) linked to a high-deductible insurance plan sold on the private market. Then-HHS Secretary Kathleen Sebelius sent a letter to Governor Pence in December stating that Indiana cannot receive full federal reimbursement for expanding Medicaid to individuals earning up to 138 percent FPL if the program requires these individuals to contribute to an HSA.12 At press time, Governor Pence and Secretary Sebelius were still working on a compromise, and Governor Pence was waiting on a ruling for a second long-term waiver to fully implement this program.

Insurance exchanges

Individuals and families were able to start enrolling in plans offered through the ACA-created health insurance exchanges on October 1, 2013. The federal exchange, the option available in 34 states, had a notably problematic roll-out. Initially blaming high traffic, the Obama Administration conceded approximately a week into open enrollment that significant technology issues were affecting the federal site and would take weeks to correct. The site only became fully functional at the end of 2013, leaving many Americans struggling to sign up for coverage before January 1. State exchanges were, overall, more successful in enrolling individuals, although a few states had and continue to experience significant technological complications with their sites. California, Colorado, and Connecticut all had fairly smooth roll-outs, whereas Maryland, Minnesota, and Oregon had significant issues.

Connecticut’s exchange program, Access Health CT, is taking advantage of its online enrollment success by offering consulting services to other states. The chief executive officer of Access Health CT is offering “exchange in a box” consulting services, ranging from basic consulting to a complete overhaul. At press time, the Connecticut exchange had approximately 55,000 enrollees. This number far exceeded the federal government-set benchmark of 33,000.13

In addition to the functional struggles of the federal exchange website, another concern emerged after the health insurance exchanges opened in October 2013, which centered on whether many of the plans being offered included an adequate network of providers. One analysis, completed by the McKinsey Center for U.S. Health System Reform, looked at all hospital networks offered in silver exchange products in 20 urban rating areas, which included 120 distinct exchange net-
The ACA requires all plans participating in the exchanges, as well as those plans not grandfathered in, to offer a set of essential health benefits; that is, designated services that all health insurers must cover at limited cost to the patient.

works offered by 80 carriers. This analysis found that within these exchange products, almost two-thirds of hospital networks in the exchanges were narrow or ultra-narrow.14 Narrow network plans and tiered-network plans are offered largely to ensure the availability of affordable coverage, but these networks are a major area of concern as people seek out health care providers. The federal government shares this concern, and HHS recently announced it would be performing more network adequacy reviews for plans offered through the exchanges in 2015.15

Physicians also have concerns regarding the ACA-established exchanges. A survey of physician group practices completed by the Medical Group Management Association in October 2013 found that most physicians held unfavorable views of the ACA. The survey had 1,000 responses from group practices, which represents 47,500 physicians. The survey found 55 percent of respondents were still evaluating whether they would participate in the exchanges; another 30 percent had decided they would participate, but 15 percent had decided they would not and more than 15 percent did not know.16 In addition to questions about network adequacy and payment, physicians also are concerned about the ACA’s 90-day grace period, which provides continued insurance coverage to patients who receive advance premium tax credits but fail to pay their premium for three months. Under this provision, insurers can hold claims to physicians during the second and third months of this grace period, though insurers are required to notify physicians of patients’ grace period status when responding to eligibility verification requests. Nonetheless, some physicians are concerned that these notifications will be insufficient and that they will find themselves providing a considerable amount of uncompensated care.

**Essential health benefits**

The ACA requires all plans participating in the exchanges, as well as those plans not grandfathered in, to offer a set of essential health benefits; that is, designated services that all health insurers must cover at limited cost to the patient. Certain individual and employer-based plans have been grandfathered in and are not subject to the essential health benefit requirements.

Currently, 10 categories of coverage are considered essential under the ACA (see sidebar, page 26). For an insurance policy to be sold on the marketplace, it must comprise all 10 of the mandated areas. Initially, the federal government was expected to identify the benchmark plan and outline which services would be included.

**ACA COVERAGE CATEGORIES**
- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services/devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental and vision care
in the essential health benefit package, but instead HHS issued regulations allowing each state to identify its own benchmark plan and the services that would be covered. These plans are further broken down into five tiers.

• The bronze plan has a minimum creditable coverage including 60 percent of benefit costs, and out-of-pocket limits equal to the HSA limits.

• The silver plan has 70 percent covered costs.

• The gold plan has 80 percent covered costs.

• The platinum plan has 90 percent covered costs.

• A catastrophic plan also will be available in the individual market for individuals ages 30 and younger and to individuals who are exempt from the individual responsibility requirement.17

The 10 coverage categories appear in the sidebar on page 26. In addition to the 10 required services, plans must establish a maximum out-of-pocket charge for individuals and families, which for 2014 is set at $6,350 for individuals and $12,700 for families. These limits are compatible with federal HSA contribution limits and, likewise, will be indexed with inflation for future increases.18

Some states are choosing to provide coverage beyond the 10 minimum standards. One of the most common additional services is bariatric surgery. Almost all plans cover obesity screening and some treatment options, but only 24 states require insurance companies to cover weight-loss procedures (26 states and the District of Columbia do not currently have plans to cover these procedures). One factor that may encourage states to include bariatric surgery as an essential benefit is the recent action taken by the American Medical Association’s House of Delegates in June 2013 to recognize obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions.

UnitedHealthcare dropping physicians
The ACA cut payments to Medicare Advantage to pay for other parts of the legislation and equalize payments between Medicare Advantage and traditional Medicare. One conse-

REFERENCES

continued on next page
A surgeon who has received notification of being dropped from a network should consider appealing this action.

REFERENCE (CONTINUED)


State enrollment numbers

At press time, the number of people enrolling in exchange plans, Medicaid, and state Children’s Health Insurance Programs was continuing to increase daily, and this trend contin-
ued as the March 31 deadline to obtain health insurance or pay a fine approached. As more states work to expand Medicaid or offer other solutions to fill the coverage gap, even more people will shift from uninsured to insured status. At press time, approximately 7 million of the roughly 28 million people eligible for coverage under the ACA nationwide had signed up for insurance using the exchange. As of April 2014, more than 908,000 New York State residents had obtained health insurance either through the exchange or expanded Medicaid. In contrast, only 7,600 Hawaiians had signed up during the four-month enrollment process—the lowest enrollment rate of any state. The White House exceeded their goal of enrolling 7 million people by the March 31 deadline. At press time, more than 7.1 million people enrolled prior to March 31. For the most up-to-date enrollment information, visit the Kaiser Family Foundation website at http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population.

College seeks feedback
ACA implementation has been a learning process for state governments, physicians, insurance companies, and the general public. The effects of the ACA are just beginning to be known, and there continues to be more to learn and more work to be done. As implementation progresses, the College asks that Fellows let the organization’s leadership know how related issues are affecting the surgical practice. The ACS also encourages Fellows to advocate for better policies at the state level, especially on coverage for bariatric surgery and protections from the tiering and narrowing of networks. For more information or to get involved, contact Tara Leystra Ackerman at tleystra@facs.org or 202-672-1522 or Justin Rosen at jrosen@facs.org or 202-672-1528.

REFERENCES (CONTINUED)
Vascular practice develops night float call system to improve attending well-being without decreasing productivity

by Christopher M. Chambers, MD, PhD, FACS; Seth Wolk, MD, FACS; M. Ash Mansour, MD, FACS; Robert Cuff, MD, FACS; Jason Slaikeu, MD, FACS; Peter Wong, MD, FACS; and Adam Mix
Surgeons are tremendously dedicated to the delivery of optimal care. The commitment of generations of surgeons affects the care of a modern vascular surgery patient, now treated with a host of open and endovascular options. This solid work ethic, coupled with personal, professional, and organizational obligations, often leads to a routine consisting of long hours, frequent nights on call, and expectations of performing a normal day of work post-call.

Since the Institute of Medicine released the report To Err Is Human: Building a Safer Health System in 1999, greater emphasis has been placed on improving patient safety and reducing complications. As a result, many policies, such as those intended to prevent wrong site surgery or medication errors, have been implemented. Additionally, new resident duty-hour restrictions were introduced in 2003. Although the effect of duty-hour restrictions on patient safety remains unclear, the trainee’s quality of life has improved.

In contrast, no duty-hour restrictions have been developed for attending surgeons. Consequently, many attending work extended hours that may increase patient risk. A study published in the Journal of the American Medical Association in 2009 suggested a link between fatigue and surgical performance. In the study, complications for elective day surgery were found to be significantly higher (6.5 percent versus 3.4 percent) when the attending surgeon had less than six hours of sleep opportunity the night before.

Extended hours and frequent call may also increase the risk of surgeon burnout and depression. Shanafelt and colleagues identified several independent risk factors for burnout, including the number of nights on call per week and the number of hours worked per week. Despite this potential increased risk to patients and risk of burnout for surgeons, alternative mechanisms of workload distribution have been only narrowly implemented. One possible explanation is the perceived cost of duty-hour restrictions. For instance, estimates indicate that if physicians were restricted to aviation industry duty-hour rules, health care costs would increase $80.4 billion annually, or $1 million per life year saved, and would require a 71 percent increase in physician workforce.

The authors recently modified the call system within their group practice with the goal of maintaining the highest level of patient safety possible while improving the vascular surgeons’ quality of life and reducing the odds of burnout.

Group structure
The Spectrum Health Medical Group is a 600-plus-member multispecialty physician group that serves a large portion of western Michigan. The vascular group consists of six board-certified vascular surgeons who share call equally. They are compensated using a work relative value unit (wRVU) model in which income is equally distributed. The group performs procedures at one hospital, covers consultations at another institution, and staffs a stand-alone vein center.

The group adheres to the philosophy of the “equivalent actor” as described by Amalberti and colleagues. Using this model, a team of vascular surgeons considers each member to be interchangeable in his or her ability to care for patients, which means the concept of the autonomous health care professional has largely been abandoned. As a result, vascular surgery patients in the hospital are treated with a team approach. Each weekday morning, the vascular surgery staff, including attendings, residents, fellows, and nurses meet to discuss each patient. If an inpatient requires intervention, the next available time and surgeon are selected. The vascular staff assumes collective responsibility for each patient.

Call schedule modifications
The call schedule was modified on July 1, 2011. Weekend call has remained the same following the call schedule modification. One member of the group takes primary call (from 7:00 am on Friday to 7:00 am on Monday), and one member is available as backup.
primary call surgeon must be available for emergency cases and will occasionally perform semi-emergent cases. The backup call surgeon must be available for emergencies, but his or her services are rarely required. Before the new call system was implemented, each member of the group took weekday call (7:00 am Monday to 7:00 am Thursday) one day at a time, and each group member was required to work a normal day post-call. After implementation, the weekend primary call surgeon covered call Monday through Thursday from 6:00 pm to 7:00 am. (This surgeon has no clinical responsibility from 7:00 am to 6:00 pm.) During this time, the surgeon will generally perform emergent and semi-emergent cases. Additionally, this surgeon will sometimes finish outstanding elective cases begun during the day. The volume of operations performed, and therefore the number of hours worked, is primarily dictated by emergent activity and is thus highly variable. The call responsibilities rotate among the six vascular surgeons, so each surgeon is on call every sixth week.

Outcomes
The surgeons’ productivity was measured by determining the mean and standard deviation of the total combined wRVUs they generated for each month of the 2011 calendar year—six months before and six months following the call schedule modification. Total combined encounters for the six vascular surgeons were determined for a period of 24 months—12 months before and 12 months after the call schedule modification. Any change in patient safety was not measured directly from patient outcomes, but was indirectly inferred based upon data gathered from the vascular surgeons. Christopher M. Chambers, MD, PhD, FACS, co-author of this article, developed a Likert scale questionnaire featuring a series of questions with a rating score from one to five, where one represented “strongly disagree” and five represented “strongly agree.” The questionnaire was presented to each member of the group and responses were summarized with data presented as a mean of the six respondents. The responses to the questionnaire were obtained before the collection of the productivity data and six months following the implementation of the call schedule modification.

