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*Titles and locations current at the time articles were submitted for publication.

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continued on next page
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As I write this last column of 2019 and as my 10th year as Executive Director of the American College of Surgeons (ACS) concludes, I would like to express my gratitude for all the hard work our surgeon volunteers and the ACS staff have done this and every year. A thorough summary of the developments and transformations that have occurred in 2019 can be found on page 37. Herein, I outline the most significant milestones.

Advocacy and Health Policy
The ACS Health Policy and Advocacy Group identified more than 40 issues that the College’s Division of Advocacy and Health Policy should address this year. Top-ranking issues included: administrative burdens and regulations, including prior authorization; the development of a value-based payment system; the electronic health record, including interoperability; new evaluation and management documentation guidelines; and surprise billing for out-of-network care.

We introduced ACS THRIVE (Transforming Health Care Resources to Increase Value and Efficiency) — developed through a collaboration of the ACS and the Harvard School of Business (HBS) Institute for Strategy and Competitiveness—which may resolve some of these challenges. THRIVE ties together the ACS track record of developing meaningful quality improvement programs with the economic principles that the HBS espouses to offer a blueprint for creating a value-based health care system. Key components of this system include development of integrated practice units, composed of all health care professionals and facilities involved in every stage of patient care; use of a time-driven, activity-based costing system; and bundled payment. Congressional staff and officials at the Centers for Medicare & Medicaid Services have continued to express interest in ACS THRIVE as a means of transforming the U.S. health care system.

To address the unique challenges that private practice surgeons are experiencing, we released ACS Resources for the Practicing Surgeon, Volume II: The Private Practice Surgeon at Clinical Congress 2019. This primer provides an overview of private practice business models, financial management and revenue cycle processes, relevant health care laws and rules, and mechanisms to ensure the ongoing prosperity of private practice.

Education
The second class of the ACS Academy of Master Surgeon Educators was inducted October 4. Academy Members, Associate Members, and new Affiliates are exploring pathways to enhance surgical education and training.

We also launched the ACS Certificate Program in Applied Surgical Education Leadership (CASEL) September 26–28. Participants in this program will learn about change management, mentorship, self-management, negotiation, and more.

Clinical Congress 2019 was a success, with approximately 13,700 attendees. A highlight for this year’s attendees was the opportunity to participate in The Surgical Metrics Project, which will provide us with useful data about perioperative clinical decision making and its effects on efficiency and efficacy.

Also at Clinical Congress, the 17th edition of Surgical Education and Self-Assessment Program (SESAP®) was unveiled. New features have been added to increase the program’s impact, and a specialty-focused program, Advanced SESAP 17, will debut in 2020.

Continuous Quality Improvement
For four years, the more than 50 member organizations of the Coalition for Quality in Geriatric Surgery Project, with funding from The John A. Hartford Foundation, have sought to improve care for older patients. The final year of the project recently concluded with many milestones completed, including the finalization of geriatric surgery standards and the launch of the Geriatric Surgery Verification (GSV) program.

The 30 GSV standards, Optimal Resources for Geriatric Care, were released at the 2019 ACS Quality Improvement Conference.

Looking forward
by David B. Hoyt, MD, FACS
A highlight for this year’s Clinical Congress attendees was the opportunity to participate in The Surgical Metrics Project, which will provide us with useful data about perioperative clinical decision making and its effects on efficiency and efficacy.

and Safety Conference and can be applied in all U.S. hospitals, regardless of size, location, or teaching status. The program will prepare for the influx of older adults considering surgery with care standards that define the resources hospitals need to have in place to perform operations effectively, efficiently, and safely in this vulnerable population. Hospitals were able to start enrolling in the GSV program at Clinical Congress 2019.

The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program’s (MBSAQIP’s) second national collaborative initiative, Employing New Enhanced Recovery Goals to Bariatric Surgery (ENERGY), ended in summer 2018. The most important finding from this work is that participating centers cut their lengths of stay in half and improved patient outcomes. In addition, MBSAQIP released the third version of its standards, launched a patient-reported outcomes initiative, and unveiled a Bariatric Surgical Risk/Benefit Calculator.

Lastly, we have conducted 12 site visits to develop the “Red Book” (Optimal Resources for Surgical Quality and Safety Manual) verification program and standards. We anticipate that this program will launch next year.

Cancer Programs

ACS Cancer Programs have accredited more than 1,533 Commission on Cancer (CoC) hospitals, 647 National Accreditation Program for Breast Centers specialty centers, and 13 National Accreditation Program for Rectal Cancer specialty centers.

New standards for the CoC have been drafted, reviewed, and finalized for implementation in 2020. The new standards were discussed at a plenary session at Clinical Congress 2019.

The National Cancer Database continues to curate 1.5 million cancer cases and support 1,000 research projects annually and is moving toward near real-time data acquisition, reporting, and inter-programmatic integration with other ACS databases through the transition to the single database platform.

The Clinical Research Program is completing volumes three and four of the Operative Standards Manual and has transitioned six standards into the new CoC standards for implementation in 2020.

The American Joint Committee on Cancer published the eighth edition of its Cancer Staging Manual, which included structured content and created an application program interface to deliver electronic content to electronic health records vendors and other content users.

Cancer Programs staff performed an assessment of the programs as part of the onboarding of the new leadership. A total of 191 surveys and 604 individual comments were reviewed and discussed in January 2019 at a retreat. Strategic planning to address identified strengths and challenges is under way.

Trauma Programs

With leadership from the ACS Committee on Trauma (COT), representatives from 45 professional medical and injury prevention organizations and the American Bar Association met February 10–11 for a Medical Summit on Firearm Injury Prevention to develop a consensus-based approach to addressing this public health issue. As a next step, the COT convened the ISAVE (Improving Social determinants to Attenuate Violence) panel to study the causes of violence and recommend innovative programs to reduce the prevalence of intentional violence.

In its third year, the Stop the Bleed® program has provided bleeding control training to more than 1.2 million people in all 50 states and more than 110 countries. And in October, the COT, Stop the Bleed staff, and the Division of Integrated Communications launched a new public-facing website, www.StoptheBleed.org, to meet the ongoing challenge of bringing information, education, and empowerment to the general public, while still serving as a clearinghouse for Stop the Bleed products, services, and updates.

Member Services

The ACS has 84,026 members, including 64,414 Fellows (56,044 U.S., 1,262 Canadian, and 7,108 International), 2,673 Associate Fellows, 11,211 Resident Mem-
The COT, Stop the Bleed staff, and the Division of Integrated Communications launched a new public-facing website, www.StoptheBleed.org, to meet the ongoing challenge of bringing information, education, and empowerment to the general public.

bers, 3,168 Medical Student Members, and 568 Affiliate Members. We welcomed our largest class of Initiates this year: 1,992.

The Division of Member Services—which has purview over the Board of Governors, Chapter Services, the Advisory Councils, the Central Judiciary Committee, the Young Fellows Association, the Resident and Associate Society (RAS), Operation Giving Back, the History and Archives Committee, and the Military Health Services Partnership ACS—continues to develop new programs and services to foster member engagement.

As reports of physician burnout continue to be released, several of these groups have sought to address this issue. RAS, for example, chose Nurturing Wellness and Fostering Resilience as its theme for this year’s August Bulletin. Earlier this year, the Division of Member Services also hosted leaders involved in well-being initiatives at their institutions to discuss areas of focus for future programs. The ACS is working on several initiatives as follow-up to this meeting.

As a leader in global health care, the College has partnered with the College of Surgeons of East, Central and Southern Africa (COSECSA) on several projects. In January, the ACS-COSECSA Surgical Training Collaborative launched an effort to establish a regional surgical training hub in Hawassa, Ethiopia. A total of 13 U.S. academic institutions deployed faculty to Hawassa to provide training and support to local surgical residents and faculty.

**Integrated Communications**

The College’s new GSV Program captured national media attention this summer with several news articles on the need for the program and how it will improve outcomes for older surgical patients. Stories were published in the New York Times, Associated Press, Kaiser Health News, AARP.com, Reuter’s Health, Becker’s Healthcare, and Fierce Healthcare.

ACS trauma surgeons appeared on CBS Sunday Morning August 4 to discuss a public health approach to firearm violence on the heels of mass shootings in El Paso, TX, and Dayton, OH. The segment featured a panel of seven surgeons and physicians working with the American Foundation for Firearm Injury Reduction in Medicine.

The ACS launched a new artificial intelligence (AI)-driven version of ACS NewsScope. Disseminated twice weekly to all members of the College, My ACS NewsScope is designed to deliver customized content to each recipient. The AI database curates information from nearly 80 sources of both clinical and nonclinical information. Each issue includes a news brief on an important ACS program and occasional updates from the Washington office. The traditional Thursday-night ACS NewsScope continues to be disseminated to more than 55,000 recipients.

With the January issue, the Journal of the American College of Surgeons (JACS) unveiled a redesigned cover. The issue featured 13 selected papers presented at the Clinical Congress 2018 Scientific Forum. It was the first Scientific Forum-dedicated issue of JACS, and the January 2020 issue will feature highlighted papers from the 2019 meeting.

In October 2018, a multistep process was used to create a Twitter strategy, which was approved and implemented to improve the College’s Twitter effectiveness. Increases occurred in all categories.

After five years, the ACS Communities continue to be a popular member benefit. Since its launch in 2014, the platform has received 4.2 million page views, and more than 35,000 members of the College have agreed to the site’s terms of use.

As this report indicates, the ACS continues to lead the way in ensuring all patients have access to value-based surgical care. It is my honor and privilege to work with all of you as your ACS Executive Director and to help lead this organization. ♦

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Caring: Isn’t that why we went to medical school?

by Sir Murray F. Brennan, MD, FACS

Imagine the missing life of your patient—the man who cares for a disabled spouse or the mother of an autistic child. Who will walk the dog?

Setting patient expectations

Many of the problems of delivering unexpected bad news can be tempered by setting expectations. For the surgeon, it’s helpful to inform the patient and family that a brief procedure may well mean that the tumor was not removed. A prolonged procedure may mean the problem is more difficult than expected. But a long procedure does not necessarily mean a problem. Taking the time and setting the stage make so much difference. The expected, no matter how unpleasant, can be handled readily—the unexpected, not so much. The caring physician must own the good and the bad.

The most unethical, unkind communication to the patient is to promise what you cannot deliver, or even worse, promising what your colleagues cannot deliver. “Operation was not possible; you will need chemotherapy.” “We think you have a bowel obstruction, so the surgeons will come and deal with it.” “Radiation will take care of it.”

Sensitivity and empathy

And what about the inpatient? How do you convey caring when you make rounds with a team,
When a patient is confronted with a diagnosis or potential diagnosis of cancer, the anger, the fear, the injustice of it all can never be underestimated. We should start by caring for the emotional pain of the presumed diagnosis.

some active participants, some observers, some redundancies? How do you change the dynamic from your power, your omnipotence, to an example of caring to the rest of the team? How easy is it to convey your power and dominance by standing, looking down at the patient, or worse, looking not at the patient but at the chart or your colleagues, or even worse, wheeling in the portable iPad? How much better to convey sensitivity and empathy by sitting on the edge of the bed, having conveyed respect by asking permission. The gentle touch of the back of the hand is often responded to by a grasp of your full hand—a grasp of fear, gratitude, desperation, or simply warmth. You care.

“I do not have time for such things,” I hear you say. “How can I make this efficient?”

It cannot be done with an erudite discussion of the latest computed tomography findings, but with a simple question: “How can I help?”

“What are your concerns?”

“How much do you understand?”

These questions are so rarely asked that the patient often does not have time to respond. How much more rewarding it is to set the scenario and turn this into a caring but efficient process. I recommend asking, “Do you have questions? If so, write them down, and we will discuss them tomorrow.”

For that one visit with a patient, however brief, time must stand still. But for the next patient, it will be a different piece of time that stops. Time was left behind with the last patient, as he or she absorbs and reflects on what was said. The time you spent will be expanded tenfold, as patients dissect your words, your touch, and that becomes distilled into what they will ask the next day. I often tell the family to come at the time that I will make rounds; meeting at the bedside embraces the family and ensures the message received by everybody—staff, patient, and family—is the same. Mixed messages breed confusion, angst, and anger. Alignment of the patient’s, the family’s, and your expectations says you care.

What is the value of the first postoperative visit to explain the pathology? Reading the full text of any report means little, if anything. Setting the expectations, explaining the meaning of the findings, and explaining the anticipated future—all say you care.

What if there is to be no more surgery, no more chemotherapy? What does that mean? Certainly, it is not a dismissive referral to palliative care or hospice. This is the time for you to explain why there is no active anticancer treatment, but more importantly, the patient needs to hear why you embrace palliation while still caring and taking care.

Caring begins at the beginning and ends at the end and should never be far from every encounter. Take time to care: it is why you went to medical school. ♦

When a patient is confronted with a diagnosis or potential diagnosis of cancer, the anger, the fear, the injustice of it all can never be underestimated. We should start by caring for the emotional pain of the presumed diagnosis.
Climate change article presents only one side of the story

Mr. Fox’s article on climate change (“Climate change: What does it mean for the future of surgery?”) in the September 2019 *Bulletin of the American College of Surgeons* is not accurate and does not meet the standards of the American College of Surgeons.

The initial point made in the article was: “Perhaps the health effect that most directly affects surgeons is the increase in extreme weather events.” Yet there is little evidence that this is happening.

Chapter 2 of the Fourth National Climate Assessment states, “Observed trends and projections of future changes in severe thunderstorms, tornadoes, hail and strong wind events are uncertain…tornado activity in the United States has become more variable, particularly over the 2000s, with a decrease in the number of days per year with tornadoes and an increase in the number of tornadoes on these days...there is only low confidence in observations that storms have already become stronger or more frequent.”

From the Fifth Assessment report of the Intergovernmental Panel on Climate Change (AR5), chapter 10, page 5:

In land regions where observational coverage is sufficient for assessment, there is medium confidence that anthropogenic forcing has contributed to a global-scale intensification of heavy precipitation over the second half of the 20th century. There is low confidence in attributing changes in drought over global land areas since the mid-20th century to human influence owing to observational uncertainties and difficulties in distinguishing decadal-scale variability in drought from long-term trends. {10.6.1, Table 10.1}

There is low confidence in attribution of changes in tropical cyclone activity to human influence owing to insufficient observational evidence, lack of physical understanding of the links between anthropogenic drivers of climate and tropical cyclone activity and the low level of agreement between studies as to the relative importance of internal variability, and anthropogenic and natural forcings.²

Again, from organizations that many (with reason) believe are partial toward the manmade climate change ideology, there is minimal endorsement of Mr. Fox’s statement about an extreme weather events increase.

Mr. Fox says, “Climate change is increasing the amount and severity of extreme heat events around the world, with the number of people who experienced extreme heat increasing by more than an estimated 125 million from 2000 to 2016.” Such a calculation needs to be analyzed in terms of how world population has increased over that interval, especially in hotter environments. Many of the countries with hotter environments are low-income countries with a higher population growth, and such population growth could logically and simply be responsible for the statistic Mr. Fox cites.

Concern over the fatal effects of extreme heat are mentioned. However, a recent article in The Lancet documents the far greater lethality of cold weather rather than hot weather: “Can we sustain success in reducing deaths to extreme weather in a hotter world? In an incredible story of human adaptation, the aggregate global risk of mortality to extreme weather declined by over two orders of magnitude over the past century.”

Mr. Fox’s mention of air pollution serves only to confuse the purpose of the article; certainly air pollution is a legitimate health concern, but not directly related to the question of “manmade climate change” in terms of the decarbonization crusade.

Mr. Fox’s concern about rising global temperature increasing some diseases, as referenced by the Lancet article, is speculative, with “model projections suggest” that “vectorial capacity” will increase. Apparently, there is minimal firm evidence at present that that is the case.

Probably the fundamental health and economic issue here is “decarbonization”; that is, the purported necessity to reduce carbon dioxide in the atmosphere. The massive uncertainties in the reasoning that decarbonization is necessary and has a favorable cost-benefit profile is not closely examined in this article, and in fact, there is good reason to believe it will cause more harm than good, especially in poorer countries.

Unfortunately, Mr. Fox’s article endorses an ideology, continued on next page
and is not a careful and critical appraisal of the facts at hand concerning “manmade climate change.” Just as in the operating room, careful and critical thinking is essential in matters of public policy.

George Chovanes, MD, FACS, FAANS
Allentown, PA

I read with dismay the September 2019 Bulletin article

“Climate change: What does it mean for the future of surgery?” I was trained in meteorology and earned a bachelor of science degree in physics prior to becoming a general surgeon. Although that doesn’t provide me the credentials to be a climatologist, it provides me with critical thinking skills. The author of this article failed to provide readers with primary source verification of climate data, which has been uniformly corrupted. The resultant public hysteria has now reached the American College of Surgeons. To wit:

• Extreme heat events: The author writes, “Climate change is increasing the amount and severity of extreme heat events around the world.” False. See
To whom it may concern,

Figure 1, page 14. Although this graph only represents weather conditions in the U.S., our nation has the most comprehensive record, and data after the 1970s accurately reflects raw satellite data before it was manipulated. Extreme heat and cold events are a false metric for climate change.

The author states, “A primary driver of climate change is the increased global burning of fossil fuels and coal, which emits a high amount of carbon dioxide.” False. The sun is the primary driver of climate change. If the author took the time to look at solar cycle 24 (see Figure 2, page 14), he would understand the cyclical nature of climate and be concerned. This shows the nearly identical pattern to the one prior to the mini-ice age, which started in 1645. Do not conflate climate change with pollution. CO2 is not a pollutant; it is essential for plant life, and plant life is essential for animal life.

