FIRST Trial examines flexible resident work hours
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*continued on next page*
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Resident work hour limits have been the source of considerable consternation in the surgical community since they were introduced by the Accreditation Council for Graduate Medical Education (ACGME) in 2003. The ACGME revised the guidelines in 2011, making them more restrictive. This action added to the growing concerns that members of the American College of Surgeons (ACS) and the leaders of the American Board of Surgery (ABS) have expressed about the effects of the rules on surgical training.

To help address these issues, leaders from the ACS and the ABS approached the ACGME about the possibility of working together to study the effects of adding some flexibility to the current duty hour requirements. After months of discussion, the groups agreed to conduct the Flexibility in Duty Hour Requirements for Surgical Trainees (FIRST) Trial.

The results of the FIRST Trial were published in the *New England Journal of Medicine* in February and show that granting training programs the latitude to allow trainees to work longer shifts or take less time off between shifts is not associated with greater risk of patient morbidity or mortality. This landmark trial, I believe, will ultimately take well-intentioned policies with unintended consequences and transform them into best practices for surgical training.

**Background**

The ACGME first issued the resident work hour restrictions in response to growing public concerns that overworked, fatigued residents were more prone to medical error. The 2003 ACGME guidelines limited resident duty hours to 80 per week, mandated that residents be provided with one day per week free from all educational and clinical responsibilities, capped continuous on-site duty at 24 consecutive hours, and required that residents have an 8-hour rest period between all daily duty periods and after in-house call. Although many members of the surgical community expressed trepidation that these restrictions would negatively affect continuity of care and surgical training, most residency programs adapted.

In 2011, the ACGME issued additional measures, which, among other provisions, shortened the shift length for interns to a maximum of 16 hours and to 24 hours for residents in their second year or more of training. The new guidelines also increased resident time off from work to 14 hours after a 24-hour in-house shift.

Residents and surgical educators have voiced concern that these additional restrictions have led to an increase in patient handoffs, thereby disrupting continuity of care and creating new opportunities for medical error. Moreover, many members of the surgical community have expressed a desire for additional flexibility in duty hour requirements to improve training and patient care.
education community believe that the duty hour restrictions may limit surgical training by inhibiting residents’ ability to follow the natural history and progress of their patients.

**FIRST Trial design**

To determine whether modified restrictions on resident work hours would affect patient care, surgical outcomes, and resident perceptions, the ACS, ABS, and ACGME undertook the FIRST Trial. Karl Y. Bilimoria, MD, MS, FACS, ACS Faculty Scholar and director, Surgical Outcomes and Quality Improvement Center (SOQIC), Northwestern University Feinberg School of Medicine, Chicago, IL, served as the lead investigator of the study, which involved 117 ACGME-approved U.S. general surgery residency programs and their 151 affiliated hospitals. (See sidebar, this page, for a list of other study leaders.) These institutions represent 95 percent of the programs that were eligible to participate in the study and were randomly assigned to either an intervention group with flexible duty hours or a control group. To gauge trainee satisfaction, we administered a survey at the January 2015 ABS In-Training Examination (ABSITE).

Both groups of training institutions that participated in the FIRST Trial adhered to ACGME policies, limiting the workweek to an average of 80 hours; residents on average got one day off per week, and residents could take call no more often than every third night. The Standard Policy control group, composed of 59 training programs and 71 affiliated hospitals, also complied with all ACGME mandates from 2003 and 2011 described previously. The 58 training programs and 80 affiliate hospitals in the Flexible Policy group received permission from the ACGME to waive the rules pertaining to intern work shifts, duty hours for senior residents, time off between shifts, and time off after 24 hours of continuous duty.
Findings
Using the ACS National Surgical Quality Improvement Program (ACS NSQIP®) platform to measure death or serious morbidity within 30 days of an operation, we found that of the nearly 139,000 patients who underwent surgery, the rate of this composite outcome was similar in both study groups (9 percent). We also found no differences between study arms for the 10 other patient outcomes studied, including the need for a second operation.

Furthermore, among the 4,330 residents who responded to the ABSITE survey, those trainees in the flexible group (2,220 respondents) reported no significant difference in their overall well-being compared with residents in the control group (2,110). There also was no difference between the first two study arms with respect to resident satisfaction with duty hours at their program and with job satisfaction.

Residents in the Flexible Policy group were more likely than participants in the Standard Policy group to report improved continuity of patient care, patient safety, acquisition of operative skills, and professionalism. Residents in the flexible work hour group also were more likely to report being present for the entirety of an operation and being able to treat their patients through critical times without interruption due to duty hour limits.

The FIRST Trial results were announced February 2 at the Academic Surgical Congress in Jacksonville, FL, hosted by the Association for Academic Surgery and the Society of University Surgeons.

For further details about the FIRST Trial, see the article on page 53, or visit facs.org/media/first-trial.

A way forward
The FIRST Trial is a landmark study because it provides the first evidence we have to show that modifying work hours is safe and actually may enhance the surgical learning environment. And I think it’s good news for patients because they are going to have physicians following them throughout the entire episode of care.

In light of the FIRST Trial findings, the ACGME has agreed to review its work hour policies. I am confident that the ACS, ABS, ACGME, and the American Board of Medical Specialties—which recently issued a statement supporting the FIRST Trial—will be able to use this initiative to develop new consensus-based protocols for resident work hours.

Overall, this study and its likely effects provide a great example of how professional organizations that are committed to setting standards for surgical education and patient care can work together to resolve issues of mutual concern. As always, we welcome your suggestions on how we can help you provide quality surgical care to your patients.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Meaningful use:

A program in transition

by Cory M. Resnick, MD, DMD, FACS; John G. Meara, MD, DMD, MBA, FACS; Molly Peltzman, MA; and Meg Gilley, MPH

HIGHLIGHTS

• Outlines the purposes and structure of the EHR Incentive Program and the MU requirements
• Describes the barriers surgeons have encountered, especially with respect to expense, in their efforts to comply with MU requirements
• Explains the potential benefits of EHR MU, particularly with respect to quality and safety of patient care
Medicare meaningful use (MU) requirements were first introduced to physicians in 2011 to promote the adoption of electronic health record (EHR) systems. MU policies were a product of the Health Information Technology for Economic and Clinical Health (HITECH) Act, a key component of the American Recovery and Reinvestment Act of 2009. The HITECH Act charged the U.S. Department of Health and Human Services (HHS) Office of the National Coordinator for Health Information Technology (ONC) with the responsibility of developing a universal infrastructure that would facilitate the secure exchange of digital information. It also authorized the Centers for Medicare & Medicaid Services (CMS) to create the Medicare and Medicaid EHR Incentive Programs, which established financial incentives for physicians who demonstrate MU of an EHR system.

**Program structure**

The Medicare EHR Incentive Program is divided into three stages, each intended to prepare a provider to successfully achieve MU of an EHR system (see Figure 1, page 12). Stage 1 established the foundation for the program by instituting requirements for the electronic capture of clinical data and by providing patients with electronic access to their health information. Providers who began participating in the program in 2011 or 2012 were eligible to achieve incentive payments totaling up to $44,000 over five years. Providers who started reporting in 2013 or 2014 could achieve up to $39,000 over four years, or $24,000 over three years, respectively. No new incentive payments were provided after 2014.

Once an eligible provider (EP) has completed two years of MU under the Stage 1 criteria, the EP must move on to Stage 2. This second stage encourages the use of health information technology (HIT) for continuous quality improvement at the point of care and the exchange of information in a structured format. Stage 2 retains the core structure of Stage 1, though some objectives were reorganized, combined, or eliminated. For many of the objectives, the thresholds were raised to show improvement and demonstrate MU for a larger proportion of patients.

To align the first two stages with the planned introduction of Stage 3, CMS released a modified version of Stage 2 requirements in 2015. The changes aimed to reduce the complexity of the program and created a single set of objectives and measures. Providers who started the MU program in 2015 used the modified Stage 2 requirements instead of the original Stage 1 criteria.

The third and final stage of MU is planned for implementation in 2018. Stage 3 will contain a single set of criteria focused on the advanced use of EHR systems. CMS recently decided to abandon the staged approach, however, and will instead require all providers (including first-time participants) to satisfy the objectives and measures of Stage 3 by 2018.

Beginning in 2019, the MU program will transition into the new Merit-based Incentive Payment System (MIPS) program established by the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act enacted last year. The Stage 3 requirements and objectives will be maintained.

**Cost**

Much has been written about the perils and virtues of the MU program, but less attention has been paid to the associated costs that frontline health care providers and their support staff are likely to incur in implementing it. In an environment of increasing demands on physician time and decreasing reimbursement, fulfillment of MU requirements has posed a challenge for physicians. Implementation costs are estimated at $250,000 per facility, and projections show that only 27 percent of practices will achieve a return on this investment. Once the initial capital purchases and training to support the EHR systems have been completed, practices experience significant recurring costs with respect to provider time required to fulfill MU criteria. Because much of the data entry for MU involves historical information, these requirements are especially burdensome to surgical and subspecialty practices where most
current access to care challenges. For physicians and hospitals that do successfully navigate these requirements, ever-increasing administrative burdens will further limit their ability to spend adequate time with patients, create disincentives to add more patients, and adversely affect job satisfaction.

Many providers anticipated that EHR would enhance the availability of clinical data, support clinical registries, and streamline daily workflow. However, early products have largely failed to provide these benefits. Paper systems have been replaced with a costly digital infrastructure that lacks ease of use in the collection, analysis, and return of useful information at the point of care. For many clinicians, the EHR is simply an expensive and inefficient means of recording data previously stored in a paper record.

Several impediments must be overcome on the path to true meaningful use of digital clinical information. Because of limited information exchange, a lack of data standards and interoperability, and inadequate real-time clinical analytics, time spent entering data into current EHR is a poor use of resources. Establishing methods for data standardization and analysis will be critical in developing a universally accepted EHR system. Improving interoperability and regulating data blocking, the process by which vendors charge providers large sums for hosting data, will be additional challenges.

**HIT leads to safer, better care**

Despite concerns with existing EHR systems, universal adoption of HIT holds the promise of facilitating safer and more efficient delivery of medical care. The spirit of health care policy that incentivizes providers
It is conceivable that, in the future, every patient will be associated with a primary care provider, and primary care networks will be financially supported, allowing them to act as portals of entry for clinical patient data stored in a universal cloud.

On the House side, Rep. Renee Ellmers (R-NC) introduced The Further Flexibility in HIT Reporting and Advancing Interoperability Act (Flex-IT 2 Act, H.R. 3309) on July 29, 2015. This legislation would delay Stage 3 implementation until 2017 or when the final MIPS regulations have been issued. The act also would expand the MU program's current hardship exceptions, including allowing eligible professionals who are at or near retirement age to be exempt from MU reporting and would adjust the reporting requirements to allow providers to choose any three-month measurement period. The ACS sent a letter of support for this legislation on September 8, 2015, and is actively seeking cosponsors.

In addition, Reps. Ellmers; Tom Price, MD, FACS (R-GA); and David Scott (D-GA) circulated a congressional sign-on letter asking HHS Secretary Sylvia Burwell to delay the final rule on Stage 3 MU requirements. Partly as a result of ACS grassroots efforts to encourage members of Congress to sign on, this letter received an impressive 116 bipartisan signatories. The Ellmers/Price/Scott letter was sent to Secretary Burwell on September 28, 2015.

Senate HELP Committee Chairman Lamar Alexander (R-TN) and Sen. John Thune (R-SD) sent similar correspondence to Secretary Burwell, asking that MU Stage 3 requirements be delayed. The final rule for Stage 3 was released October 16, 2015, and includes an optional 2017 implementation and a required 2018 implementation deadline.

Since the release of the final rule for Stage 3, the ACS has shifted its advocacy focus to improving MU requirements and implementation. CMS has solicited public comments on the program, and the College submitted its comments on December 15, 2015.

In a related move, Sens. Bill Cassidy (R-LA) and Sheldon Whitehouse (D-RI) introduced the Transparent Ratings on Usability and Security to Transform Information Technology (TRUST IT) Act of 2015, S. 2141, on October 6, 2015. This bill encourages fairness and transparency in the process of choosing vendors for EHR systems. Under this legislation, HIT vendors must attest that they abstain from information blocking activities and face a fine if they do engage in these activities.

ACS advocacy

The American College of Surgeons (ACS) dedicated significant time in 2015 to educating members of Congress about MU’s shortcomings and the challenges it presents for surgeons. More specifically, the College has called for a delay in the introduction of Stage 3 of MU in light of the fact that, as of the time of this publication, only 19 percent of health care professionals and 48 percent of hospitals have successfully met Stage 2 requirements. For example, the College provided testimony outlining its priorities for the meaningful use of HIT at one of six hearings convened by the Senate Committee on Health, Education, Labor, and Pensions (HELP). Lawmakers have been receptive to the ACS’ concerns and have taken responsive steps.
practices. Furthermore, the legislation calls for the establishment of an HIT rating program; fines would be collected from noncompliant vendors and used to provide financial assistance for providers who use a system that loses certification. The ACS sent a letter of support for this legislation on November 11, 2015, and is actively seeking cosponsorship.

Most recently, CMS has compelled providers to attest that they met Stage 2 requirements for a period of 90 consecutive days in 2015 to avoid a penalty. CMS did not publish the modified rule for Stage 2, which altered and added requirements, until after October 1, 2015. As a result, by the time providers were informed of these modified requirements, fewer than the 90 required days remained in the calendar year. Before adjourning in December, Congress passed ACS-backed legislation—H.R. 3940, the Meaningful Use Hardship Relief Act of 2015, introduced by Rep. Price—requiring CMS to grant blanket exceptions to providers who apply for one.