Patient safety
Although the study did not measure patient outcomes before and after the call schedule modification, the Likert scale questionnaire did attempt to determine if members of the group perceived a difference in the quality of patient care during the study period (see table, questions A–C, this page). The individuals felt strongly that, prior to the call system changes, they had operated while sleep-deprived (Likert score 4.3) and that the new call system had improved the quality of patient care (Likert score 4.5). The perceived improved quality of care may be related to surgeons no longer performing elective day surgery following a night on call. In addition, the surgeons believe that patient care is often expedited after having a dedicated night surgeon (Likert score 4.8).

The number of nights on call per week and the number of hours worked per week are both independent risk factors for surgeon burnout. Follow-

### Likert Scale Questionnaire Results

<table>
<thead>
<tr>
<th>Letter</th>
<th>Question</th>
<th>Mean Likert score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>As an attending, you have performed surgery while severely sleep-deprived.</td>
<td>4.3</td>
</tr>
<tr>
<td>B</td>
<td>The new call schedule has improved the quality of patient care.</td>
<td>4.5</td>
</tr>
<tr>
<td>C</td>
<td>Patient care is often expedited after having a dedicated night surgeon.</td>
<td>4.8</td>
</tr>
<tr>
<td>D</td>
<td>The new call schedule has improved your quality of life.</td>
<td>4.6</td>
</tr>
<tr>
<td>E</td>
<td>The new call schedule has improved the relationship with your family.</td>
<td>4.1</td>
</tr>
<tr>
<td>F</td>
<td>The new call schedule has improved the relationship with your vascular surgery partners.</td>
<td>4.0</td>
</tr>
<tr>
<td>G</td>
<td>The biggest advantage of the new call system is that it allows you to spend more time with family and have personal scheduled time off during the week.</td>
<td>4.7</td>
</tr>
<tr>
<td>H</td>
<td>The group should continue this call system.</td>
<td>4.8</td>
</tr>
</tbody>
</table>

 Mean score of six respondents are reported (1=strongly disagree, 5=strongly agree). Questions related to patient care=A–C. Questions related to surgeon quality of life=D–G. Question related to group satisfaction with new call system=H.
ing the implementation of the new call schedule, the surgeons strongly agreed that their quality of life improved (Likert score 4.6). Relationships with their families (Likert score 4.1) and with their vascular surgery partners (Likert score 4.0) were both felt to have improved (see table, Questions D–G). Those surveyed strongly agreed that the new call system allowed more time with family and personal scheduled time off during the week (Likert score 4.7).

One barrier to call system modification was the potential loss of revenue. Productivity was measured by total wRVUs generated by the six surgeons for a 12-month period, six months before and six months after the call system change. Data are shown in Figure 1, this page. The difference between the two six-month periods was minor. Mean total practice wRVUs per month was 4,852 ± 564 before and 4,772 ± 362 (p=0.41) after the call schedule change.

The group’s productivity was also assessed by determining total patient encounters each month for a period of 12 months before and 12 months following the call schedule change (Figure 2, this page). No significant difference was noted following the call schedule change. The total number of patient consults and operations by the group in the 12 months before the call system change was 20,945 and 20,910 for the 12-month period after the call system change.

The final question of the Likert scale questionnaire relates to the individual’s satisfaction with the

![FIGURE 1. TOTAL wRVUs BEFORE AND AFTER MODIFICATION](image1)

*Each bar represents the mean wRVUs + standard deviation for each six-month period.

![FIGURE 2. TOTAL ENCOUNTERS BEFORE AND AFTER MODIFICATION](image2)

Total encounters for the six vascular surgeons for 12 months before and 12 months after the call schedule modification. Arrow represents July 1, 2011, the date the call schedule was modified.
The authors recently modified the call system within their group practice with the goal of maintaining the highest level of patient safety possible while improving the vascular surgeons’ quality of life and reducing the risk of burnout.

new call schedule after the initial six-month period. There was strong agreement that the new call system should be continued (see table on page 32, question H, Likert score 4.8).

Discussion
Efforts to reshape health care systems to resemble ultra-safe industries are under way. Adoption of system processes such as the operative “time out” have been shown to improve safety and decrease perioperative complications.11,12 Nonetheless, preventable errors still occur with distressing frequency.13 For example, The Joint Commission reports approximately 40 wrong site surgeries per month in the U.S.14

Both staff surgeons and trainees have traditionally worked extensive hours. Prolonged wakefulness produces fatigue, which is believed to negatively affect performance. As a result, high-risk industries such as aviation have limited duty hours.9 A major change among medical care professionals was the establishment of duty-hour restrictions for physicians in training. An unintended consequence of the resident work-hour restrictions, however, is that staff surgeons may work longer hours and frequently perform elective surgery following a night on call, sometimes without sleep opportunity. The outcomes of daytime operations performed by surgeons with less than and greater than six hours of sleep opportunity were examined, and the number of complications was significantly higher in daytime surgeries performed by surgeons with less than six hours sleep opportunity (6.5 versus 3.4 percent, odds ratios, 1.47; 95 percent confidence intervals, 0.96–2.27).7

Health insurers are increasingly likely to deny reimbursement for complications arising from surgical errors. The Centers for Medicare & Medicaid Services (CMS) has had payment programs in place for many years to reimburse for a standard of care through diagnosis-related group payments that do not necessarily include payment for ancillary co-morbidities. Additionally, payment is denied for many hospital-acquired infections.3

In 2011, CMS published the final rules for the Value-Based Purchasing Program in the Federal Register. This program combines some measures from the existing Hospital Inpatient Quality Reporting Program to provide incentive payments based on quality measures.15 Commercial health insurance plans often adopt Medicare payment policies, further increasing the finan-

REFERENCES
8. continued on next page
The group’s productivity was also assessed by determining total patient encounters performed each month for a period of 12 months before and 12 months following the call schedule change. No significant difference was noted following the call schedule change.

cial impact on quality-related errors in the future. The potential for decreased reimbursement resulting from surgical errors increases the benefit of a reduction in continuous work hours.

Due to occupational stresses, professional burnout is a real concern for surgeons—a comprehensive national survey documented a 40 percent burnout rate. Several factors were independently associated with burnout, including the subspecialty choice of vascular surgery. Additional factors associated with burnout include the number of hours worked per week and the number of nights on call per week.

The revised night float call system implemented in the authors’ practice—in which one surgeon on the team doesn’t perform surgery during the day one out of every six weeks—has significantly improved the quality of life for the surgeons and established a predictable call schedule. Limiting the on-call surgeon to nights had two positive effects for the surgeon’s quality of life. First, the on-call surgeon believed he was not overworked or stressed, having the day to rest. Second, the on-call surgeons found that they were able to get home in the early evening more frequently and spend more time with their families.

In an era of decreasing reimbursement and increasing expectation of productivity, changing to a night float call system may seem impractical. However, the development of this call system, and its subsequent improvement in surgeon quality of life, has been realized without a loss in productivity. The system was created without the predicted need of adding surgeons to the practice in part because of movement toward the equivalent actor model. This model of care has allowed significant improvements in the efficiency of delivering care to both elective and emergent vascular surgery patients, and when coupled with a compensation model of equal revenue sharing, professional teamwork has developed and grown among the surgeons. These results have led to expedited care of patients in need of surgical procedures. A call schedule change to create a night float system improved the surgeons’ quality of life without decreasing productivity. Additionally, the new call schedule eliminated the need to perform elective procedures post-call, potentially improving patient safety and quality of care.

REFERENCES (CONTINUED)


Billing for services performed by nonphysician practitioners

by Linda Barney, MD, FACS; Betsy Nicoletti, CPC; and Mark Savarise, MD, FACS

When surgeons find their workload is getting overwhelming, they sometimes consider adding another surgeon or a nonphysician practitioner (NPP), such as an advanced practice registered nurse (APRN) or physician assistant (PA), to their practices. The volume of surgical demand and the need for additional surgeons for on-call responsibilities are typically met by adding an additional surgeon to the group. Some surgical practices, however, determine that the volume of procedures they perform does not warrant adding another surgeon, and an APRN or PA could fulfill the necessary functions. Tasks that might be assigned to these individuals include preoperative evaluations, preoperative patient education, triage assessment, postoperative visits, and returning phone calls.

Once the group has decided to hire an NPP, the question is how to get paid for these services. Some surgical practices, however, determine that the volume of procedures they perform does not warrant adding another surgeon, and an APRN or PA could fulfill the necessary functions. Tasks that might be assigned to these individuals include preoperative evaluations, preoperative patient education, triage assessment, postoperative visits, and returning phone calls.

What are incident-to services? NPPs often render services that are incident-to procedures and care that the surgeon provides. Incident-to services are provided in the physician's office and billed as if the physician provided the care and using the physician's NPI. These services must be of the type that are usually provided in the office and must be integral to the plan of care. Staff members who provide the services must be an expense to the practice that employs the physician.

What are some of the general guidelines that Medicare and other payors apply toward reimbursement for NPP services? Unfortunately, the rules vary by payor. Medicare has specific rules for reporting services provided by an NPP, but private insurers can set their own standards. Likewise, state Medicaid programs and managed Medicare and managed Medicaid plans may set their own rules.

For Medicare, a service that is provided by an NPP and reported to Medicare is reimbursed at 85 percent of the physician fee schedule when the NPP's national provider identification (NPI) number is used. Services that are reported incident-to a physician's services or as shared services are reported to Medicare under the physician's NPI and are paid at 100 percent of the Medicare physician fee schedule.
What surgeons should know about…

Reported in the office, not in the outpatient department.

To bill for the NPP, the physician must have seen the patient first at a previous encounter and established the plan of care. Care provided to a new patient or an established patient with a new health care problem may never be billed as incident-to a physician service. If an NPP sees a new patient or assesses an established patient for a new problem, the practice should report that service under the NPP’s provider number, not the physician’s. Additionally the physician must be in the suite of offices when the services are performed and must stay involved with the patient’s care.

According to Medicare rules, the services provided by the NPP must be within his or her scope of practice as mandated in the state where the practice is located. This model is used in billing for health care services provided to patients with chronic or ongoing conditions, such as wounds. The physician sees the patient at the initial visit, establishes the plan of care, and tells the patient to return to the office and see the APRN at the next visit. If the physician is in the office when the patient returns and the NPP is carrying out the plan of care, then the evaluation and management (E/M) service may be reported under the physician’s NPI as if the physician had provided the service. If the physician is out of the office, the service should be reported under the NPP’s NPI.

**What are shared services, and how do they differ from incident-to services?**

Unlike incident-to services, shared services may be reported in the emergency department (ED), outpatient department, or inpatient department of the hospital. Shared services represent the model that many physicians would like to use everywhere in working with NPP practitioners. Shared services are E/M services that a physician and an NPP provide jointly.

**What are the guidelines for shared services?**

Both the physician and the NPP must provide a face-to-face service to the patient on the same calendar day and both must document their portion of the work. Typically the NPP’s documentation is more detailed than that of the physician, but the physician should document the clinically relevant encounter with the patient and then tie his or her note to the NPP’s. When these patient encounters occur on the same calendar day, the level of service is determined by combining elements in both notes to select the level of service. Remember, this applies to services provided in an inpatient setting, an outpatient department, or the ED. If the physician practice is a provider-based clinic using the outpatient department as the location (22) to submit claims, shared services are permitted.

**When should a practice bill patient care as a shared service?**

This model is very useful for initial hospital services, ED visits, and consults. It allows the NPP to see and evaluate the patient first, take a detailed or comprehensive history, perform a thorough exam, and formulate a treatment plan. The physician then is able to do a more focused history and exam to confirm the assessment and plan.

Both clinicians must document their own participation in the care. If only the NPP sees the patient on that date, then report the service under the NPP’s provider number, not under the physician’s provider number.

**Sometimes an APRN or a PA will assist with an operation. How do we bill in these instances?**

Some surgical groups employ an APRN or PA to serve as an assistant at surgery, freeing up a surgeon to perform evaluations or surgical procedures. For a surgical practice to report and receive third-party reimbursement for the service, the NPP must be an expense to the practice. If the hospital employs the...
NPP, and the NPP is not an expense to the practice, the practice may not report and be paid for those services.