• Climate-sensitive diseases: The author writes, “The rising global temperature has changed the capacity for the transmission of some insect- and water-borne illnesses, such as dengue fever, Lyme disease, and malaria.” False premise. As Figure 3, page 14 shows, global temperatures have not been rising. The only anthropogenic warming is by the corrupted data manipulation, raw actual data versus reported data. No plausible reason is given for the manipulation, and more than 60 percent of reported data are now calculated (unmeasured) by the computer models.

• The author refers to “extreme weather events, such as prolonged, severe drought.” False premise. Contrary to every prediction by the “experts,” the U.S. has record low drought (see Figure 4, page 14).

There is no reason to offer solutions to a nonexisting problem. The real problem is junk science, incompetent journalists who fail to provide primary source verification, and a poorly educated public with limited capacity for critical thinking, placing them at risk for indoctrination and hysteria. Consensus is not science. True scientists understand the nobility of their profession, would never claim that “the science is settled,” would encourage robust debate, and would not engage in ad hominem attacks directed at those with an opposing viewpoint. Those who debase themselves in junk science to increase federal grants to their academic institutions at the expense of the truth deserve nothing short of expulsion from academia. The politicization of junk science results in junk policies and more than 50 years of false, apocalyptic forecasts (ice age, melting sea ice, ice free arctic, polar bear extinction, receding glaciers, and so on) do not serve the public interest. I am arrogant enough to challenge every “climate expert” in the world to a debate. I have a 23-slide, 15-minute presentation that would embarrass and humiliate them off the stage. This is serious because it is affecting public policy that will harm the middle class. First, do no harm.

Razi Saydjari, MD, FACS
Casper, WY

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The joys of learning, collaborating, and giving back

by Valerie W. Rusch, MD, FACS
Thank you, [Ronald M. Maier, MD, FACS, FRCSEd(Hon), FCSHK(Hon), FCCS(Hon)] for your generous introduction. May I extend my warmest greetings to all of you gathered here today: to the Regents, Governors, and Officers of the College; to David B. Hoyt, MD, FACS, Executive Director of the College; to our new Honorary Fellows and ACS awardees; to the Initiates and your friends and families; and to our wonderful ACS staff who work hard behind the scenes every day to make all of this possible. I am grateful for the privilege of serving as your ACS President during the coming year.

The Convocation has always been one of my favorite parts of the ACS Clinical Congress. It is a joyous occasion that provides an opportunity to recognize Fellows who have made outstanding contributions to the College; to welcome as Honorary Fellows highly distinguished surgeons from around the world; and, perhaps most importantly, to celebrate all of you—the Initiates—becoming new Fellows of the College after many years of very hard work. Congratulations on this wonderful milestone in your career.

Viewed over the past decade, you, the Initiates, not only represent the largest number of new ACS Fellows but also reflect the increasing diversity of our membership. Today, roughly 30 percent of new Fellows are women, 40 percent work outside of North America, and 40 percent practice in specialties other than general surgery. As I look around this auditorium, I see diversity in gender, race, ethnicity, and countries of origin. This diversity not only strengthens the College as an organization, but also benefits our patients. This is a far different situation from what I recall when I became an ACS Fellow in the mid-1980s.

Key principles for success
Each of us stands on the shoulders of our predecessors, both professionally and personally. A few years ago, when I was visiting professor at the University of Washington in Seattle where I did my residency, one of the faculty remarked to me, “You probably don’t remember, but when I was a resident, you helped me place my first chest tube.” Indeed, I didn’t recall this particular event, but it was a reminder of the myriad ways each of us is influenced and elevated by our predecessors, mentors, colleagues, hospital staff, friends, and family. I, too, have benefited from the support of many throughout the course of my career. For me to name just a few would be to do a disservice to the many. Suffice it to say, I will always be grateful for the guidance and help that I have had along the way.

Perhaps each of us is most indelibly marked by our family environment and childhood experiences. Like many parents and their children, I didn’t always agree with my parents. However, they steadfastly instilled several important life principles that have stood me in good stead through my career.

Commitment to education
First, was the supreme importance of education. My mother, who came of age during the Great Depression, and who was only able to attend college because of a scholarship and a part-time job, always impressed upon us the privilege and transformative effect of higher education. My father, a physician who came from a more privileged background and had many interests outside of medicine, was multilingual and an accomplished musician. Thanks to him, we children also had multilingual and multicultural educations. To their last years, both of my parents remained avidly interested in the changing world around them and were good examples of lifelong learning. Occasionally, such interests bordered on the quixotic. Long before climate change was recognized, my father decided that hydrogen power was going to be the solution to the world’s energy needs. Who knows—perhaps he was right!
Commitment to excellence

The second life principle exemplified by my parents was the importance of hard work, integrity, and the pursuit of excellence. Idleness was not part of the family ethic. When we children were not in school, we were expected to be avidly pursuing a wide range of extracurricular activities. Even when all of this stretched the family financially, my parents did their utmost to ensure that we had the best possible educational opportunities. High levels of achievement were expected. At one point early in my medical career, when I was talking with my father about the difficulties of being among what was then a very small number of women in surgery, his simple answer was: “No one can argue with excellence.” End of discussion.

Commitment to diversity

The third principle was a commitment to equality irrespective of race, ethnicity, religion, or gender. Both of my parents were politically active in the turbulent period of the 1930s through the 1960s. Long before it was politically correct or even acceptable, they impressed upon us the pivotal importance of racial equality and respect for religious preferences. My mother was a feminist before the term came into common use and regularly asserted that there should be no barriers to women achieving their highest professional ambitions. Both of my parents emphasized the rewards and importance of being involved in activities that extended beyond oneself and in some way benefited others.

If all of this sounds like a dress rehearsal for residency training and a career in surgery, indeed it was. However, I believe that these principles would stand any of us in good stead professionally and personally, and they parallel many of the principles upon which this College was founded and how it functions today.

Paradigm-shifting science

As new Fellows of the College, most of you are in the early phase of your career at a time that could not be more exciting. In fact, as I witness recent extraordinary scientific and technological advances, I wish that I, too, were just starting my career. Allow me to borrow an example from what I do every day—the care of patients with non-small cell lung cancer. For many decades, we saw relatively little progress in the treatment of this difficult disease. The past 15 years have seen a rapid evolution in our understanding of fundamental tumor biology (as shown with the discovery of many
so-called driver mutations in lung adenocarcinomas) and the development of many novel therapies—either therapies targeting specific mutations or immunotherapy with checkpoint inhibitors—leading to more precise treatment with far better outcomes. These novel therapies, shown definitively to improve survival in patients with advanced disease, are being rapidly moved into the care of patients with earlier stage, resectable tumors.

Most of the diseases that we care for as surgeons (and not just in oncology) are now being touched by rapid, paradigm-shifting scientific and technological advances. Never before has the science of what we do been more exciting and the opportunities to advance treatment greater. However, achieving those advances in ways that truly benefit our patients requires that we be nimble in our thinking, adaptable in learning new techniques and technologies, highly collaborative in our work, and rigorous in evaluating outcomes. “Lifelong learning,” “team science,” “team care,” and “quality care” have become overly popular bywords, but they are indeed now central to achieving clinically meaningful progress.

Challenges in health care

However, we also face many challenges. To paraphrase Charles Dickens, this is the best of times, but also the worst of times. Rapid changes in today’s health care environment are leaving some surgeons feeling overwhelmed and isolated. Recent studies report that burnout affects 30 to 50 percent of residents and practicing surgeons, with perhaps surgical residents and women being at greatest risk.1-4

While the factors responsible for this situation are not fully understood, increasing administrative and documentation demands, the loss of personal autonomy related to the corporatization of medicine, and long work hours and work-life imbalance are consistently cited as culprits. Added to this are national problems in health care delivery. While lower- and middle-income countries often struggle with a lack of resources and infrastructure, the U.S. has a highly resourced but also highly politicized and dysfunctional health care system with many disparities in the provision of care. It is easy to focus on the daily frustrations of our work environment while losing sight of the great opportunities to improve the care of our patients.

How can we best move forward under these challenging and often frustrating circumstances? As discussed in the August issue of the ACS Bulletin, collaboration with others and participation in efforts that address a common need or common good not only lead to more effective results, but also can be personally rewarding.5 For those of us who practice oncology, multidisciplinary collaboration is inherent in what we do every day. Increasingly, though, this is true of all surgical specialties. Today, such collaborations may reach across surgical specialties, reach across specialties outside of surgery, or reach across disciplines outside of medicine. As new ACS Fellows, many of you may look to various subspecialty societies as the primary source for education and a forum for scientific presentation in your area of interest. By contrast, the ACS provides a unique environment for the multidisciplinary collaboration that is needed to ensure the highest quality care for our patients.
ACS Quality Programs

The ACS has more than a century’s experience in establishing and running programs designed to ensure high-quality patient care (see Figure 1, page 19). These programs run the gamut from cancer to trauma to bariatric surgery to pediatric care, and then some. In the U.S., the ACS Commission on Cancer and the ACS Committee on Trauma ensure quality care at more than 1,500 cancer centers and across a nationwide network of all levels of trauma centers. The accreditation program for breast centers also now extends internationally.

Ample published data show that these quality and verification programs are successful in improving patient care. For instance, the development of standards for bariatric surgery and an ACS program of accreditation for bariatric programs directly led to a significant national decrease in operative mortality.

Each ACS program follows four principles of quality improvement: first, the establishment of evidence-based standards that can be individualized by patient; second, the assurance of optimal infrastructure; third, assessment through rigorous data extraction and analysis; and fourth, external peer-reviewed verification that creates public assurance.

As exemplified by the ACS National Surgical Quality Improvement Program or NSQIP®, the approach of containing health care costs by rigorously ensuring higher quality care is a concept understood by physicians and patients that also has proven to be a very persuasive approach in national discussions regarding health care reform. It also is a concept that is applicable both nationally and internationally.

No matter what your personal career focus, the ACS offers an extraordinary breadth and depth of activities. As illustrated by the expanding reach of ACS international chapters, it also is an organization with great international reach.

The educational reach of the ACS is perhaps best illustrated by the success of the Advanced Trauma Life Support® (ATLS®) course. Figure 2, this page, shows the many countries around the world where ATLS is now offered; this course is considered the foundation for teaching trauma care. The ACS is working to make many other of its superb educational products available internationally.

The ACS also is increasingly seeking to engage and support younger surgeons from around the world, especially from lower-resource environments. Each year, generous support from ACS Fellows enables many international surgeons to receive support for their academic work, to travel to the Clinical Congress, and to visit institutions here in North America (see Figure 3, page 21).

One of the ACS programs that speaks to the highest ideals of our profession is Operation Giving Back (OGB), which seeks to leverage the passion, skills, and humanitarian ethos of the surgical community.
to effectively meet the needs of the medically underserved, both domestically and internationall. While originally organized in 2004 to coordinate the efforts of interested volunteers, OGB has, in the past few years, developed a more formal program to develop sustainable partnerships to promote surgical education and quality in low-resource international environments. This past year, in collaboration with more than a dozen U.S. academic institutions with established expertise in global surgery, OGB inaugurated the first such partnership in sub-Saharan Africa, specifically at Hawassa University, Ethiopia. 6

None of the ACS activities that I have described would be possible without a veritable army of enthusiastic, talented, and very hard-working surgeon volunteers. They come from all surgical specialties and from all corners of the ACS membership. Their efforts benefit all of our patients. They exemplify the joys of learning, collaborating, and giving back. These may be the best of times and the worst of times, but on balance, I think that, together, we can make them the best of times. To those of you as new Fellows of the College, I invite you to join in the process. I predict that you will find it exciting and rewarding.

REFERENCES

The Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2020 Inpatient Prospective Payment System (IPPS) final rule August 2. The IPPS outlines coverage, reimbursement, and quality reporting criteria for Medicare Part A inpatient hospital claims. Because a large proportion of surgical care is provided in the inpatient setting, the provisions in this rule are likely to affect many surgeons.

The IPPS pays hospitals for services provided to Medicare beneficiaries using a national base payment rate, adjusted for a number of factors that affect hospital expenses, including the patient’s condition and the cost of clinical labor in the hospital’s geographic area. This rule establishes policies for Medicare payments to hospitals for inpatient stays occurring between October 1, 2019, and September 30, 2020. On June 24, the American College of Surgeons (ACS) submitted comments to CMS on the IPPS proposed rule released earlier in the year, which the agency took into consideration when drafting the final regulation. This article describes some of the policy changes that CMS finalized for FY 2020.

MS-DRG classifications
For hospital payment under the IPPS, CMS classifies a Medicare beneficiary’s inpatient stay into various Medicare Severity Diagnosis-Related Groups (MS-DRGs), which are used to calculate reimbursement rates for
inpatient claims based on the severity of the patient’s illness and the amount of hospital resources required to manage the patient’s condition. CMS updates MS-DRGs annually to reflect changes in treatment patterns, technology, and any other factors that may affect hospital resource consumption. Each year, the ACS evaluates the MS-DRG updates CMS proposes to ensure that these adjustments are representative of the nature of the underlying disease (that is, the principal diagnosis) and the resource use associated with the disease relative to other cases within the same MS-DRG.

For FY 2020, CMS reviewed instances in which International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) procedure codes 0TY00Z0 \((\text{Transplantation of right kidney, allogeneic, open approach})\) or 0TY10Z0 \((\text{Transplantation of left kidney, allogeneic, open approach})\) were reported with principal diagnoses of heart failure and chronic kidney disease. The agency noted that these cases were assigned to MS-DRGs describing procedures unrelated to the principal diagnoses and proposed to reassign these cases to MS-DRGs describing circulatory operating room (OR) procedures. This change, however, would result in lower reimbursement for transplant cases in which the patient presents with both heart failure and chronic kidney disease than for cases without serious comorbidities.

The ACS opposed CMS’ proposal, indicating that this reassignment would significantly reduce hospital reimbursement for kidney transplantation procedures reported with heart failure and chronic kidney disease as the principal diagnoses.

**TABLE 1. NEARLY DESIGNATED OR PROCEDURE FOR FY 2020**

<table>
<thead>
<tr>
<th>ICD-10 procedure code</th>
<th>Code descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>4L23DZ</td>
<td>Occlusion of gastric artery with intraluminal device, percutaneous approach</td>
</tr>
</tbody>
</table>

**TABLE 2. NEARLY DESIGNATED NON-OR PROCEDURES FOR FY 2020**

<table>
<thead>
<tr>
<th>ICD-10 procedure code</th>
<th>Code descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0W9J3ZX</td>
<td>Drainage of pelvic cavity, percutaneous approach, diagnostic</td>
</tr>
<tr>
<td>0FPG3OZ</td>
<td>Removal of drainage device from pancreas, percutaneous approach</td>
</tr>
</tbody>
</table>

**OR and non-OR procedure designations**

CMS conducts annual reviews of the designation of specific ICD-10 procedure codes as non-OR or OR procedures. Services assigned OR status are typically expected to require the resources available in an OR, such as sterile technique and anesthesia, whereas non-OR procedures generally can be performed in less resource-intensive settings. For FY 2020, CMS reclassified one ICD-10 procedure code describing the percutaneous occlusion of the gastric artery with an intraluminal device as an OR, rather than non-OR, procedure, indicating that the provision of this service often necessitates the specialized setting that an OR provides. The newly designated OR code is listed in Table 1, this page.

In addition, CMS reclassified two ICD-10 procedure codes describing percutaneous drainage of the pelvic cavity and the percutaneous removal of drainage devices from the pancreas as non-OR procedures, rather than OR procedures, for FY 2020, indicating that the provision of these services does not typically require the resources of an OR. These newly designated non-OR codes are listed in Table 2, this page.

**Payment for GME costs in CAHs**

In this IPPS final rule, CMS clarified the criteria hospitals must meet to receive reimbursement under the Medicare program to cover graduate medical education (GME) costs. Teaching hospitals’ full-time
equivalent (FTE) caps dictate the maximum number of residents for whom the hospital is eligible to collect Medicare payment for the GME costs associated with resident training. Under CMS policy, a hospital may include residents training in a “nonprovider” setting in its FTE count if the hospital incurs the residents’ salaries and fringe benefits while the residents are training at that site.

The agency noted in the FY 2020 IPPS proposed rule that it received questions about whether critical access hospitals (CAHs) are considered nonprovider sites for the purposes of GME payment, considering that CAHs are omitted from the definition of a hospital and that the term nonprovider is not explicitly defined in Medicare statute. In recognizing that its existing rules lack both a clear statutory description of a nonprovider site and a definitive determination as to whether a CAH is considered a hospital, the agency finalized its policy to allow hospitals to include FTE residents training at a CAH in its FTE count starting October 1, 2019. The ACS’ position is that it is important to support residency training in rural and underserved areas, including at CAHs, and the College stated its support of CMS’ decision to consider CAHs eligible nonprovider settings for GME payment.

Quality data reporting requirements
In the final rule, CMS takes steps to reduce reporting burden by further aligning measures across programs, thereby limiting the number of separate programs in which hospitals have to report in order to streamline workflows and reduce administrative burden. In its comments, the College supported the consolidation of measures but urged CMS to incorporate measures that are both meaningful and actionable to surgeons and important to patients. The final rule introduces several opioid-related measures, as well as requests for information (RFIs) on developing new opioid measures throughout the various quality programs. Additional RFIs are included on health information technology (HIT) and how to increase provider efficiency through advanced HIT.

Hospital Readmissions Reduction Program
The Hospital Readmission Reduction Program (HRRP) is a value-based purchasing program in which facilities are assessed based on their risk-adjusted readmission rate for six clinical domains during a three-year period. The program requires a reduction in a hospital’s base operating DRG to account for excess readmissions for the applicable conditions, including acute myocardial infarction, chronic obstructive pulmonary disease, heart failure, pneumonia, coronary artery bypass graft, and elective primary total hip arthroplasty and/or total knee arthroplasty. To comply with the 21st Century Cures Act requirement to stratify HRRP performance based on patient social risk factors, CMS implemented policies to compare a hospital’s performance on the six readmissions measures to other hospitals with a similar proportion of dual-eligible patients.