### A way forward
Health care must keep pace with the changing landscape of the digital age by embracing EHR technology. Achievement of this goal requires a partnership between policymakers and providers, with buy-in from both parties. The essence of MU is ultimately

### TABLE 1. AVERAGE TIME AND COST FOR COMPLETING STAGE 1 AND 2 MU CRITERIA

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<thead>
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<th>Stage</th>
<th>Meaningful use criteria (clinical staff member)</th>
<th>Average time (minutes)</th>
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<tbody>
<tr>
<td></td>
<td>Log into system (OSA and OMS)</td>
<td>0.25</td>
</tr>
<tr>
<td></td>
<td>Record patient demographic measures (receptionist)</td>
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<td></td>
<td>Maintain up-to-date problem list of diagnoses (OMS)</td>
<td>1</td>
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<td></td>
<td>Use CPOE for medication orders (OMS)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Incorporate laboratory test results into EHR (OMS)</td>
<td>0.5</td>
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<tr>
<td></td>
<td>Generate and transmit prescriptions electronically (OMS)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Reconcile home medication list (OMS)</td>
<td>2.5</td>
</tr>
<tr>
<td></td>
<td>Provide clinical summary for patients for each visit (OMS)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Record vital signs (OSA)</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Maintain active medication list (OSA)</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Maintain active allergy list (OSA)</td>
<td>0.25</td>
</tr>
<tr>
<td></td>
<td>Record smoking status for patients ≥13 years (OSA)</td>
<td>0.25</td>
</tr>
<tr>
<td></td>
<td>Total Stage 1 time</td>
<td>20.5</td>
</tr>
<tr>
<td></td>
<td>Total Stage 1 cost</td>
<td>$74.26</td>
</tr>
</tbody>
</table>

Abbreviations:
OSA = Oral surgery assistant, OMS= Oral and maxillofacial surgeon,
EHR = Electronic health record, CPOE = Computerized physician order entry
*Time estimates were not obtained for processes that were either automated or uncommon to the daily activities of oral and maxillofacial surgery practices.

continued on next page
### TABLE 1. AVERAGE TIME AND COST FOR COMPLETING STAGE 1 AND 2 MU CRITERIA (CONTINUED)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Meaningful use criteria (clinical staff member)</th>
<th>Average time (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Use secure electronic messaging to communicate with patients on relevant health information (OMS)*</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Send reminders to patients regarding preventative and follow-up care (receptionist)</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>Electronically transmit summary of care (receptionist)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Use CPOE for lab orders (OMS)</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Use CPOE for radiology orders (OMS)</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Use electronic notes during the EHR reporting period (OMS)</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Use EHR to identify patient-specific education resources and provide those resources to the patient (OMS)</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Provide online access (within 4 business days) to patient health information with the ability to view, download, and transmit to a third party (OMS)*</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Patients view, download, or transmit to a third party their health information (OMS)*</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Imaging results made accessible through EHR (OMS)*</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Record patient family health history as structured data (OMS)</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Provide a summary of care record for each transition of care (OMS)</td>
<td>2.5</td>
</tr>
<tr>
<td></td>
<td>Total Stage 2 time</td>
<td>19.25</td>
</tr>
<tr>
<td></td>
<td>Total Stage 2 cost</td>
<td>$110.41</td>
</tr>
<tr>
<td>Stage 1 and 2 total time</td>
<td></td>
<td>39.75</td>
</tr>
<tr>
<td>Stage 1 and 2 total cost</td>
<td></td>
<td>$184.67</td>
</tr>
</tbody>
</table>

to allow a free flow of clinical data to inform physician workflows and improve quality at the point of care. The EHR Incentive Program has done much to expand the use of EHR but little to attain these goals. However, in the creation of a secure and universal digital clinical data warehouse, an opportunity exists for a mutually beneficial arrangement that could also significantly improve safety and the patient experience.

Streamlining CMS quality programs, including the Medicare EHR Incentive Program, into the single MIPS program provides an opportunity to re-examine our priorities and broaden our understanding of what constitutes MU. MU should be viewed in terms of facilitating efficient and effective use of the data to improve patient outcomes and patient experience, rather than use of the EHR technology itself. This type of MU may exist in many forms, likely extending beyond the limits of the EHRs themselves.

Adoption of EHR systems and other forms of HIT have been critical steps toward this future. To take advantage of a shared cloud-based highway of secure clinical data, we must first fully live in a digital arena. Although most large medical centers have managed to make this switch, the task of converting to an EHR system may be daunting for smaller physician groups and community hospitals. Organizations like the ACS
As providers dedicate resources to adopting EHR systems, the federal government must do its part.

and the American Medical Association have an opportunity to support this transition by acting as conduits for information about the collective experiences of those hospital systems that have successfully overcome these hurdles. Furthermore, better, more flexible, universal standards for health data elements will be needed to improve HIT and attain true interoperability.

As providers dedicate resources to adopting EHR systems, the federal government must do its part. This starts with conception of a shared digital environment and continues with creation of health policy that allows for the unencumbered sharing of data in a secure way. Finding the balance between safeguarding privacy and facilitating the free exchange of information will be a struggle down the road.

This task is complex, and many challenges to its fruition will arise. However, surgeons and other health care professionals must prudently and tirelessly work toward a solution for the good of our patients and our profession. Universal real-time access by treating physicians to relevant patient data that is collectively updated with minimal burden to individual providers would constitute true meaningful use.

REFERENCES

The 'Stop the Bleed' campaign was initiated by a federal interagency workgroup convened by the National Security Council ... is to build national resilience by better preparing the public to save lives by raising awareness of basic actions to stop life threatening bleeding following everyday emergencies and man-made and natural disasters. Advances made by ... during the wars in Afghanistan and Iraq have informed the work of this initiative which exemplifies translation of knowl-

The Hartford Consensus IV:
A Call for Increased National Resilience

by Lenworth M. Jacobs, Jr., MD, MPH, FACS,
and the Joint Committee to Create a National Policy to Enhance Survivability from Intentional Mass Casualty and Active Shooter Events

MAR 2016 BULLETIN American College of Surgeons
The overarching principle of the Hartford Consensus, outlined in previous reports, is that no one should die from uncontrolled bleeding.

Editor’s note: The Joint Committee to Create a National Policy to Enhance Survivability from Intentional Mass Casualty and Active Shooter Events developed the following call to action at its January 7–8 meeting in Dallas, TX. This committee meeting, chaired by American College of Surgeons (ACS) Regent Lenworth M. Jacobs, Jr., MD, MPH, FACS, focused on the implementation of strategies to empower bystanders to help victims of mass casualty events. The following is the Hartford Consensus IV, edited to conform with Bulletin style.

Despite advances in the response to active shooter and intentional mass casualty events, a gap remains in our national preparedness and resilience. Drawing from experiences at myriad mass casualty events, the immediate responder (volunteer responder) represents an underutilized resource, yet one capable of dramatically increasing our all-hazards (injuries from all natural and man-made causes) national resilience. The overarching principle of the Hartford Consensus, outlined in previous reports, is that no one should die from uncontrolled bleeding. We have championed the following acronym to summarize what we have determined are appropriate steps to ensure that the maximum number of victims of these tragic events can be saved:

THREAT:
• Threat suppression
• Hemorrhage control
• Rapid Extrication to safety
• Assessment by medical providers
• Transport to definitive care

Status update
Continuing in our efforts to improve survival from these events and the more common traumatic injuries that occur daily in the U.S., the Hartford Consensus met for the fourth time in January. The discussion at this meeting was focused on the role of individuals in immediate proximity to victims of injury, whatever the etiology.

Based on foundational work by the U.S. Department of Defense and the Committee on Tactical Combat Casualty Care (CoTCCC), previous Hartford Consensus reports have centered on improvements in the professional responder’s role in providing care to individuals wounded in active shooter and intentional mass casualty events. We submit that harnessing the power of immediate responders is not a new concept, as the public has been used to successfully initiate cardiopulmonary resuscitation (CPR) in the event of an out-of-hospital cardiac arrest. Furthermore, seminal work describing the lifesaving benefit of TCCC training in maximizing casualty survival among our troops wounded in combat in Iraq and Afghanistan has uniformly emphasized the importance of all personnel in dangerous environments, not just medics, being trained and equipped to control external hemorrhage when their unit members are injured (also known as Buddy Care). Because the public, by and large, has the will to help in these situations, this report seeks to outline the next steps necessary to continue to fortify our national resilience for a public response to hemorrhage control.

To date, the professional first responder community, including emergency medical services (EMS), law enforcement officers, fire and rescue personnel, and public safety officials, have widely accepted the Hartford Consensus’ principles. For example, the concept of immediate Threat suppression, which maximizes survival from life-threatening injuries, has been embraced and implemented on a national level.

External Hemorrhage control is the intervention that has proven most effective in the prehospital setting. The victim, an immediate responder, or a professional first responder should use this technique as quickly as possible once the immediate threat of further injury has been mitigated.

The concept of Rapid Extrication of casualties from areas of direct threat (hot zones) to less dangerous but not completely secure areas (warm zones) or secure areas (cold zones) expedites Assessment and Transport to definitive care. Furthermore, casualties no longer are expected to remain untreated for significant periods of time until the area is completely secure.
It is clear that the immediate responder has a role to play in rendering aid between the time of injury and the arrival of the professional first responder. The immediate responder can and should be actively involved in hemorrhage control until care is transferred to the professional first responder. Hemorrhage control kits, much like automatic external defibrillators, should be widely available in public places for immediate responder use. The professional first responder will have medical training and be equipped with bleeding control kits containing hemostatic dressings and tourniquets.

Prehospital and hospital emergency medical services have made substantial improvements in their ability to respond to mass casualty events by taking part in multi-agency drills and training scenarios, which allow hospitals to immediately assemble appropriate teams to receive and manage trauma patients.
Sophisticated triage networks must be exercised to evenly distribute the injured so that individual hospitals are not overwhelmed. Hospitals located further from the incident should be seamlessly involved in the preparation and management of significant numbers of severely injured patients.

**Current national opinion**

The Hartford Consensus III focused on empowering the public to provide care. In intentional mass casualty events, those individuals present at the point of wounding have proven invaluable in responding to the initial hemorrhage control needs of the injured. While traditionally described as “bystanders,” these immediate responders need not be passive observers and can provide effective lifesaving first-line treatment. Examples of the effectiveness of such actions by immediate responders have been observed not only in the aftermath of the Boston Marathon bombings, multiple active shooter events, and the recent attacks in Paris, France, but also in the wake of hurricanes, tornadoes, industrial accidents, and everyday incidents, such as motor vehicle collisions. The Hartford Consensus IV meeting focused on building national resilience by outlining strategies to educate the public to become immediate responders.

When the Hartford Consensus called for the public to assume the role of immediate responder, it was uncertain how capable the average person would be at carrying out this charge. To determine the public’s ability and willingness to serve as immediate responders, a nationally representative survey was conducted to assess public opinion regarding the following:

- Current level of training in first aid, including bleeding control
- Willingness to render first aid for severe bleeding
- Potential impediments to willingness to act
- Support for changes in first responder policy to allow police and emergency medical services to render aid more quickly
- Willingness to be trained in bleeding control
- Support for the distribution of bleeding control kits in public places
- There is broad support for initiatives to train and equip first responders and for the public to render first aid for bleeding control in mass casualty incidents.
- Large majorities of able-bodied Americans report that they are willing to offer such aid, especially if training and supplies are made available.
- Training, including instruction in bleeding control, is strongly associated with the following:
  - Greater willingness to give aid
  - Fewer concerns about reasons not to give aid
  - Interest in receiving further, updated training
- Concerns to be addressed include:
  - Getting injured during an active shooter event
  - Causing greater pain or injury
  - Bearing responsibility for bad outcomes
  - Contracting disease
- Support for policies and procedures to make hemorrhage control training and equipment widely

*Note: A full report on the survey will be published in an upcoming issue of the Journal of the American College of Surgeons.*
The Hartford Consensus intends to create a vision for best-practice hemorrhage control for increasing survival after all-hazards injuries including active shooter and intentional mass casualty events.

available is overwhelming. Specific examples include the following:

- Near unanimous support for deployment of kits into public spaces (93 percent)
- Strong support for training police to provide bleeding control as a part of their duties (91 percent)
- Substantial support for faster access to active shooter and intentional mass casualty events (65 percent)

**Current state of readiness and national resilience**
The Hartford Consensus intends to create a vision for best-practice hemorrhage control for increasing survival after all-hazards injuries including active shooter and intentional mass casualty events. The goal is to inform and inspire decision makers around the country to effect this vision by establishing appropriate metrics, applying these metrics, and using this information to motivate decision makers.

**Metrics for readiness**
Metrics to assess readiness include course completion records for TCCC-based medical training. Examples of these training programs include the following:

- Tactical Emergency Casualty Care
- Bleeding Control for the Injured (B-Con)
  - Available through the ACS and the National Association of Emergency Medical Technicians (NAEMT)
- Law Enforcement and First Response Tactical Casualty Care
  - Available through the ACS and NAEMT
- Specialized Tactics for Operational Rescue and Medicine (STORM)
- Available through Georgia Regents University, Augusta
- Advanced Law Enforcement Rapid Response Training (ALERRT)
  - Available through Texas State University, San Marcos

**Metrics for resilience**
Metrics to assess resilience include the following:

- Registry data for all wounded law enforcement officers and all casualties from active shooter and intentional mass casualty events
- Case series reports describing injuries, treatments, and outcomes for all casualties, including reports on wounded law enforcement officers and all victims wounded in mass casualty events
- Preventable death analyses for law enforcement officers killed in the line of duty and victims of active shooter and intentional mass casualty events

Many trauma deaths result from injuries that are intrinsically non-survivable, whereas others occur from injuries that were potentially survivable had optimal care been rendered. Obtaining a clear understanding of the proximate cause of all law enforcement officer deaths that result from trauma as well as all fatalities in active shooter or intentional mass casualty events will identify opportunities to improve care for officers wounded in the line of duty.

**Enhancing citizen resilience**
All potential responders to victims of a trauma event should be able to recognize the signs that indicate that bleeding is life-threatening, including the following:

- Pulsatile or steady bleeding is coming from the wound.
- Blood is pooling on the ground.

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The overlying clothes are soaked in blood.

Bandages or makeshift bandages used to cover the wound are ineffective and steadily become soaked with blood.

An arm or leg is traumatically amputated.

The patient was bleeding and is now in shock (unconscious, confused, pale).