Some hospitals employ NPPs to support their surgical groups. These NPPs are listed as an expense to the hospital on their Part A expense report. According to the Centers for Medicare & Medicaid Services’ (CMS) Medicare Benefit Policy Manual, Chapter 15, Section 60.1:

For hospital patients and for [skilled nursing facility, or SNF] patients who are in a Medicare covered stay, there is no Medicare Part B coverage of the services of physician-employed auxiliary personnel as services incident to physicians’ services under §1861(s)(2)(A) of the Act. Such services can be covered only under the hospital or SNF benefit and payment for such services can be made to only the hospital or SNF by a Medicare intermediary. (See §80 concerning physician supervision of technicians performing diagnostic x-ray procedures in a physician’s office.)

Surgical groups may bill for the services that their staff or contracted employees performed but may not report and be paid for services that the hospital’s staff or contracted employees provide.

What about patients with commercial insurance?
In many markets, commercial insurers enroll and credential APRNs but not PAs. There is no consistent national policy. States usually require that PAs have physician supervision, although that does not mean being physically in the same location when the PA provides services. A group must check with each payor about its policies for reporting APRN and PA services.

Two national insurers—Aetna and Anthem—have policies on NPPs. Aetna credentials both APRNs and PAs and follows Medicare rules for incident-to and shared services.

Anthem doesn’t follow incident-to rules for any NPP who has been assigned an Anthem NPI number. In other words, if the NPP is enrolled in and credentialed by Anthem, services are to be reported under the NPP’s NPI number. NPPs who are not enrolled and credentialed by Anthem are permitted to report their services incident-to the physician. Typically, APRNs are credentialed and report their services under their own provider numbers. PAs, however, are not enrolled or credentialed by Anthem and must report their services incident-to. Anthem does not follow all of Medicare’s incident-to rules but notes these two policies on its website.

Pursuant to its incident-to policy, Anthem requires that the supervising provider be physically present in the office suite and immediately available when necessary to provide assistance and direction throughout the E/M visit and/or rendered service. The supervising provider must stay involved and take an active part in the ongoing care of the patient. For details, go to http://www.anthem.com/provider/noapplication/f1/s0/t0/pw_e182215.pdf?refer=ahpprovider.

How will following these guidelines benefit my practice?
The lack of consistency and standardization among payors adds to the complexity and cost of employing NPPs; however, many practices find that the benefits outweigh the difficulties of learning and applying the billing rules.

Editor’s note
Accurate coding is the responsibility of the provider. This summary is only a resource to assist in the billing process.
The Agency for Healthcare Research and Quality’s (AHRQ) patient safety indicator (PSI)-15 for accidental puncture or laceration is a quality measure that is intended to gauge and report a physician’s rate of inadvertent cuts, punctures, perforations, and lacerations during a surgical procedure. The American College of Surgeons (ACS) sought clarification from the Centers for Medicare & Medicaid Services (CMS) regarding the correct reporting of PSI-15. At the crux of the ACS’ concerns is the lack of clarity as to what constitutes an “accident.” Punctures or lacerations that occur in surgical procedures often are incorrectly coded as “accidental” when the puncture or laceration was, in fact, a natural consequence or part of the operation.

The importance of seeking clarification on PSI-15 was spurred by CMS’ decision to include both PSI-15 and PSI-90, a hospital measures group that includes PSI-15, in several CMS quality reporting programs, including the Inpatient Hospital Reporting Program, the Hospital Value-Based Purchasing Program, and the Hospital-Acquired Conditions Reduction Program. Although PSI-15 currently is used in CMS programs that measure and report the quality and performance of hospitals, PSI-15 itself is a provider-level measure, which means that the results of PSI-15 can be attributed to the physician rather than the facility. At present, the results of PSI-15 are not separately reported as part of these CMS quality programs; however, surgeons for whom PSI-15 is inappropriately reported could be affected based on how their facilities are conducting their internal quality improvement efforts. In addition, it is unclear how CMS, private payors, and hospitals will use PSI-15 in the future. For these reasons, it is important that hospital and office coding staff understand how to correctly report this quality measure.

CMS response
CMS acknowledged and responded to the ACS’ concerns regarding this measure in the fiscal year 2014 inpatient prospective payment system (IPPS) final rule. More specifically, CMS finalized proposals to include PSI-15 in the three hospital quality reporting programs identified previously, but the agency maintains that the concerns about what constitutes an accidental puncture or laceration can be alleviated with proper coding guidance. Hence, in the final rule CMS responded that, “according to explicit guidance from the [American Hospital Association’s] Coding Clinic for ICD-9-CM (Second Quarter, 2007 and First Quarter, 2010), ‘expected’ enterotomies are not coded with...
code 998.2. By definition, this code is limited to ‘accidental’ punctures and lacerations that are not ‘intrinsic’ or ‘inherent’ in a major procedure.”

Although the CMS guidance is straightforward, the ACS has received comments from Fellows indicating that some hospital quality reporting departments continue to misunderstand how to correctly report PSI-15. This column provides more background and coding guidance to assist surgeons in working with their hospital staff on reporting PSI-15.

ICD-9-CM coding-related issue
As indicated in CMS’ response, proper reporting of PSI-15 hinges on International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code 998.2: “Accidental puncture or laceration during a procedure, not elsewhere classified.” In addition to clarification regarding the term “accidental,” it is important to know that ICD-9-CM 998.2 explicitly excludes iatrogenic [postoperative] pneumothorax (512.1); puncture or laceration caused by implanted device intentionally left in operation wound (996.0-996.5); and specified complications classified elsewhere such as: broad ligament laceration syndrome (620.6), dural tear (349.31), incidental durotomy (349.31), and trauma from instruments during delivery (664.0-665.9). Hospital coders use this ICD-9-CM code predominantly for general surgery cases, but also for otolaryngology, urology, gynecology, neurosurgery, gastrointestinal, cardiology, internal medicine, and other cases. It is important to note that hospital coders should not report this ICD-9-CM code when punctures or lacerations are “expected.”

PSI-15 is a measure that generates a ratio of reported events. The denominator includes most surgical and medical discharges, with a few exclusions. The numerator is intended to capture accidental cuts, punctures, perforations, or hemorrhages during medical care and is triggered when the hospital codes 998.2. Therefore, if a hospital handles “expected” punctures or lacerations correctly by not coding 998.2, the ratio of accidental punctures or lacerations per discharge will not be inappropriately diminished and will be more accurate.

When hospitals report 998.2 as an additional diagnosis, it counts as a complication or comorbidity (CC) or a major complication or comorbidity (MCC). The billing of CCs or MCCs often contributes to a higher diagnosis related group (DRG), resulting in increased reimbursement for the hospital. Given that hospitals could have an incentive to report 998.2 in order to increase reimbursement, it is important that hospital coders, who are primarily responsible for determining whether to report 998.2, understand how to use it correctly.

AHA coding guidance
As noted in CMS’ response to the ACS’ concerns, the American Hospital Association (AHA) Coding Clinic for ICD-9-CM sought to clarify the issue regarding punctures and laceration in response to providers’ questions. The following questions and answers are taken from two AHA Coding Clinic publications.4,5

AHA 2007 guidance
• Question: The patient presented with a left upper quadrant retroperitoneal cystic mass, involving intra-abdominal organs, and was brought to the operating room where she underwent radical excision of retroperitoneal cystic mass with adrenalectomy. During the procedure, the surgeon noted “a small capsular injury of the spleen, which was hemostatic.” This injury did not require repair. An esophagogastroduodenoscopy (EGD) was then performed for evaluation of the distal esophagus since the mass had adhered at the gastroesophageal junction. The EGD revealed a serosal injury to the stomach, which was repaired with interrupted Lembert sutures. The surgeon did not include the intraoperative tears in the diagnostic statement. What are the appropriate code assignments?
Although the CMS guidance is straightforward, the ACS has received comments from Fellows indicating that some hospital quality reporting departments continue to misunderstand how to correctly report PSI-15.

• Answer: Query the provider, and if the provider states the tear is not clinically significant, omit codes for both the diagnosis and procedure. When a tear is documented in the operative report, such as a small serosal tear of the stomach, the surgeon should be queried as to whether the small tear was an incidental occurrence inherent in the surgical procedure or whether the tear should be considered by the physician to be a complication of the procedure. If the provider documents that the seromuscular tear is a complication of the surgery, assign code 998.2, Accidental puncture or laceration during a procedure, as an additional diagnosis. This advice is consistent with that previously published in Coding Clinic, Third Quarter, 1990, page 18.

Note: this advice differs from that previously published in Coding Clinic, First Quarter, 2006, page 15, regarding dural tear occurring during surgery. The dural tear was coded in that case, because a dural tear is always clinically significant due to the potential for cerebrospinal fluid leakage.4

AHA 2010 guidance

• Question: The patient underwent lysis of adhesions for small bowel obstruction. Because of the extensive dense adhesions, significant time was spent taking them down from the abdominal wall, pelvis, small bowel, and colon. Multiple enterotomies were made dissecting the small intestine. A full thickness injury was identified in a section of small intestine, which could not be repaired primarily; therefore, a portion of the small intestine was resected with side-to-side stapled anastomosis. The other enterotomies involving the small bowel were repaired with Lembert-style sutures. At the close of the surgery, Seprafilm was placed in the abdomen and pelvis and the operative wound was reapproximated. Coding Clinic, Second Quarter, 2007, pages 11–12, stated that a serosal tear should not be coded. In this case, however, the full thickness injury of the small bowel appears to be significant due to the fact that a partial resection of the small intestine was carried out to repair the injury. How should this case be coded?

• Answer: Assign code 560.81, Intestinal or peritoneal adhesions with obstruction, as the principal diagnosis. Code 998.2, Accidental puncture or laceration during a procedure, and code E870.0, Accidental cut/puncture/perforation/hemorrhage during surgical operation, should also be assigned. For the procedures, assign code 54.59, Other lysis of peritoneal adhesions; code 45.62, Other partial resection of small intestine; code 45.91, Small-to-small intestinal anastomosis; code 46.73, Suture of laceration of small intestine, except duodenum; and code 99.77, Application or administration of adhesion barrier substance, for the placement of the Seprafilm.

This case involved more than a minor serosal tear. In this instance, the surgeon has clearly documented that the multiple enterotomies were clinically significant and a complication of the procedure.5

ACS’ advice

ACS coding experts disagree with the premise of the 2010 AHA guidance—that the degree of penetration of the bowel determines whether the occurrence is incidental to the operation or is an accidental injury. Rather, the determination should be based upon the nature of the operative field and operation performed. For example, during an adhesiolysis in a densely adherent abdomen, multiple full thickness small bowel repairs and resections might be expected if the surgeon documents that the enterotomies are intrinsic or inherent to the procedure of freeing the bowel. In contrast, puncture of the bowel by a Veress needle during creation of a pneumoperitoneum in a previously unoperated abdomen would be considered accidental and reportable.

The ACS encourages surgeons to carefully word operative reports to make clear whether a puncture or incision is accidental or expected. If the “injury” to a structure is
expected, then the surgeon should use language such as:

- “The adjacent organ was densely adherent to the tumor. In order to obtain adequate margin around the malignancy, the serosal surface was necessarily incised and removed, and the defect was closed.”

- “Adhesiolysis was difficult. As expected, multiple serosal tears and full thickness enterotomies were created during mobilization of the bowel, then were repaired with….”

- “At this point in the operation, entry into the normal adjacent bowel was unavoidable. This segment of bowel was resected and reanastomosed in two layers.”

In addition, if a surgeon is operating to repair an iatrogenic perforation or other organ injury, whether from a previous operation or from another procedure (such as a vascular access, an endoscopic procedure, or a diagnostic procedure) that resulted in the injury, he or she should clearly state in both the diagnosis and in the indications paragraph that this injury was present before the operation he or she is currently reporting. This clarification is necessary to prevent hospital coders from assigning 998.2 to a procedure when the accidental puncture or laceration is related to a previous procedure.