To prevent the misidentification of hospitals when assigning them peer groups, CMS finalized an updated definition of dual-eligible in the final rule. Another notable change adds two more data points to confidential hospital-specific reports, which are intended to provide meaningful comparisons and assessments of the quality of care hospitals provide to patients with social risk factors and help facilities identify gaps in care for this population group.

The ACS supported both policies and encouraged CMS to further study socioeconomic status factors that could play a role in higher health care spending or poorer patient outcomes. For the FY 2020 performance year, CMS did not propose or finalize any updates to the measures included in this program.

Hospital IQR Program measure set
The Hospital Inpatient Quality Reporting (IQR) Program is a pay-for-reporting program that requires hospitals to report specific quality measures to CMS. Successful participation is determined based only on
whether hospitals report the Hospital IQR measures and not on performance. The Hospital IQR primarily functions as a reporting mechanism for hospital quality performance on the Hospital Compare website, where the performance results are publicly available. Under the Hospital IQR Program, hospitals must meet the requirements for reporting specific quality measures to receive the full market basket update for that year.

The final rule finalizes the adoption of one opioid-related electronic clinical quality measure (eCQM) for the Hospital IQR Program beginning with the FY 2021 reporting period/FY 2023 payment determination. The adopted measure, Safe Use of Opioids—Concurrent Prescribing, assesses patients ages 18 and older who were prescribed two or more opioids or an opioid and benzodiazepine concurrently at discharge. The College supported the inclusion of this measure in the eCQM measure set in 2021 based on the exclusion of cancer patients, patients receiving palliative care, and patients with hospital-based encounters of 120 days or longer.

The ACS opposed the inclusion of another opioid-related eCQM, Hospital Harm—Opioid Related Adverse Events, which CMS chose not to finalize for the FY 2021 reporting period/FY 2023 payment determination. The measure focuses on patients who experience opioid-related adverse events during admission in an acute care setting. It uses the administration of Naloxone, an opioid-reversal agent, after 24 hours from hospital arrival or in the first 24 hours after hospital arrival with evidence of hospital-administered opioids to account for opioid-related adverse respiratory events. The College opposed the adoption of this measure because of concern that unintended consequences may arise if physicians interpret the measure as a deterrent to Naloxone administration. To address this concern, the ACS recommended that CMS add a measure that captures patient outcomes following Naloxone administration.

Hospital VBP Program
Under the Hospital Value-Based Purchasing (VBP) Program, CMS calculates incentive payments to hospitals based on their performance and improvement on specified measures. CMS did not propose any changes to the measures included in the Hospital VBP Program; therefore, for the 2020 reporting year, 12 measures remain in the Hospital VBP Program measure set. Because the Hospital VBP and Hospital IQR Programs assess performance in the calendar year (CY) two years before the payment year, performance in CY 2020 will be reflected in a hospital’s 2022 payment adjustment.

It is important to remember that as of the 2019 performance year, the Hospital VBP Program takes on greater significance because of the new “facility-based scoring option” under the Merit-Based Incentive Payment System (MIPS). Under this new scoring option, clinicians who meet CMS’ definition of “facility-based” may qualify to automatically receive a MIPS quality and cost score based on their facility’s Hospital VBP Program Total Performance Score. This new scoring mechanism was first applied to MIPS performance scores in 2019, which affects 2021 Medicare payments. CMS will initially rely on FY 2020 Hospital VBP Program scores, which were released in the fall. In the meantime, facility-based clinicians can access informational-only MIPS preview data based on FY 2019 Hospital VBP Program performance.

PCHQR Program
The PPS-exempt Cancer Hospital Quality Reporting (PCHQR) Program began in 2014 as a pay-for-reporting program for cancer hospitals. In the 2020 final rule, CMS finalized the removal of one measure and added a new measure to the PCHQR measure set for the FY 2022 program year. In 2016, CMS adopted the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey into the PCHQR Program measure set and...
began publicly reporting the measure. To align with the agency’s efforts to reduce adverse events and patient harm related to opioid misuse, CMS finalized the removal of three pain management questions in the HCAHPS survey used for the PCHQR Program. Similar questions were removed from HCAHPS in both the Hospital IQR and Hospital VBP Programs in previous years.

The College supported the removal of these questions until evidence emerges to inform their effect on the prevention of opioid misuse. The College highlighted that cancer patients may require unique pain management therapies, and, therefore, frequent communication between patients and their physicians is critical. To support continued communication and assist physicians in managing pain in these patient populations, the College urged CMS to rethink the HCAHPS surveys and move beyond an era of long retrospective surveys to one of patient-reported outcome (PRO) measures. The ACS envisions a process that distributes fewer questions more frequently to patients on easily accessible platforms (such as smartphones) to actively engage patients as they move through each phase of their health care journey.

CMS also finalized the adoption of a new measure in the PCHQR Program, Surgical Treatment of Complications for Localized Prostate Cancer. The measure aims to identify urinary incontinence and erectile dysfunction among patients undergoing localized prostate cancer surgery.

The ACS opposed the adoption of this measure and agreed with the Measure Application Partnership’s (MAP’s) recommendations to delay the use of this measure until it is revised and tested. The ACS also agreed with the MAP’s comments that this outcome could be measured best as a PRO that allows patients to identify their symptoms following the procedure. The ACS will continue to track the implementation and progress of this measure going forward.

**EHRs and interoperability**

CMS aims to reduce reporting burden by aligning measures across programs, thereby limiting the number of separate hospital reporting programs.

**PI Program**

The Promoting Interoperability (PI) Program is designed to encourage and reward the use of Certified Electronic Health Record Technology for data exchange and to increase patient engagement. The PI Program has four broad objectives, each containing a measure set: public health and clinical data exchange, electronic prescribing, health information exchange, and provider to patient exchange. For the CY 2020 PI Program, CMS continues to make adjustments to achieve the following goals: stabilize the program, align it with the PI category in the Quality Payment Program, continue to broadly advance interoperability, reduce administrative burden, and improve the accessibility of electronic health record (EHR) data to patients.

**Electronic Prescribing Objective**

The Electronic Prescribing Objective is the only objective that had finalized changes in the PI Program. The Electronic Prescribing Objective is meant to promote the use of writing and sending allowable prescriptions electronically. This objective contains three measures: e-prescribing, query of the Prescription Drug Monitoring Program (PDMP), and verify opioid treatment agreement. As part of the electronic prescribing objective for the PI Program in 2019, CMS included two opioid measures: query of the PDMP and verify opioid treatment agreement. Both measures were optional in 2019, and query of the PDMP was to be required in 2020. However, for 2020, CMS finalized the following changes:

- Query of PDMP measure: CMS is not requiring this measure for CY 2020. Instead, it will remain optional in CY 2020 and eligible for five bonus points.
The College advocated that positive incentives (not penalties) or simple attestations are productive ways to incentivize early adoption of technology.

- Verify opioid treatment agreement measure: CMS is removing this measure in CY 2020 because of feedback from stakeholders on the challenges with documentation that prevent adequate reporting on this measure.

  The ACS advocated for these changes because both measures are challenging to report and would require additional documentation and use of an additional external system outside of the EHR, creating increased surgeon administrative burden. The College further suggested that CMS delay creating and requiring any measures that involve PDMPs until PDMPs and EHRs are more integrated to avoid additional reporting burden on surgeons.

Proposed clinical quality measures for 2021
To align the PI Program with the Hospital IQR Program requirements, CMS adopted the Safe Use of Opioids–Concurrent Prescribing measure as part of the PI measure set beginning in CY 2021. For reasons outlined previously, the College supported this addition.

  The ACS opposed the inclusion of another opioid-related eCQM, Hospital Harm–Opioid Related Adverse Events, which CMS chose not to finalize for the FY 2021 reporting period. As discussed previously, the College opposed the inclusion of this measure. Based on the ACS’ and other stakeholders’ feedback, CMS will not include this measure in the PI measure set.

Requests for information
CMS included multiple RFIs within the IPPS proposed rule to collect feedback on ways to encourage the adoption of advanced HIT and updated standards for data exchange, without increasing physician burden. The ACS encouraged CMS to work with other regulatory bodies, such as the Office of the National Coordinator (ONC), to ensure that technology standards are consistent across programs in order to reduce regulatory burden and better allow for information exchange across technology platforms and vendors. The College also recommended that government agencies work together to update patient privacy protections, particularly because standards for data exchange will increase the flow and reach of health information in order to improve patient matching, create a more complete and accurate health record, and better protect surgical patient information.

  The College advocated that positive incentives (not penalties) or simple attestations are productive ways to incentivize early adoption of technology. This will give hospitals and practices time to test and choose technologies that are most appropriate for their workflows in order to improve quality of care and reduce administrative burden. Examples of surgery-specific technological enhancements that could be incentivized include surgical risk calculation within EHRs, electronic workflow integration of the Enhanced Recovery After Surgery protocols, telehealth, and other digital care service options, such as making the prior authorization process electronic. The ACS will continue to monitor CMS’ activity, and will remain actively engaged in advancing HIT and eager to work in partnership with CMS and the ONC. ♦
Surgeons across the U.S. are facing setbacks in providing services to patients because of stringent prior authorization processes both private insurance companies and the Centers for Medicare & Medicaid Services (CMS) contractors that administer Medicare Advantage health plans have implemented.

Participants in a recent American College of Surgeons (ACS) questionnaire ranked prior authorization as the top administrative burden for surgical practices in 2019. Although utilization review requirements, such as prior authorization, can sometimes play a role in ensuring that patients receive clinically appropriate treatment while controlling costs, many of these requirements are applied to services performed in accordance with a routine, evidence-based plan of care for a given health care condition. Over the past two years, the number of prior authorizations required nationally is estimated to have increased by 27 percent, growing from 143 million in 2016 to 182 million in 2018, according to the Council for Affordable Quality Healthcare Index. This cost-control mechanism, which physicians describe as having a negative impact on clinical outcomes and an interference to continuity of care, is increasingly being used by payors as an extra and unnecessary step to obtain coverage and reimbursement for common services that almost always are approved in the end. Even if a physician completes the prior authorization process and obtains preapproval for a portion or the entirety

ACS acts to address burdensome, inappropriate use of

by Lauren M. Foe, MPH, and Carrie Zlatos

HIGHLIGHTS
- Outlines the College’s recommendations for relieving the administrative burdens associated with prior authorization
- Summarizes the flaws of nondigital prior authorization processes
- Describes how surgeons can get involved in ACS advocacy efforts related to prior authorization
of the treatment plan, insurers may later deny or retrospectively collect payment for previously authorized services.

As insurers continue to subject a growing number of services to prior authorization, many medical and surgical practices can no longer absorb the costs of complying with these increasingly time-consuming requirements, forcing surgeons and practices to end their contractual relationships with insurers as participants in various health plan networks. When surgeons become out-of-network providers, their patients must either seek care elsewhere or pay out of pocket to continue their course of care, both of which inappropriately delay care at the expense of patients’ health and financial resources.

The College’s perspective is that the federal government needs to intervene quickly to decrease the overwhelming administrative burden of prior authorization requirements and to maintain timely patient access to a range of health care services. The ACS Division of Advocacy and Health Policy (DAHP) has worked to position the College at the forefront of the regulatory relief movement and has developed a number of recommendations described in this article to ease the extraordinary administrative burden of prior authorization and allow surgeons to reinvest their time in what matters most to them—their patients.

Digitizing prior authorization processes

While many aspects of the clinical workflow have become automated, prior authorization remains a manual, paper-based task for many physicians. The number and cost of resources that practices devote to prior authorization are attributable to the lack of automated, standardized processes that integrate with electronic health records (EHRs) and other practice management systems. To facilitate uniformity, the ACS recommends that insurers adopt a standard electronic transaction that physicians and facilities can use to ask insurers to review proposed services and obtain authorization for those services. The College also urges insurers to make all prior authorization requirements available online or in EHRs at the point of care to provide physicians with the real-time coverage information they need when making treatment decisions.

In its March 1 comment letter to CMS on methodological changes to 2020 Medicare Advantage and Part D payment policies, the ACS commended the agency’s efforts to prompt all payors, including Medicare Advantage plans, to align their prior authorization processes with recommendations made under the Da Vinci Project—an industry-led initiative to identify and implement care delivery use cases for the exchange of information between health plans and providers.3

CMS noted in the draft call letter that, in support of the Da Vinci Project, it began developing a prototype Medicare Fee-for-Service (FFS) Documentation Requirement Lookup Service (DRLS), which would digitally use the information physicians insert into their EHRs for a specific Medicare FFS beneficiary to determine what, if any, documentation or prior authorization requirements might affect clinical decision making or coverage for that patient. If the DRLS identifies any such requirements, it would automatically respond to the physician through the EHR with the appropriate documentation or prior authorization policies, as well as any related templates the physician should complete and provide to CMS in a claims submission. The agency recommended that payors develop a similar lookup service and populate the tool with their documentation rules and list of items and services that require prior authorization.

The College supported CMS’ message to payors in the draft call letter and agreed that patient and payor data should be leveraged in EHRs to notify physicians of prior authorization and other documentation requirements when a service is ordered. The ACS letter further states that any such integrated solutions should automate prior authorization decisions for routine therapies and prepopulate forms for cases requiring further review. The use of information already stored in EHRs to complete such processes could streamline
payor-provider communication, improve the accuracy and efficiency of these administrative tasks, and reduce interruptions in the provision of care.  

**Addressing nondigital prior authorization process flaws in the Medicare Advantage program**  
In addition to enhancing the interoperability of prior authorization, the ACS has asked CMS to correct the numerous nondigital process flaws associated with this process. We recommend that these issues be addressed through the following actions.  

**Selective application of prior authorization**  
CMS should require Medicare Advantage plans to limit the scope of prior authorization requirements to physician practices that stray from evidence-based medicine or suggest a pattern of overutilization after adjusting for patient population. Prior authorization should not be applied to services that are typical for a specific condition, are part of an ongoing therapy regimen, exhibit low variation in utilization or denial rates, or have been approved previously as part of a patient’s care plan.  

**Elimination of trivial barriers to payment**  
Payment for services for which prior authorization was granted should not be denied or rescinded based on billing technicalities. For example, reimbursement should not be withheld when the service performed is clinically comparable to an approved service but is more properly reported using a different Current Procedural Terminology code, when a procedure’s necessity was unanticipated, or the procedure is performed incident to or in the course of an approved operation.  

**Data collection**  
Reasonable resolution of physician and patient grievances with respect to prior authorization requires comprehensive and specific information regarding Medicare Advantage plans’ processes and outcomes. Therefore, CMS should require Medicare Advantage plans to report on the extent to which they use prior authorization and their approval and denial rate by service. This documentation should include the following data as one component of Medicare Advantage’s annual reports to CMS: information about the specific procedures subject to prior authorization, the proportion of each service approved, and the time lapsed from submission until a determination is issued.  

**Guidance to Medicare Advantage organizations**  
CMS should issue guidance requiring these plans to follow the set of prior authorization principles endorsed in January 2018 by associations representing managed care plans, including America’s Health Insurance Plans and Blue Cross Blue Shield Association. Such principles, described in the Consensus Statement on Improving the Prior Authorization Process, identified areas that “offer opportunities for improvement in prior authorization programs and processes that, once implemented, can achieve meaningful reform.” These policies include, among others, an annual review of services subject to prior authorization and the removal of services from these lists for which prior authorization is unnecessary; protections for continuity of care for patients on appropriate, stable therapy; and the industry-wide adoption of automated processes.  

**College takes action on Capitol Hill**  
As part of this year’s Leadership & Advocacy Summit, the ACS convened a panel on the issues associated with prior authorization. Panelists discussed the burdens that physicians are facing, the Capitol Hill perspective, and what insurers are doing to address these issues. To follow up on the concerns addressed in the panel discussion, nearly 300 summit attendees went to Capitol Hill to explain why Congress needs to address the inappropriate application of prior authorization by Medicare Advantage plans. These efforts, in conjunction with supplemental grassroots activities—including a legislative call to action via the American College of Surgeons Professional
Association SurgeonsVoice and additional opportunities for surgeon advocates to educate their members of Congress at home—led to the introduction of legislation to bring transparency to Medicare Advantage use of prior authorization requirements.

The ACS has joined with the Regulatory Relief Coalition, a collective of specialty physician organizations, to work with key members of Congress to develop bipartisan solutions that would improve the transparency and efficiency of the prior authorization process in the Medicare Advantage program.

As part of this collaboration, the ACS participated in an effort last year to gain support for a congressional sign-on letter to CMS, requesting that the agency provide guidance to Medicare Advantage plans on the use of prior authorization. More than 100 members of the U.S. Congress signed on to this ACS-supported bipartisan letter, demonstrating that members of Congress are concerned that overuse of prior authorization could result in significant barriers to timely, medically appropriate care. In addition, through the Regulatory Relief Coalition, the ACS has contributed to the development of legislation to address improper Medicare Advantage plan application of prior authorization.

**Congress responds with legislation**

In June, Reps. Suzan DelBene (D-WA); Mike Kelly (R-PA); Roger Marshall, MD (R-KS); and Ami Bera, MD (D-CA), introduced the Improving Seniors’ Timely Access to Care Act, H.R. 3107. This ACS-supported legislation is modeled on the Consensus Statement on Improving the Prior Authorization Process and is a critical step toward improving the transparency and efficiency of the prior authorization process in the Medicare Advantage program.

H.R. 3107 would require CMS to regulate the Medicare Advantage plan’s use of prior authorization. The ACS is particularly appreciative of a provision in the bill that would prohibit these plans from requiring prior authorization for any surgical or other invasive procedure if the procedure is furnished during the course of a procedure that already was approved or did not require prior authorization.