Immediate responders should attempt to stop or slow massive hemorrhaging initially by using their hands (gloved whenever possible) to initiate primary compression. This compression should be applied directly or just proximal to the site of hemorrhage and with the use of sustained, direct pressure. Performing this task may be difficult for someone without any first aid training, but it will significantly enhance the survival of the actively hemorrhaging injured victim.

Once the professional responder arrives at the scene, care should be transferred to this individual because he or she will be equipped with and trained in the use of more sophisticated hemorrhage control methods, such as hemostatic dressings and tourniquets.

In a manner similar to the presentation of CPR training, hemorrhage control training programs should be available to the public and offered by employers, civic and religious groups, schools, and the health care community at large.

As an increasing number of public and private locations implement plans to preplace hemorrhage control equipment or co-locate this equipment with automatic external defibrillators, clear messaging and signage should be posted so people can easily and rapidly access this equipment.

Training considerations

The primary components of enhancing citizen resilience must focus on training considerations including:

- Determination of terminal learning objectives for bleeding control courses
- Establishment of standard curriculum for bleeding control

- Education of the public in bleeding control using multiple teaching methods, including:
  - Didactic education programs
  - Online modules
  - Smartphone applications

- Tiered bleeding control education for the following:

- Immediate responders with no equipment other than their hands
- Immediate responders with bleeding control kits (hemostatic dressings and tourniquets)
- Professional first responders with bleeding control kits

- Creation of public awareness through “Bleeding Safe” communities similar to the “Heart Safe” communities that were designed to promote survival from sudden out-of-hospital cardiac arrest

Specifically, the Hartford Consensus recommends developing a curriculum for the immediate responder. The curriculum would feature a tiered approach that uses the hands of the immediate responder followed by hemostatic dressings and tourniquets when these lifesaving interventions become available. This
curriculum should also outline the specific anatomic locations for effective compression of large vessels to stop massive life-threatening hemorrhage. In most cases, control of external hemorrhage can be accomplished by applying direct pressure on the bleeding vessel—even major vessels such as the carotid or femoral arteries. However, victims with life-threatening hemorrhage often bleed to death when direct pressure is the only treatment available to achieve hemostasis. For direct pressure to be effective, it must be applied with both hands using significant sustained and direct force. The patient should be stationary on a surface firm enough to provide effective counter pressure. Frequently, direct pressure cannot be effectively applied while the patient is being moved. Discontinuation of pressure to check the status of the bleeding site during transport must be avoided to ensure bleeding control.

In addition, immediate responders should be taught how to apply hemostatic dressings. For life-threatening hemorrhage from an extremity, immediate responders should be taught to apply a tourniquet. Application of direct pressure, a hemostatic dressing, or a tourniquet must be maintained without interruption until the patient reaches a location where the damaged vessel can be repaired surgically. Wounds with minimal external bleeding, suggesting no major blood vessels have been injured, may be dressed with gauze or a hemostatic dressing until the patient arrives at definitive care.

The successful completion of this curriculum should result in the receipt of merit-type badges for scouts and explorer posts and certification in bleeding control.

**Dissemination and implementation of a national resilience plan**

A critical first step to achieving national resilience is training and equipping immediate responders and professional first responders to control external hemorrhage, along with the strategic positioning of bleeding control kits in locations where active shooter or intentional mass casualty incidents have been observed to occur.

The next step is a campaign to inspire the public to obtain bleeding control training and sustain that training. This should be actively promoted through the following:

- Emotional appeals such as, “When you stop the bleed, you save a life”
- Simple, consistent messaging
- Messages that can be delivered across diverse platforms

To achieve sustainable changes in behavior aimed at immediate control of life-threatening external hemorrhage, the implementation plan should take into account the following considerations:

- The content of the plan should include:
  - The immediate responder concept
  - An all-hazards approach
  - A standard curriculum
  - Funding for implementation and sustainability
The audience for bleeding control courses are:

- Immediate first responders (public)
- Professional first responders
- Law enforcement officers
- Firefighters
- EMS personnel

Potential content distribution networks include:

- The Medical Response Corps
- The Red Cross
- The National Disaster Medical System
- The National Guard
- Boy and Girl Scouts
- Professional medical societies and organizations
- Federal, regional, and local health departments
- Emergency service agencies

Strategies to promote these concepts include:

- Work with other groups concerned with safety
- Gather stakeholder input and explain the value of prospective buy-in by all
- Develop a strategic communications plan that drives demand and builds community acceptance
- Deliver a message of health literacy and cultural competence that informs but does not inflame
- Explain the political barriers and facilitators of implementation
- Establish a liaison with state legal authorities to guarantee the validity of Good Samaritan protections as applied to immediate responders and first responders to encourage their participation in bleeding control

Summary

National implementation of the Hartford Consensus is a meticulous and incremental process. It consists of many elements that require collaboration and strategic leadership to achieve an efficient, effective, knowledgeable, resilient, and prepared citizenry.

We strongly believe the public can and should act as immediate responders to stop bleeding from all hazards, including active shooter and intentional mass casualty events. The ACS has a long history of setting standards and educating responders through its Committee on Trauma and its programs. The ACS is therefore well-positioned to use its national and international networks to implement bleeding control education to improve survival and enhance resilience.

Author’s note:
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The “Stop the Bleed” poster featured on page 17 was developed for public education purposes and will be available for wide distribution. To obtain copies, contact Dr. Jacobs.
Applying advocacy skills: Gaining influence from the statehouse to Capitol Hill

by Amy E. Liepert, MD, FACS

HIGHLIGHTS
• Explains why and how the role of surgeon advocates has changed in recent years
• Describes the grassroots advocacy process, with a focus on relationship building over the course of an elected official’s political career
• Offers insights into how the College assists surgeon advocates

Docere, meaning “to teach,” is the Latin origin of the word doctor. Advocacy means the act or process of supporting a cause or proposal. In other words, an advocate is someone who educates interested parties—frequently lawmakers—about a topic. Therefore, serving as a physician advocate is an extension of what most surgeons already do as a part of their responsibilities to teach and lead. Within their daily practices, surgeons teach their patients, patient families, residents, students, nurses, other physicians, and a multitude of other stakeholders. Advocacy is a continuation of those same concepts to a group not directly involved in patient care.

To be an advocate, a surgeon must make her or his opinions or preferences known to lawmakers and policymakers through some form of communication, be it written, verbal, or by attendance at an event. Often the advocate’s perspective may match the expected and generally accepted position of the population majority. However, their perspective also could draw dissension and present a need to create or offer an alternative solution. Such a position can expose an individual’s or an organization’s vulnerabilities, drawing sometimes unwanted attention. Socially and professionally, the path of least resistance often is to steer clear of conflict by focusing on clinical and professional concerns and challenges that face individual patients at the local level. As a result, surgeon advocates traditionally have focused on the science of medicine and clinical application as it applies...
to their individual practice, patient population, or the local hospital environment.

**Increasing interest in federal advocacy**

In recent years, however, North American medical and surgical organizations have sought to think of the physician advocate role more broadly. The Royal College of Physicians and Surgeons of Canada (RCPSC), for example, has developed the CanMEDS Physician Competency Framework, which includes health advocate among one of seven roles needed to be better physicians.4,5 In the U.S., the Accreditation Council for Graduate Medical Education (ACGME) Pediatrics Residency Review Committee (P-RRC) now requires training programs to provide advocacy training and experience to all pediatric residents, and the American Medical Association has been a longtime advocate for both patients and physicians in Washington, DC.3,6

The American College of Surgeons (ACS) has developed a reputation as an increasingly influential leader in surgical advocacy. This is highlighted by the important role that the ACS played in the passage of legislation in 2015 that repealed the broken sustainable growth rate (SGR) formula used to calculate Medicare physician payments. The ACS Division of Advocacy and Health Policy (DAHP) maintains strong relationships with state and federal legislative and regulatory leaders and is a resource for Fellows seeking to engage in advocacy.

Traditionally, health policy advocacy has focused on policies that affect the delivery of care for specific medical conditions, such as amyotrophic lateral sclerosis or renal failure, rather than advocating for broad legislation that protects patients on a macro scale or that provides a framework for systematic approaches to patient care. This approach has changed as health care costs have risen and federal legislation and regulations have played an expanding role in health care delivery.

Indeed, many of the intricacies of health care delivery are affected by policy, politics, and bureaucracy. Consequently, myriad stakeholders participate in the health care delivery system, including device manufacturers, pharmaceutical companies, insurance companies, and privately run health care organizations. Each group has built relationships in Washington and in state capitals to ensure that lawmakers hear their viewpoints. The surgeon is best suited to educate decision makers on the needs of surgical patients and the surgical profession.

Because a primary focus of the government is the development and management of the federal budget, many policymakers are concerned about the impact of health care spending. Physicians generate significant economic output—each U.S. physician supports an average of $2.2 million in economic output for a total of $1.6 trillion nationwide yearly, and physicians support 10 million jobs nationwide that provide $775 billion in wages annually.7 As these figures indicate, physicians have a substantial impact on the national economy, which positions surgeons to have considerable influence with lawmakers.

**The relevance of surgeon leadership**

As David B. Hoyt, MD, FACS, ACS Executive Director, said at the 2015 Leadership & Advocacy Summit, “Physicians, I would argue, are natural leaders, and creativity is the most desirable leadership attribute.”8 Surgeons lead in the operating room, in the clinic, in the boardroom, and in the community. They have the courage to approach one of the most sacred depths of the universe, the human body, in an attempt to restore health or quality of life in a direct and physical manner. They have the dedication to complete a long and arduous education and training process. They are masters of both immediate results and delayed gratification. Policy change is a formidable opponent, as are cancer, inflammation, immunosuppression, and countless other barriers to the clinical management of patients. Yet, these challenges are met head-on by the well-trained professional surgeon.

Health care’s involvement in governmental regulation is not new. The evolution of modern medicine came with rising costs and society’s commitment to
provide for those Americans who could not provide for themselves, namely seniors. In 1965, President Lyndon B. Johnson signed legislation that established Medicare under the Social Security Act, providing health insurance to individuals ages 65 and older. At the time, senior citizens were paying up to three times what younger Americans paid for health insurance, and 35 percent of older Americans were unable to afford health insurance coverage at all. Medicare coverage has gradually expanded due to a growing elderly population, increased life expectancy, and broader scope of coverage, which now includes rehabilitative care, dialysis, prescription drugs, and hospice services.

Health care organizations, like other advocacy groups, must play an active role not only in resolving crises, but also in the day-to-day decisions that will affect patient care. For effective and sustained advocacy to take root, surgeons must cultivate personal relationships with their lawmakers.

Grassroots advocacy
Legislative advocates often refer to advocacy efforts with the sometimes nebulous “grassroots” label. Typically a grassroots campaign is an organized effort to influence or raise awareness about a particular cause or issue at its base, which may be at the local, state, regional, or national level. Regardless of the level at which a policy issue is being addressed, grassroots advocacy refers to individuals communicating directly with the appropriate elected official. Due to a rising number of health care issues that transcend compartmentalization, physician advocates must be active across the entire policymaking spectrum.

It is worth noting that political advancement typically follows a hierarchical model. Most often politicians start their career at a lower elected level—such as on city council or the school board—and then progressively ascend the political ladder, perhaps moving into a county-level position, followed by serving in the state government, and ultimately moving on to federal office. With this typical career ascension, it makes sense to build relationships with politicians early in their career, when they are likely to be more accessible. If that opportunity is not available, it is important to develop relationships with politicians who are already in elected positions, as it is their responsibility to represent the interests and concerns of their constituents.

Surgeons are uniquely positioned to build relationships with lawmakers because of the high regard in which they are held in their local communities. Lawmakers respect surgeons and their expertise on health-related issues. In general, very few Americans are involved in the political process. Only 1 percent of the general public is actively involved in political activities, such as fundraising or volunteering in a campaign. Surgeons, therefore, can hold additional influence with lawmakers through their increased engagement in the political process combined with their professional influence.

The ascension of power
Although it is optimal to foster relationships and get acquainted with political leaders early in their careers, this approach has an inherent problem—no one can predict which elected officials will hold positions of particular strength or influence in the future. Development of relationships at this earlier stage may pay off later as specific lawmakers ascend the political ladder. Following are examples of two congressional leaders who followed different paths to their current positions, but each provided an opportunity for relationship building with surgical constituents.

Speaker of the U.S. House of Representatives Paul Ryan (R-WI) was originally elected to Congress without holding any previous office. Speaker Ryan was, however, a respected and involved member of his community and remains an ardent supporter of his local constituency. Speaker Ryan was elected to represent Wisconsin’s 1st District in the House in 1999 after the incumbent stepped down to make an unsuccessful bid for the U.S. Senate. He quickly became a respected member among his peers and was nominated to the
House Committee on the Budget, which he chaired for two years (2013–2015). In 2015, he became chairman of the powerful Committee on Ways and Means and a member of its Health Subcommittee. This committee holds great influence, as it is the main author of legislation relating to taxes and payments for health care, health delivery systems, and health research. Speaker Ryan’s tenure in the House has provided ample time for a constituent to build a relationship. When in his district, Speaker Ryan focuses primarily on his family and his constituents. However, he also supports a broader audience via speaking sessions and forums.

In an effort to broaden my own grassroots experience, I participated in a forum held for Representative Ryan, then-Chairman of Ways and Means. The forum was small enough that I was able to interact with the congressman and to make a personal connection discussing bow hunting and personal fitness. A roundtable question-and-answer session followed, allowing for direct policy-level discussion. At the roundtable, Representative Ryan recognized me as the only surgeon in the room of physicians. Topics discussed on this occasion included repeal of the SGR, during which the congressman acknowledged the important role that the ACS played in achieving its elimination.

Another topic addressed at the forum was that of the quality and safety metrics outlined in the new Merit-based Incentive Payment System (MIPS) created by the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act of 2015. Because most members of Congress are in professions other than medicine, it is the responsibility of physicians, particularly surgeons, to help them develop meaningful metrics applicable to surgical practice.