The ACS also encourages surgeons to work with hospital staff to ensure proper coding. Using ICD-9-CM code 998.2 in situations where the puncture or laceration is expected and not accidental would be inappropriate use of the ICD-9-CM code and could negatively affect a hospital’s and surgeon’s quality reports. Appropriate use of ICD-9-CM code 998.2 will contribute to a more accurate picture of both the hospital’s and surgeon’s quality of care and also give the Medicare program and patients more useful quality measurement information.

If you have questions or comments regarding this column, contact Vinita Ollapally at vollapally@facs.org or 202-672-1510. If you have additional coding questions, contact the ACS Coding Hotline at 800-227-7911 between 8:00 am 5:00 pm, CST, excluding holidays. ♦

**Editor’s note**

Accurate coding is the responsibility of the provider. This summary is only a resource to assist in the billing process.

**REFERENCES**


first saw the name Henry (Hank) T. Bahnson, MD, FACS, in 1977. I had purchased the Sabiston Textbook of Surgery: The Biological Basis of Modern Surgical Practice and was paging through the table of contents in my Brighton, MA, apartment prior to starting my third-year clerkship in surgery at Boston Veterans Affairs Hospital, today known as the VA Boston Healthcare System. Dr. Bahnson, a Past-President of the American College of Surgeons (ACS), had authored a chapter on diseases of the aorta, and I was surprised to find a chair of surgery who shared my surname. I was intrigued and eager to learn about him.

During my surgical residency, Julia Spencer, MD, FACS, the first woman resident in the department of urology at Northwestern University, Chicago, IL, reminded me of my interest in Dr. Bahnson. Encountering me on the ward, she would teasingly greet me as "Hank," and I would return the favor by calling her "Frank" to spoof an assumed lineage to the famous New York, NY, heart surgeon and ACS Past-President, Frank C. Spencer, MD, FACS. Little did we know at the time, but Hank Bahnson and Frank Spencer often accompanied Alfred Blalock, MD, FACS, in his travels to surgery centers around the world to help demonstrate techniques he had devised in cardiac surgery.

John T. Grayhack, MD, FACS, then chair of the department of urology at Northwestern, would jokingly tell colleagues he had accepted me into his postgraduate training program only because he thought I was a scion of the famed Bahnson medical family. Dr. Grayhack had served under Dr. Bahnson at Johns Hopkins University School of Medicine, Baltimore, MD, during his general surgical training, and he and his wife, Betty, had fond memories of Hank and his wife, Louise. The Bahnson’s gracious hospitality was evident even
then, when “Wee” Bahnson would host afternoon gatherings on her porch in Baltimore for the wives and children of the surgical house staff.

**Ingenuity**

I first met Henry Bahnson in his office at the University of Pittsburgh (PA) Medical Center’s Presbyterian Hospital in the fall of 1986. I had seen him in a few group photographs before our introduction, but I was unprepared for his striking physical resemblance to some of my older relatives. He admitted to a mild degree of excitement over our upcoming interview when he read my curriculum vitae the evening before our meeting. In July 1987, our family moved to Pennsylvania, and I began a professional relationship with him at the University of Pittsburgh that lasted nine years.

The first operation I performed in Pittsburgh involved regional hypothermia to facilitate a partial nephrectomy. Dr. Bahnson came into the operating room (OR) to observe me, which increased the nerves of an already anxious surgeon. In those days, slush machines were rarities, so the OR staff had placed bags of normal saline in the freezer to chill overnight. A scrub nurse was preparing the slush by pounding the bags of frozen saline with an orthopaedic hammer on a metal back table. Quietly and without being officious, Dr. Bahnson pointed out that placing the bags at the corner of the table would make the fracturing force of the hammer blows more efficient. This was the first of countless opportunities for me to witness his extraordinary skills of observation and workmanship.

His home in Fox Chapel, PA, was further testimony to the ingenuity he applied to almost any endeavor. No one ever would have considered featuring the house in an architectural or home decorating magazine. He kept beehives for honey, a stocked pond for fishing, horses for riding, a rope tow for skiing, and an orchard for both apples and his special brand of hard cider. At the conclusion of required clerkships in surgery at the University of Pittsburgh School of Medicine, students and selected departmental faculty were invited.
to his home for an afternoon party. The menu usually centered on lamb or beef cooked on his homemade barbecue spit, which he had fashioned from an old tractor. His working tractor was used to give hayrides for all of the children who attended the picnic. He and Louise also hosted a huge Christmas party every year for the surgical faculty and their families. New recruits were required to sing “We Three Kings” accompanied by Hank on his Hohner harmonica. Handel’s “Hallelujah Chorus” was sung with few, if any, in the gathering hitting the high notes. His seamless ability to combine work and fellowship was perhaps his greatest asset. It was as instinctive as breathing for him, and his inspiration was a natural product of his normal activity.

During my years in Pittsburgh, I was often asked in the hospital hallways how my dad was doing. For the first several years, I would carefully explain that Hank Bahnson was not my father, but near the end, to save time, I would simply say that he was fine. His son, Alfred Blalock Bahnson, was pursuing a PhD at that time at the medical center. His friends from high school called him “Blay,” his colleagues at the medical school called him “Al,” and he would always greet me as “cous.” His observation of similarities in physiognomy led him to believe that we had to be kin.

**Lasting impact**

I left Pittsburgh in 1996 but continued to be reminded of Dr. Bahnson in my new home in Ohio. Henry Bahnson was featured in a front-page article from the *Wall Street Journal* on Monday, February 8, 1999. The story, “Hank’s inquisitive approach to a harmonica virtuoso,” highlighted a series of experiments that Dr. Bahnson performed with his collaborator, a bioengineer, James Antaki, using endoscopy to videotape a harmonica virtuoso as he played “America the Beautiful.” The study led to a publication of a research article titled “Acoustical and physical dynamics of the diatonic harmonica” and led to Dr. Bahnson’s patent for his “Bahnson Overblow Harmonica.”* The modification, which has a slide mechanism, makes it easier for less experienced players to hit notes only a master can normally achieve. In April of that same year, *National Geographic* published a picture (circa 1892) of Henry Bahnson (a physician) of Salem, NC, and his children. The four children and a dog were sitting atop giant lily pads in his backyard pond. Dr. Bahnson (Hank’s grandfather) had propagated the lily pads (Victoria amazonica), native to South America, which could grow to a size of 20 feet in circumference and could support up to 300 pounds.

The last time I saw Hank was in the café of the San Francisco (CA) Hilton during the October 2002 ACS Clinical Congress. He was having breakfast with his son, Alfred, and he introduced me to his good friend Ben Eiseman, MD, FACS. I was unable to join them, but when I shook his hand and offered my goodbye, he fixed his penetrating eyes upon me, smiled, and advised me to “be brave.” He died a few months later in January 2003 at his home in Pittsburgh.

Every so often, I still think of Hank, usually when I am walking to and from work. In those moments, I remember his forthright approach to problems, his propensity to be candid, and his quiet, decisive nature. However, most of all, I remember that we share a last name, and I am reminded to have courage.

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Patient quality of life: 
Vitally important

by Juliane Bingener, MD, FACS; Jeff Sloan, PhD; and Judy C. Boughey, MB, BChir, FACS

Postoperative QOL measures can serve as a guide for anyone who may need additional interventions to support a successful recovery (for example, depression screening and anxiety intervention after cancer surgery). Most importantly, QOL brings the patient’s perspective into decision making.

Patient-reported outcomes have been described as key vital signs, with quality of life (QOL) having predictive value for patient survival. A recent study reported on 2,442 patients with non-small-cell lung cancer using a single-item measure of overall QOL within six months of lung cancer diagnosis. The study featured a single question, similar to the visual analog scale. A clinically deficient score (more than two points below average population) was associated with a median survival of 1.6 years versus 5.6 years for a nonclinically deficient score. Even after the performance status, age, gender, treatment factors, smoking history, and stage of disease were taken into account, single-item QOL remained a significant and independent prognostic factor for survival. Similar findings were reported for preoperative short form—36 scores for patients undergoing pancreatic cancer surgery with lower scores predicting survival of less than one year.

Opportunities for QOL assessment in surgery
A PubMed search conducted January 24 illustrated surgeons’ growing interest in the topic, including the terms “QOL and surgery.” The search resulted in 5,185 citations, a dramatic increase from 18 citations in 1993 and 644 citations in 2013 (see figure, page 47).

Assessment of QOL in surgical practice can serve multiple purposes, including measuring whether a procedure improved the patient’s QOL and which operation has the greater effect on a patient’s QOL. It is amazing to realize that, as described earlier in this column, it is possible to predict patient survival using preoperative QOL. Postoperative QOL measures can serve as a guide for anyone who may need additional interventions to support a successful recovery (for example, depression screening and anxiety intervention after cancer surgery). Most importantly, QOL brings the patient’s perspective into decision making. Patient and surgeon perspectives may be quite different, as demonstrated by recent data regarding patient symptoms and their impact on QOL after rectal cancer operations and other procedures.

Getting started
Surgeons may be uncertain about which QOL questions to ask and when. Following are some suggested guidelines:

1. Patient-reported outcomes have been described as key vital signs, with quality of life (QOL) having predictive value for patient survival.
2. A recent study reported on 2,442 patients with non-small-cell lung cancer using a single-item measure of overall QOL within six months of lung cancer diagnosis. The study featured a single question, similar to the visual analog scale. A clinically deficient score (more than two points below average population) was associated with a median survival of 1.6 years versus 5.6 years for a nonclinically deficient score. Even after the performance status, age, gender, treatment factors, smoking history, and stage of disease were taken into account, single-item QOL remained a significant and independent prognostic factor for survival.
3. Similar findings were reported for preoperative short form—36 scores for patients undergoing pancreatic cancer surgery with lower scores predicting survival of less than one year.
4. A PubMed search conducted January 24 illustrated surgeons’ growing interest in the topic, including the terms “QOL and surgery.” The search resulted in 5,185 citations, a dramatic increase from 18 citations in 1993 and 644 citations in 2013.
5. Assessment of QOL in surgical practice can serve multiple purposes, including measuring whether a procedure improved the patient’s QOL and which operation has the greater effect on a patient’s QOL.
6. It is amazing to realize that, as described earlier in this column, it is possible to predict patient survival using preoperative QOL.
7. Postoperative QOL measures can serve as a guide for anyone who may need additional interventions to support a successful recovery (for example, depression screening and anxiety intervention after cancer surgery).
8. Most importantly, QOL brings the patient’s perspective into decision making. Patient and surgeon perspectives may be quite different, as demonstrated by recent data regarding patient symptoms and their impact on QOL after rectal cancer operations and other procedures.
9. Getting started
   Surgeons may be uncertain about which QOL questions to ask and when. Following are some suggested guidelines:
The QOL domains should interest both the patient and the surgeon and be adaptable to the specific disease or treatment. Both general well-being and disease-specific issues are relevant.

A QOL expert or QOL assessment repository, such as www.proqol.org, can identify measures for each domain of interest to the patient and surgeon, including general measures and disease-specific measures. The tool chosen should be mainly based on the link between the domain of interest and each question (item) asked. It is preferred that reasonable psychometric data be available for the QOL measure, but they are not critical to the choice as long as the topics covered (face validity) are appropriate for the setting. Previous use of a particular measure in a different setting does not necessarily make it the best choice for the current clinical setting. Each environment has unique goals and characteristics to address. Patients often prefer short questionnaires over comprehensive ones.

Consider the following when reviewing the QOL assessment package: Are any questions confusing, controversial, or annoying? Are any questions redundant? Are any issues missing?

After the QOL assessment package is assembled, it is helpful to construct a workflow diagram with all personnel involved to establish precisely when, who, and how the QOL measures will be performed. Running through the complete package with a clinician and test patients provides an estimate of time and workload involved. Lack of intimate staff involvement in the decision-making process may result in missing data and a poor-quality assessment.