Whereas the legislation includes some beneficiary protection standards to ensure continuity of care, the ACS anticipates that this bill will serve as a stepping stone for further patient protections and standardization of prior authorization requirements and processes. Because of the lack of standardized Medicare Advantage plan prior authorization processes, the ACS anticipates that the inclusion of electronic transmission and transaction standards are a step in the right direction. The College is optimistic that the inclusion of these electronic standards will help to facilitate real-time decisions for those services that are routinely approved.

In addition, H.R. 3107 will bring greater transparency by requiring Medicare Advantage plans to report to CMS on the extent of their prior authorization use and the rate of approvals or denials by service and/or prescription medication—thus helping to reduce unnecessary requests and to ensure patient access to timely and medically necessary care.

The ACS continues its efforts to build bipartisan support for this legislation and to advocate for its consideration in the House Committee on Ways and Means.

**How can surgeons get involved?**

Meeting with lawmakers and demonstrating strength in numbers both in Washington, DC, and at in-district meetings are effective ways to raise awareness about important health care policy priorities. Senators and representatives return to their home states and districts during congressional work periods, and in-district meetings are an opportunity to educate and assist legislators to gauge what issues are of importance to constituents, particularly surgeons and surgical patients. Through the 2019 Advocate at Home Program (facs.org/advocacy/surgeonsvoice/at-home), DAHP staff facilitated in-district meetings for a number of surgeon advocates. While participants
discussed several advocacy issues (facs.org/advocacy) during these meetings, surgeons highlighted that H.R. 3107 was a priority.

The College has several other federal legislative priorities (facs.org/advocacy/federal) that have the potential to be considered during the 116th Congress. Surgeons can visit the SurgeonsVoice Advocacy Center (facs.quorum.us/action_center/) to learn more and to identify issues that are important to them and advocate on their profession’s behalf by sending prewritten letters to their members of Congress.

The ACS DAHP encourages surgeons to tell us about their own experiences with prior authorization and its impact on surgical patient care. Feedback from Fellows is essential to the College’s efforts to identify and advocate for the elimination of burdensome requirements through the ACS Stop Overregulating My OR (SOMO) initiative, through which the ACS collaborates with federal agencies and congressional leaders to address policies that are overwhelming surgeons across the country. To share your administrative burden story, contact Lauren Foe, Senior Regulatory Associate, at lfoe@facs.org. Visit the SOMO website (facs.org/somo) to learn more about the College’s regulatory relief successes and advocacy efforts. ♦

REFERENCES
In 2019, the American College of Surgeons (ACS) State Affairs team in the Division of Advocacy and Health Policy led a proactive state advocacy program that resulted in the introduction and passage of Stop the Bleed® legislation and legislation addressing surprise billing for out-of-network services, both of which were discussed in recent issues of the Bulletin. In addition, state lawmakers have been receptive to adopting legislation that is aligned with the College’s policies in the areas of cancer coverage, trauma prevention, and access to bariatric surgery as a result of the ACS Chapter Lobby Day grant program and state member grassroots advocacy.

Using state legislative tracking services, the ACS monitored more than 1,800 bills across all 50 states during state legislative sessions between January and June. State Affairs initiated 21 calls to action for Fellows and other ACS members to communicate with their state legislators, resulting in more than 13,000 e-mails that were sent to 406 state representatives and senators. Working with ACS state chapters, Action Alerts were sent to support passage of the following state-level bills:

- **Connecticut’s** universal helmet law (H.B. 7140) legislation mandating that all health insurers in the state offer coverage for coverage of bariatric and metabolic surgery (S.B. 317), and a law that protects funding for trauma care
- **Indiana, Tennessee, and Texas** legislation (H.B. 1063, H.B. 215 and S.B. 259, and H.B. 496, respectively) that calls for providing Stop the Bleed training and bleeding control kits in public schools
- **Louisiana** legislation (H.B. 380) that increases trauma funding in the state
- **Louisiana** (S.B. 76) and **New York** (A. 6163 and S. 4346) bills implementing automobile passenger safety standards

Conversely, Action Alerts were sent calling for chapters and ACS members to oppose the following:

- Legislation on Maintenance of Certification (MOC) in **Indiana** (S.B. 203) and **Michigan** (H.B. 4135)
- Surprise billing legislation in **Georgia** (H.B. 84 and S.B. 56)
- Repeal of the universal motorcycle helmet laws in **North Carolina** (H.B. 276) and **Missouri** (S.B. 147)
- **Legislation in Pennsylvania** to grant independent practice for certified registered nurse practitioners (S.B. 25)
- A provider tax on ambulatory surgery centers outlined in **Pennsylvania** Gov. Tom Wolf’s (D) budget proposal

Surgeons also engaged in face-to-face meetings with their state lawmakers during chapter lobby days. In
Using state legislative tracking services, the ACS monitored more than 1,800 bills across all 50 states during state legislative sessions between January and June.

2019, ACS chapters in 27 states received grants as part of the ACS Chapter Lobby Day Grant Program. For a complete summary of ACS Chapter Lobby Day activities, read the Bulletin article “2019 State Lobby Days: Advocating for patient care in state capitols” in the October issue.* As noted in this Bulletin article, ACS Chapter Lobby Days are important, if not vital, components of efforts to pass or defeat legislation at the state level. One chapter in particular, the Georgia Society of the ACS, remains a lobbying rock star when it comes to supporting chapter leadership for advocacy, a comprehensive legislative strategy to effectively implement a grassroots advocacy agenda and employs a long-term lobbyist who provides guidance and expertise in legislative advocacy.

The Georgia Society was inadvertently left out of the Bulletin article wrapping up lobby day activity in 2019, but it should be noted that the Society’s February 13 lobby day exceeded expectations for attendance, with more than 100 surgeons and others engaged with state legislators. During the lobby day, attendees “worked the rope line,” where constituents were able to request that their legislator leave the Senate or House chamber and come out into the hallway to talk about a specific bill or issue. During this lobby day, surgeons were able to discuss continued budget support for the Georgia Trauma Commission and the reinstatement of bariatric surgery coverage for the state health benefits plan.

In addition, society members thanked legislators for their support last year of the hands-free Georgia legislation that bans the use of any cellular device while driving and reminded lawmakers that their passage of the distracted driving legislation had a direct impact on reducing the number of lives lost on Georgia highways. To top it off, information and training tables were set up in the capitol to provide additional opportunities to discuss issues with legislators and their staff, as well as to provide Stop the Bleed training and remind legislators of the importance of their continued support for bleeding control kits in public schools—legislation that was passed in the state several years ago.

In addition to grassroots advocacy, the ACS directly sent letters or coordinated with state chapters 15 letter-writing campaigns stating the College’s policy positions and official Statements approved by the ACS Board of Regents. These letters also supported ACS Fellows testifying before state legislative committees regarding Stop the Bleed legislation in Tennessee and Texas and opposing independent practice for advanced practice registered nurses in Indiana.

Advancing a proactive legislative agenda
The College continuously monitors and supports a range of health care and safety issues in the states, but two ACS priorities dominated the 2019 state advocacy agenda: bringing Stop the Bleed training and bleeding control kits to public places and expanding insurance coverage for bariatric surgery.

Stop the Bleed legislation was introduced in California (A.B. 1705) and Massachusetts (H. 870 and S. 1337). Legislation to require installation of bleeding control kits and Stop the Bleed training of school personnel was introduced in Illinois (H.B. 3432), Michigan (H.B. 4334), Missouri (H.B. 1005 and H.B. 249), New York (A. 4484), North Carolina (H.B. 288), Pennsylvania (H.B. 1072), and Tennessee (S.B. 259 and H.B. 215).

ACS-sponsored Stop the Bleed legislation was enacted in Indiana (H.B. 1063) and Texas (H.B. 496), and Arkansas passed legislation (H.B. 1014) that makes participation in Stop the Bleed training a requirement for high school graduation. Both the Indiana and Texas Chapters led advocacy campaigns to push enactment of their respective bills, including using their lobby days to educate lawmakers on the importance of the legislation to garner support and initiating grassroots as mentioned above, as well as working with other organizations to achieve legislative success. For a

detailed description of the advocacy effort in Texas, read the Bulletin article, “Stopping the bleed in Texas: The importance of surgeons and health care professionals as advocates,” in the November issue.†

The Kansas and Connecticut Chapters led efforts to enact legislation in their states to expand essential health insurance benefits to include coverage for bariatric surgery. The Connecticut Chapter used an advocacy strategy that included submitting testimony to legislative committees, and initiating grassroots Action Alerts and lobby day meetings with key legislators in support of their bariatric coverage legislation (S.B. 317). The Kansas Chapter met with House Majority Leader Dan Hawkins (R) and Insurance Commissioner Vicki Schmidt to discuss the potential need for state legislation to expand coverage and attempted to negotiate with the state’s leading insurance providers; however, other pressing issues in Kansas distracted attention from the effort.

The Louisiana Chapter added its support for legislation (S.R. 35) calling for the state to study the effects of expanding bariatric coverage at a meeting with the sponsor, Sen. Gerald Boudreaux (D), and other legislators during the chapter’s lobby day event. The chapter plans to continue to focus its advocacy efforts in 2020 on expanding access to bariatric surgery.

Billing for out-of-network services
In 2019, out-of-network surprise medical bills became a pervasive public policy topic in the states, as well as the U.S. Congress, with 28 states introducing various proposals to address the issue: California, Colorado, Connecticut, Georgia, Hawaii, Kentucky, Louisiana, Massachusetts, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, and West Virginia.

The College has been engaged in billing for out-of-network services at the state level over the past several years and was able to use that experience to influence some of the legislation that passed in Colorado, Nevada, Texas, and Washington. The College worked with the Texas Medical Association to secure the inclusion of amendments in legislation (S.B. 1264) to protect surgeons and ensure that the law did not impede patients’ ability to choose their preferred physician for surgery. The Georgia Society of the ACS employed grassroots Action Alerts and direct lobbying to defeat insurance industry-supported legislation (H.B. 84 and S.B. 56). A detailed summary of those bills that were enacted can be found in the Bulletin article, “State legislatures consider surprise billing legislation in 2019,” in the November issue.‡

MOC
Preventing government intrusion on physician MOC requirements continued to be a priority for the ACS in 2019. MOC refers to the process that surgical and medical specialty boards use to verify that the physicians with whom they have engaged in lifelong learning through Continuing Medical Education activities, self-assessment, and quality improvement and have adhered to professional standards of practice. The ACS maintains the position that board certification and continuous certification are necessary to affirm that surgeons have the education, training, and competencies needed to provide quality care. This verification process is integral to ensuring that health care professionals have the rare privilege of self-regulation. Legislation restricting the use of MOC was introduced

Legislation that would expand the scope of practice for nonphysician health care providers to include the practice of medicine and perform surgical procedures continues to be a significant focus of the College’s State Affairs team.

The College initiated grassroots Action Alerts and sent policy letters to lawmakers opposing the bills. Members of the Indiana and Virginia Chapters testified or officially recorded their opposition to the legislation (Indiana S.B. 203 and Virginia H.B. 1967) during committee hearings. In Texas, Fellows spoke with legislators about the College’s opposition to legislation (S.B. 1882) that would further government involvement in MOC during their lobby day in Austin on April 11. Those efforts resulted in successfully preventing the passage of the bills. However, legislation did pass in Arkansas (S.B. 339) and North Dakota (H.B. 1433) that restricts the use of MOC as a requirement for hospital employment and admitting privileges, as well as reimbursement.

**Scope of practice**

Legislation that would expand the scope of practice for nonphysician health care providers to include the practice of medicine and perform surgical procedures continues to be a significant focus of the College’s State Affairs team. The College and ACS chapters weighed in via letters, Action Alerts, and testimonies opposing state legislation that would allow optometrists to perform surgical procedures, and advanced practice registered nurses (APRNs) and certified nurse anesthetists to practice independently—all without additional training or educational requirements.

The ACS took action to oppose legislation that would permit optometrists to perform certain procedures, including laser surgery in Arkansas (H.B. 1251), Maryland (S.B. 447), and Nebraska (L.B. 528), and sent an Action Alert on the bill in Maryland. The bills in Maryland and Nebraska failed, whereas the Arkansas legislation was enacted despite an ACS Action Alert targeting Gov. Asa Hutchinson (R), which urged him to veto the bill.

In addition, the College opposed attempts by advanced practice nurse practitioners and certified nurse anesthetists to gain independent practice, sending letters of opposition in Alabama (S.B. 156), Arkansas (S.B. 184), Illinois (H.B. 2813), and Pennsylvania (S.B. 25). The College initiated an Action Alert to oppose the Indiana Senate bill that would allow APRNs to practice independently in the state (S.B. 394), and the Indiana Chapter testified in opposition to the House companion legislation (H.B. 1097). Both bills failed to advance.

In August, the ACS joined in grassroots advocacy efforts with other national specialty societies and sent a letter to Mississippi Gov. Phil Bryant (R) urging him to not “opt out” from the physician supervision requirement of nurse anesthetists. The governor had been seeking input from the Mississippi boards of nursing and medicine, as well as from the medical profession. As a result of these collaborative advocacy efforts, Governor Bryant decided to maintain existing policies in Mississippi.

**Get engaged**

ACS Fellow engagement is critical to ensure that surgeons continue to be leaders in patient safety and health care quality. Fellows are encouraged to support ACS advocacy efforts by participating in state chapter meetings and lobby days, building relationships with elected state officials (critical to effective grassroots advocacy), speaking about public policy issues with colleagues, responding to grassroots Action Alerts from the College, and attending the annual ACS Leadership & Advocacy Summit.

The ACS State Affairs team is always available to answer questions and provide background information regarding state issues and policy programs. Numerous state advocacy resources are available on the College’s website at facs.org/advocacy/state, and Fellows may contact staff at state_affairs@facs.org or at 202-337-2701.

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**in Arkansas, Connecticut, Indiana, Massachusetts, Minnesota, North Dakota, New Jersey, New York, Rhode Island, Texas, Utah, and Virginia.**

The College initiated grassroots Action Alerts and sent policy letters to lawmakers opposing the bills. Members of the Indiana and Virginia Chapters testified or officially recorded their opposition to the legislation (Indiana S.B. 203 and Virginia H.B. 1967) during committee hearings. In Texas, Fellows spoke with legislators about the College’s opposition to legislation (S.B. 1882) that would further government involvement in MOC during their lobby day in Austin on April 11. Those efforts resulted in successfully preventing the passage of the bills. However, legislation did pass in Arkansas (S.B. 339) and North Dakota (H.B. 1433) that restricts the use of MOC as a requirement for hospital employment and admitting privileges, as well as reimbursement.
Executive Director’s annual report

by David B. Hoyt, MD, FACS
This year has been an exciting one for the American College of Surgeons (ACS). The staff and volunteers have developed and implemented several new programs that will allow the Fellows and other members of the organization to improve and safeguard surgical patient care. The following summarizes those innovations. This account is presented as I near the end of my 10th year as Executive Director of the College.

Advocacy and Health Policy
The ACS Health Policy and Advocacy Group identified more than 40 issues that the College’s Division of Advocacy and Health Policy should address. Top-ranking issues are as follows:

- Administrative burdens and regulations, including prior authorization
- Payment reform, including adding value-based payment
- Electronic health records (EHRs), including interoperability
- Evaluation and management (E/M) documentation guidelines
- Out-of-network care, including surprise billing
- Firearm safety
- Joint contract negotiations
- Opioids
- Pediatric
- Scope of practice
- Trauma advocacy
- Workforce issues

ACS THRIVE
A key way that we are making headway on several of these issues is through ACS THRIVE (Transforming Health Care Resources to Increase Value and Efficiency). THRIVE developed through a collaboration of the ACS and the Harvard School of Business (HBS) Institute for Strategy and Competitiveness. This partnership started in January when Frank G. Opelka, MD, FACS, ACS Director, Quality and Health Policy; Clifford Y. Ko, MD, MS, MSHS, FACS, Director, ACS Division of Research and Optimal Patient Care (DROPC); and I participated in an HBS course.

THRIVE ties together the ACS Quality Programs’ proven track record of producing better outcomes at lower costs with economic principles that the HBS espouses for creating a value-based health care system. Key components of this system include development of integrated practice units, composed of all health care professionals and facilities involved in every stage of surgical patient care—from diagnosis to postdischarge care; use of time-driven, activity-based costing; and bundled payment. Congressional staff and officials at the Centers for Medicare & Medicaid Services (CMS) have continued to express interest in ACS THRIVE as a means of transforming the U.S. health care system.

Regulatory issues affecting payment
On July 29, CMS released the calendar year (CY) 2020 Medicare Physician Fee Schedule (MPFS) proposed rule. This annual rule updates payment policies, payment rates, and quality provisions for services furnished under the MPFS on or after January 1, 2020. CMS estimates a 0 percent impact on total allowed charges for general surgery services relative to its proposals for CY 2020. The final rule was released November 4 and will be described in detail in the January 2020 issue of the Bulletin.

The proposed rule introduces changes related to office/outpatient E/M visits that take effect in 2021. CMS proposes to align Medicare’s office/outpatient E/M coding with changes laid out by the Current Procedural Terminology Editorial Panel for office/
outpatient E/M visits, specifically: retain five levels of coding for established patients and reduce the number of levels to four for new patients; eliminate history and physical as elements for E/M code selection and allow clinicians to choose the E/M visit level based on either medical decision making or time; and create add-on codes for prolonged services and for primary care/nonprocedural specialty care. CMS also proposes to increase the values for most office/outpatient E/M codes based on recommendations from the American Medical Association/Specialty Society Relative Value Scale Update Committee, but these increases will not apply to global surgery codes.

The final rule retains the proposals regarding E/M codes.

The CMS issued the fiscal year (FY) 2020 Inpatient Prospective Payment System (IPPS) final rule August 2. The IPPS outlines coverage, reimbursement, and quality reporting criteria for Medicare Part A inpatient hospital claims. Because a large proportion of surgical care is provided in the inpatient setting, the provisions in this rule are likely to affect many surgeons. For details, see the article on page 22 in this issue of the Bulletin.