It was helpful to have raw insight into the inner workings of Congress. This experience showed me that members of Congress value knowledge and input from subject matter experts. If surgeons fail to fill the vacuum of knowledge and experience about patient care on Capitol Hill, other stakeholders will fill that void, and we and our patients will suffer the consequences. Now is the optimal time and opportunity for surgeons to share their expertise and educate their lawmakers in a way that will have a meaningful and lasting influence.

Rep. Tom Price, MD, FACS (R-GA), has been directly involved in politics for a longer period. Congressman Price has represented Georgia’s sixth district since 2005. Previously, he served in the Georgia Senate, starting in 1997, until he won his current seat in the U.S. House of Representatives. Representative Price has been a strong advocate for health care, and surgical care in particular. For example, he was instrumental in the repeal of the SGR and in stopping the Centers for Medicare & Medicaid Services’ (CMS) plan to turn all 30- and 90-day global surgical codes into 0-day codes. Most recently, he was instrumental in the passage of legislation providing physicians with a blanket exception from Stage 2 requirements in CMS’ electronic health record meaningful use program (see related article, page 10). Representative Price’s participation offers a novel example of surgeon involvement in governing and provides a framework with which to understand and develop relationships in advocacy.

**Relationship building**

It is imperative to develop relationships with lawmakers at the local, state, and federal levels, as they may be looking for an expert health care advisor. For surgeons in active practice, relationship building can seem like one more activity competing for their finite time. However, with the changing landscape of the economy and the building of new health care bureaucracies to regulate ever-expanding care options and treatment, every Fellow must make the time to serve as a surgeon advocate.

Involvement in advocacy does not need to be overwhelming or excessively time-consuming. In addition to building relationships with lawmakers, surgeons can help to influence the legislative process by contributing directly to the campaigns of candidates who support surgery’s legislative agenda or who support the efforts of organized medicine.
The ACS can help

The College offers several ways for Fellows to get involved with grassroots advocacy at the state and federal levels. First, the Leadership & Advocacy Summit is an efficient way to learn about federal health care issues and techniques to engage your personal legislators. (See sidebar, page 27, for information about the 2016 Leadership & Advocacy Summit.)

The ACS Chapter Lobby Day Grant Program offers Fellows an opportunity to expand advocacy efforts at the state level. More than 20 chapters have hosted a state lobby day since the program’s inception in 2010. (See sidebar, this page, for more information.)

Another way to engage with legislators is to arrange, either individually or with the assistance of ACS staff, participation in in-district meetings. When legislators are in their home districts, they are often more accessible than when Congress is in session. Surgeon advocates might also consider attending or hosting a fund-raising event.

E-mails and phone calls are another important way to inform lawmakers about a surgery-related topic.

A valuable tool that the College offers is Surgeons-Voice (surgeonsvoice.org). This website provides direct communication with your legislators’ offices, summaries of current legislative issues, and a portal to the ACS Professional Association Political Action Committee (ACSPA-SurgeonsPAC). Simply log on with your ACS ID and last name to access these tools.

Advocacy encompasses many possibilities and activities. To be an advocate, one need not be a spokesperson or policy leader. Your role can range from writing a letter to your member of Congress, to attending the Leadership & Advocacy Summit, or to meeting with lawmakers while they are in their district offices. What matters is that you find a way to be involved—as a teacher and as a leader.

REFERENCES

Optimal in-home postoperative care made possible through new Patient Feeding Tube Home Skills Kit

by Kathleen Heneghan, PhD, RN, PN-C; Sarah B. Klein, MPA; Nancy Strand, MPH, RN; and John M. Daly, MD, FACS, FRCSI(Hon)

HIGHLIGHTS

• Describes some of the problems patients and their caregivers experience when trying to use a feeding tube during at-home postoperative recovery

• Outlines the reasons why the College’s Patient Education Program chose to develop a skills kit on the proper use of feeding tubes, including the reduction of postoperative complications, increases in the number of in-home postoperative recoveries, and compliance with regulatory demands

• Explains how charitable donations from corporations and ACS members contributed to the development of this program
fter undergoing throat surgery as part of his cancer treatment, Dr. Clint B. temporarily needed to rely on a feeding tube to maintain proper nutrition. Even with a PhD in psychology and after years of conducting research in technology, gaming, and learning outcomes, Dr. B. was surprised to find that he and his caregiver were woefully ill-prepared for his feeding tube experience.

“We ended up being unnecessarily frustrated, worried, and stressed during an already difficult time. This led to several calls and visits to health care providers. We felt our anxiety and these visits could have been avoided had we been adequately prepared,” Dr. B. said at the American College of Surgeons (ACS) Clinical Congress 2011 Panel Session, What Do I Do When I Get Home?: Pre-Operative Skills Training for Your Patients.

Dr. B. went on to explain that he was so affected by his difficult experience that he decided to find out whether other patients who had used or were using feeding tubes shared his frustration. He invited patients from a variety of medical support blogs to describe the challenges they had encountered when using feeding tubes. Dr. B. received responses from 76 individuals who raised such common questions as the following:

- What can go in the tube?
- How do I clear an obstruction?
- How can I clean it without damaging it?
- Why does the tube keep coming loose when moving about and is this dangerous?

Based on the concerns that the respondents offered, Dr. B. reported, “Although the use of a feeding tube may seem elementary, the data suggest that these aids are anything but
intuitive. Patients are distressingly uninformed about the use and maintenance of feeding tubes. This leads to needless anxiety and, doubtless, unnecessary visits to health care professionals. There is also a risk that patients will harm themselves in attempting to solve common feeding tube problems.”

To address the types of challenges that Dr. B. and other researchers have identified with regard to in-home use of feeding tubes, the ACS has developed a Patient Feeding Tube Home Skills Kit (see Figure 1, page 31). This new patient education resource applies the same principles that the Surgical Patient Education Committee of the ACS Division of Education has used to develop other patient education programs and is the second in a series of tool kits for in-home postoperative care. Building on the model used to create the first such resource—the ACS Ostomy Home Skills Kit—the feeding tube program provides patients and their caregivers with the tools and information they need to develop the skills needed to experience optimal recovery from an operation and to manage enteral nutrition.

**Rationale for the program**

As part of the series of skills training programs, the Patient Feeding Tube Home Skills program was created based on the following primary considerations:

- Many patients and their families experience the types of problems that Dr. B. identified.
- Clinical research has shown that a high number of postoperative complications occur when a feeding tube is used in the home setting.
- Shorter inpatient stays have led to greater patient/family responsibility for self-care.
- Surgeons can use this type of patient education to comply with government regulations pertaining to meaningful use of the electronic health record (EHR).

Although home enteral tube feeding is perceived positively in most situations, particularly because it means improved nutrition, strength, and survival,
most patients who undergo this type of treatment and their families identify ambulatory restriction, practical problems, and overall distress in their daily lives. The amount and quality of information they receive from health care professionals is strongly related to their ability to manage their care, and patients overwhelmingly choose their physicians as their primary source of information about their postoperative care. Unfortunately, caretakers report a lack of consistent, anticipatory education to support the knowledge, coping skills, and confidence patients need to manage the often complex realities of the postoperative experience.

Furthermore, clinical research has confirmed the need for this ACS home skills program. While feeding tube insertion is a safe procedure, complications in the home care setting are high and range from 7 percent to 92 percent within the first two years of tube insertion. Common complications include the following:

- Development of granulation tissue (67 percent) at the tube insertion site, with 67 percent of patients reporting substantial pain
- A broken or clogged tube (45 percent to 56 percent)
- Tube leakage (56 percent)
- Infection requiring antibiotics (6 percent to 45 percent), gastrointestinal complications (63 percent), and pneumonia (50 percent)

A recent review showed that these complications occur globally, and while the incidence may vary across countries, the complication rate in the home setting remains high.7 Feeding tube complications are associated with family distress, increased health care costs, frequent practitioner visits, and higher rehospitalization rates.4,6,8 For patients who are elderly or have dementia, a study found that in 17 months, 33 patients had 138 separate emergency room (ER) visits; 92 percent of these visits were for unintentional extubation, and another 6 percent were for clogged tubes.9

Moreover, the Agency for Healthcare Research and Quality (AHRQ) Guide to Patient and Family Engagement in Hospital Quality and Safety identifies increasing discharge knowledge and skills as...
a key strategy to increase engagement, reduce adverse events, and reduce hospital readmissions.\textsuperscript{10} Many studies report up to a 20 percent incidence of an adverse event within four weeks of hospital discharge, and 75 percent of these adverse events could have been prevented. The authors estimate that the cost of these unplanned hospitalizations was $17.4 billion.\textsuperscript{11-13} Discontinuity in instructions among providers, misunderstanding of information, and inadequate preparation for discharge were all cited as challenges that could be improved.

In addition, technological advances in surgery, anesthesia, and nursing have accelerated postoperative recovery times and resulted in shorter hospital stays. At present, 65 percent of procedures are performed on an outpatient basis.\textsuperscript{10}

“The patient and their caregivers are playing an increasingly important role in postoperative care. Thus, education and training to best prepare them is critical to a safe discharge and recovery,” said Ajit K. Sachdeva, MD, FACS, FRCSC, Director, ACS Division of Education, and Co-Chair, ACS Patient Education Committee. “With nearly 500,000 patients in the U.S. relying on feeding tubes as part of their treatment plans, the home skills kit will make a widespread impact.”

Providing patients with the skills and information they need to have a safe and effective in-home recovery also has affected a surgeon’s ability to comply with regulatory standards. More specifically, the Centers for Medicare & Medicaid Services’ (CMS) Meaningful Use Stage 2 Core Measures require that eligible providers offer patient-centered education resources to their patients in order to maintain the ability to participate in the Electronic Health Record Incentive Program.\textsuperscript{14} This regulatory mandate responds to a finding in the Institute of Medicine report, \textit{Crossing the Quality Chasm: A New Health System for the 21st Century}, which identified that improved health care requires the development of a system designed to serve the needs of patients and that ensures they are fully informed and able to retain control and participate in care delivery.\textsuperscript{15}

The ACS home skills program is ideal for certified providers and hospitals seeking to meet the patient education core meaningful use requirement and improve a patient’s quality of care. “Patient education is recognized as critical to improving the health care system, and now electronic health records all require info button-enabled materials that are ready to print or be e-mailed to the patient with a copy placed in their EHR,” said John M. Daly, MD, FACS, FRCSI(Hon), Co-Chair, ACS Patient Education Committee, and coauthor of this article.

\textbf{How the program works}

To achieve a national consensus on the best methods for teaching patients and their families about feeding tube management, the Patient Feeding Tube Home Skills Kit was developed in collaboration with patients and multiple professional associations (see Table 1, page 33). The Patient Feeding Tube Home Skills Kit explains and demonstrates the distinct steps involved in home management and delivery of nutrition through a feeding tube. The educational simulation is intended for patients and/or caregivers, as well as surgeons, nurses, and other health care professionals, to learn and practice the skills necessary for optimal recovery and delivery of enteral nutrition.
The kit includes the following items (see Figure 2, page 32):

• A 44-page booklet divided into four easy-to-reference chapters.

• The Skills Simulation Equipment, including the enteral feeding tube (EFT) practice model; syringes and extension set kit; and two medicine cups. The feeding tube and syringe set has a label with the model number to comply with standards, a warning that the tube is for demonstration only, and 1-800 customer service number.

• The instructional video demonstrating feeding tube management supported by a step-by-step checklist to guide skill acquisition.

• A professional medical provider checklist for validation of knowledge and ability.

• A patient evaluation of the home care experience.

Funded through philanthropy
The ACS Surgical Patient Education Program is ideally aligned with the charitable mission of many corporations. With its emphasis on improving care for the surgical patient, the program has provided medical device manufacturers with a way to give back to the surgical community through philanthropic support. For example, Coloplast has been a multi-year partner in the Ostomy Home Skills Kits, and Smith & Nephew has provided funding for the wound care program. Educational grants from these companies have helped fund the development and distribution of the patient skills kits.

As with any new product, the initial expense to produce and evaluate the educational kits is significant. In partnership with the ACS Foundation, the ACS Division of Education has received generous grant funding for patient education programs and sees this resource as a way to not only improve surgical outcomes and the quality of life for patients but also to provide an additional benefit to ACS surgeon members. These educational grants allow the kits to remain affordable.

In this latest venture, the ACS Surgical Patient Education Program will produce, distribute, and evaluate 2,500 Feeding Tube Home Skills Kits over the next two years, funded by an educational grant from Applied Medical Technology, Inc. (AMT).

“Applied Medical Technology is proud to partner with the ACS to support patients and their surgical caregivers with evidence-based education materials on feeding tube management post-discharge. AMT is committed to the care of their patients through education, innovation, quality products, and building customer loyalty. We have focused on enteral feeding for over 25 years and it is our core concern and business,” said AMT founder George Picha, MD, FACS.

The ACS Foundation’s Sustaining Fund, which supports ACS programs that are not fully funded, is an additional source of philanthropic contributions. According to Shane Hollett, Executive Director, ACS Foundation, “The Surgical Patient Education Program, with its emphasis on an optimal care experience for patients, falls perfectly within the crosshairs of the Sustaining Fund’s directive.”

Promising results
If past experience with the skills kits developed through the ACS Surgical Patient Education Program is any indication, the Patient Feeding Tube Home Skills Kit promises to be a welcome aid to patients. Two trial data collection programs have been completed to assess the effectiveness of the ostomy skills program (see Figures 3 and 4, pages 33 and 34, respectively). Results from the ACS Ostomy Trial 1 indicate that ACS Ostomy Home Skills Kit users have significantly greater self-confidence, satisfaction, and knowledge in comparison with patients who have undergone traditional training. These patients also have demonstrated higher skill levels in less time when compared with patients who have undergone traditional lecture.
education with images. Data from more than 400 ostomy patients from Trial 2 identified the skills kit as their best prep resource, presenting fewer complications, using 50 percent fewer resources (visits, calls, and home care nursing), and leading to a 50 percent lower admission rate within the first three weeks following discharge.

Early surgeon users of the EFT skills kits have offered positive feedback. “This is fantastic material and an excellent patient education curriculum; this is from a person who leads the patient education center. I wholeheartedly support this effort and hope to direct patients to this resource,” said Brian B. Burkey, MD, MEd, FACS, vice-chairman and section head of the Section of Head and Neck Surgery and Oncology, Cleveland Clinic Head and Neck Institute, OH.