Some oncologic practices now ask each patient not only for a pain score, but also for an

REFERENCES


continued on next page
Surgical QOL questions can be an important part of assessing the impact of changes in treatment and therefore can play a significant role in prospective clinical trials.

assessment of overall QOL and fatigue. Collection of baseline QOL data can fit nicely into an established workflow, such as when taking the patient’s medication history or vital signs. This process may be completed electronically or on paper, depending on the available technology. Integrating the postoperative QOL data collection may be more challenging, as multiple health care providers are often involved in clinical care. Prepared questionnaires with return envelopes can be provided at hospital discharge for time points in the near future. Later time points can be obtained in person or by mail/phone, depending on the clinical situation.

Surgical QOL questions can be an important part of assessing the impact of changes in treatment and therefore can play a significant role in prospective clinical trials. Examples of currently open clinical trials with QOL components that are being conducted through the Alliance for Clinical Trials in Oncology include the following:

• 40903: Phase II study of neoadjuvant letrozole for postmenopausal women with estrogen receptor positive ductal carcinoma in situ
• 70807: The men’s eating and living study: A randomized trial of diet to alter disease progression in prostate cancer patients on active surveillance
• N1048: A phase II/III trial of neoadjuvant FOLFOX, with selective use of combined modality chemoradiation versus preoperative combined modality chemoradiation for locally advanced rectal cancer patients undergoing low anterior resection with total mesorectal excision
• N107C: A phase III trial of postoperative stereotactic radiosurgery compared with whole brain radiotherapy (WBRT) for resected metastatic brain disease
• Z11102: Impact of breast conservation surgery on surgical outcomes and cosmesis in patients with multiple ipsilateral breast cancers

Learning how to efficiently measure and integrate metrics that are important to surgical patients and their QOL will help us improve perioperative care and develop faster recovery pathways.

REFERENCES (CONTINUED)

Physicians play important role in on-site survey process

Physician leadership and involvement are critically important to the success of efforts to improve patient care and safety. Surgeons and other physicians must be fully engaged in these efforts because their knowledge, skills, and experience are essential to ensuring positive patient care experiences. For this reason, physician participation in The Joint Commission’s unannounced survey process is critically important in evaluating the quality of care that patients receive from an organization.

Dialogue with physicians
Engaging physicians in a productive dialogue makes a difference before, during, and after the on-site accreditation process. Joint Commission surveyors evaluate whether an organization’s written processes and procedures are actually being carried out for the benefit and safety of patients. To do so, surveyors and individual physicians interact in both formal and informal settings to discuss the provision of care. Physicians should know, however, that Joint Commission surveyors are not attempting to evaluate clinical decisions; their role is to determine how an organization’s systems provide the foundation for safe, effective treatment. The Joint Commission is striving to learn about physician priorities and strategies for improving the quality and safety of care provided to their patients. This communication forges a strategically important relationship between physicians and The Joint Commission. It also emphasizes the shared goal of physicians and physician surveyors—safe, quality care.

Medical staff preparation
Surveyors do not expect physicians to recite accreditation standards and an institution’s mission statement. Instead, surveyors want to discuss the systems and processes of patient care—an area with which physicians should be acutely familiar as part of their work at the institution. Surveyors understand that a primary objective of physicians is to provide their patients with safe, high-quality care.

When The Joint Commission arrives for an on-site survey, it is easy to tell which medical staffs are prepared. The physicians on these teams want the opportunity to shine and receive credit for their excellent work. They do not want to be put on the spot, not knowing what is being asked of them, nor is the physician surveyor looking to create that scenario. Medical staffs that are prepared for survey activities and understand when they are likely to encounter Joint Commission surveyors are more likely to have positive experiences that contribute to the accreditation process and are less likely to have awkward or defensive exchanges.

The Joint Commission is striving to learn about physician priorities and strategies for improving the quality and safety of care provided to their patients.
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Although Joint Commission surveys are unannounced, the accreditation coordinator usually alerts the hospital staff to an expected time frame for the next full survey. The time period leading up to the survey is a prime opportunity to schedule a number of short discussions with the medical staff about what to expect. For example, physicians may be interviewed during the on-site survey as part of the patient tracer or system tracer activities to discuss their involvement in meeting National Patient Safety Goals and use of the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery. Physicians and Joint Commission surveyors may also engage in dialogue about performance measurement activities.

Suggestions
A physician surveyor who now works as a field director in The Joint Commission’s Accreditation and Certification Operations Division offers the following pieces of advice to help the medical staff ensure a successful session:

• In the opening meeting, the medical staff should present a brief overview of their work, including the challenges they have encountered, such as patient flow issues in the emergency department, infection rates, or unclear hand-off communications. Providing this information up front indicates that the medical staff and the hospital as a whole are proactive in dealing with known quality and safety challenges.

• During the session on the hospital’s medication management system, members of the Pharmacy and Therapeutics Committee should expect to discuss their analysis and response to medication variance and adverse reaction data. This area is one that medical staffs generally know a great deal about, so being prepared allows them to display their knowledge.

• The surveyor will want to understand how the medical staff is monitoring the quality of history and physical exams. The surveyor also will want to understand the staff’s system for ongoing professional practice evaluation and focused professional practice evaluation. Staff members should, at the very least, be familiar with these terms and their meanings; even better, medical staff should be actively involved in discussion of the quality indicators that are being used to evaluate patient care.

• The medical staff may be asked to discuss treatment in a specific case, but should not assume that this means the surveyor has found an issue of concern. More often, the surveyor is trying to understand the institution’s approach by tracing patient care on hospital units. As part of the on-site process, surveyors use this individual tracer methodology to trace a patient’s care experiences and the organization’s systems for providing care and services. This process means that surveyors spend much of their time talking to direct caregivers, including physicians, and observing direct care.

• On the final day of the survey, a leadership session will take place. This meeting provides an opportunity for open discussion and allows the medical staff to showcase performance improvement projects they have undertaken and their involvement in the hospital. Topics discussed range from strengths and weaknesses identified during the survey to big picture issues, such as how institutions achieve high reliability in health care or the effects of health care reform.

For more information, visit www.jointcommission.org/physicians.aspx. The website includes information tailored specifically for physicians as well as other information about patient safety, access to evidence-based data, solutions related to persistent patient quality and safety problems, and registration for notification of field reviews and other news and events.
Residential institutions

Residential institutions have played a prominent role in American and British society for some time. A recent book titled *Residential Institutions in Britain, 1725–1970: Inmates and Environments* describes the development of “residential institutions” over time. These institutions were established to mold their inhabitants and were organized in line with professional and economic constraints. In order to be successful, these facilities needed to appeal to both the residents and the general public. The book looks at a variety of residential institutions, including those housing and caring for the poor, the mentally ill, and the infirm, as well as displaced young women and convicts.* The Collins Cobuild English Dictionary for Advanced Learners describes a residential institution as one in which people live while they are studying or receiving care at the facility.†

Injuries at residential institutions

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) has a set of external cause of injury codes that details the types of places where an injury occurs. These codes are routinely collected as part of the dataset of the National Trauma Data Bank® (NTDB®). Places where an injury may occur include home, public building, street/highway, recreational/sporting center, industrial site, farm, mine, or residential institution. Residential institution is further defined to include a children’s home, dormitory, hospital, jail, old people’s home (nursing home), orphanage, prison, or reform school. Notably, residential institutions have the highest case fatality rate—7.43 percent—by location E code in the 2013 report. This case fatality rate is 1.6 times greater than at the next highest location, which is the home.

To examine the occurrence of injuries in a residential institution in the NTDB research dataset for 2013, admissions medical records were searched using the ICD-9-CM place of injury codes. Specifically searched were records that contained place of injury code E849.7 (children’s home, dormitory, hospital, jail, old people’s home, orphanage, prison, or reform school). A total of 29,976 records was found; 27,812 records contained a discharge status, including 6,875 patients discharged to home, 3,120 to acute care/rehab, 15,660 sent to skilled nursing facilities, and 814 sent to hospice; 1,343 died. These patients were 60 percent female, an average of 74.1 years old, had an average hospital length of stay of 5.3 days, an intensive care unit length of stay of 3.7 days, an average injury severity score of 9.4, and were on the ventilator for an average of 4.8 days (see Figures 1 and 2, page 52).

**Room for improvement**

It is not uncommon for surgeons and other health care professionals to provide care to the unfortunate victims of injuries that have occurred in these residential institutions. Hospitals have made great strides toward decreasing the number of unassisted falls, especially those that result in significant injury. Nursing homes have a unique set of challenges with their resident population but have implemented several strategies to decrease injuries, as well. From our heritage to the historical reflections as noted in this column, residential institutions were intended to mold and care for their inhabitants, not injure them.

Throughout the year, we will be highlighting these data through brief reports in the *Bulletin*. The National Trauma Data Bank Annual Report 2013 is available on the ACS website as a PDF file at [www.ntdb.org](http://www.ntdb.org).

In addition, information about how to obtain NTDB data for more detailed study is available on the website. To learn more about submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

**Acknowledgement**

Statistical support for this article has been provided by Alice Rollins, NTDB Coordinator.
The American College of Surgeons (ACS) hosted the ACS Surgical Health Care Quality Forum Ohio on March 28, one in a series of community forums held across the U.S. Participants in this 17th stop on the College’s Inspiring Quality (IQ) tour, which began in 2011, focused on ways to improve patient safety, reduce costs, and share examples of how surgeon-led quality improvement programs have set higher health care standards.

Cohosting the event, which took place at The Ohio State University (OSU), Columbus, were E. Christopher Ellison, MD, FACS, and Susan Moffatt-Bruce, MD, PhD, FACS. Dr. Ellison is distinguished professor and Robert M. Zollinger Professor of Surgery; chief executive officer, faculty group practice; vice-dean, clinical affairs; and a general surgeon, The OSU College of Medicine. Dr. Moffatt-Bruce is chief quality and patient safety officer; associate dean for clinical affairs, quality, and patient safety; cardiothoracic surgeon; and associate professor of surgery, division of thoracic surgery, department of surgery, OSU Wexner Medical Center.

The forum featured a panel discussion on the state of health care in Ohio, during which panelists demonstrated how community leaders, in both government and surgery, can work together to increase the value of health care. “With more institutions implementing payment strategies that reward quality care, it provides even more motivation to increase quality outcomes for patients. The health care industry is moving toward patients paying for better care, not just more care, and hospitals that implement quality programs will be better equipped for this shift,” said keynote speaker Greg Moody, director, Office of Health Transformation, State of Ohio. Mr. Moody spoke specifically of the urgency for payment and delivery reform and Ohio’s comprehensive approach to health transformation.

Dr. Ellison urged continuing collaboration among all stakeholders in the health care system. “Quality improvement within our operating rooms has evolved greatly over the past 10 years through the combined effort of providers and hospital administration. We need to continue our collaborative efforts to prioritize quality programs and consistently incorporate proven practices across the state to ensure that care given in rural Ohio is equal to care provided in Cleveland and Columbus.”

Speakers from OSU discussed programs that have helped them achieve quality improvement, including the ACS National Surgical Quality Improvement Program (ACS...
NSQIP®), which provides reliable surgical data to more than 500 hospitals and helps to pinpoint areas for improvement.

“ACS programs have been proven to increase quality in trauma and cancer care, bariatric surgery, and in overall surgical care. The underpinning of our programs, and what makes them most effective, is based on four principles: set the standards, build the right infrastructure, use the right data, and verify with outside experts,” said David B. Hoyt, MD, FACS, ACS Executive Director. “Verifying quality results through a third party is particularly important because it reassures the public that what they are promised is what they are getting.”

Dr. Moffatt-Bruce added, “In addition to quality improvement programs, hospitals have been implementing crew resource management to help create a team approach to patient safety and the very best patient care and outcomes loyalty. These programs have been used to improve physician engagement and have provided a significant return on investment for hospitals in preventing patient harm events.”

The full video of the Ohio forum is available at InspiringQuality.facs.org and on the College’s YouTube channel.

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**1913 Legacy Campaign announces $1.75 million raised toward goal**

The Board of Directors of the American College of Surgeons (ACS) Foundation announced that as of mid-March, Fellows and friends had contributed $1.75 million to the 1913 Legacy Campaign, which meets 35 percent of the campaign’s $5 million goal. Applied Medical Technology, Inc. and Coloplast Corp. both recently donated Leadership Gifts ($100,000 and up) to the campaign in support of the ACS Division of Education’s Patient Education Program.