Federal legislation
The ACS testified before two congressional committees this year on firearm injury prevention and the Senate Finance Committee on Medicare payment reform. The College also provided extensive comments on the surprise billing issue and actively educated members of Congress and their staffs on this important issue. Furthermore, the College led the effort to achieve passage of the Pandemic and All-Hazards Preparedness and Advancing Innovation (PAHPAI) Act of 2019, which includes Mission Zero language.

State affairs
ACS chapters in 27 states received State Lobby Day grants this year. The financial grants can be as much as $5,000, with a $2,500 match, along with ACS State Affairs staff support for the event. Details about this program were published in the October issue of the Bulletin and can be accessed at bulletin.facs.org/2019/10/2019-state-lobby-days-advocating-for-patient-care-in-state-capitols/.

Private practice
College leaders met with the ACS Private Practice Workgroup in July to discuss the challenges of maintaining this time-honored way of delivering care. We released ACS Resources for the Practicing Surgeon, Volume II: The Private Practice Surgeon at Clinical Congress 2019. This new primer provides an overview of various private practice business arrangements, financial management and revenue cycle processes, relevant health care laws and rules, and mechanisms to ensure the ongoing prosperity of private practice.

ACSPA-SurgeonsPAC
The staff and surgeon contributors to the ACS Professional Association Political Action Committee (ACSPA-SurgeonsPAC) attended more than 150 fundraisers and meet and greets for members of Congress in 2019.

Education
The ACS continues to steer the national strategic direction in surgical education, training, validation, credentialing, and accreditation.

Education and training for practicing surgeons
The ACS Academy of Master Surgeon Educators launched in 2017. Initial Members and Associate Members were inducted in October 2018. The Members and Associate Members submitted suggestions regarding initiatives the Academy should pursue. Steps are being taken to pursue the top two priorities for 2019–2020. The second class of Members and Associate Members and new Affiliate Members were inducted October 4, 2019.

The ACS Certificate Program in Applied Surgical Education Leadership (CASEL) launched in
The one-day, annual course, Surgical Education: Principles and Practice, is offered at the Clinical Congress. Plans are under way for regional dissemination of this course, and an online Faculty Development Program on the Fundamentals of Assessment is in development.

A new Comprehensive Faculty Development Program will address national needs through a complete portfolio of courses and programs anchored to the four levels of professional accomplishment of surgeon educators—Teacher, Master Teacher, Educator, and Master Educator.

Activities directed at senior surgeons include the following:

• Introduction to simulation-based teaching helps senior surgeons acquire teaching skills in simulation-based education and training.

• A new program for senior surgeons interested in coaching mid-career and junior surgeons is in development.

• Courses on effective teaching, assessment, and evaluation are being designed using the Surgical Education: Principles and Practice Course model.

The 15th anniversary of the Surgeons as Leaders: From Operating Room to Boardroom Course was celebrated at the 2019 course in April.

Surgical training
The Fourth Annual ACS Summit on Surgical Training convened in May and focused on Competency-based Surgical Education and Training. A panel addressed this topic from the perspectives of the ACS, American Board of Surgery (ABS), Association of Program Directors in Surgery (APDS), and Resident and Associate Society of the ACS (RAS-ACS).

The Future of General Surgery Training Collaborative includes leaders from the ACS, ABS, APDS, Accreditation Council for Graduate Medical Education, Residency Review Council for Surgery, and American Surgical Association. The collaborative is focusing on resident selection, end-product of training, resident attrition, and other issues.

We have initiated a project to develop an Optimal Resource Guide for Surgical Training to define the essential resources needed for modern surgical training.

Simulation-based education
The flagship simulation-based education and training program is the ACS-Accredited Education Institutes (ACS-AEIs). In total, 98 institutions have ACS accreditation, and 16 ACS-AEI Simulation Fellowship Programs have been established. The 2019 Annual ACS Surgical Simulation Summit (12th Annual Meeting of the Consortium of ACS-AEIs) took place in March.

A Joint Program with Engineers took place prior to the 2019 Surgical Simulation Summit. Key individuals from the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Defense (DoD), and National Institutes of Health (NIH) participated and provided information on funding opportunities.

The ACS was awarded a DoD subcontract to design and conduct validation for the Advanced Modular Manikin Project of the University of Washington, Seattle, and the University of Minnesota, Minneapolis. Three ACS-AEIs have been selected to participate in this project.

The ACS Fundamentals of Surgery Curriculum® was awarded a patent by the U.S. Patent and Trademark Office. A total of 109 peer-reviewed case scenarios are available in 14 content areas, and advanced cases are in development.

The ACS Entering Resident Readiness Assessment is an online program in which case simulation is used to assess the clinical decision-making skills of entering surgery residents. Advanced cases will be developed over the next year.
Premier programming

The ACS Clinical Congress remains the premier annual surgical meeting, offering a range of educational opportunities to surgeons, residents, medical students, and members of surgical teams. All Skills Courses offered at the Clinical Congress involve verification using the ACS Division of Education’s Five-Level Verification Model. Clinical Congress 2019 offered Continuing Medical Education (CME) and Self-Assessment Credits for most sessions, and Certificates of Verification were provided for Postgraduate Courses.

Now in its 47th year, the Surgical Education and Self-Assessment Program (SESAP®) remains the premier self-assessment and guided cognitive skills education program for practicing surgeons. SESAP 17 was released at Clinical Congress 2019. New features have been added to increase its impact, and a specialty-focused program, Advanced SESAP 17, will be released in 2020.

Recent innovations

Cosponsored by the ACS and ABS, the Alternate Pathway includes individualized study plans with in-person coaching for surgeons who have either not taken board examinations and have run out of eligibility or repeatedly have failed the exams. To date, the pass rate for participants in the program is twice that of nonparticipants.

A three-day course, ACS Core General Surgery Review for Residents, has been developed, which should benefit individuals preparing for the General Surgery Qualifying Examination or transitioning to general surgery practice. The inaugural course took place in July.

A multidisciplinary panel is developing Optimizing Perioperative Pain Management: An Evidence-based Approach.

E-learning programs

The third edition of Ultrasound Essentials for Surgeons, released in May, includes several updates and enhancements. A companion course for residents, Ultrasound Essentials for Residents, has been developed.

The Bariatric Surgery volume of the Multimedia Atlas was released this spring. The atlas contains videos, medical illustrations, didactic presentations, and expert commentaries.

Resident and medical student education

The simulation-based ACS Surgery Resident Objective Structured Clinical Examination program includes 10 integrated stations on patient safety and is aimed at entering surgery residents.

The ACS/APDS Surgery Resident Skills Curriculum is a proficiency-based skills curriculum designed to address the needs of surgery residents. Efforts are under way to replace resource-intense models with simulators.

At Clinical Congress 2019, the Division of Education again partnered with the Division of Member Services and the RAS-ACS to offer an integrated two-day program focused on Essential Skills for Surgery Residents.

Clinical Congress 2018 and 2019 included a session, Pathways in Surgical Education for Residents and Medical Students. Developed as a collaborative venture between the ACS and ASE, the one-hour session provided an informal forum for residents and medical students to learn about opportunities in surgical education.

Surgical Patient Education Program

A focus of the Surgical Patient Education Program over the last year has been on surgical opioid-sparing pain control. The program has grant support and includes resources for patients and providers, which are available at facs.org/safepaincontrol.

The Patient Education web page has been updated to include patient and caregiver training. Translation of the materials to different languages is being pursued with the ACS international chapters. A new endeavor being pursued by the Patient Education Committee is the use of technology to enhance communication between surgeons and patients.
Continuous Quality Improvement

The Continuous Quality Improvement (CQI) area of DROPC continues to grow, offering an array of programs.

Quality and Safety Conference

The 2019 ACS Quality and Safety Conference took place in July, with more than 2,100 attendees. The conference theme, Putting Our Patients First, was evident during the four-day meeting. For details, see the October Bulletin, available at bulletin.facs.org/2019/10/2019-acs-quality-and-safety-conference-focuses-on-putting-the-patient-first-value-based-care/.

Quality improvement programs

A total of 856 hospitals participate in the ACS National Surgical Quality Improvement Program (ACS NSQIP®)—718 in ACS NSQIP Adult and 138 in ACS NSQIP Pediatric. Approximately 75 percent of ACS NSQIP Adult hospitals are involved in more than 60 formal collaboratives.

Voluntary public reporting on Hospital Compare is available to ACS NSQIP participating sites through CMS. ACS NSQIP sites may voluntarily publicly report three surgery-related, risk-adjusted outcomes measures on the Hospital Compare website.

ACS NSQIP has partnered with the American Society for Transplant Surgeons on the ACS TransQIP Pilot Project to fill a gap in surveillance and data collection for the transplantation community. Discussions to create a full TransQIP program (ACS NSQIP Transplant) continue.

Since the Children’s Surgery Verification (CSV) Program launched in 2017, enrollment in ACS NSQIP Pediatric has increased. Verification for specialty pediatric hospitals began in July. After meeting with leaders from oncology and musculoskeletal specialty hospitals over the last year, CSV developed modified Level I standards that will allow hospitals that offer these services to apply to the program and achieve a Level I designation.

In November 2018, CSV launched the ACS NSQIP Pediatric Antibiotic Stewardship Pilot. Antibiotics were chosen as a focus based on the variation among children’s hospitals and the increasing public health implications associated with antibiotic overuse. The pilot likely will run for a year.

The Metabolic and Bariatric Surgery Accreditation and Improvement Program (MBSAQIP) has 912 participating hospitals; 822 are fully accredited. MBSAQIP’s second national collaborative initiative, Employing New Enhanced Recovery Goals to Bariatric Surgery (ENERGY) ended last year. The most important finding from this work is that ENERGY centers cut their lengths of stay in half. Furthermore, centers that closely adhered to process measures were more likely to improve patient outcomes.

In May, MBSAQIP released the third version of its standards. Important changes in this edition include improved direction and support for quality improvement projects, the addition of a patient risk assessment and follow-up protocol, and a medical weight loss accreditation option to recognize centers that offer nonsurgical weight management treatment.

MBSAQIP launched a patient-reported outcomes (PROs) project, which will provide the first results from comparative effectiveness analyses of the three most common metabolic and bariatric procedures (gastric sleeve, gastric bypass, and gastric band) based on patient-centered, patient-reported, one-year outcomes. This program will provide patients and providers with timely metrics on what patients care about most to inform decision making.

MBSAQIP unveiled a Bariatric Surgical Risk/Benefit Calculator to support preoperative decision making, enabling patients and clinicians to select a particular procedure and estimate risk of complications, body mass index reduction, and postoperative comorbidity resolution.

MBSAQIP also launched its third national collaborative project focused on opioid reduction—the Bariatric Surgery Targeting Opioid Prescriptions—and
continues its work toward the release of its new data registry in January 2020.

Approximately 5,000 surgeons have entered more than 10.8 million cases into the Surgeon Specific Registry (SSR). In addition to serving as a mobile friendly case log system, the SSR helps surgeons comply with regulatory mandates, such as requirements stipulated in the CMS Quality Payment Program (QPP) Merit-based Incentive Payment System (MIPS) and the ABS Continuous Certification Program. CMS has approved the SSR to provide MIPS participation through registry-based reporting for the 2019 Performance Year. For the 2019 MIPS Performance Year, the SSR supports the Quality and Improvement Activity (IA) components. Surgeons can choose from 88 surgically relevant IAs for attestation. Surgeons may further select one of the following Quality reporting options for MIPS 2019 participation in the SSR:

• General Surgery Specialty Measures Set includes options for general surgeons and plastic surgeons (MIPS-Qualified Registry)

• ACS Surgical Phases of Care Measures includes options for a range of surgical specialties (MIPS-Qualified Clinical Data Registry [QCDR])

The ACS Surgical Phases of Care QCDR includes a measure for electronic PROs (ePROs). A total of 266 surgeons submitted MIPS 2018 data using the SSR; 223 participated in the General Surgery Specialty Measures Set and 11 in the ACS Surgical Phases of Care Measures Set. Some individuals reported on the Quality and the IA components, but 43 submitted IAs only.

The ACS Quality Data Platform Project is ongoing. Eventually, all ACS clinical data platforms will migrate to a single platform to allow a common data entry platform, data warehouse, and advanced reporting and data visualization tools. The SSR, ACS NSQIP, AHRQ Safety Program for Improving Surgical Care and Recovery (ISCR), NSQIP Pediatric, and Trauma registries are active on the Quality Data Platform, and the Cancer and MBSAQIP registries will move to the platform in 2020.

Another part of the project aims to improve data quality and reduce the data entry burden through the use of an EHR Adapter, which has been piloted at several ACS NSQIP sites and is being modified based on pilot hospital feedback and survey results. The platform will incorporate PROs to give participating hospitals insights into the quality of care from the patient perspective. The ACS has tested PROs in NSQIP, MBSAQIP, and SSR.

Strong for Surgery (S4S) continues to grow. More than 500 sites have accessed the online program toolkit since its release in July 2017. The S4S toolkit offers four original checklists—nutrition, blood glucose control, smoking, and medication—and has added four new checklists—delirium, prehabilitation, advance directives, and safe and effective pain control. Six comprehensive checklists were added to S4S this year, covering topics such as chronic disease management, mental health, and substance abuse.

Standard setting

The four-year Coalition for Quality in Geriatric Surgery (CQGS) Project, funded by The John A. Hartford Foundation, aims to improve care for older patients. The project recently concluded with many milestones completed, including the finalization of geriatric surgery standards, initiation of a media campaign, and launch of the Geriatric Surgery Verification (GSV) program. The 30 GSV standards, Optimal Resources for Geriatric Care, were released this year for use in all U.S. hospitals. The program will prepare hospitals for the influx of older adults with care standards that define the resources hospitals need to provide surgical care to this vulnerable population.

The AHRQ Safety Program for ISCR is a collaborative program between the ACS and Johns Hopkins Medicine Armstrong Institute for Patient Safety and Quality, Baltimore, MD, to enhance recovery for surgical patients. ISCR is a five-year project that seeks to improve clinical outcomes by supporting hospitals...
in the implementation of evidence-based enhanced recovery pathways that improve perioperative care and reduce variability. ISCR will now comprise five cohorts, each lasting 12 months. Hospitals can now implement enhanced recovery pathways for colorectal, orthopaedic (hip and bone), gynecology, and emergency general surgery patients. The emergency general surgery cohort will launch in March 2020. (See the January 2020 Bulletin for details.)

Several organizations have approached the ACS to partner in the development of new specialty-specific verification programs. Clinical areas of development include: high-risk gastrointestinal surgery, vascular, thoracic, emergency general surgery, and rural surgery. Other areas are in discussion. Pilot testing with the Society for Vascular Surgery, the Society of Thoracic Surgeons, and the American Association of Trauma Surgeons will begin soon.

The ACS CQI team has been involved in THRIVE, described in the Advocacy and Health Policy section of this report. The program will be piloted at U.S. hospitals, focusing on measuring the full cycle of care for three surgical conditions. Once the program has better defined participation criteria, hospital recruitment will begin.

The College is developing adjunct resource standards based on the Optimal Resources for Surgical Quality and Safety to develop a Red Book Verification Program. An initial draft of the standards and a prereview questionnaire have been completed. Pilot site visits occurred throughout 2019, and the program standards are nearly complete.

Educational programs
The December 2018 Health Services Research Methods Course had 51 attendees and 14 faculty members. The course was designed to meet the needs of clinical and health services researchers with varying degrees of experience in the field. The course was introductory and best suited for new researchers, suggesting that a more advanced course for experienced members should be explored.

The College continues to provide opportunities for surgical residents to become involved with ACS Quality Programs through the ACS Clinical Scholars in Residence Program. At present, the ACS has four Clinical Scholars in Residence; two are receiving support through The John A. Hartford Foundation for the CQGS, one is receiving support from the AHRQ Safety Program for ISCR, and one has funding from his home institution and is focusing on quality in colorectal and oncologic surgery.

Cancer Programs
The six ACS Cancer Programs continue to function at a high level, delivering on their mission to improve cancer patient care.

CoC
The CoC is the largest and most mature cancer program and accredits more than 1,533 Commission on Cancer (CoC) hospitals. Strengths of the program include its size, legacy, and impact. New standards for the CoC have been drafted, reviewed, and finalized for implementation in 2020.

NAPBC
The National Accreditation Program for Breast Centers (NAPBC) certifies 647 specialty centers. The NAPBC is the first accreditation program focused on specialty care for a site-specific disease. Peer-review publications demonstrate superior outcomes for patients treated at NAPBC centers, providing support for the value of NAPBC and its mission.

NAPRC
The National Accreditation Program for Rectal Cancer (NAPRC) is the second accreditation program focused on specialty care and has recently been added to the portfolio of multidisciplinary programs focused on the quality of cancer care. NAPRC has 13 newly accredited centers, with 37 in the pipeline.
NCDB
The National Cancer Database (NCDB) has curated more than 39 million cancer records and is the largest database of its kind in the U.S. The NCDB, through CoC-accredited sites, continues to collect roughly 1.5 million cancer cases with each annual call for data, which represents 72 percent of all newly diagnosed cancer cases in the U.S. Nearly 300 data items are collected for each cancer patient, and 10 reports are provided to CoC institutions, including Rapid Quality Reporting System, survival outcomes, hospital comparison benchmarks, Cancer Program Practice Profile Reports, and Cancer Quality Improvement Program reports. The NCDB supports approximately 1,000 research projects annually.

AJCC
The eighth edition of the American Joint Committee on Cancer (AJCC) Staging Manual comprises 80 chapters and 100 staging systems. The manual can be formatted to meet different stakeholder needs, and the electronic content can be licensed to EHR vendors and partner organizations. The eighth edition has incorporated biologic markers of cancer outcomes as a foray into personalized medicine.