To learn more about the ACS Patient Feeding Tube Home Skills Kit, listen to the March installment of The Recovery Room, an ACS-sponsored podcast with experts in surgery, medicine, ethics, and public health about the latest developments in medicine and health care, hosted by Frederick “Rick” L. Greene, MD, FACS. The podcast will be available on the ACS website at facs.org. For more information, visit the ACS Surgical Patient Education Program website at facs.org/patienteducation/ or e-mail Nancy Strand, MPH, RN, Manager, Surgical Patient Education, ACS Division of Education, at nstrand@facs.org.

REFERENCES
Report from the Past-Chair of the Board of Regents:
Impressions on the relevance of a professional organization

by Mark C. Weissler, MD, FACS
I have served the American College of Surgeons (ACS) for more than a quarter of a century, most recently as Chair of the Board of Regents (2014–2015) after two years as Vice-Chair (2012–2014) and seven years as a member of the Board. My involvement with the College has helped to shape my impressions about much of the profession of surgery, but two observations are most notable. The first is my belief in the importance of professional organizations, especially the College, in protecting, maintaining, and nurturing the profession. The second is my belief in the importance of a professional organization that ties all of the surgical subspecialties together.

Guardians of our contract with society

The late bioethicist Edmund D. Pellegrino, MD, defined a profession as a group that possesses a special body of knowledge, practices within an ethical framework, fulfills some broad societal need, and has a social mandate that affords it significant discretion in setting standards for performance and educating its members. A profession has a special contract with the society in which it functions. In return for a degree of altruism on the part of the profession—that is, a duty to put the needs of others (our patients) before the needs of ourselves—the profession is granted certain privileges of self-regulation.*

A professional organization like the College is the embodiment of the contract between our profession and the society we serve. The ACS is the professional home of surgery in the U.S. It is the “self-regulating” body for the profession of surgery in the U.S.

Surgical organizations have an inherent interest in codifying and documenting the body of knowledge that defines the profession as it evolves over time, in setting standards of clinical and professional conduct, and in educating members about both the craft and ethical framework of the profession. They have a duty to collect data about the profession, to monitor the status of the profession, and to fully understand the relationship between the profession and the society it serves. The College is increasingly able to do this through its National Surgical Quality Improvement Program (ACS NSQIP®) and other clinical data registries.

Surgical professional organizations have an interest in training new professionals in the body of knowledge that defines surgery and in ensuring that certified professionals maintain their proficiency. They have an interest in the regulatory actions of our government as they relate to our profession and the particulars of the contract that we have with our society and our patients, including fiscal concerns. The College addresses these issues through its Division of Advocacy and Health Policy, housed at 20 F Street NW, Washington, DC, and has invested greatly in these endeavors over the course of my tenure.

Furthermore, a professional organization like the College has a duty to enforce the clinical and ethical standards that define membership in the profession and to ensure that the individual surgeon continues to meet those standards over the course of his or her career. Professional organizations maintain and ensure the fulfillment of the contract between the profession and society, looking out for the interests of both the surgeon and the patient. By serving the profession, they ensure that their members have the integrity to best serve our patients.

Serving and maintaining the profession entails providing a range of services and fulfilling a wide spectrum of functions: ensuring new members are properly trained and credentialed, training new surgeons, certifying that members are proficient and maintain their competencies, and ensuring ethical and professional standards of conduct. As regulatory demands become more complex, outcomes and performance data are becoming increasingly critical to the credentialing process and to the overall contract with society.

In the U.S., these various administrative and policy-making functions are distributed among a variety of professional organizations, particularly the surgical specialty societies, the Accreditation Council for Graduate Medical Education (ACGME), and the member boards of the American Board of Medical Specialties (ABMS). In general, the specialty societies are responsible for maintaining the fund of knowledge, interacting with government regulatory agencies, and providing educational programs; the member boards of the ABMS are responsible for initial certification and Maintenance of Certification (MOC); and the ACGME is responsible for training surgery residents.

The House of Surgery
I believe that one of our most pressing needs is to better align and coordinate the various duties of a professional organization and to do that across all surgical specialties. That does not mean eliminating the specialty societies, the ACGME, or the ABMS; rather, it means casting the College in a role as arbiter and enabler of other professional organizations that serve these various roles. Through its Surgical Quality Alliance and many other pathways, the College has greatly increased its interaction with the various surgical subspecialty societies over the last decade. The College has sought input from the specialties in the development of its quality manual, scheduled for release later this year; in the various online ACS Communities; in development of statements on a variety of topics, such as care of the geriatric patient; and to address common surgical issues.

All of this discussion brings us to my second main impression of the surgical profession after serving in the College’s leadership over the years—that some overarching professional surgical organization is needed to tie all of the surgical subspecialties together. I have always believed, and continue to believe, that the profession of surgery is a sufficiently distinct part of medicine to warrant its own professional identity.

The ACS, through its size, resources, and enduring commitment to professionalism, is best positioned to serve as a truly unifying organization for surgery in the U.S. Increasingly complex regulatory demands and access to more comprehensive “big data” collections, certification processes, and validation processes make it increasingly difficult for smaller professional organizations with access to less comprehensive datasets and fewer resources to adequately perform these functions. The College has invested heavily over recent years in a database integration project to help collect and codify important information about surgery and surgical procedures so that we will have the information we need to best serve the profession as we negotiate surgery’s position in the overall health care landscape of the future.

It is clear to me that there needs to be some umbrella entity that can look at the big picture, including graduate medical education, training and certification of residents, MOC, monitoring of continued competency, introduction of new technology, establishment and enforcement of ethical and professional standards, and the administration of disciplinary action. At present, the fulfillment of these functions seems to be occurring in a fragmented fashion, and the more surgeons subspecialize, the worse this situation becomes. I believe this fragmentation is one of the factors leading to the commonly heard dictum, “Physician, heal thyself.”

The current decentralization of key administrative functions is a part of the growing discomfort on the part of the public regarding professionalism in medicine and surgery and represents a real chink in the contract we have with society. One unifying professional organization should take responsibility for the care of the surgical profession and take ultimate responsibility for the contract we have with society and our patients.

Some may say that it is inappropriate and self-serving to think of a surgical organization as answering the needs of the profession rather than focusing exclusively...
on our patients, but I would argue otherwise. Our profession needs protection and nurturing to remain viable in the future. Unless the House of Surgery stays strong and true to its contract with society, unless we ensure the vitality and viability of our profession down the road, we ultimately harm our patients and the future of surgical care. Protecting our profession entails ensuring that we can continue to attract new, competent members; maintain and enforce clinical and professional standards; and maintain our contract with society as it evolves.

Personal reflections

In my tenure on the Board of Regents, much has happened internally in the College’s leadership to redefine the organization. For example, the ACS Regents have reorganized themselves. Two new Regents were added recently, bringing the total number of Board members to 23, plus the President. This move occurred in an effort to ensure representation across all of the surgical specialties as recognized by the ABMS. The Regents were revitalized and steps were taken to increase engagement. Likewise, the Board of Governors was restructured along with all of the Divisions of the College in an effort to align and integrate all aspects of the organization.

David B. Hoyt, MD, FACS, has proved to be a rejuvenating force within the College since he came on board as Executive Director in 2010. The Washington Office relocated to 20 F Street NW, and our advocacy efforts have more than redoubled with the permanent staffing of that new facility. The Surgical Quality Alliance was formed to ensure cross-communication among the various surgical specialties. The ACS Health Policy and Advocacy Group was reorganized, and the annual Leadership & Advocacy Summit was greatly expanded.

ACS NSQIP has expanded and the College has invested heavily in the collection of big data to be used to help the College advocate for our profession and help guide us into an era of merit-based payment and patient-centered care. The Clinical Congress has been reorganized to include specialty tracks, which help the specialty surgeon more efficiently navigate the plethora of educational programming offered at this event. Our certification and verification programs also have been greatly expanded in areas like breast surgery and bariatric surgery.

The College website (facs.org) was rebuilt, and the ACS Communities that launched in conjunction with the redeveloped site have been fertile ground for cross-pollination among the surgical specialties. The communities also provide a platform for surgeons of all stripes to communicate about subjects of mutual interest, including the history of surgery and advocacy.

This is a short list of the College’s activities over the last decade. We really should be proud of all the organization has accomplished. We have developed and fulfilled an expansive agenda and experienced an unprecedented period of growth and accomplishment. I feel fortunate to have been involved in one of the most exciting periods in the history of the College.
The Physician Compare website

by Molly Peltzman, MA

The Centers for Medicare & Medicaid Services (CMS) established the Physician Compare website in January 2011 to help patients locate and obtain data regarding physicians who participate in the Medicare program. CMS is using a phased-in approach for the physician information that the agency publicly reports on the website. For example, in 2017 more physician information pertaining to the value-based payment modifier (VM) will be included on the website than in 2016. The information on Physician Compare is generally derived using data from the previous year; thus, information appearing on the site in 2017 will be based on 2016 physician data. This column addresses questions surgeons may have about new information they can expect to find on the Physician Compare website in 2016.

Where does CMS get its information, and what kind of information is reported about me?
CMS will share data from multiple sources. Beginning this year, CMS is releasing all of the Physician Quality Reporting System (PQRS) data for measures on which a physician reports, regardless of the reporting option used to participate in the program. (For more information about the various PQRS reporting options, go to facs.org/advocacy/regulatory/pqrs.)

In addition, information will be available from the VM program, which is based on both the quality and cost of care a physician provides to Medicare beneficiaries. For 2016, the VM cost and quality tiers will reflect performance in 2014. Physician Compare also will include all measures reported by the Medicare Shared Savings Program, as well as indicate physicians who support the U.S. Department of Health and Human Services Million Hearts initiative.

Lastly, Physician Compare will report utilization data generated from Medicare Part B claims using Healthcare Common Procedure Coding System codes to describe services and procedures rendered. (See Table 1, page 42).

This information will be made available either on a physician’s profile page, or available for download. PQRS measures information will be split between the formats. CMS has yet to determine which PQRS measures will be available in which format, but VM information will be available for download.

What does the star rating on my profile mean?
CMS will publicly report measure-level benchmarks derived using the achievable benchmark of care (ABC) methodology based on PQRS performance. The ABC methodology evaluates who the top-performing providers are and then uses that ranking to set a point of comparison for all of those groups or individual providers who report the same measure. CMS will use the ABC methodology to systematically apply a five-star rating to the measures. For more information about the ABC methodology, go to www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/Downloads/Physician-Compare-Benchmark-TEP-2015.pdf.

Are the measure results that are posted statistically valid and reliable?
Before measures are posted, CMS performs reliability and validity testing. In addition, measures must have a minimum
For more information about Physician Compare, visit the CMS website at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/index.html, or e-mail the agency at PhysicianCompare@Westat.com.

### TABLE 1. SUMMARY OF TIMELINE AND DATA AVAILABLE FOR PHYSICIAN COMPARE

<table>
<thead>
<tr>
<th>Data collection year</th>
<th>Public reporting year</th>
<th>Data type</th>
<th>Reporting mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>2016</td>
<td>PQRS—Group practices</td>
<td>Web interface (WI), electronic health records (EHR), registry, claims, Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey (CAHPS)</td>
</tr>
<tr>
<td>2015</td>
<td>2016</td>
<td>PQRS—Individual eligible professionals (EPs)</td>
<td>Registry, EHR, claims, qualified clinical data registry (QCDR)</td>
</tr>
<tr>
<td>2015</td>
<td>2016</td>
<td>Medicare Shared Savings Program Accountable Care Organizations (ACOs)</td>
<td>WI, survey vendor, administrative claims</td>
</tr>
<tr>
<td>2016</td>
<td>2017</td>
<td>PQRS—Group practices</td>
<td>WI, EHR, registry, claims, CAHPS, QCDR</td>
</tr>
<tr>
<td>2016</td>
<td>2017</td>
<td>PQRS—Individual EPs</td>
<td>Registry, EHR, claims, QCDR</td>
</tr>
<tr>
<td>2016</td>
<td>2017</td>
<td>Utilization data</td>
<td>Claims</td>
</tr>
<tr>
<td>2016</td>
<td>2017</td>
<td>VM</td>
<td>Claims</td>
</tr>
</tbody>
</table>

sample size of 20 patients and “resonate with consumers,” which means they have been consumer tested. New measures are not reported until after their first year of use in PQRS.

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**If I participate in PQRS, when will the data be posted on Physician Compare?**

Physician Compare reports the previous year’s data. For example, 2016 PQRS data will appear on Physician Compare in 2017. However, the 2018 VM will reflect 2016 data and be included on the site late in 2017 at the earliest.

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**Can I preview my information before it is made public on Physician Compare?**

Yes, CMS provides a 30-day preview period before posting the measures on Physician Compare. To report an error in the information, physicians should notify CMS at PhysicianCompare@Westat.com. Issues raised must be addressed prior to public reporting as Physician Compare does not have an appeals process. Physicians also may preview their VM tier using the Quality and Resource Use Reports (QRURs)—confidential feedback reports that provide information about the resources used (cost) and the quality of care physicians and group practices provide to Medicare fee-for-service patients. The QRUR can be accessed at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html.

For more information about Physician Compare, visit the CMS website at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/index.html, or e-mail the agency at PhysicianCompare@Westat.com. ♦
In October 2015, the Centers for Medicare & Medicaid Services (CMS) released the 2016 Hospital Outpatient Prospective Payment System (OPPS) final rule, which finalized changes to the Two-Midnight Rule. The Two-Midnight Rule, which took effect January 1, addresses when inpatient admissions are appropriate for Medicare Part A payment. The OPPS rule includes a significant change that will allow Medicare Part A payment, under certain circumstances, for stays lasting less than two midnights. This deviation was prohibited under the original Two-Midnight Rule. Another modification will transition review of claims for inpatient admissions from Recovery Audit Contractors (RACs) and Medicare Administrative Contractors (MACs) to Quality Improvement Organizations (QIOs). This column provides more detail on the origins of the Two-Midnight Rule and the changes to it under the OPPS final rule.