The 1913 Legacy Campaign, officially announced at the 25th Annual Fellows Leadership Society Luncheon during the 2013 ACS Clinical Congress, continues to secure gifts to advance programming that is critical to the College’s mission.

Philanthropic investments work for the benefit of the Surgeon, the Profession, and the Societal Good:

- **The Surgeon:** Investments in the development of innovative programs to advance simulation-based surgical education and training; funding to better engage and embrace international surgeons.

- **The Profession:** Promoting best practices and quality improvements through the newly established Codman Quality and Safety Fund and programs for rural surgery and surgical ethics. The Codman Fund is named in honor of Ernest A. Codman, MD, FACS, a key figure in founding the College who advocated for the “End-Result Idea”—the premise that hospital staffs should follow every patient long enough to determine whether the treatment was successful and then learn from failures.

- **The Societal Good:** Funding opportunities for patient education programs and support for surgical volunteerism. For more information on how to participate in this unprecedented campaign that honors the College’s Centennial, contact the ACS Foundation at 312-202-5338 or visit www.facs.org/1913Campaign.
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The American College of Surgeons (ACS) has initiated a search for a full-time Medical Director for the Operation Giving Back (OGB) program and is accepting applications for the position through May 30. The individual selected for this position will be based in the Chicago, IL, ACS headquarters and will work with the staff of the Division of Member Services and other staff throughout the organization.

About OGB

OGB’s mission is to leverage the passion, skills, and humanitarian ethos of the surgical community to effectively meet the needs of the medically underserved. The program provides the tools necessary to facilitate humanitarian outreach, which promotes both domestic and international service, among surgeons of all specialties at all stages of their career. By delivering information on opportunities to volunteer through patient care, education, training, systems strengthening, advocacy efforts, and donation of needed equipment and supplies, OGB focuses these resources to address critical public health issues as they relate to the provision of safe, timely, necessary surgical care around the globe. For more information about the OGB program, go to www.operationgivingback.facs.org.

Medical Director responsibilities

The Medical Director of OGB will be responsible for the following activities:

- Program design, implementation, maintenance, and growth. The Medical Director will be responsible for creating and overseeing all forums, tools, and resources available for surgical volunteers. This aspect of the position includes managing the OGB website content, developing thematic messaging for the annual ACS Clinical Congress, responding to urgent and emergent humanitarian needs across the globe to convey trusted information, directing a response, and creating resources as needed.

- Development of a strategy to foster and sustain program funding. This responsibility will entail working with external sources and collaborating with the ACS Foundation for philanthropy and grant writing to ensure the long-term viability of the program. The Medical Director will be responsible for collecting and analyzing financial data on the program’s impact.

- Communications. Responsibilities in this area include managing website content, developing e-newsletters, writing articles for publication in external peer-reviewed journals and ACS publications, and giving oral presentations at international and national conferences and meetings. Establishing relationships with mainstream and social media outlets will be an important part of eliciting immediate responses to crises.

- External relations and partnership to include collaboration and coalition building. The Medical Director will be responsible for bridging efforts of the ACS with other strategic partners and nongovernmental organizations to fill programmatic gaps, create synergistic relationships, and maintain a leadership position for the ACS. This area of responsibility includes communicating shared priorities, as well as convening meetings and other work-related forums.
OGB’s mission is to leverage the passion, skills, and humanitarian ethos of the surgical community to effectively meet the needs of the medically underserved.

• Resource management. The Medical Director will be responsible for managing OGB staff, developing the program budget, and overseeing administrative workgroup and volunteer support.

Requirements
Successful candidates for the position must meet the following educational and work experience criteria:

• MD with a minimum of four years of experience in program management of global health/public health programs required
• Understanding of surgical skills and sensibilities needed to successfully engage in humanitarian outreach
• Strong management and fiscal abilities
• Fellow of the American College of Surgeons a plus

For the complete job description, go to https://www.linkedin.com/jobs2/view/13064306. Interested applicants should send a curriculum vitae and a statement of interest to acssearchcom@facs.org. Applications will be accepted through May 30, 2014. (The American College of Surgeons is an Equal Opportunity/Affirmative Action Employer, AA/EEO/M/F/D/V.)

Study shows secondary thyroid tumors more deadly in young people

A study in the February 24 issue of Cancer, a peer-reviewed journal of the American Cancer Society, indicates that adolescents and young adults who develop thyroid cancer secondary to another type of cancer have a 6.6-times greater risk of mortality than patients with primary thyroid cancer.

The researchers—Melanie Goldfarb, MD, FACS, assistant professor, Keck School of Medicine of the University of Southern California, and David Freyer, DO, MS, Children’s Hospital, Los Angeles—used the American College of Surgeons National Cancer Data Base (NCDB) to identify 41,062 patients, ages 15 to 39, diagnosed with thyroid cancer in 1998 through 2010. Of those patients, 3.3 percent had thyroid cancer as secondary malignant neoplasms.

Thyroid cancer is one of the five most common malignancies in adolescent and young adult patients. The researchers stress the importance of screening young cancer survivors to detect early signs of a potentially life-threatening thyroid malignancy. For more information, go to http://goo.gl/wacph5.
Are you taking advantage of all the American College of Surgeons has to offer?

ACS members are dedicated to promoting the highest standards of surgical care through education and advocacy for Fellows and their peers. The College serves as an international forum through which surgeons can reinforce the values, ideals, and ethics that characterize the surgical profession.

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- Access to a broad range of CME programming, including resources to support Maintenance of Certification
- Subscriptions to ACS publications that bring you cutting-edge research and news from the College and surgical community
- Access to College-sponsored insurance programs
- Free access to the College coding consultation hotline, career opportunities, and resume posting
- And much more

**THERE IS STRENGTH IN NUMBERS**

Our members represent every surgical specialty, practice setting, and stage of practice. Their views and concerns help shape the College’s agenda for the future.

If you aren’t a member of the American College of Surgeons, apply for Fellowship today. If you are already a member, maintain your status and consider getting involved in the College’s efforts to make a difference.

Together, we can bring about positive change for our patients and partners—and for the surgeons of the future.

Information on becoming a member of the College and an application form are available online at [www.facs.org/memberservices/documents.html](http://www.facs.org/memberservices/documents.html) or contact Cynthia Hicks, Credentials Section, Division of Member Services, at 800-293-9623 or [chicks@facs.org](mailto:chicks@facs.org).
A collection of historic films is now available for viewing on the American College of Surgeons (ACS) Archives website, including the following:

- The College’s first “talkie,” 1929. ACS Founder and Director General Franklin H. Martin, MD, FACS, introduces the Officers, Board of Regents, and Past-Presidents. This film was recently transferred from the original 35mm nitrate negative to preservation-quality film stock. A nitrate film vault at the Library of Congress holds the original negative.

- Surgical operation films from the Gamble Collection. Hugh Agnew Gamble, MD, FACS, recorded many of his surgical operations in the 1940s on 16mm silent color film. Dr. Gamble’s grandson, Hugh A. Gamble II, MD, FACS, donated the collection to the College. The film features Refrigeration Anesthesia in the Treatment of Arteriosclerotic and Diabetic Gangrene in the Poor-Risk Patient; and Gangrene Bowel Resection.

- White Battalions, 1941. This ACS film describes modern hospital care to the layperson.

- Fractures: An Introduction, 1948. This film was produced by the Committee on Fractures and other Traumas (now the Committee on Trauma).

- To Serve All, 1963 and 1970. Past-Presidents and others explain the College’s history and accomplishments.

You can view these films on the ACS website at http://www.facs.org/archives/films.html.

Approximately 100 of the films and videos in the Archives have been transferred to a digital format. The Archives also is planning a new online system that will provide visitors with access to full descriptions of all cataloged materials, including links to more films, videos, sound recordings, images, and texts. Many Archives resources are already available online at http://www.facs.org/archives/onlineresources.html.
AMERICAN COLLEGE OF SURGEONS PROFESSIONAL ASSOCIATION (ACSPA)

In 2013, the American College of Surgeons Professional Association political action committee (ACSPA-Surgeons PAC) raised $606,148, in personal and corporate contributions. This total is nearly $96,000 less than the PAC raised in 2012. The ACSPA believes that more education is needed to increase surgeons’ awareness of what the PAC does. To this end, Town Hall Meetings centered on ACSPA-Surgeons PAC activities will convene at the 2014 Clinical Congress, October 26–30 in San Francisco, CA, and educational materials will be provided to young surgeons. In addition, members of the PAC Board of Directors will continue to reach out to American College of Surgeons (ACS) Fellows at chapter and other member-based meetings and seek PAC-inclusive advocacy messaging from ACS leaders and staff.

AMERICAN COLLEGE OF SURGEONS

Member Services

The Division of Member Services has developed audience-specific brochures for all membership categories, which are now available. The Division has asked ACS Governors whether they prefer electronic or paper copies of the brochures, or if posting them on the SharePoint sites would be most convenient.

In addition, the College is developing a campaign strategy to recruit members younger than 45 years of age.

Furthermore, the College is revitalizing its international strategy with a new structure, mission, and goals. As part of this effort, an international General Surgery Review Course is being planned. The Governors have broadened opportunities to international members but not exclusively to this population.

Other developments occurring under the aegis of Member Services include the following:

- Efforts are under way to form a Surgical History Club, with details to be announced.
- The Operation Giving Back program is evolving with a potential connection to global surgery initiatives.

Board of Governors

The Board of Governors (BOG) strategic transformation is complete. BOG workgroups that were created under the redesign are progressing on several projects that fall under the purview of the five Pillars of the BOG: Education, Advocacy, Communications, Quality, and Member Services. In addition, the BOG has begun publishing a newsletter to communicate information and news about ACS and BOG initiatives.

Plans are under way to restructure the ACS Advisory Councils in a similar manner.

Chapters

The newest chapter to receive the Board of Regents approval is the United Arab Emirates Chapter. It is the 38th international chapter, bringing the total number of chapters to 104—66 domestic, two Canadian, and 38 international.

Young Fellows Association

The College has identified specific roles for interested Young Fellows Association (YFA) members to assume on ACS committees. The following three Panel Sessions aimed at young surgeons will take place at the 2014 Clinical Congress: Initiates Program, Managing Debt, and Lean and Green. The YFA Mentorship Program matched 20 pairs of mentors and mentees at the 2013 Clinical Congress and plans to broaden the experience at the 2014 Clinical Congress. The YFA also plans to publicize the program to ACS chapters via a Web-based mentorship training package. An exciting new video project is in development with the theme of “What’s It Like to Have a Surgeon in Your House?” The YFA also has a quarterly newsletter and is initiating an essay contest.
Surgical Jeopardy, an interactive competition that the RAS-ACS introduced several years ago at Clinical Congress, has been packaged into an attractive tool kit with all the materials needed to host a competition at the chapter level.

Resident and Associate Society
The Resident and Associate Society (RAS-ACS) continues to create opportunities for young surgeons to get involved with the College and to identify leadership positions. The RAS-ACS also is involved in several outreach efforts through the Advisory Council and state specialty societies to recruit resident members.

Surgical Jeopardy, an interactive competition that the RAS-ACS introduced several years ago at Clinical Congress, has been packaged into an attractive tool kit with all the materials needed to host a competition at the chapter level. ACS Chapters will be contacted to determine their interest in piloting the competition. RAS-ACS intends to continue updating the game to keep it current and relevant.

Advocacy
Communications to ACS Fellows regarding the College’s advocacy efforts have steadily increased. One example of these efforts to communicate with ACS members was the development of the monthly e-newsletter, The ACS Advocate, which launched more than a year ago. Efforts to advocate for a permanent Medicare physician payment fix have been covered extensively in this newsletter, as well as in NewsScope, the Bulletin, and other special communications.