CRP
The Cancer Research Program (CRP) has conducted several research projects on cancer surveillance and has led several clinical trials (Z6051, Z6041, and Z0011, Z1071), each of which has informed and affected oncologic care in the U.S. CRP recently has focused on the dissemination of new knowledge generated from clinical trials through the development of informational videos distributed to multidisciplinary tumor boards.

Since 2011, the CRP has developed Operative Standards for Cancer Surgery manuals, two of which have been published, covering nine cancer sites. It is anticipated that the introduction of six operative standards into the 2020 CoC standards will accelerate the dissemination and implementation of these technical standards. Theoretically, the CRP could serve as a knowledge engine and could advance the methodologies associated with alternative trial design, as well as standards and quality, for example by defining the characteristics and thresholds of an impactful standard.

Cancer Programs staff performed an assessment of these programs as part of the onboarding of the new leadership. A total of 191 surveys and 604 individual comments were reviewed and discussed at a January 2019 retreat. Survey data support that the programs remain strong in staging and standards, with less support for an authoritative role in quality. Each program was reviewed for strengths and challenges.

Trauma Programs
Participation in ACS Trauma Quality Programs has grown this year.

TQIP
A total of 834 hospitals participate in the Trauma Quality Improvement Program (TQIP) and 18 in the collaborative. In addition, 555 hospitals are ACS-Verified Trauma Centers.

The 2019 TQIP Conference took place November 16–18 and featured the release of “Non-Accidental Trauma Best Practice Guidelines”; sessions on the TQIP mortality study, error management, and getting the most out of your TQIP reports; and a general session that included a live trauma simulation and debriefing. The Committee on Trauma (COT) also launched the Advancing Leadership for Trauma Center Management Course at the TQIP Conference. This course provides insight on the infrastructure necessary to develop and lead a trauma center to success.

Firearms
The ACS surveyed U.S. members to gain a better understanding of their views on firearm ownership and firearm injury prevention strategies. The results were presented during a Special Session at Clinical Congress.
Representatives from 45 professional medical and injury prevention organizations and the American Bar Association met February 10–11 for the inaugural Medical Summit on Firearm Injury Prevention. Details about the Summit were published in the October issue of the Bulletin at bulletin.facs.org/2019/10/a-comprehensive-approach-to-firearm-injury-prevention-acs-committee-on-trauma-hosts-historic-summit/.

The COT has convened the ISAVE (Improving Social determinants to Attenuate ViolencE) panel to study the causes of violence and recommend innovative programs within the trauma systems to reduce the prevalence of intentional violence.

Research
The COT hosted a Research Methods Conference in July for COT and Coalition for National Trauma Research (CNTR) members. In partnership with CNTR, the COT is exploring opportunities to submit grant applications to leverage the TQIP infrastructure for high-quality research.

The ACS, in partnership with the National Association of State EMS (emergency medical services) Officials and with support from the National Highway Transportation Safety Authority, drafted a joint statement on linking traffic collision data across the trauma/EMS care continuum.

The COT PROs workgroup held a consensus conference in January that focused on patient inclusion criteria, data elements to be collected, and data collection methodology. The conference brought together national and international experts to discuss and plan strategies to achieve PROs in trauma.

ATLS
The transition from the ninth to the 10th edition of the Advanced Trauma Life Support® (ATLS®) program ended in September. The 10th edition is the most transformational revision of the ATLS course to date, and more than 10,000 students have completed the 10th edition course. For details, see the March 2018 issue of the Bulletin at bulletin.facs.org/2018/03/atls-at-40-distinguished-past-bright-future/.

Attendance at the 2019 ATLS Global Symposium has increased over the last five years from 125 attendees to 240 attendees. Representatives from more than 30 countries shared best practices and discussed the evolution of trauma education.

Other trauma education programs
The Basic Endovascular Skills for Trauma course and workshop released updated and expanded course materials and is experiencing expanded international interest. The second edition of the Advanced Surgical Skills for Exposure in Trauma (ASSET) launched this year. In addition to revised and updated content, the new ASSET curriculum features add-on topics, such as ophthalmology, obstetrics, and amputations. In 2020, the third edition of the Advanced Trauma Operative Management course and a fourth edition of the Trauma Evaluation and Management course for medical students will be released.

Stop the Bleed
The Stop the Bleed® program has increased in size and scope. With an expanding reach through the growing roster of instructors, more than 1.2 million people in all 50 states and more than 110 countries have been trained in bleeding control techniques.

The redesigned Stop the Bleed course is more succinct, easier to present to nonclinical audiences, and gives students a graphic presentation of the material. This new course will be translated into several languages for a growing international audience.

A new website, www.stopthebleed.org, will meet the ongoing challenge of bringing information, education, and empowerment to the general public, while still serving as a clearinghouse for Stop the Bleed products, services, and updates. Developed in part with funding from the Hartford, the website’s design is a result of extensive research and marketing guidance.
**Member Services**

The ACS has 84,026 members: 64,414 Fellows (56,044 U.S., 1,262 Canadian, and 7,108 International). Of the 64,414 Fellows, 9,654 hold senior status and 16,181 are retired. The ACS has 2,673 Associate Fellows, 11,211 Resident Members, 3,168 Medical Student Members, and 568 Affiliate Members. This year’s Initiate class totals 1,992.

**Recruitment and retention**

The ACS identified opportunities for recruitment among lapsed members in the Resident, Associate, and Fellow categories; marketed membership to more than 4,500 former residents; and created a marketing plan for nonmember surgeons who have attended College meetings or purchased ACS products. We also tested a Win-Back campaign for lapsed Fellows.

We are developing an onboarding program for Associate Fellows to enhance communications and increase the number of Associates applying for Fellowship. We are developing a plan to involve Regents, Advisory Councils (ACs), Governors, and Chapter leaders in encouraging Associates to apply for Fellowship.

**International activities**

A benchmark analysis was conducted to ensure the ACS membership complements and is competitive with other international organizations and to identify areas for growth.

Member Services promoted engagement among international Initiates at Clinical Congress with WhatsApp groups for individual countries, which allows the ACS to send targeted information about Clinical Congress and facilitate virtual introductions before the meeting. The ACS also facilitated relationships between International Relations Committee (IRC) members and Initiates at Clinical Congress.

**Chapters**

ACS chapters work with the College to provide members with benefits, including the opportunity to network with surgical peers locally, to participate in advocacy activities at the state and federal levels, and to attend CME meetings. Chapter Services provides guidance and assistance in these areas to the College’s 114 chapters—67 domestic and 47 international.

Highlights from the last year are as follows:

- Iraq and South Africa were granted chapter charters
- Chapters completed the required annual report summarizing their activities in 2018, and the leadership of each chapter received a personalized report with suggested areas of focus
- The third annual Chapter Officer Leadership Program took place in March to provide domestic chapter leaders with the skills they need to build sustainable success through strong volunteer leadership
- An online toolbox was developed to assist chapters with recruitment

The Board of Governors (B/G) Chapter Activities Domestic Workgroup reviewed the *Chapter Guidebook*, advised on the Chapter Officer Leadership Program, participated in the Chapter Speed Networking event, and reviewed questions for the Annual Report and provided insights on the collected data.

**B/G**

The ACS has 290 Governors: 154 Governors at-Large, representing each U.S. state and Canadian province and territory; 87 specialty society Governors; and 49 international Governors.

The B/G Executive Committee’s Strategic Planning Retreat in June focused on progress in meeting these priorities, evaluation of the work of the Pillars and Workgroups, and finalization of preparations for the Annual Business Meeting at Clinical Congress. At the Joint Session with the Board of Regents (B/R), attendees engaged in an interactive session, The Healthcare Landscape in the Future, featuring brief
talks on the College’s role, private practice surgeons, and Quality Programs.

The B/G is structured under five Pillars and 13 Workgroups. For a summary of their activities, see the October issue of the Bulletin at bulletin.facs.org/2019/10/board-of-governors-continues-to-make-your-voice-heard/.

ACs
The ACs assisted with the review of expert witness testimony for the Central Judiciary Committee (CJC), nominated members for boards and specialty review committees, recommended members to represent the ACS on specialty guidelines writing and review panels, and submitted 123 proposals for Clinical Congress 2020. AC Chairs and Regents communicated with specialty program directors to encourage them to enroll their residents in the ACS.

AC Pillars and B/G Pillars met at the Leadership & Advocacy Summit and Clinical Congress and are working on collaborative efforts. The AC for Rural Surgery is working to develop a resident scholarship for a one-month rotation at a training program with a rural surgery focus, and all the ACs are participating in an ACS Foundation Challenge.

YFA
The Young Fellows Association’s (YFA’s) Equity Taskforce works to improve diversity and invited members of the Latino Surgical Society and the Society of Asian Academic Surgeons to join the ACS. The task force also developed a white paper on parental leave.

Eight triads, each composed of one mature Fellow, one young Fellow, and one Associate Fellow, were created for an Annual Mentor Program. More than 50 mentors and mentees participated in an hour-long Speed Mentoring program at Clinical Congress 2019.

The YFA engaged with members and potential members on social media, @yfaacs, and published 15 essays on Surgical Patients: On Becoming the Surgeon Advocate, Leader, and Learner. The YFA also worked with DROPC to begin a Future Quality Leaders program and with Selected Readings in General Surgery to engage young Fellows in content development.

RAS
RAS presented the inaugural Outstanding Mentor of the Year Award at Clinical Congress to honor a surgeon who has helped an RAS member become an ACS leader. RAS offered 15 Phone Hangouts to medical students and residents on various subjects, as well as 16 webinars on additional relevant topics. More than 25 residents co-authored four articles and an introduction on Wellness and Resilience in the August issue of the Bulletin.

Two more host countries—Greece and Kuwait—have agreed to participate in the annual International Scholarship Exchange. A total of 70 scholarships were awarded to residents attending the 2019 Leadership & Advocacy Summit.

OGB
Operation Giving Back (OGB), in the aftermath of Hurricane Maria in 2017, has worked to establish a volunteer response program for uninsured and underserved people in Puerto Rico. Since March 2019, in partnership with the Puerto Rico Department of Health, the Puerto Rico Chapter of the ACS, and local nongovernmental organizations, OGB has mobilized volunteer surgeons on a rotating, weekly basis.

OGB has worked to establish the inaugural ACS-College of Surgeons of Eastern, Central and Southern Africa (COSECSA) Surgical Training Hub at Hawassa University, Ethiopia. The six-month pilot of this capacity-building program included two-week rotations by each of the 13 participating U.S. academic institutions and concluded in July.

OGB participated in the 2019 Leadership & Advocacy Summit and is developing a global surgery advocacy one-pager to spread awareness. The director of the Fogarty International Center at NIH attended the Hawassa Hub annual workplan meeting, signaling a step forward for OGB’s advocacy agenda.
Five ACS-Pfizer Surgical Volunteerism and Humanitarian Award recipients were honored at the B/G dinner and presented their work at Clinical Congress. For details about the award recipients, go to bulletin.facs.org/2019/10/surgeons-honored-for-volunteerism-and-humanitarianism-3/.

OGB hosted the third annual Global Surgery Program Leaders meeting at Clinical Congress and facilitated one-hour meetings for medical students and residents interested in global surgery.

The ACS-COSECSA Women Scholars Program expanded this year to provide up to 20 scholarships for women to enter specialty tracks upon completion of their basic surgical training. In spring 2019, 10 women were awarded this assistance. This winter, OGB plans to grant funding to four women scholars to cover their final examination and five years of membership in COSECSA and the ACS, with co-funding from the Association of Women Surgeons Foundation.

MHSSPACS

With assistance from the Military Health System Strategic Partnership American College of Surgeons (MHSSPACS) and ACS DROPC, a military Surgical Quality Consortium (SQC) has been formed to include all 47 U.S. Military Treatment Facilities (MTFs) that have inpatient surgical capabilities, as well as a few outside of the U.S.

MTFs are undergoing Red Book consultations, and ACS NSQIP has recognized MTFs as “meritorious.” In addition, Health Affairs recently published a paper describing the inception of the military SQC and its impact on surgical quality within the MHS.

The National Defense Authorization Act of 2017 requires all major MTFs to either participate in their regional civilian trauma system or partner with a civilian trauma center to ensure military trauma surgeons and teams are prepared for deployment. The PAHPAI Act provides funding for civilian trauma centers to train combat casualty care teams and individual physicians. How these centers might be chosen and evaluated, as well as the challenges of establishing such programs within civilian trauma centers, was the focus of several MHSSPACS meetings, resulting in the compilation of standards.

The military Clinical Readiness Program (also known as the Knowledge Skills and Abilities Project) includes all members of the combat casualty care team and has resulted in each group formulating the essential knowledge points and skill sets needed for their specialty. The MHSSPACS has generated more than 500 knowledge-point questions, and from them two versions of a beta test were devised and distributed to 138 military surgeons. The test could distinguish between novice and experienced trauma surgeons and between surgeons with and without extensive deployment histories, indicating content validity. In addition, we have worked to develop a hands-on skills assessment course for the expeditionary surgeon based on ASSET with added elements for damage-control orthopaedics, neurosurgery, ophthalmology, and obstetrics.

The ACS has secured funding from the DoD/Combat Casualty Care Research Project to study posttraumatic pulmonary embolism. This study, which includes 17 U.S. trauma centers, has both a clinical and a basic research component.

The Excelsior Surgical Society has 285 Active, Associate, Distinguished, and Honorary members. In addition to the annual Scientific Meeting, Business Meeting, and reception at Clinical Congress, the society is resurrecting the Senior Visiting Surgeons Program, which will allow for exchange of surgeons between military and civilian centers.

Committees

The IRC has created a database of international surgeons who are subject matter experts for the Clinical Congress Program Committee to use in selecting speakers and identified ways to engage international Clinical Congress attendees.

The IRC oversaw the selection of awardees for the 2019 International Chapter Opportunity Program. One of the ACS’ most successful international
initiatives, this program provides financial support for chapters to host a local educational course. The Argentina and Australia and New Zealand Chapters were awardees in 2019.

The IRC collaborated with the ACS Foundation to develop a report for the International Chapter Opportunity Program that communicates the impact and reach of the program to its primary funder and prospective supporters. Furthermore, the subcommittee is helping to create an e-book to help breast surgeons in low- and low-middle-income countries to better serve their patients.

The IRC is identifying meaningful benefits and opportunities for international surgeons and is working with the Division of Education to make ACS educational materials available at tiered cost and is working with international Governors to identify chapter meetings where ACS Officers can present on pathways for professional growth and leadership for women surgeons.

The IRC is responsible for scholarships that provide opportunities for international surgeons to attend ACS meetings. In 2019, these programs benefitted 20 international and three domestic surgeons.

Among its activities, the Women in Surgery Committee (WiSC) administers the Women Surgeons Community, which has more than 5,300 members. The WiSC nominates worthy women surgeons for leadership roles in the College, Honorary Fellowship, and other awards, including the Dr. Mary Edwards Walker Inspiring Women in Surgery Award. The 2019 recipient was Vice Admiral Raquel C. Bono, MD, FACS, retiring Director, Defense Health Agency Medical Corps.

The Mentorship Program Subcommittee pairs women surgeons for one year to address topics such as career development, research goals, work-life balance, practice development, and leadership. The subcommittee received 31 mentee applications for 2019–2020.

The WiSC, with input from the ACS Committee on Diversity Issues, developed the updated Statement on Harassment, Bullying, and Discrimination, which the B/R approved in June.

The Committee on Diversity Issues posts and updates Diversity Resources on the ACS website to assist surgeons with the challenges they may face. These resources address needs assessment, cultural competency, implicit bias, and diverse surgical team building.

The first in a “Profiles in Diversity” series, which spotlights ACS Fellows who have overcome obstacles or have created or led diversity initiatives within their institution, featured Julie Freischlag, MD, FACS, FRCS(Ed)(Hon), Past-Chair, ACS B/R. The podcast is available online, and the interview was published in the April Bulletin.

IPV Task Force

The Intimate Partner Violence (IPV) Task Force, formed in January 2018, has developed the ACS Statement on Intimate Partner Violence; published articles in the October 2018 issue of the Bulletin to raise awareness of this issue during Domestic Violence Awareness month; released an ACS IPV Toolkit; posted a set of pages on the ACS website with information and resources; developed a case scenario on IPV for the ACS Fundamentals of Surgery Curriculum; convened a Town Hall on IPV at Clinical Congress 2018; deployed an ACS Member Survey on IPV; created an IPV Grand Rounds presentation slide set; given an IPV presentation during a RAS-ACS Grand Rounds Webinar; and sponsored an IPV and the Surgical Workforce Panel Session at Clinical Congress 2019.

CJC

The CJC reviewed 20 cases this year and has made 16 recommendations to the B/R for disciplinary actions.

Society of Surgical Chairs

The Society of Surgical Chairs (SSC) has 191 dues-paying members. The 2019 annual meeting program focused on the patient and the impact of EHR. The
SSC Mentorship Program for new chairs focused on managing up. In April, the SSC Women’s Committee hosted the third annual leadership symposium, Not a Moment in Time.

Leadership & Advocacy Summit
More than 560 ACS leaders and members attended the Leadership portion of the eighth annual Leadership & Advocacy Summit. For details, see the June 2019 issue of the Bulletin.

Archives
The ACS Archives responded to 104 research requests over the last year and has received 35 new acquisitions. The Archives led several projects to increase the accessibility and use of the collections. This included professionally photographing all presidential oil portraits and other ACS artworks and artifacts.

Clinical Congress program books from 2013 to 2018 are now available online for research. More will be added as they are digitized.

The Surgical History Group of the History and Archives Committee published four Bulletin articles this past year based on the 2018 Clinical Congress panel World War I: The Dawn of Evidence-Based Casualty Care.