**Original Two-Midnight Rule**
CMS first issued the Two-Midnight Rule in August 2013 in an attempt to bring clarity to the circumstances in which an inpatient admission is considered appropriate for Medicare Part A payment. Before the Two-Midnight Rule, CMS, via the RAC program, had identified high rates of inpatient admissions that were not medically necessary and should have instead been billed as outpatient cases.

At the same time, CMS observed a higher frequency of patients being treated as outpatients and receiving extended “observation” services. Hospitals, physicians, patient advocates, members of Congress, and others expressed concern about this trend since days spent as a hospital outpatient do not count toward the three-day inpatient hospital stay that is required before a patient is eligible for Medicare coverage of skilled nursing facility services. As such, the main purpose of the Two-Midnight Rule was to establish Medicare payment policy regarding the benchmark criteria that should be used when determining whether inpatient admission is reasonable and payable under Medicare Part A.

The original Two-Midnight Rule provided that a hospital inpatient admission was generally considered reasonable and necessary if the physician (or other qualified practitioner) ordered the admission based on her or his expectation that the patient would require at least two midnights of medically necessary hospital services. Hospitals, physicians, patient advocates, members of Congress, and others expressed concern about this
Conversely, if the physician expected to keep the patient in the hospital for a period of time of fewer than two midnights, the services would generally be billable for outpatient payment only. RACs and MACs were responsible for reviewing claims for inpatient admissions.

### 2016 changes to the Two-Midnight Rule

CMS received much feedback from hospitals and other stakeholders regarding this controversial rule. In response, CMS has attempted to make changes that will allow more deference to the physician’s medical judgment in meeting the needs of Medicare patients. Thus, if a physician anticipates that the patient will need fewer than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise specifically listed by CMS as an exception), an inpatient admission is now payable under Medicare Part A on a case-by-case basis. The documentation in the medical record must support that an inpatient admission is medically necessary. Previously, all cases in which the patient was expected to need less than two midnights of hospital care were presumed to be appropriate only for outpatient payment.

CMS does not make any changes to the policy for hospital stays that are expected to be two midnights or longer. That is, if the admitting physician expects the patient to require hospital care that spans at least two midnights, the services are generally appropriate for Medicare Part A payment. This policy applies to inpatient hospital admissions if the patient is reasonably expected to stay at least two midnights and the medical record supports that expectation. This includes stays in which the physician’s expectation is supported, but the length of the actual stay is less than two midnights due to unforeseen circumstances, such as patient death, transfer, clinical improvement, or departure against medical advice.

CMS will also transition the first line of medical reviews of providers who submit claims for inpatient admissions from RACs and MACs to QIOs. While RACs work on a contingency fee basis and are paid to identify and recoup overpayments, QIOs have a history of collaborating with hospitals and other stakeholders to promote high-quality care. QIO patient status reviews are intended to focus on educating physicians and hospitals about the Medicare Part A payment policy for inpatient admissions. RAC audits could later be conducted for those hospitals that have a consistently high denial rate based on QIO patient status review outcomes.

LaSalle D. Leffall, Jr., MD, FACS, Past-President of the American College of Surgeons (ACS) and the Charles R. Drew Professor of Surgery at Howard University Medical Center, Washington, DC, did not spend his 85th birthday in May 2015 engaged in typical celebratory activities. Rather, he gave a presentation on coping skills for tense situations in the operating room to surgical residents at Howard University.

But then, Dr. Leffall’s remarkable contributions to the surgical profession and medical community are far from typical. He continues to serve as an educator and mentor, modeling the role of the beloved teachers who had mentored him as a surgeon in training. In his ACS Presidential Address in 1995, Dr. Leffall paid homage to one of these early mentors, Burke Syphax, MD, FACS, who was in the audience that evening, approaching his own 85th birthday at the time. No doubt, the wisdom of Dr. Leffall’s mentors, such as Dr. Syphax, combined with his own lessons learned, was passed on to the eager surgical residents in that lecture hall. It is one example of how “paying it forward” has been a guiding principle throughout Dr. Leffall’s career and life.

The ACS Foundation proudly highlights Dr. Leffall and his wife, Ruth M. Leffall, as Mayne Heritage Society (MHS) members. The MHS recognizes Fellows who have provided a bequest or other “planned” gift of any size to the College through their estate plan.

Early interest in medicine
Born May 22, 1930, in Tallahassee, FL, to two school principals, Dr. Leffall had early exposure to a love of education. “I’ll never forget what my father told me as a child: ‘With a good education and hard work combined with honesty and integrity, there are no boundaries,’” Dr. Leffall said in a video interview with the College in 2013. “That really meant something to me, especially growing up in Quincy, FL, when segregation was still in force.”

Inspired by a family friend who, according to Dr. Leffall, was the lone African-American physician in Quincy, Dr. Leffall was interested in pursuing a career in medicine from the time he was in elementary school. He recalled that his first patient was an injured bird, and he fell in love with healing when he mended its wing back into full, airborne recovery.

At the young age of 18, Dr. Leffall graduated summa cum laude from Florida A&M College, Tallahassee, with a bachelor degree in biology and English. In 1952, he received a doctor of medicine degree from Howard University College of Medicine, graduating first in his class.

Remarkable career
After completing his internship at Homer G. Phillips Hospital, St. Louis, MO, and surgical residency at Freedmen’s Hospital (now Howard University Hospital), Washington, DC, Dr. Leffall did a surgical oncology fellowship at Memorial Sloan Kettering Cancer Center, New York, NY, from 1957 to 1959. Dr. Leffall then began his military career as Captain, U.S. Army Medical Corps, serving as Chief of General Surgery, U.S. Army Hospital, Munich, Germany, 1960–1961.

His membership with Howard University’s faculty began in 1962, and he progressed to professor and chairman, department of surgery, in 1970—a position he held for 25 years. In 1992, Dr. Leffall was named Charles R. Drew Professor of Medicine.

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Surgery—Howard University’s first endowed chair in surgery. Numerous awards and accolades bear his name, including The LaSalle D. Leffall, Jr., Surgical Society and the Leffall Chair of Surgery at Howard University. The Biennial LaSalle D. Leffall, Jr., Cancer Prevention and Control Award is sponsored by the Intercultural Cancer Council, Nashville, TN, and the MD Anderson Cancer Center, Houston, TX.

His life as a surgeon has been focused on the study of cancer and scholarly research. Through his work with the American Cancer Society, Dr. Leffall launched a nationwide initiative to address the increasing incidence of and mortality from cancer among African Americans. Widely regarded as a subject matter expert in surgical oncology, he has served as visiting professor and guest lecturer at more than 200 medical institutions in the U.S. and abroad, while authoring or coauthoring more than 150 articles and book chapters. Although he is officially retired from surgery after a 60-year career, Dr. Leffall still gets to the office at Howard University Medical Center by 6:00 am to teach the next generation of surgeons. “My philosophy is that as long as you have your health and you enjoy what you do, then you should continue,” Dr. Leffall said.1

Having taught approximately 6,000 medical students and trained 280 general surgery residents, Dr. Leffall has become one of the most beloved mentors of his generation. The many young men and women who have studied under his tutelage have gone on to successful surgical careers. They are now most likely “paying forward” the guidance they took from Dr. Leffall to their own mentees.

At a Howard University luncheon in celebration of Dr. Leffall’s 85th birthday, Edward E. Cornwell III, MD, FACS, FCCM, ACS Secretary and the LaSalle D. Leffall, Jr., Professor and Chairman of Surgery at Howard University, thanked Dr. Leffall for his guidance and friendship. “There is always a quote you live by; mine is equanimity under duress, which Dr. Leffall has exemplified and I’ve subscribed to,” Dr. Cornwell said at the luncheon.4

Legacy of leadership

Throughout his career as a surgeon, Dr. Leffall has exemplified a selfless dedication not only to the profession but also to the service of others. He has served at the highest levels in many professional and public service organizations. He was the first African-American President of the ACS, American Cancer Society, Society of Surgical Oncology, Society of Surgical Chairmen, and Washington Academy of Surgery. He is also a past-president of the Society of Black Academic Surgeons; chair, President’s Cancer Panel; and past-chair, Surgical Section, National Medical Association.

Speaking on Dr. Leffall’s breakthrough career, Dr. Cornwell said, “Dr. Leffall is the living link for modern-day surgeons and medical pioneers like Dr. Drew, a medical pioneer whose research with blood transfusion helped to develop blood bank technology around the world.”1

Dr. Leffall’s tireless efforts on behalf of the ACS Foundation and the College have demonstrated the type of philanthropic spirit that can serve as an
example to ACS Fellows. He served on the Committee on Development—the predecessor to the ACS Foundation—and as Chair of the Fellows Leadership Society, the ACS Foundation’s major gift society.

Dr. and Mrs. Leffall have established a significant planned gift through the ACS Foundation as members of the MHS. Dr. Leffall has been an advocate for the ACS Foundation, resulting in generous contributions from a charitable private foundation to fund ACS education programs. For their leadership in philanthropy and service to the medical community, the couple was named the ACS Distinguished Philanthropist of the Year in 1998.

As loyal donors to the College and many other worthy causes, Dr. and Mrs. Leffall will continue to inspire the next generation of students. Together with Dr. Leffall’s sister, in honor of their parents they established the Martha J. and LaSalle D. Leffall, Sr., Endowed Scholarship Fund and Endowed Professorship in Science at Florida A&M University.

Dr. and Mrs. Leffall’s MHS commitment will support ACS scholarships. In his ACS Presidential Address, Dr. Leffall implored Fellows to contribute to the ACS Foundation. “Support for funding scholarships, fellowships, and research career development awards can pay handsome dividends that may have enormous benefits for improved patient care,” he said.2

In an e-mail communication on January 12, 2016, with the author, Dr. Leffall commented, “My wife and I are pleased to support an organization that has meant so much to the surgical profession and patients. I have been a Fellow for more than 50 years and have seen such marvelous ACS initiatives established, such as the nationally recognized National Cancer Data Base. Supporting the College and my beloved profession is important to us…we want to help those who will become future leaders, just as those who came before me helped set me on a successful path.”

If you are interested in learning about how you can join Dr. and Mrs. Leffall in planning a future gift to the College, contact Shane Hollett, Executive Director, ACS Foundation, at 312-202-5506.

REFERENCES


Improvements continue in surgical care accountability measures

by Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), FRCS(Hon), FRCSEd(Hon)

In November 2015, The Joint Commission recognized 1,043 hospitals for outstanding performance on accountability measures as part of its Top Performer on Key Quality Measures program. These institutions comprise 31.5 percent of all Joint Commission-accredited hospitals that reported accountability measure performance data for 2014 and included general, critical access, children’s, psychiatric, surgical, and cardiac-specialty hospitals.

The Joint Commission began emphasizing accountability measures in 2010, when it categorized its process performance measures as accountability and non-accountability measures. Accountability measures meet four criteria designed to identify measures that have proven to produce the greatest positive effect on patient outcomes: research, proximity, accuracy, and adverse effects. Non-accountability measures are suitable for secondary uses, such as exploration or learning within individual health care organizations, and can offer guidance for providing appropriate patient care.

Achieving Top Performer status
To be designated as a Top Performer, a hospital had to achieve cumulative performance of 95 percent or above on all reported accountability measures and 95 percent or above on each reported accountability measure, with at least 30 denominator cases. Top Performers also had to have at least one core measure set with a composite rate of 95 percent or above and, within that measure set, have achieved a performance rate of 95 percent or above on all applicable individual accountability measures—meaning a hospital provided an evidence-based practice 95 times out of 100.

Hospitals reported on seven performance measures in the surgical care measure sets for 2014. The average number of hospitals reporting data throughout the program is 2,060. The 2014 data for those measures were as follows:

- 99.9 percent of hospitals reported that surgery patients had appropriate hair removal.
- 99.8 percent of surgery patients received appropriate venous thromboembolism prophylaxis within 24 hours before an operation to 24 hours after an operation.
- 99 percent of hospitals reported giving patients a prophylactic antibiotic within one hour before surgical incision.
- 98.7 percent of hospitals selected a prophylactic antibiotic for surgical patients.
- 98.4 percent of patients had a urinary catheter removed on postoperative day (POD) one or POD two with day of surgery defined as day zero.
- 98.3 percent of hospitals reported that prophylactic antibiotics were discontinued within 24 hours after an operation’s end time.
- 98.3 percent of surgery patients on a beta-blocker prior to hospital arrival received a beta-blocker during the perioperative period.

When the surgical care measure set was introduced in 2005, it included only three measures: prophylactic antibiotics within one hour prior to surgical incision; prophylactic antibiotic selection for surgical patients; and discontinuing prophylactic antibiotics within 24 hours after an operation’s end time. Therefore, those three measures have the most robust data for year-to-year comparison purposes. Also, each of these measures report on rates for the following seven types of surgery:

- Coronary artery bypass grafting surgery
- Other cardiac surgery
To be designated as a Top Performer, a hospital had to achieve cumulative performance of 95 percent or above on all reported accountability measures and 95 percent or above on each reported accountability measure, with at least 30 denominator cases.

Focus on what counts
At a November 17, 2015, press conference to announce the annual report, Joint Commission president and chief executive officer Mark R. Chassin, MD, MPP, MPH, FACP, said the Top Performer program identifies hospitals with a record of extraordinary performance on an increasing number of important quality measures. However, he said the report rates only certain measures of quality of care in hospitals.

“In fact, the evidence is crystal clear that quality varies quite a lot within individual hospitals—from one service to another, and from one measure to another,” Dr. Chassin said. “That’s why we are very careful to specify in this report exactly which measures resulted in each Top Performer achieving their recognition. This is just one of many Joint Commission programs that address many different aspects of quality in hospitals and all the other health care organizations we work with. Achieving the Top Performer eligibility criteria is not easy, and for most hospitals, it took many years of hard work. More than ever, hospitals are focusing on what counts. This represents real progress.”

Dr. Chassin noted that improvements on individual measures since 2010 have ranged from small fractions of a percentage point to as much as 38.7 percentage points.