Examples of some of the advocacy initiatives that the College led from February 2013 through February 2014 include:

• Played an important role in achieving passage of legislation that delayed a nearly 30 percent cut in Medicare physician reimbursements

• Supported Children’s Hospital Graduate Medical Education Support Reauthorization Act

• Sought repeal of the Independent Payment Advisory Board established under the Affordable Care Act

• Opposed sequestration cuts that resulted in a 2 percent reduction in Medicare physician payments and graduate medical education (GME) funding

• Supported the introduction of three GME bills:
  – Resident Physician Shortage Reduction Act of 2013
  – Training Tomorrow’s Doctors Today Act
  – Conrad State 30 and Physician Access Act

• Worked with the Division of Integrated Communications to publish a special edition of the
Bulletin covering a comprehensive list of medical liability reforms

• Released the Surgeons and Bundled Payment Models: A Primer for Understanding Alternative Physician Payment Approaches

• Sent a joint letter to the Office of the National Coordinator for Health Information Technology (ONC) commenting on several policies and programs that the Centers for Medicare & Medicaid Services (CMS) and ONC have been considering, which are aimed at helping advance interoperability and health information exchange

• Advocated for passage of the Good Samaritan Health Professionals Act

• Submitted two letters, one to the CMS and a similar letter to the U.S. Department of Health and Human Services (HHS) Office of the Inspector General, regarding the extension of a federal physician self-referral statute (Stark Law) exception and comparable anti-kickback safe harbor for firms that donate electronic health record (EHR) software to physicians

• Commented on the calendar year (CY) 2013 physician fee schedule proposed rule

• Commented on the CY 2013 outpatient prospective payment system/ambulatory surgical center proposed rule

• Launched SurgeonsVoice, an enhanced grassroots advocacy program for recruiting, educating, and motivating Fellows to use their influence to change the dynamic in Washington, DC, by equipping ACS members with the knowledge and tools necessary to become an integral part of the nationwide grassroots advocacy network of surgeon advocates

• Released Our Changing Health Care System Since the Inception of the Affordable Care Act, a compendium of articles and other resources that the ACS has published on legislative and regulatory issues, which provides a retrospective look at the changing health care landscape

• Issued a letter voicing the ACS’ opposition to the proposed Senate Finance Committee legislation to repeal the sustainable growth rate formula

• Lobbied on several state-specific bills, including legislation pertaining to health insurance, medical liability, and workforce issues

Communications

At the time of the Board meeting, the College’s ongoing Inspiring Quality campaign had made 16 tour stops around the U.S. To further increase awareness among hospital C-suite leaders of the ACS’ quality programs, particularly the College’s National Surgical Quality Improvement Program (ACS NSQIP®), the ACS was a sponsor of the U.S. News & World Report’s Hospital of Tomorrow Conference held in Washington, DC, November 4–6, 2013.

The College is in the process of overhauling its website. The new website will be unveiled this summer and will feature responsive design, an enhanced search function that will allow visitors to find a Fellow of the College or an ACS-verified or accredited center easily, and a new online community. Tyler Hughes, MD, FACS, has been named the Online Community Editor. In addition, the new site will comprise:

• A home page that showcases the College’s five pillars: member services, quality programs, education, advocacy, and communications

• Time-sensitive announcements at the top of the home page

• Links to easily direct visitors to their unique needs

• Sections that highlight the latest news, feeds from the physician online community, and upcoming events

• An enhanced member profile feature

• Streamlined e-commerce
**Journal of the American College of Surgeons**

The *Journal of the American College of Surgeons (JACS)* website has progressively become more user-friendly. It now has an “open access” option for authors and has added a new “featured video” and a “Journal Insights” feature that displays JACS metrics of impact, speed, and authors.

In 2013, *JACS* provided 82,771 continuing medical education (CME) credits to 3,579 readers, averaging 23.1 credits per person. An iPad app is available for Fellows and JACS subscribers to access the full text of articles, providing an easy way to earn CME credits. Feature articles are also on the JACS Twitter feed @IAMCollSurg, which may be accessed at [https://twitter.com/amcollsurgeons](https://twitter.com/amcollsurgeons).

In addition, five Chinese-language editions of JACS have been published, with more planned for the future, and JACS articles have been publicized in various media outlets, such as *U.S. News & World Report*, *Bloomberg Businessweek*, and *Science Daily*.

**Bulletin of the American College of Surgeons**

The *Bulletin*’s print and online presence continues to grow and gained additional prominence from the launch of a dedicated Web presence (*bulletin.facs.org*). In recognition of the College’s Centennial year, from September 2012 to the October 2013 issue, the *Bulletin* showcased an article from past editions to provide readers with a reminder of the College’s history and legacy.

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**Quality, Research, and Optimal Patient Care**

The Division of Research and Optimal Patient Care has set the following goals for 2014:

- Launch a new Outcomes Research Course, December 4–6, in Chicago, IL
- Expand the Clinical Scholars program
- Continue development of the pediatric accreditation program
- Bring the four overarching aims of the division into horizontal alignment: accreditation (internal/external), registries, regulatory, and achieving quality
- Develop new clinical areas
- Generate technology solutions
- Expand support for improvement (for example, collaboratives, real-time reports, and cost data)
- Collaborate further with other societies

**Advanced Trauma Life Support**

The Advanced Trauma Life Support (ATLS®) course trains more than 40,000 students annually and has been presented in 65 countries. Health care professionals in 158 countries have downloaded the ATLS mobile device application, resulting in more than 56,000 downloads. The 9th edition of the ATLS textbook will be offered as an e-book with enhanced imaging and other features.

Furthermore, ATLS and Operation Giving Back have formed a partnership to provide course materials to surgeons on humanitarian missions in Haiti and Zimbabwe. Challenges include growth, meeting the demands of international promulgation, continuous development of infrastructure, and the development of digital learning.

**ACS NSQIP**

As of the Board meeting, 526 hospitals were participating in the ACS NSQIP, and 61 additional hospitals were in various stages of the application and contracting process. The following is a breakdown of participating sites by ACS NSQIP program options:

- Small and rural: 27
- Procedure targeted: 181
- Essentials: 243
- Measures: 9
- Florida Surgical Care Initiative (FSCI): 11
In 2013, ACS NSQIP entered into an agreement with Epic Systems to incorporate ACS NSQIP variables into a module of Epic’s electronic health records (EHR). The primary goal of the collaboration is to use data automation and to reduce the burden of data collection for the surgical clinical reviewer and data abstractor. The project is progressing well and is expected to go live in the fourth quarter of 2014. Additional efforts to expand continue, and program staff will work with Cerner Critical Outcomes, another EHR provider, to begin developing an ACS NSQIP module. The ACS is working to broaden opportunities for Fellows to work with a number of EHR providers.

Several surgical specialty societies have approached ACS NSQIP with various models for collaboration. Much of the discussion centers on adding specific data points to ACS NSQIP that could, in turn, measure outcomes and improve care in the surgical specialties. The additional target areas that are currently being considered for inclusion include transplant, head and neck, orthopaedics, urology, neurology, and enhanced recovery methods. Pilot programs for transplant and enhanced recovery will begin in 2014.

The Task Force on Geriatric Surgery formally launched its pilot program on January 6, when 19 sites began collecting data on geriatric specific variables. The Task Force identified 14 specific variables to be collected as part of this pilot.

The next ACS NSQIP conference is scheduled for July 26–29, 2014, at the Hilton Midtown, New York, NY. Linda Groah, executive director and chief executive officer for the Association of Perioperative Registered Nurses, will deliver the keynote address on the topic of accountability and quality care.

Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)

As of the Board meeting, 732 bariatric surgery centers were participating in MBSAQIP; 634 were fully accredited, and 98 had provisional approval. Another seven initial applications were under review.

Three areas of focus for MBSAQIP in 2014 include:

• New joint standards, which were published in January
• Initiation of surgeon site verification that also supports facility accreditation
• Release of the first semiannual report
The MBSAQIP submitted a letter of intent to CMS on January 31 requesting that the program be recognized as a CMS Qualified Clinical Data Registry (QCDR). The QCDR is a new reporting mechanism available for participation in the Physician Quality Reporting System (PQRS) beginning in 2014. As a CMS-recognized QCDR, the MBSAQIP data registry will be able to collect and report PQRS measures at the request of eligible professionals.

**Surgeon Specific Registry**

According to recent estimates, approximately 5,000 surgeons have submitted at least 20 cases and more than 4.4 million records to the ACS’ Surgeon Specific Registry (SSR). Surgeons continue to use the registry as a case log system. The overarching aim of the SSR is to target the “regulatory items” being used to assess individual surgeons. Three of the regulatory items being addressed include, but are not limited to:

- Maintenance of Certification (MOC) by the American Board of Surgery (ABS), the American Board of Colon and Rectal Surgery (ABCRS), and other surgical boards
- Recertification by the ABS
- The PQRS

The SSR continues to have ABS and ABCRS approval for fulfilling requirements under MOC Part IV. Plans are in the works to develop the next set of measures for ABS MOC and PQRS. The College has met with the American Board of Medical Specialties and the American Board of Thoracic Surgery to discuss prospective SSR endorsements.

In addition, CMS approved the General Surgery Measures Group for PQRS 2014, and the American Urological Association promoted the SSR to its members as a resource for PQRS participation.

**SSR goals for 2014 include:**

- Expand regulatory content in SSR
- Enhance SSR methodology/validation
- Explore technology

**Quality manual**
The *ACS Quality Manual: Resources for Optimal Quality Surgical Care* will provide an authoritative reference for surgical leaders, as well as a road map for new ACS programs, to recognize excellence in quality and safety. At press time, chapter outlines and initial drafts were due for review in spring 2014.

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**American College of Surgeons Foundation**
The Foundation launched the 1913 Legacy Campaign: Investing in the New Century of the ACS last year with the goal of raising $5 million in contributions in 2014. The Foundation received its first corporate donation to the campaign in February 2014. A coordinated marketing campaign will raise visibility of and interest in this campaign, which to date has raised $1.75 million from Fellows, friends, chapters, and corporations.

**Finance**
The College continues to be in good financial health; investments are on target with a 10.6 percent year-to-date return for the six months ending December 31, 2013. Year-to-date (December 31) operating revenues represented growth of 8.1 percent over the same period in 2012. The revenue growth is primarily driven by Cancer, Education, and Continuous Quality Improvement programs, partially offset by a decrease in Clinical Congress revenue. ✷
Editor’s note: Media around the world, including social media, frequently report on American College of Surgeons (ACS) activities. Following are brief excerpts from news stories published from January through March 2014 that mention key ACS programs and initiatives, including research findings that appear in the *Journal of the American College of Surgeons*. To access the news items in their entirety, visit the online ACS Newsroom at http://www.facs.org/newsroom/acs-in-the-news.html.

**Report Criticizes L.A. County spending on emergency medical services**

*Los Angeles Times*, February 20

“Auditors concluded that the county should contract with the American College of Surgeons to undertake a comprehensive assessment of its trauma care system and look at ways to better serve areas including Malibu, the eastern San Gabriel Valley, and large swathes of the Antelope Valley that don’t have nearby trauma centers.”

**Better bariatric surgery outcomes depend on data, accreditation**

*HealthLeaders Media*, February 6

“The [Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program] melds two accreditation programs that had been operated separately, one by the American College of Surgeons, which accredited about 550 hospitals, and the other by the American Society for Metabolic and Bariatric Surgery, which accredited 150 hospitals. Under the new combined program, hospitals will all have a specially trained nurse reviewer, ‘a person outside the direct medical practice’ to independently and accurately collect 100 or more patient variables abstracted manually from charts.”

**Riverside County Regional Med Center drastically cuts infection rates**

*Southern California Public Radio*, January 31

“‘Improvement is sometimes a very complex, complicated process,’ said Dr. Clifford Ko [MD, FACS], director of the Division of Research and Optimal Patient Care at the American College of Surgeons. ‘And so anytime a hospital is able to improve on something like [surgical site infection], we like to learn from them and see what they did and share their successes and their experiences with everyone else.’”