The second Archives Fellowship was awarded this year to Cynthia Tang, a doctor of philosophy candidate at McGill University, Montreal, QC. Ms. Tang will receive a $2,000 award and will use the ACS Archives to conduct research on the laparoscopic revolution through surgical training.

Surgeon Well-Being
The Physician Well-Being Index enables users to track fatigue and burnout over time and provides resources for self-education. The ACS provides this online resource to Fellows and residents.

Earlier this year, Member Services hosted leaders involved in well-being initiatives at their institutions to discuss areas of focus for future initiatives. The ACS is working on the following initiatives as follow-up to this meeting: a survey of specialties to understand well-being and wellness initiatives and potential collaboration on areas of mutual interest, multimedia content for the ACS website, guides for career stages, increased programming at the Leadership & Advocacy Summit, and further incorporation of wellness opportunities at ACS events.

Integrated Communications
The Division of Integrated Communications supports the College’s public profile and visibility, member communications, and marketing activities. A new Director of Integrated Communications, Cori McKeever Ashford, began working in Chicago headquarters December 2.

Public profile and visibility
The GSV Program captured national media attention this summer, with several news articles on the need for the program and how it will improve outcomes for older surgical patients. Stories were published in the New York Times, Associated Press, Kaiser Health News, AARP.com, Reuter’s Health, Becker’s Healthcare, and Fierce Healthcare. An estimated 98 percent of these articles included a link to the ACS website. An ACS press release, along with the program launch video link, captured 503 media mentions, representing a potential audience reach of 549.6 million readers/viewers/listeners.

ACS trauma surgeons appeared on CBS Sunday Morning to discuss a public health approach to firearm violence. The interviews appeared on the heels of two mass shooting incidents in August. The segment featured a panel of seven surgeons and physicians working with the American Foundation for Firearm Injury Reduction in Medicine. Ronald M. Stewart, MD, FACS, Medical Director, ACS Trauma Programs—who was featured along with COT member Stephanie Bonne, MD, FACS—laid out some of the work already under way to tackle firearm violence as a public health
problem, as recommended at the Medical Summit on Firearm Injury Prevention.

Following are print and online media clip highlights on a variety of ACS initiatives and programs:

• Race May Matter for Liver Transplant Success, U.S. News & World Report, January 15

• Sweeping Study Finds Overlapping Surgeries Generally Safe—With Exceptions, WBUR, February 26

• Turning Bystanders into First Responders, New Yorker, April 8

• Military Considers Sweeping Changes to Surgical Safety Programs, U.S. News & World Report, May 23

• Hospitals look to cut opioids from surgery and beyond, Modern Healthcare, July 8

• Harvard, American College of Surgeons team up to improve health care quality, BenefitsPRO, July 24

Integrated Communications played an integral role in launching StoptheBleed.org—the College’s first entirely public-facing website. Content developed by Integrated Communications, Stop the Bleed staff, and COT leaders reflects a new approach to informing, educating, and empowering the public to learn more about the program.

NewsScope
The ACS launched an artificial intelligence-driven version of ACS NewsScope. Disseminated twice a week, My ACS NewsScope delivers customized content to each recipient. The database curates information from nearly 80 sources of both clinical and nonclinical information on topics that are relevant to surgeons. Each issue also includes a “News Brief” on an ACS program and occasional updates from the Washington office.

This new version of NewsScope was developed partly to fill the void when ACS Surgery News ceased publication December 31, 2018. Pilot testing began in February with a randomly selected pool of ACS members. In response to the demand for more clinical information, we added posts from the top 50 surgical journals. My ACS NewsScope launched College-wide May 1.

The traditional ACS NewsScope continues to be disseminated to more than 55,000 recipients on Thursday nights.

Bulletin
Integrated Communications met in January to develop a strategic plan to keep both the print and online editions of the Bulletin fresh. As a result, some incremental content and design changes have been made in both the print and online versions.

The Bulletin has recruited 10 new editorial advisors to provide input and guidance from a broad pool of College leaders, including not only ACS Regents, but also Governors, AC members, young surgeons, and residents.

JACS
With the January 2019 issue, the Journal of the American College of Surgeons (JACS) unveiled a redesigned cover to reflect a more modern look. The January 2019 issue centered on 13 papers presented at the Clinical Congress 2018 Scientific Forum. It was the first Scientific Forum-dedicated issue of JACS, and the January 2020 issue will feature highlighted papers from the 2019 meeting.

At the end of 2018, JACS successfully achieved a subscription benchmark of converting 40 percent of College members to an online-only format and has recently incorporated an interactive PDF version that is distributed via a monthly e-Table of Contents.

Social media
Upward trajectories continue on the ACS Facebook, Twitter, and LinkedIn sites. In October 2018, a multistep process was used to create a Twitter strategy, which was approved and implemented.
After five years, the ACS Communities continue to be a popular member benefit. Since its launch in 2014, the platform has received 4.2 million page views. The 123 ACS Communities have become the go-to place for ACS members who want to collaborate with their peers. Popular discussion topics in 2019 included gender equity, family members in the hospital, surprise billing legislation, health care access, gender reassignment surgery, and surgeon replacements. In all, site visitors have posted more than 93,000 discussion group posts and viewed library items 155,000 times.

Marketing
Demand for marketing and design services continues to grow, reflecting the success of the College’s programs, meetings, and conferences. Projects range from program branding, advertising, and supporting materials, to developing and executing comprehensive marketing plans and signage for ACS conferences and meetings. Marketing and design for ACS conferences accounted for more than half the projects the marketing team completed this year and contributed to the continued growth in awareness of and attendance at our meetings.

Weber-Shandwick
Weber-Shandwick has played an instrumental role in launching ACS THRIVE and recommending future areas of opportunity for our Communications team, particularly with regard to developing a more deliberate social media strategy and website redevelopment. Weber-Shandwick also is responsible for Clinical Congress Highlights, which focuses on scientific meeting coverage at the conference and supplements Clinical Congress News, which covers more general programs and activities and is staffed by the Bulletin team.

ACS Foundation
The number of individual contributors to the Foundation increased by 14 percent, rising to 1,316 in this fiscal year. The annual Fall Appeal generated $147,481, a 21.5 percent increase from FY 2018 and a 17.3 percent increase in individual donors.

National Doctors’ Day has experienced strong growth since its inception in 2016. Contributions have increased to $92,086 in FY 2019 from $17,280 FY 2016, representing a 433 percent increase.

The Sponsor a Medical Student initiative, in its second year, offers donors the opportunity to cover the cost of medical students attending Clinical Congress. OGB, Stop the Bleed training in rural communities, international scholarship travel awards, fellowship research awards, as well as the ACS Greatest Needs Fund continue to be supported by philanthropic gifts from Fellows.

Corporate grants secured by the ACS Foundation provided support for the Resident Surgical Skills Competition, 13 Skills Courses at Clinical Congress, and Patient Education resources.

Closing comments
The College continues to be fiscally sound and to offer generous benefits and training opportunities to its staff. This year, the College’s headquarters building is being renovated and we are updating our technology capabilities—a tremendous undertaking, but one I believe will pay off in terms of our ability to grow and continue to provide ACS Members with the tools and services they need to deliver quality care.

I want to thank the ACS volunteers and staff for their dedication to improving the care of the surgical patient. Through their hard work and commitment, the ACS continues to lead the way in ensuring patients have access to value-based surgical care. ♦
JOINT CONTRACTING UNDER ANTITRUST LAWS

HIGHLIGHTS
• Describes how joint contracting may be considered lawful via integration
• Summarizes the two forms of integration: Clinical integration and financial integration
• Identifies other potential antitrust considerations, specifically the analysis of the joint venture's impact on competition

Author's note: This article provides an overview of some key antitrust risk factors based on publicly available guidance from the federal antitrust authorities. This overview is not legal advice. Please consult legal counsel before engaging in any joint contracting activity.

Surgeons who are part of the same practice may lawfully engage in joint contracting as part of their routine course of business. However, joint contracting by independent health care providers, who are otherwise competitors or potential competitors, is typically viewed by the antitrust authorities as per se unlawful. In other words, joint contracting by competing or potentially competing independent physicians is considered unlawful without any evaluation of the competitive impact of the contracting arrangement. In order for the arrangement potentially to be considered lawful, the physicians must integrate. The most complete form of integration is actually to combine into a single practice entity, but joint contracting by independent phy-
physicians also may be acceptable if those physicians partially integrate. The acquisition of one practice by another, or the combination of more than one practice, is subject to review under the antitrust laws, and if a single practice has a significant market share, then its actions may also come under antitrust scrutiny. In contrast to clinical integration, there are several documented examples of single-specialty physician networks that have been deemed financially integrated by the antitrust authorities for purposes of joint contracting.

Some key details of financial integration follow.

**Two forms of partial integration**

The two forms of partial integration are known as clinical integration and financial integration. In either form, independent physicians will usually create a network entity to deliver services, and it is the network entity that actually conducts the joint contracting activity.

If physicians successfully meet the standards for either of these forms of partial integration, then the antitrust authorities will typically analyze their joint contracting arrangement under what is known as the “rule of reason” standard. The rule of reason analysis is a balancing test in which the overall procompetitive and anticompetitive impacts of the contracting are weighed. Qualifying for rule of reason treatment does not completely eliminate antitrust risk, but it does reduce the risk.

Clinical integration requires network physicians to work closely together to coordinate and deliver patient care. A clinically integrated network would normally establish patient care protocols and performance standards and coordinate monitoring, training, disease management, and evaluation to ensure that those protocols and performance standards are being met. In most cases, clinical integration is only available to multispecialty networks in which physicians in multiple disciplines work together to coordinate and deliver care across a range of patient needs.

Financial integration requires physicians to share substantial financial risk. The risk-sharing encourages the physicians to work together more efficiently, with the goal of reducing costs and improving care.

**Financial integration**

As noted previously, the most complete form of financial integration is when physicians are co-owners of the same practice and share fully in profits and losses of that entity. Outside of that sort of complete structural integration, partial financial integration can be achieved via a variety of contracting arrangements between the physician contracting entity and the payors. The central requirement of any such arrangement is that it provides strong incentives for the network to institute and implement protocols to increase efficiency and reduce cost.

The most common forms of financial integration accepted by the antitrust authorities include the following:

- Capitation or case-rate contracts under which the network assumes financial risk for the cost of care
- Earmarking reimbursement to a percentage of premium or revenue from the plan
- Withhold arrangements, or bonus, shared savings and other pay-for-performance contracts under which the payor withholds or pays out a substantial share of fees (usually greater than 15 percent), to be paid to the network only if the network meets cost and quality goals

**Capitation arrangements**

A capitation arrangement is payment based on a fixed, predetermined payment per covered life in exchange for the network (not just an individual physician)
providing and guaranteeing provision of a defined set of covered services. Specific criteria are as follows:

- The capitated rate must be paid to the network itself, rather than to any individual physician, so that all of the physicians bear the risk associated with the performance of the network as a whole.

- If the network also is negotiating nonrisk-sharing services (for example, fee-for-service contracts), the negotiations of those contracts do not necessarily qualify for rule-of-reason analysis; only the risk-sharing aspects of the network are routinely considered under the financial integration umbrella. In some circumstances, the antitrust authorities may consider it acceptable to jointly negotiate fee-for-service rates on a temporary basis if needed, for example, in order to help determine long-term capitated rates.

Percentage of premium or revenue arrangements
These arrangements are similar to capitation arrangements, except instead of a predetermined fixed amount, the physician network is compensated based on a predetermined percentage of the plan’s premium or revenue. Unlike capitation, the actual amount paid to the providers will vary; other requirements are similar to capitation.

Withholding, penalty, or bonus arrangements
Payor contracts include financial incentives for the network members as a group to achieve specified cost, utilization, or quality containment goals. Specifics of these arrangements are as follows:

- Goals should be based on the network as a whole and not any individual physician.

- Payments that are withheld and not earned should be kept by the payor or its designee; they should not be distributed to the physician-controlled network or to any individual physicians.

- The amount of potential forfeiture must be large enough to create significant incentives for the physicians to meet cost and quality goals. The minimum amount of forfeiture is typically 15 percent, but the appropriate figure is a fact-specific analysis, taking into account the number of physicians in the network and prevailing fee schedules, among other considerations.

Other considerations
Even if independent providers form a financially integrated network and establish a joint-contracting arrangement that qualifies for rule of reason analysis under the antitrust laws, that does not immunize a joint-contracting arrangement from additional antitrust scrutiny. Instead, as noted previously, the legality of the physician network joint venture would then be analyzed based on its impact on competition. This assessment is highly fact-specific based on the market in question and, therefore, often quite complex. This overview addresses some key issues that should be considered, but it is not legal advice and it is not tailored to any particular market. Any Fellows who are interested in further exploring the formation of such an entity for the purposes of potentially jointly contracting with payors would be well advised to obtain competent legal counsel who can provide guidance regarding their particular circumstances before engaging in any joint contracting activity.

In addition, the American College of Surgeons (ACS) would be interested in speaking with any groups of Fellows that are currently competitors in their individual market areas and would be interested in exploring the formation of a physician network joint venture for purposes of joint contracting. For more information, contact Patrick Bailey, MD, MLS, FACS, ACS Medical Director, Advocacy, by phone at 202-337-2701 or by e-mail at pvbailey@facs.org.
What surgeons should know about...

Medicare enrollment and participation

by Lauren Foe, MPH, and Haley Jeffcoat, MPH

Physicians, nonphysician practitioners, and other Medicare Part B suppliers are required to enroll in the Medicare program to receive compensation for covered services provided to Medicare beneficiaries. Providers must make their 2020 Medicare determinations by December 31. As the deadline approaches and providers consider their options with respect to Medicare participation, this column provides guidance to assist Fellows in navigating their contractual relationships with the Centers for Medicare & Medicaid Services (CMS).

What are the participation options?

Three participation options are available to surgeons:

• Sign a participation (PAR) agreement: PAR surgeons choose to participate in the Medicare program and agree to provide all covered services for all Medicare beneficiaries on an assigned claims basis.

• Elect non-participation (non-PAR): Non-PAR surgeons may choose on a case-by-case basis whether to accept Medicare assignment of claims. Surgeons who do not accept Medicare assignment may bill patients for more than the Medicare-allowed amount for a particular service.

• Become a private contracting physician (opt out): Surgeons who opt out of Medicare participation must bill their patients directly and forgo any Medicare reimbursement.

How are PAR surgeons paid?

PAR surgeons are contractually obligated to accept Medicare assignment for all claims submitted for covered services furnished to Medicare beneficiaries. By agreeing to always accept assignment, surgeons also agree to always accept Medicare physician fee schedule (PFS)-allowed amounts as payment in full and not to collect more than the Medicare deductible and coinsurance or copayment from any beneficiary.

How does CMS determine payment for non-PAR surgeons?

When non-PAR surgeons accept assigned claims, they receive a total Medicare

As the December 31 Medicare determination deadline approaches and providers consider their options with respect to Medicare participation, this column provides guidance to assist Fellows in navigating their contractual relationships with CMS.
payment that is 5 percent lower than reimbursement to PAR surgeons. Non-PAR surgeons are not reimbursed directly by Medicare for the assigned claims they submit; instead, Medicare pays patients for 80 percent of a service’s PFS amount. Patients are then responsible for passing along to the surgeon the Medicare payment plus the 20 percent copayment, which may be covered by supplementary insurance.

For unassigned claims, non-PAR surgeons may bill up to 115 percent of the PFS-allowed amount, known as the “limiting charge.” The limiting charge is the maximum amount a non-PAR surgeon may legally charge a patient when filing an unassigned claim.

**What is the difference between PAR and non-PAR reimbursement?**

Payments made to PAR and non-PAR surgeons differ in three ways: the fee that is charged, the amount Medicare and the patient each pay, and where Medicare sends the payment. Table 1, this page, shows how surgeons would be paid for a service with a $100 PFS-allowed amount based on their Medicare payment arrangement.

### What if I want to opt out of Medicare participation?

Surgeons who opt out of Medicare cannot bill CMS or Medicare beneficiaries for services rendered, but instead may enter private contracting agreements with Medicare beneficiaries and charge patients without being subject to the MPFS. Such contracts, which must be signed by both the surgeon and patient, indicate that neither party will receive Medicare reimbursement for any covered services. Surgeons are prohibited from opting out on a claim-by-claim or patient-by-patient basis.

To opt out, surgeons are required to file an affidavit with CMS in which they agree to forgo Medicare reimbursement. CMS does not offer a standard opt-out affidavit form, but many Medicare Administrative Contractors (MACs) have forms available on their websites. ¹

PAR surgeons may opt out of Medicare at the beginning of each quarter of the calendar year (January, April, July, or October). Non-PAR surgeons may opt out at any time.

### How do I enroll?

Surgeons may make their Medicare participation decision for the upcoming calendar year during the designated annual open enrollment period, typically mid-November through December 31. Participation agreements for 2020 will cover the period from January 1 through December 31 and may not be changed once open enrollment has ended.

Surgeons should take the following steps to successfully

---

**TABLE 1. PAR AND NON-PAR REIMBURSEMENT**

<table>
<thead>
<tr>
<th>Payment arrangement</th>
<th>Total payment rate</th>
<th>Payment amount from Medicare</th>
<th>Payment amount from patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAR provider with assigned claims</td>
<td>100% MPFS allowed amount = $100</td>
<td>$80 (80%) directly to provider</td>
<td>$20 (20%) copayment paid by patient or supplemental insurance</td>
</tr>
<tr>
<td>Non-PAR provider with Medicare assigned claims</td>
<td>95% MPFS allowed amount = $95</td>
<td>$76 (80%) directly to patient for provider reimbursement</td>
<td>$19 (20%) copayment paid by patient or supplemental insurance</td>
</tr>
<tr>
<td>Non-PAR provider with unassigned claim</td>
<td>Limiting charge of 115% of 95% MPFS allowed amount (effectively, 109.25% MPFS allowed amount) = $109.25</td>
<td>$0</td>
<td>$76 (80%) paid by Medicare to patient + $19 (20%) copayment paid by patient or supplemental insurance + $14.25 balance bill paid by patient</td>
</tr>
</tbody>
</table>
Surgeons who opt out of Medicare cannot bill CMS or Medicare beneficiaries for services rendered, but instead may enter private contracting agreements with Medicare beneficiaries and charge patients without being subject to the MPFS.

enroll and participate in the Medicare program.