“It is important to note that relatively small percentage point improvements in measures, especially those for which performance is already strong, can often require as much or even more diligence than large percentage point improvements where much room for improvement exists,” Dr. Chassin said. “All improvements are important and contribute to better care for patients.”

In 2010, the composite rate for Joint Commission-accredited hospitals submitting data for surgical care accountability measures was 96.4 percent. In 2014, it was 99.1 percent—an improvement of 2.7 percentage points.

In the press conference, Dr. Chassin also announced that the Top Performer program will take a hiatus for 2016 in order to reevaluate the program to better fit the evolving national measure environment—particularly within the Centers for Medicare & Medicaid Services (CMS). CMS has made significant changes to the performance measures in the Hospital Inpatient Quality Reporting program, including retiring a number of chart-based measures (Note: The surgical care measures are chart-based, having all been retired over the past four years, with the last measure retired as of December 31, 2015).

The Joint Commission will return with a refreshed program that will better fit the evolving national measure environment while supporting Top Performers and hospitals on track to achieving this recognition.

For more information on accountability measures, visit [www.jointcommission.org/accountability_measures.aspx](http://www.jointcommission.org/accountability_measures.aspx).

Disclaimer
The thoughts and opinions expressed in this column are solely those of Dr. Pellegrini and do not necessarily reflect those of The Joint Commission or the American College of Surgeons.
Soon after the invention of the telescope in the 17th century, the advantages of mounting two of these instruments side-by-side were explored, leading to the development of binoculars. Binoculars are two mirror-symmetrical or identical telescopes that are mounted next to each other, aligned, and pointed in the same direction, allowing the user to view distant objects with both eyes. Unlike a monocular telescope, binoculars present the viewer with a three-dimensional image.¹ Today, binoculars are used by many bird watchers, hunters, theatergoers, spectators at sporting events, and military personnel, as well as other hobbyists and professionals.

Binocular vision is a key attribute of human physiology and enables people to more adequately view their surroundings. Binocular single vision is a state of simultaneous vision that results from the fusion of two slightly dissimilar images from each eye. This form of vision requires a clear visual axis, sensory fusion through proper alignment of the eyes. Binocular vision provides multiple advantages, such as a larger field of vision, compensation for blind spots, and stereopsis. Stereopsis refers to the ability to merge two horizontally disparate images simultaneously, which results in three-dimensional perception of an image and, thus, depth perception.²

Effects of enucleation
When a patient suffers a unilateral enucleation, their field of vision becomes compromised and they lose stereopsis. According to previous studies, monocular vision in contrast to binocular vision results in approximately 10 percent to 20 percent loss of peripheral vision.³ This decreased visual field, in combination with the lack of stereopsis, can interfere with hand-eye coordination and many activities of daily living such as driving, crossing the street, and navigating stairs. Furthermore, loss of binocular vision can affect patients’ ability to work, especially if they are in a field that involves...
visual tasks within three feet of the subject—such as surgery. Another primary concern with unilateral enucleation is the protection of the contralateral eye, which typically results in the recommendation that the patient wear polycarbonate lenses to protect the “good eye” from trauma.

Despite the loss of stereopsis, patients with monocular vision can still use other cues to determine depth perception and visual orientation, such as apparent size of objects, shading, and motion parallax. Motion parallax occurs when movement of the head causes nearby objects to move in the opposite direction and distant objects to move in the same direction as the head when using an intermediate distance fixation point. In addition, an earlier study that analyzed surveys of patients with acquired monocular vision indicated that patients generally achieve a new baseline level of function within a year. However, this study also demonstrated that 91 percent of these patients receive no formal training to assist with adaptation, suggesting that there is yet a possible benefit of a formal training program for patients with unilateral enucleation.

Findings
To examine the occurrence of injuries that resulted in a traumatic enucleation of the eye in the National Trauma Data Bank® (NTDB®) research dataset for 2014, medical records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification diagnoses codes. Specifically searched were records that contained the diagnosis code 871.3 (avulsion, displacement, enucleation, or evisceration of the eye). A total of 230 records were found; 176 records contained a discharge status, including 109 patients discharged to home, 18 to acute care/rehab, and 17 sent to skilled nursing facilities; 32 died. (See Figure 1, this page). Of these patients, 72.6 percent were male, an average of 41.5-years old, had an average hospital length of stay of 9.5 days, an intensive care unit length of stay of 8.1 days, an average injury severity score of 18.4, and were on the ventilator for an average of 6.5 days. The top two mechanisms that accounted for two-thirds of the injuries...
were firearms (36.6 percent) and motor vehicles (28.9 percent). (See Figure 2, this page).

**Watch for hazards**

Traumatic globe enucleation is the most severe form of ocular trauma that instantly results in monocular vision. To simulate the effect, imagine looking through a pair of binoculars and then closing one eye. The resulting image is flat with reduced peripheral vision. These severe injuries can happen at home, in the workplace, or anywhere in between. Prevention is the best treatment, so keep an eye out and try to avoid potential ocular hazards.

Throughout the year, we will be highlighting NTDB data through brief monthly reports in the *Bulletin*. The NTDB Annual Report 2015 is available as a PDF file at facs.org/quality-programs/trauma/ntdb/docpub. In addition, information is available on our website about how to obtain NTDB data for more detailed study. To submit your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org. ♦

**Acknowledgment**

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**REFERENCES**

Results of the first national multicenter randomized trial of resident duty hour policies indicate that allowing residents the flexibility to work longer shifts than currently allowed in the U.S. and/or take less time off between shifts to facilitate continuity of patient care does not result in a greater risk of postoperative complications or death. The study, called the Flexibility in Duty Hour Requirements for Surgical Trainees (FIRST) Trial, involved 117 U.S. general surgery residency programs and 151 affiliate hospitals. Residents who participated in the study reported that flexibility in work hours made it less likely they would need to leave during an operation or hand off an active patient care issue to another provider.

The trial results were presented February 2 at the Academic Surgical Congress in Jacksonville, FL, hosted by the Association for Academic Surgery and the Society of University Surgeons. The results were reported concurrently in the *New England Journal of Medicine* and indicate that less restrictive work-hour policies resulted in no significant difference in residents’ self-reported satisfaction with their overall well-being and quality of their training.

“Making duty hour policies more flexible for surgeons in training appears to be safe for patients and beneficial to the trainees in numerous ways,” said lead study investigator Karl Y. Bilimoria, MD, MS, FACS, a Faculty Scholar at the American College of Surgeons (ACS) and director of the Surgical Outcomes and Quality Improvement Center, Northwestern University Feinberg School of Medicine, Chicago, IL.

**Study design and findings**

The FIRST Trial investigated whether surgical patients’ complication rates in the first postoperative month would be affected by less restrictive duty hour policies than under current policies of the Accreditation Council for Graduate Medical Education (ACGME), the standards-setting body for approximately 9,500 U.S. medical residency programs, of which 252 are general surgery programs.

The researchers studied the complication rates of 139,000 patients obtained from participating hospitals’ data submitted to the ACS National Surgical Quality Improvement Program (ACS NSQIP®)—the leading nationally validated, risk-adjusted program that measures outcomes for surgical care provided in hospitals.

Before the release of the FIRST Trial results, little high-quality data was available to show the effects of work hour restrictions on surgical patient care. “This is the first time we have high-level national prospective evidence to inform resident duty hour
policies,” Dr. Bilimoria said. More recent changes further shortened the shift length for interns and increased residents’ time off work after a 24-hour shift.* Dr. Bilimoria said the newest restrictions increased the frequency of patient handoffs.

For the study, one group of 59 programs and their 71 affiliated hospitals participated in Standard Policy, in compliance with all existing ACGME duty hour policies. The other group, consisting of 58 programs and 80 affiliated hospitals, received permission from the ACGME to waive rules on maximum shift lengths and time off between shifts (Flexible Policy). In this flexible duty hour group, programs were able to implement one or more of the following policy changes: interns’ work shifts could extend beyond the current maximum of 16 hours; more senior residents’ duty hour periods could exceed 24 hours; residents were not required to take off at least eight hours between shifts; and residents did not have to take off at least 14 hours after 24 hours of continuous duty.

**Residents’ experience**

In addition, the FIRST Trial used a survey administered at the January 2015 American Board of Surgery (ABS) In-Training Examination to measure residents’ overall well-being, quality of education, and patient care. The ABS sets the standards for the board certification of surgeons upon completion of residency training.

“Our goal was to revise only the policies that would interfere with continuity of care or would result in increased handoffs, particularly at unsafe times,” Dr. Bilimoria explained. “Residents in the flexible duty hour group did not work more hours; rather, they worked more effectively by rearranging their hours.”

The Flexible Policy residents were more likely than the Standard Policy group to report improved experiences on several measures, including continuity of patient care, acquisition of operative skills, and professionalism, Dr. Bilimoria reported. Residents in the flexible duty hour group were far more likely to report being present for the entire duration of an operation and provide care for their patients through an entire episode of illness, rather than handing off care to another provider, he said. Among the 4,330 residents responding to the survey, those in the flexible duty hour group (2,220) were no more likely to report dissatisfaction with their educational program than the Standard Policy group (2,110).

A joint press release from the ACS and the ABS that describes results of the study is available at facs.org/media/press-releases/2016/first0216. For details about how the College, the ABS, and the ACGME worked together on this project, see “Looking forward,” page 7. ♦

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Residents: Prepare to take your ACS membership to the next level

Surgical residents are interested in pursuing educational and professional excellence, both as surgeons and as members of the surgical community. Associate Fellowship in the American College of Surgeons (ACS) can provide the tools, resources, and opportunities surgeons will need to succeed when they embark on their professional careers.

The Associate Fellow category is open only to surgeons who are devoted to practicing surgery in accordance with the College’s professional and ethical standards, which are outlined in the ACS Fellowship Pledge and Statements on Principles—both available on the College’s website at facs.org.

Benefits of Associate Fellowship
As young surgeons move from training into practice, the College’s leadership encourages graduating residents to apply for Associate Fellowship. Applicants will be asked to provide basic information regarding education and training, licensure, board certification, and current hospital and academic affiliations—much of which already exists in ACS Resident Member records. The College will waive the application fee for Resident Members who are current with their dues.

Associate Fellow membership is limited to a period of six years in order to foster the progression of membership to the Fellows level. The College encourages Associate Fellows to consider applying for full Fellowship once they have met the following basic requirements:

- Certification by an appropriate American Board of Medical Specialties Surgical Specialty Board, an American Osteopathic Surgical Specialty Board, or the Royal College of Surgeons of Canada
- One year of surgical practice after the completion of all formal training (including fellowships)
- Current appointment at a primary hospital

How to apply
To submit the electronic application for Associate Fellowship, visit the College’s website at facs.org/member-services/join/associate. You will need your ACS website log-in information. If you do not have your log-in information, contact the Division of Member Services at 800-293-4029 or via e-mail at enroll@facs.org for assistance.

When your application has been processed, you will receive an e-mail notification providing updated information about your membership status.

The College looks forward to helping you with your transition from a Resident Member to an Associate Fellow of the ACS.
The American College of Surgeons (ACS) Children’s Surgery Verification Quality Improvement Program recently released its latest standards document, *Optimal Resources for Children’s Surgical Care*. These standards, developed by the ACS in collaboration with the Task Force for Children’s Surgical Care from 2012 through 2014, are the nation’s first and only multispecialty standards that seek to improve surgical care for pediatric surgical patients.

“This is the first time that there has been a formal delineation of resource standards that relate specifically to children’s surgical care across all relevant disciplines,” said Keith T. Oldham, MD, FACS, chair, Children’s Surgery Verification Quality Improvement Program, and surgeon in chief, Children’s Hospital of Wisconsin, Milwaukee.

The pilot phase of the program launched in April 2015. Within one month, six pilot site visits were completed at diverse institutions nationwide. The final document includes revisions to the 2014 draft standards and updates from lessons learned during the pilot phase of the program, such as the need for alternative training pathways for anesthesiology, emergency medicine, and radiology. The new standards also clearly define the safety data elements required for all level designations.

The new standards document comes in advance of the online application—a pre-review questionnaire for centers seeking designation through the Children’s Surgery Verification Quality Improvement Program—expected to launch later this year.

“The standards presented in this document are the basis for the Children’s Surgery Verification Quality Improvement Program, for which the ACS will visit centers periodically and verify that relevant standards are met and related quality improvement mechanisms are in place,” Dr. Oldham said.

To access the standards, visit [facs.org/quality-programs/childrens-surgery-verification/standards](https://facs.org/quality-programs/childrens-surgery-verification/standards).
ACS cosponsors fellowships in ethics and leadership

The American College of Surgeons (ACS) Division of Education is offering two new fellowships—one in conjunction with the MacLean Center for Clinical Medical Ethics, University of Chicago, IL, and the other with the department of surgery at the University of Wisconsin (UW), Madison.

The MacLean Center will prepare two surgeons for careers that combine clinical surgery with scholarly studies in surgical ethics, beginning with a five-week, full-time course in Chicago in July and August. From September 2016 to June 2017, fellowship recipients will meet weekly for a structured ethics curriculum. In addition, fellows will participate in an ethics consultation service and complete a research project. For additional information, contact Patrice Gabler Blair, MPH, Associate Director, ACS Division of Education, at pbair@facs.org. Application materials are due April 30, 2016.

In addition, the ACS Division of Education and UW department of surgery have developed a fellowship program that will allow surgery residents who have completed two or three years of postgraduate training to attain leadership skills in surgical education. This two-year fellowship also allows fellows to participate in the UW School of Education master’s degree program. Faculty from the ACS Division of Education, UW department of surgery, and UW School of Education will guide the participants in a mentored surgical education research project. Two years of funding will become available in July 2016. Additional information can be found online at www.surgery.wisc.edu/uw-acs or by contacting Maria Branca-Afrazi, department of surgery, UW School of Medicine and Public Health, at afrazi@surgery.wisc.edu. Applications will be accepted on a rolling basis until the positions are filled.
Save the date for the ACS Surgeons as Leaders Course in June

**Save the date for the American College of Surgeons (ACS) Surgeons as Leaders: From Operating Room to Boardroom course, June 5–8 in Durham, NC.** Surgeons who aspire to meet the challenges of exemplary leadership across all settings are encouraged to join senior surgical leaders in the three-day course.