**Health leaders discuss lessons learned from Asiana crash response**

*CBS San Francisco*, January 14

“The American College of Surgeons met on Tuesday in San Francisco’s Mission Bay, where health leaders discussed the lessons learned from the emergency response to the crash of Asiana Airlines Flight 214.”
### American College of Surgeons Official Jewelry & Accessories

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<th>Model</th>
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### Risk factors for complications after knee replacement

**Yahoo! Health, January 9**

“Dr. Belmont and team analyzed data from 15,321 patients in the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) between 2006 and 2010. Patients were excluded if they had knee replacement surgery on both knees.”

### Surgeon-led mortality review can improve patient outcomes

**FierceHealthcare, January 3**

“Surgeon-led mortality reviews resulted in improved observed-to-expected ratios and University Health System Consortium postsurgical relative rankings, according to a study published in the *Journal of the American College of Surgeons.”**
NEWS

Disciplinary actions taken

The Board of Regents of the American College of Surgeons (ACS) took the following disciplinary actions at its February 7, 2014, meeting:

- Efrain Diego Gonzalez, MD, a gynecology and obstetrics surgeon from Rocklin, CA, was expelled from the College. This action was taken following disciplinary action by the California Medical Board based on a determination that, over a four-year period, he engaged in multiple extreme departures from the standard of care involving multiple patients. The State of California accepted the surrender of his license to practice medicine on January 6, 2014.

- Daniel Leslie Myers, MD, a general surgeon from Overland Park, KS, had his Fellowship suspended with conditions for reinstatement. This action was taken following disciplinary action by the Kansas Board of Healing Arts, resulting in the disciplinary surrender of his license to practice medicine in June 2013.

- Edward J. S. Picardi, MD, a general surgeon from Sturgis, SD, had his Fellowship suspended with conditions for reinstatement. This action was taken following his conviction in federal court for income tax evasion. The South Dakota Board of Medical and Osteopathic Examiners revoked his license to practice medicine based upon the federal court conviction.

- Oscar M. Ramirez, MD, a plastic surgeon from Weston, FL, had his Fellowship suspended with conditions for reinstatement. This action was taken following disciplinary action by the Maryland Board of Physicians based on a finding that he failed to meet the standards of quality medical care in his treatment of two patients in 2004 and 2005. The Florida Medical Board placed obligations on his license in that state based upon the actions in Maryland.

The Board of Regents of the ACS took the following disciplinary action at its October 5, 2013, meeting:

- Michael L. Smith, MD, a general surgeon from Kitty Hawk, NC, was expelled from the College. This action was taken following repeated disciplinary action by the North Carolina Medical Board and reciprocal action in the states of Virginia and Illinois.

DEFINITION OF TERMS

Following are the disciplinary actions that may be imposed for violations of the principles of the College.

- **Admonition**: A written notification, warning, or serious rebuke.

- **Censure**: A written judgment, condemning the Fellow or Member’s actions as wrong. This is a firm reprimand.

- **Probation**: A punitive action for a stated period of time, during which the Member:
  - (a) loses the rights to hold office and to participate as a leader in College programs;
  - (b) retains other privileges and obligations of membership;
  - (c) will be reconsidered by the Central Judiciary Committee periodically and at the end of the stated term.

- **Suspension**: A severe punitive action for a period of time, during which the Fellow or Member, according to the membership status:
  - (a) loses the rights to attend and vote at College meetings, to hold office, and to participate as a leader, speaker, or panelist in College programs;
  - (b) is subject to the removal of the Member’s name from the public listing and mailing list of the College;
  - (c) surrenders his or her Fellowship certificate to the College, and no longer explicitly or implicitly claims to be a Fellow of the American College of Surgeons;
  - (d) pays the visitor’s registration fee when attending College programs;
  - (e) is not subject to the payment of annual dues. When the suspension is lifted, the Fellow or Member is returned to full privileges and obligations of Fellowship.

- **Expulsion**: The certificate of Fellowship and all other indicia of Fellowship or membership previously issued by the College must be forthwith returned to the College. The surgeon thereafter shall not explicitly or implicitly claim to be a Fellow or Member of the American College of Surgeons and may not participate as a leader, speaker, or panelist in College programs.
ATTEND AN AMERICAN COLLEGE OF SURGEONS 2014 SURGICAL CODING WORKSHOP

GET TRAINED | SEE RESULTS | PRACTICE WITH EASE

General Surgery Coding Three-Day Workshops
• ICD-10 Training for General Surgery (Wednesday course)
• E/M Coding, Profitable Practice Operations, and Strategy Workshop (Thursday course)
• Mastering General Surgery CPT Coding Workshop (Friday course)

Develop Expertise in Surgical Coding for Optimal Reimbursement
• Avoid denials
• Avoid down coding
• Improve coding and reimbursement
• Prevent abuse and fraud
• Achieve coding compliance
• Attain optimal reimbursement
• Increase practice management competency

What's New in 2014?
• Revised soft tissue reinforcement code and guidelines
• New breast biopsy codes
• Revised radical resection of tumor codes
• New and revised endoscopy codes

CME Credit
The American College of Surgeons designates this live activity for a maximum of 6.5 AMA PRA Category 1 Credits™ for Thursday and Friday. American Association of Professional Coders members can also earn a maximum of 6.5 credits for the Thursday and Friday course. No credits will be offered for the ICD-10 session on Wednesday.

ACS members and their staff are eligible for a discounted course registration fee.

For additional dates, locations, registration fees, and to register, visit www.facs.org/ahp/practmanagement or call 312-642-8310.
The American College of Surgeons (ACS) Faculty Research Fellowships for 2014 were awarded earlier this year. These fellowships are offered to surgeons who are embarking on a career in general surgery or a surgical specialty and carry awards of $40,000 per year. Faculty Research Fellowships are sponsored by the Scholarship Endowment Fund of the ACS.

The two-year Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons honors the College’s founder. The two-year C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care honors the late Dr. Carrico. The one-year Louis Argenta, MD, FACS, Faculty Research Fellowship is presented by Kinetic Concepts, Inc. to support research in wound healing in honor of Dr. Argenta, who is a plastic surgeon.

The recipients of these fellowships are as follows:

- Franklin H. Martin, MD, FACS, Faculty Research Fellow (July 1, 2014, to June 30, 2016): Sunit Das, MD, assistant professor of surgery, University of Toronto, ON. Research project: Elucidating the Role of Vascular Mimicry in Glioblastoma.
- C. James Carrico, MD, FACS, Faculty Research Fellow (July 1, 2014, to June 30, 2016): Isaiah R. Turnbull, MD, assistant professor of surgery, Washington University, St. Louis, MO. Research project: Role of Innate Lymphoid Cells in the Pathogenesis of Sepsis.
- Louis Argenta, MD, FACS, Faculty Research Fellow (July 1, 2014, to June 30, 2015): Robert D. Winfield, MD, assistant professor of surgery, Washington University, St. Louis, MO. Research project: Adipose Tissue and Post-Injury Immune Dysfunction.

Additional undesignated Faculty Research Fellowships for 2014–2016 were awarded to:

- Ali Zarrinpar, MD, assistant professor of surgery, David Geffen School of Medicine at University of California, Los Angeles. Research project: Integrated Analysis of Lipid Metabolism and Gene Expression in Hepatocellular Carcinoma.
- Fumito Ito, MD, PhD, assistant professor of surgery, University of Michigan, Ann Arbor. Research project: Induced Pluripotent Stem Cells to Generate Patient- and Tumor-Specific T cells.

Applying for fellowships

The description and requirements for this program are posted on the ACS website at http://www.facs.org/memberservices/acsfaculty.html. The application deadline for the 2015 Faculty Research Fellowships is November 3, 2014.

The ACS Scholarship Endowment Fund was established to provide income to fund scholarships and fellowships awarded by the Board of Regents. Direct contributions to support the Scholarship Endowment Fund are welcome. Fellows who would like to make tax-deductible gifts to fund these vital programs are encouraged to contact the ACS Foundation at 312-202-5338.
The Board of Regents of the American College of Surgeons (ACS) recently awarded six Resident Research Scholarships for 2014. The ACS offers the scholarships to encourage residents to pursue careers in academic surgery. These scholarships, which carry awards of $30,000 for each of two years, beginning July 1, 2014, are sponsored by the ACS Scholarship Endowment Fund.

Scholarship recipients are as follows:


**Luka Pocivavsek, MD**, University of Pittsburgh, PA, PGY-4. Projected specialty: Vascular surgery. Research project:

**Scholarships**

The Board of Regents of the American College of Surgeons (ACS) recently awarded six Resident Research Scholarships for 2014. The ACS offers the scholarships to encourage residents to pursue careers in academic surgery. These scholarships, which carry awards of $30,000 for each of two years, beginning July 1, 2014, are sponsored by the ACS Scholarship Endowment Fund.

Scholarship recipients are as follows:


**Luka Pocivavsek, MD**, University of Pittsburgh, PA, PGY-4. Projected specialty: Vascular surgery. Research project:


**Applying for 2015**

The description and requirements for this program are posted on the College website, http://www.facs.org/memberservices/acsresident.html. The application deadline for the 2015 Resident Research Scholarships is **September 1, 2014**.

The Scholarship Endowment Fund was established to provide income to subsidize scholarships and fellowships awarded by the Board of Regents. Direct contributions to support the Scholarship Endowment Fund are welcome. Fellows who would like to make tax-deductible gifts to fund these vital programs are encouraged to contact the ACS Foundation at 312-202-5338.
**MEETINGS CALENDAR**

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**Calendar of events**

*Dates and locations subject to change. For more information on College events, visit http://www.facs.org/cme/index.html or http://www.facs.org/ChapterMeetings.cfm

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**MAY**

- **Michigan Chapter**
  - May 14–16
  - Petoskey, MI
  - Contact: Angie Kemppainen, akemppainen@msms.org, www.michiganacs.org

- **Northern California Chapter**
  - May 17
  - Berkeley, CA
  - Contact: Christina McDevitt, nccacs@att.net, www.nccacs.org

- **Metro Philadelphia Chapter**
  - May 19
  - Philadelphia, PA
  - Contact: Jennifer Keeler, jkeeler@pamedsoc.org, www.metrophilasurgeons.org

- **New York Chapter**
  - May 19
  - Albany, NY
  - Contact: Amy Clinton, nycfacs@yahoo.com, www.nysurgeon.org

- **Vermont Chapter**
  - May 22
  - Stowe, VT
  - Contact: Jeanne M. Kunkle, jeanne.kunkle@vtmednet.org

- **Missouri Chapter**
  - May 30–June 1
  - Lake Ozark, MO
  - Contact: Denise Boland, bolannd@health.missouri.edu, www.moacs.org

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**JUNE**

- **Missouri Chapter**
  - May 30–June 1
  - Lake Ozark, MO
  - Contact: Denise Boland, bolannd@health.missouri.edu, www.moacs.org

- **Brooklyn-Long Island**
  - June 10
  - Garden City, NY
  - Contact: Teresa Barzyz, acsteresa@aol.com, http://www.bliacs.org/

- **Alabama Chapter**
  - June 12–14
  - West Miramar Beach, FL
  - Contact: Lisa Beard, acollegesurgeons@yahoo.com, www.acsalabama.org

- **Oregon and Washington Chapter**
  - June 12–15
  - Sunriver, OR
  - Contact: Harvey Gail, harvey@spiremanagement.com, www.oregonchapteracs.org

- **Maine and New Hampshire Chapter**
  - June 13–15
  - Bretton Woods, NH

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**AUSTRIA-HUNGARY CHAPTER**

- **June 25–27**
  - Graz, Austria
  - Contact: Albert Tuchmann, albert.tuchmann@wienkav.at

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**JULY**

- **North Carolina and South Carolina Chapters**
  - July 17–20
  - Myrtle Beach, SC
  - Contact: Debbie Shealy, debbie@scmanet.org, www.ncfacs.org, www.scfacs.org

- **Latin American and International Chapters**
  - July 28–31
  - Cartagena, Colombia
  - www.ascolcirugia.org

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**FUTURE CLINICAL CONGRESSES**

- 2014
  - October 26–30
  - San Francisco, CA

- 2015
  - October 4–8
  - Chicago, IL

- 2016
  - October 16–20
  - Washington, DC