Faculty will include the following:

- **Course Chair Andrew L. Warshaw, MD, FACS, FRCSEd(Hon),** senior consultant, international and regional clinical relations, Massachusetts General Hospital and Partners HealthCare, Boston, MA, and Immediate Past-President of the ACS
- **Julie A. Freischlag, MD, FACS,** vice-chancellor, human health sciences, and dean, school of medicine; University of California-Davis Health System, and Past-Chair of the ACS Board of Regents
- **Matthew M. Hutter, MD, MPH, FACS,** director, Codman Center for Clinical Effectiveness in Surgery, Massachusetts General Hospital, and associate professor of surgery, Harvard Medical School, Boston
- **Larry R. Kaiser, MD, FACS,** president and chief executive officer, Temple University Health System, and dean, Lewis Katz School of Medicine, Temple University, Philadelphia, PA
- **Fabrizio Michelassi, MD, FACS,** Lewis Atterbury Stimson Professor and chairman, department of surgery, Weill Cornell Medical College; surgeon-in-chief, New York-Presbyterian/Weill Cornell Medical Center, New York, NY; and Chair, ACS Board of Governors
- **Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), FRCS(Hon), FRCSEd(Hon),** chief medical officer, UW Medicine; vice-president for medical affairs, University of Washington, Seattle; and ACS Past-President
- **Nathaniel J. Soper, MD, FACS,** Loyal and Edith Davis Professor and chair, department of surgery, and surgeon-in-chief, Northwestern Medicine, Chicago, IL, and a Past-Governor of the ACS
- **Beth H. Sutton, MD, FACS,** general surgeon, Wichita Falls, TX; clinical professor of surgery, University of Texas Southwestern Medical School, Dallas; and ACS Regent
- **Michael Useem, PhD,** William and Jacalyn Egan Professor of Management and director, Center for Leadership and Change Management, Wharton School of University of Pennsylvania, Philadelphia
- **The keynote speaker will be David F. Torchiana, MD, FACS,** president and chief executive officer, Partners HealthCare System, Boston

Organized by the ACS Division of Education, the course will help surgeons exhibit leadership attributes; use consensus development and vision to set, align, and achieve goals; build and maintain effective teams; identify factors that hamper the ability to lead; change culture, resolve conflict, and balance demands within the larger environment; and translate the principles of leadership into action.

For additional information, e-mail ulangenscheidt@facs.org, or call 312-202-5018.
The American College of Surgeons (ACS) offers International Guest Scholarships to young surgeons from countries other than the U.S. or Canada who have demonstrated a strong interest in teaching and research. The 12 scholarships are available for 2017, in the amount of $10,000 each, and will provide the scholars with an opportunity to engage in clinical, teaching, and research activities in the U.S. and Canada and to attend and participate fully in the educational opportunities and activities of the ACS Clinical Congress. For consideration by the Selection Committee, completed applications for the 2017 International Guest Scholarships and all supporting documentation must be received at the office of the International Liaison Section by June 30, 2016.

Paul R. Hawley, MD, FACS(Hon), Past-ACS Executive Director (1950−1961), left a legacy to the College for the scholarship endowment. More recently, gifts to the International Guest Scholarship endowment from the family of Abdol Islami, MD, FACS, and Joan Islami; the Stavros Niarchos Foundation; and others have enabled the College to increase the number of these scholarship awards.

The scholarship requirements are as follows:

• Applicants must be medical school graduates who have completed their surgical training.

• Applicants must be between 35 and 50 years old on the date that the completed application is filed.

• Applicants must submit their applications from their intended permanent location.

• Applicants must have demonstrated a commitment to teaching and/or research in accordance with the standards of the applicant’s country.

• Applicants early in their career are deemed more suitable than those surgeons who are in senior academic positions.

• Applicants must submit a fully completed application form available on the ACS website at facs.org/member-services/scholarships/international/igs. The application and accompanying materials must be submitted in English. Submission of a curriculum vitae without a completed application is unacceptable.

• Applicants must provide a list of all of their publication credits and must submit three complete reprints or manuscripts from that list.

• Preference may be given to applicants who have not already experienced training or surgical fellowships in the U.S. or Canada.

• Applicants must submit independently prepared letters of recommendation from three of their colleagues. One letter must be from the chair of the department in which the applicant holds an academic appointment or an ACS Fellow residing in the applicant’s country. This
The 12 scholarships are available for 2017, in the amount of $10,000 each, and will provide the scholars with an opportunity to engage in clinical, teaching, and research activities in the U.S. and Canada and to attend and participate fully in the educational opportunities and activities of the ACS Clinical Congress.

letter must include a statement regarding the nature and extent of the teaching and other academic involvement of the applicant. Letters of recommendation should be submitted by the person making the recommendation.

• The online application form is structured to assist the Scholarship Selection Subcommittee and assists the applicant in submitting a structured curriculum vitae.

• The International Guest Scholarships must be used in the year for which they are designated. They may not be postponed.

• Applicants who are awarded scholarships will provide a full written report of the experiences provided through the scholarships upon completion of their tours.

• An unsuccessful applicant may reapply only twice and only by completing and submitting a new application and new supporting documentation.

The scholarships will provide successful applicants with public recognition of their presence. Assistance will be provided in arranging visits, following the Clinical Congress, to various clinics and universities of their choice.

For consideration by the Selection Committee, applicants must fulfill all of the requirements. Applicants are urged to submit their completed applications and supporting documents as early as possible to provide sufficient time for processing.

Send supporting materials to International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL, 60611-3211; or via fax to 312-202-5021. Questions should be directed to Kate Early, International Liaison, at kearly@facs.org.

ACS and Triological Society offer Clinical Scientist Development Award

Applications for a competitive grant program sponsored by the American College of Surgeons (ACS) and the Triological Society to provide supplemental funding to otolaryngologists–head and neck surgeons who have received a new National Institutes of Health Mentored Clinical Scientist Development Award (K08/K23), or who have an existing award with a minimum of three years remaining in the funding period as of June 1, 2016, are due May 26, 2016. This award is intended to facilitate the research career development of otolaryngologists-head and neck surgeons, with the expectation that the awardee will have sufficient pilot data to submit a competitive R01 proposal before the conclusion of the K award period. This award provides financial support in the amount of $80,000 per year for up to five years or for the remainder of the term of existing grants, to supplement the K08/K23 awards. Funding is dependent upon receipt of meritorious applications.

For more information, visit the Triological Society’s website at www.triological.org/researchgrants.html or contact info@triological.org.
Applications and supporting documentation for two 2017 Community Surgeon Travel Awards, sponsored by the International Relations Committee of the American College of Surgeons (ACS), are due July 1, 2016. The travel awards, $4,000 each and available to surgeons ages 30 to 50, allow international surgeons to attend and participate in the educational activities of the annual ACS Clinical Congress. The awards are intended specifically to assist surgeons who work in community or regional hospitals or clinics in countries other than the U.S. and Canada, or who are from under-resourced academic departments of surgery in under-resourced countries.

The College will cover each awardee’s registration fees for Clinical Congress 2017, October 22–26, in San Diego, CA, as well as the cost of one Postgraduate Course at the meeting. The ACS also will assist the recipients in finding preferential housing in an economical hotel. All applicants will be notified of the Selection Committee’s decision in November 2016.

Application requirements are as follows:

• Applicants must be medical school graduates who have completed their surgical training.
• Applicants must be between 30 and 50 years old on the date that the application is filed.
• Applicants must submit their applications from their intended permanent location. Applications will be accepted for processing only when the applicants have been in surgical practice, teaching, or research for at least one year at their intended permanent location and following completion of all formal training (including fellowships and scholarships).
• Applicants must show evidence of commitment to quality care, surgical teaching, and improving access to surgical care in their community.
• Applicants must submit a fully completed application form provided on the ACS website at facs.org/member-services/scholarships/international/communitytravel. The application and accompanying materials must be submitted in English. Submission of a curriculum vitae without a completed application is unacceptable.
• Applicants who have not already experienced training or surgical fellowships in the U.S. or Canada will receive preference for the awards.
• Applicants must independently prepare letters of recommendation from three colleagues. One letter must be from the chair of the department in which the applicant holds a clinical or academic appointment or from an ACS Fellow residing in their country. The recommendation letter must directly address the applicant’s commitment to quality care, surgical teaching, and improving access to surgical care locally. Letters of recommendation should be submitted by the individuals making the recommendations.
• The Community Surgeon Travel Awards must be used in the year for which they are designated. They may not be postponed.
• Awardees are expected to provide a written report upon their return home, specifically focusing on the value of the visit to the awardee and the potentially beneficial effect for patients in the country of origin.
• Unsuccessful applicants may reapply only twice and only by completing and submitting a new application together with new supporting documentation.

To qualify for consideration by the Selection Committee, all of the requirements must be fulfilled.

Supporting materials and questions should be directed to Kate Early, International Liaison, at kearly@facs.org or faxed to 312-202-5021.
Apply now for 2016 international scholarships for surgical education

The American College of Surgeons (ACS) Division of Education and the International Relations Committee have announced the availability of two international scholarships focused on surgical education for 2016. These awards will offer faculty members from countries other than the U.S. and Canada the opportunity to participate in a variety of faculty development activities that will result in acquisition of new knowledge and skills in surgical education and training. The intent of the program is to help scholars improve surgical education and training in their home institutions and countries. All application materials and supporting documents are due no later than May 2 for attendance at the ACS Clinical Congress 2016, October 16–20 in Washington, DC.

About the program
The two scholars will participate in the annual Clinical Congress, including the Surgical Education: Principles and Practice course, as well as other plenary sessions and Postgraduate Courses that address surgical education and training needs across the continuum of professional development. This continuum may include the needs of surgery residents, medical students, and other members of the surgical team. After the Clinical Congress, each scholar will visit two Level I ACS Accredited Education Institutes (ACS-AEIs) selected in advance based on the scholars’ interest areas in surgical education and training. At the conclusion of the Clinical Congress and the scholars’ visits to the ACS-AEIs, each recipient will send to the International Relations Committee and the Division of Education a brief report outlining the outcomes that have been achieved as a result of the scholarship; this report should specifically focus on the objectives outlined in their application for the scholarship. The scholarships will facilitate the scholars’ involvement in subsequent collaborative ventures in education and training under the aegis of the ACS Division of Education.

Each scholarship provides a stipend of $10,000, supporting travel and per diem in North America and the cost of Postgraduate Courses undertaken at the Clinical Congress and at the ACS-AEIs to be visited. Clinical Congress registration and fees for attendance at the Surgical Education: Principles and Practices course will be provided. Assistance will be offered to reserve affordable housing in Washington, DC, during the Clinical Congress.

Application requirements
Applicants must document prior experience in surgical education and training, such as involvement in the development and evaluation of education modules, use of novel teaching and assessment strategies, or curriculum design. In addition, applicants must submit a one-paragraph description of their education philosophies, a list of specific educational goals and objectives for their visits, and evidence of support of these goals and objectives from the leadership at their home institutions. These documents will be reviewed by the Division of Education as part of the selection process. At least five years of experience beyond completion of all training and fellowships is required. Scholarships must be used in the year awarded; they may not be postponed.

Full scholarship requirements for this program may be reviewed at facs.org/member-services/scholarships/international/issurged. The application for the scholarship may be accessed at the bottom of the requirements page. Questions should be directed to Kate Early, ACS International Liaison, at kearly@facs.org.

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Calendar of events

*Dates and locations subject to change. For more information on College events, visit www.facs.org/events or http://web2.facs.org/ChapterMeetings.cfm.

APRIL

ACS Leadership & Advocacy Summit 2016
April 9–12
Washington, DC
Contact: Donna Tieberg, dtieberg@facs.org, facs.org/advocacy/participate/summit-2016

Japan Chapter
April 14–16
Osaka, Japan
Contact: Kazuhiko Yoshida, kaz-yoshida@jikei.ac.jp

Egypt Chapter
April 21–22
Cairo, Egypt
Contact: Mohey Elbanna, moheyelbanna@yahoo.com

North Dakota Chapter & South Dakota Chapter
April 22–23
Watertown, SD
Contact: Terry Marks, tmarks@sdsma.org

Indiana Chapter
April 22–24
French Lick, IN
Contact: Carolyn Downing, cdowing@ismanet.org, www.imsfacs.org

Northern California Chapter
April 29–30
Berkeley, CA
Contact: Christina McDevitt, nccacs@att.net, www.nccacs.org

Metropolitan Washington DC Chapter & Virginia Chapter
April 30
Washington, DC
Contact: Norma Smalls, drnormasmalls@gmail.com, www.dc.facs.org, www.virginiaacs.org

MAY

Minnesota Surgical Society
May 5–7
Minneapolis, MN
Contact: Janna Pecquet, janna@mn.mnsurgicalsociety.org, www.mnsurgicalsociety.org

Jordan Chapter
May 5–8
Amman, Jordan
Contact: Osama Hamed, ohamed@ccf.org, www.acs-jordan.org

Ohio Chapter
May 6–7
Columbus, OH
Contact: Walter Sun Cha, chaw@ccf.org, www.ohiofacs.org

Florida Chapter
May 7
Tampa, FL
Contact: Nicole Woodsmall, nwoodsmall@floridafacs.org

Chile Chapter
May 8–11
Valparaiso, Chile
Contact: Patricio Burdiles, pburdiles@acschile.cl, www.acschile.cl

Turkey Chapter
May 11–13
Istanbul, Turkey
Contact: Mehmet Ali Haberal, rectorate@baskent.edu.tr

West Virginia Chapter
May 12–14
White Sulphur Springs, WV
Contact: Sharon Bartholomew, vvacs@labs.net

Metropolitan Philadelphia Chapter
May 16
Philadelphia, PA
Contact: Lauren Newmaster, mpcacs@pamedsoc.org, metrophilasurgeons.org

FUTURE CLINICAL CONGRESSES

2016
October 16–20
Washington, DC

2017
October 22–26
San Diego, CA

2018
October 21–25
Boston, MA