Obtain an NPI
You must be assigned a unique 10-digit national provider identifier (NPI) before enrolling in the Medicare program. To receive an NPI, submit an online, paper, or Electronic File Interchange application.² If you have already applied, you can access the identifier via the National Plan and Provider Enumeration System NPI Registry.³

Complete the proper Medicare enrollment application
Once an NPI is assigned, you may enroll in the Medicare program, revalidate your enrollment, or change your enrollment information. Review CMS’ Medicare enrollment checklist to ensure you have all the required information before initiating the application process.⁴

You may submit either a paper enrollment application⁵ or complete an electronic enrollment application through the Medicare Provider Enrollment, Chain, and Ownership (PECOS) online portal.⁶

To avoid delays in application processing, verify the following before submission:

• All required forms are appropriately signed and dated
• All data elements are completed accurately
• Supporting documents (tax forms, proof of licensure, and so on) are attached

If you are applying for Medicare enrollment, you also must pay an application fee electronically via PECOS. Applications will be rejected if the fee is not paid within 30 days of the application submission.

Await application processing and respond to requests for more information
MACs process and screen all provider information on the enrollment application once it is submitted and may employ additional review methods (for example, licensure verification, documentation requests, site visits) as needed. Respond to any requests from your MAC as soon as possible, but within 30 days of the request. Failure to do so may delay enrollment or result in the rejection of the submitted application.

Once a MAC has determined a surgeon is eligible for Medicare billing privileges, it will send the surgeon an approval letter and will designate the surgeon as “approved” in PECOS.

Finalize enrollment
After receiving approval, a surgeon must submit the Medicare Participating Physician or Supplier Agreement (CMS-460) to the appropriate MAC to finalize enrollment.⁷ You have 90 days from when the CMS-460 is submitted to decide to accept your participation status or revoke your enrollment. If you choose to become a Medicare PAR, you continue to participate until your MAC’s next annual enrollment period begins.

Keep your information up-to-date
You should regularly verify the accuracy of your enrollment information on file with CMS and must formally revalidate your Medicare enrollment record every five years. If you are actively enrolled in the program, use the Medicare Revalidation Lookup Tool to find your revalidation due date.⁸

If you submit your application after the due date, your MAC may place a hold on your Medicare payments or revoke your billing privileges. In the event that your information changes following revalidation
(for example, your practice moves to a different location), you should update your information in PECOS within 30 days of the event.

Where can I find more information about Medicare participation?

For more information about the Medicare provider enrollment process, review the Medicare Learning Network Part B Enrollment Booklet or visit the ACS website. Contact Lauren Foe, Senior Regulatory Associate, ACS Division of Advocacy and Health Policy, at lfoe@facs.org with questions. ♦

REFERENCES


A look at The Joint Commission:
Retained foreign bodies and wrong site surgery continue to be a challenge

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

The Joint Commission releases biennial statistics on sentinel events—patient safety events that affect patient outcome and result in death, permanent harm, or severe temporary harm that requires intervention to sustain life. These events are termed “sentinel” because they require immediate investigation and action.

The Joint Commission received 436 sentinel event reports in the first six months of 2019, and the two most frequently reported types of events were surgery-related: unintended retention of a foreign body (URFO), with 60 reported events; and wrong site surgical or invasive procedures, with 29 reported events. The institutions where these events occurred must review them to maintain accreditation and are subject to review by The Joint Commission. These reviews can assist hospitals and other health care institutions in developing quality and patient safety improvement programs.

New reporting categories
The classification system used to describe sentinel events was updated in fall 2018, with the goal of capturing these events in more detail. More specifically, The Joint Commission improved the process for grouping events and accommodated more detailed categories. The latest data comply with the new categories for describing sentinel events, including more specific surgical or invasive procedure events. Of note, burns associated with surgery are differentiated from environmental fire, and wrong site surgery is better differentiated based on site, patient, procedure, and implant. Other new categories are as follows:

- Anesthesia-related events
- Care management events
- Criminal events
- Environmental events
- Product or device events
- Protection events
- Suicide—emergency department
- Suicide—inpatient
- Suicide—offsite within 72 hours

In addition to being the most reported sentinel event in the first half of 2019, URFO was the most reported sentinel event in both 2017 and 2018, with 124 events and 131 events reported, respectively. A review of reported URFO events from 2012 to 2018 in the Joint Commission Journal on Quality and Patient Safety—which included an analysis of the types of objects retained, anatomical regions where the items were left, the care settings, and contributing factors—along with several recommendations on ways to reduce these events.

Addressing sentinel events
With regard to addressing human factors, the authors recommended the following:

- Provide team training
- Address disruptive behavior
- Minimize distractions and interruptions
- Account for objects inserted in the wound
- Methodologically explore the surgical site before closure
- Verify the integrity of objects upon removal
- Educate the care team about risk for URFOs, as well as risk-reduction strategies
- Assess competency of personnel

In terms of leadership factors, the commission’s recommendations called for the following:

- Cultivate a culture of safety
- Conduct a proactive risk assessment
The Joint Commission received 436 sentinel event reports in the first six months of 2019, and the two most frequently reported types of events were surgery-related: URFO, with 60 reported events; and wrong site surgical or invasive procedures, with 29 reported events.

- Implement policies and procedures based on the risk assessment
- Audit and provide feedback of compliance with policies and procedures
- Celebrate successes
- Encourage reporting of near misses
- Use the whiteboard to demonstrate insertion of devices
- Verbally acknowledge removal of objects
- Discuss removal of objects during standardized debriefing after procedures
- Discuss need for packing removal during handoff
- Minimize nonurgent verbal orders
- Provide written orders for packing removal
- Document verification of removal and integrity of objects
- Issue a best practice alert to remind the team to remove packing materials

Furthermore, wrong site surgery continues to be a commonly reported sentinel event—with 104 events reported in 2017 and 105 events in 2018. To reduce these events, The Joint Commission refers health care professions to several resources, including The Joint Commission’s Universal Protocol, the Joint Commission Center for Transforming Healthcare’s Safe Surgery Targeted Solutions Tool, and the World Health Organization Surgical Safety Checklist.

Recommended communication strategies included the following:

- Use the whiteboard to demonstrate insertion of devices
- Verbally acknowledge removal of objects
- Discuss removal of objects during standardized debriefing after procedures
- Discuss need for packing removal during handoff
- Minimize nonurgent verbal orders
- Provide written orders for packing removal
- Document verification of removal and integrity of objects
- Issue a best practice alert to remind the team to remove packing materials

In addition, The Joint Commission’s Universal Protocol and other resources have well-established procedures and processes that can help prevent wrong patient, wrong site, and wrong procedure events from occurring.

As a note, it is estimated that fewer than 2 percent of all sentinel events are reported to The Joint Commission. Of these, 58.4 percent (8,714 of 14,925 events) have been self-reported since 2005. Therefore, these data are not an epidemiologic data set, and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

Health care institutions can learn more about sentinel events at www.jointcommission.org/sentinel_event.aspx.

**References**


**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.
Cytoreductive surgery (CRS) with hyperthermic intraperitoneal chemotherapy (HIPEC) has emerged as an acceptable treatment modality for patients with peritoneal surface malignancies. This combined treatment can be considered standard of care for pseudomyxoma peritonei (PMP) and peritoneal mesothelioma, as well as for select patients with peritoneal metastasis from colorectal and advanced epithelial ovarian cancers.1,2 Since the late-1990s, this treatment modality has grown in practice significantly throughout the U.S.3 In addition to the normal physiologic responses after CRS, administration of intra-abdominal chemotherapy and patient hyperthermia lead to myriad biologic responses, including exaggerated fluid and electrolyte shifts, hemodynamic derangements, bone marrow suppression, and inhibited wound healing.4,5 Consequently, HIPEC procedures traditionally have resulted in high rates of postoperative complications.6,8 Contemporary approaches to perioperative care have included liberal use of intravenous fluids to mitigate against chemotherapy-induced nephrotoxicity, routine use of feeding/nasogastric tubes for anticipated ileus, delayed feeding, transabdominal drains, and use of intensive care units—all associated with prolonged lengths of stay.6,12

The Mayo Clinic in Arizona, Phoenix, implemented the HIPEC program in 2010. Morbidity, mortality, and length of stay (LOS) were carefully monitored from the outset. The research team prospectively maintained a database of patients undergoing HIPEC as part of a quality monitoring and improvement initiative. Our initial experience of 49 cases had an overall complication rate of 63 percent with a grade III/IV complication rate of 24 percent. The mean LOS was 10.3 ± 8.9 days, the rate of unplanned surgical intervention was 12 percent, and the rate of 30-day readmission was 16 percent. The surgical oncology group decided to implement an Enhanced Recovery After Surgery (ERAS) program for patients undergoing HIPEC to try to improve on these outcomes.

Implementing the initiative

The Mayo Clinic in Arizona is a 270-bed hospital with 21 operating rooms (ORs). The hospital started operations in 1998 and employs close to 6,000 people. The institution focuses heavily on quality of care and achieving value-based care. Employees have the option of becoming bronze-, silver-, or gold-certified in quality by participating in quality initiatives and projects within their clinical realm. The hospital already has a robust ERAS program in place for colorectal operations, which facilitated implementation of a new program.

The author identified major stakeholders in the HIPEC practice, partnering with anesthesiologists, nursing staff, OR pharmacists, perfusion staff, allied health staff, and general surgery residents. A review of the literature related to perioperative management of patients undergoing CRS and HIPEC was undertaken to identify areas of intervention. Traditional management of HIPEC patients involves large-volume resuscitation, prolonged durations of no peroral intake, and liberal use of narcotic pain medicines. These patients have high rates of morbidity and mortality and prolonged LOS leading to significant use of hospital resources and costs of care.

A literature review yielded no prior studies on implementation of ERAS principles in HIPEC patients, so our team developed interventions that we believed...
would be safe and efficacious based on published literature on implementation of ERAS principles in patients undergoing colon surgery. The physician lead discussed relevant interventions with each stakeholder. Changes to practice were clearly outlined, and written protocols were disseminated and placed on the institutional Intranet for access. Buy-in was not an issue as ERAS pathways were well established in the institution, and all participants appreciated the opportunity to potentially reduce morbidity, mortality, and LOS in HIPEC patients.

Implementing the quality improvement activity
Table 1, this page, outlines the major interventions made following implementation of an ERAS pathway in patients undergoing CRS and HIPEC at our institution. Traditional management prior to implementation also is shown for purposes of comparison. Our program was launched over several months in early 2016.

Table 1. Implemented ERAS Principles vs. Traditional Perioperative Management

<table>
<thead>
<tr>
<th></th>
<th>Traditional approach</th>
<th>Implemented ERAS principle</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nutrition</strong></td>
<td>No routine preoperative protein and carbohydrate supplementation</td>
<td>Routine preoperative protein and carbohydrate supplementation</td>
</tr>
<tr>
<td><strong>Intravenous fluid</strong></td>
<td>Liberal fluid use</td>
<td>Goal-directed/balanced fluids</td>
</tr>
<tr>
<td><strong>Pain control</strong></td>
<td>Reliance on opioids</td>
<td>Multimodal pain therapy including TAP block</td>
</tr>
<tr>
<td><strong>Gastrointestinal function and oral intake</strong></td>
<td>Not per oral until return of bowel function, feeding tubes</td>
<td>Clear liquid diet postoperative day 0, advance as tolerated, no feeding tube</td>
</tr>
<tr>
<td><strong>Drains and tubes</strong></td>
<td>Routine use of nasogastric tubes</td>
<td>Use of drains and tubes only when indicated</td>
</tr>
<tr>
<td><strong>Postoperative level of care</strong></td>
<td>Intensive care unit</td>
<td>Intermediate/step-down</td>
</tr>
</tbody>
</table>

Only one surgeon at Mayo Clinic in Arizona performs CRS and HIPEC procedures, and he served as the project lead. Two anesthesiologists served as the leads for the institution’s other ERAS programs and were responsible for training related to preoperative performance of transversus abdominus plane (TAP) blocks under ultrasound guidance. No additional costs were incurred beyond the normal operating expenses associated with clinical care of these patients, and no dedicated funding was required for the project.

Results
Our study population consisted of 130 CRS and HIPEC procedures, 49 (38 percent) in the pre-ERAS group, and 81 (62 percent) in the post-ERAS group. There was no significant difference in mean Peritoneal Cancer Index, operating time, and patient demographics between both groups. Our primary outcome measure was 30-day morbidity and mortality. Secondary outcome metrics were LOS, 30-day rates of unplanned readmission and reoperation, and rates of acute kidney injury (see Figure 1, page 65).

Only one patient in the cohort in the ERAS cohort (0.8 percent) died, secondary to respiratory failure. After implementation of ERAS, the rate of serious grade III/IV complications decreased from 24 percent to 15 percent, p = 0.243. The rate of all grade I–IV complications fell from 63 percent pre-ERAS to 37 percent post-ERAS, p = 0.004.

Length of hospital stay decreased significantly from a mean of 10.3 ± 8.9 days in the pre-ERAS group to 6.9 ± 5.0 days in the ERAS group (p = 0.007). Rates of 30-day readmission and acute kidney injury did not change significantly. Total opioid use measured in oral morphine equivalents decreased from a median of 272.6 to 159.7 mg, a difference that was statistically significant in the open but not the laparoscopic group. Net total hospital fluid balance decreased from a mean of 6.07 ± 16.8 liters to 3.00 ± 6.3 liters. On multivariable analyses implementation of an ERAS
The program was associated with a reduction in LOS ($\beta = -2.89$ days, 95 percent CI $-0.94$ to $-4.84$) and a reduction in complications (OR 0.22, 95 percent CI 0.08-0.57).

The team encountered no significant barriers related to implementation, which may be attributable to the small size of the team involved and the fact that there was no significant variation in practice, as only one surgeon performed these procedures. Furthermore, a robust ERAS program for colorectal surgery was already in place at our institution so that existing clinical pathways and electronic health record order sets were easily customizable to suit our needs. The most technical aspect of our program—the TAP blocks—required little training as they already were being used by the anesthesiologists on the team.

A formal cost analysis was not conducted, but one is in development. As a ballpark estimate, we cut our mean LOS from 10 to seven days. The average cost for a one-day stay in an Arizona not-for-profit hospital is $2,675,14 which translates to an average savings of $9,095 per CRS and HIPEC performed. This estimate does not take into account the 38 percent reduction in complication rates.

**Tips for others**

Other institutions interested in conducting similar quality improvement programs are advised to do the following:
A formal cost analysis was not conducted, but as a ballpark estimate, reduction in mean LOS from 10 to seven days results in savings of $9,095 per HIPEC case.

REFERENCES

Surgical resection is the most effective treatment for early-stage non-small cell lung cancer (NSCLC), but in many cases, surgery alone is not enough. Despite advances in surgical techniques and radiation technology, up to 75 percent of patients will develop metastatic disease. The addition of adjuvant chemotherapy can improve five-year disease-free survival (DFS) 5 to 15 percent; however, long-term survival after treatment for early-stage NSCLC remains a significant challenge, especially in comparison with the improvements that have been made in other solid tumors, such as breast and colon cancer. Identification of a therapeutic regimen that successfully reduces recurrence rates after surgical resection of early-stage NSCLC could improve many lives.

Significant advances have been made in the treatment of metastatic NSCLC, particularly with the addition of immune checkpoint inhibitors, such as pembrolizumab, an anti-programmed death (PD)-1 antibody that works by releasing the brakes on the immune system, resulting in T-cell activation and tumor cell death. In metastatic NSCLC without a targeted therapy option (for example, epithelial growth factor receptor [EGFR] mutations or anaplastic lymphoma kinase [ALK] fusion), pembrolizumab +/- chemotherapy is now the first-line standard of care. For patients with unresectable stage III NSCLC, durvalumab (anti-PD-L1 antibody), is now standard of care treatment after concurrent chemotherapy + radiation, with an 11 percent improvement in disease-free survival at two years and an increase in median progression-free survival from 5.6 months to 17.2 months.

Fortunately, these therapies typically are well-tolerated, even when received regularly for extended periods of time. The question then becomes: if these regimens are showing promising results for patients with advanced disease, can they be used to improve survival in early-stage, resectable NSCLC patients? Promising data for short-course neoadjuvant checkpoint blockade were presented at the 2019 American Society of Clinical Oncology meeting, demonstrating a major pathologic response of 24 percent for patients with stage I–IIIA resectable NSCLC, treated with three cycles of checkpoint blockade. Other ongoing studies are evaluating checkpoint inhibitors after completion of postoperative chemotherapy and enroll only after completing adjuvant chemotherapy. Although a sequential approach represented a logical next step in adjuvant therapy, there has been considerable success in the metastatic setting, safely administering immune therapy drugs with chemotherapy. This more aggressive strategy may have the most potential in patients with minimal disease burden, such as the surgically resected population.

ACSM Clinical Research Program:

ALCHEMIST trial has potential to improve outcomes after lung cancer resection

by Jacob Sands, MD; Linda W. Martin, MD, MPH; Dennis Wigle, MD, PhD; Matthew Facktor, MD; and Christina L. Roland, MD
receiving any chemotherapy (see Figure 1, this page). In this trial, patients with stage IB–IIIA NSCLC treated with definitive surgical resection will be randomized to one of three arms: platinum doublet chemotherapy alone, platinum doublet followed by pembrolizumab (anti-PD-1 therapy), or platinum doublet with concurrent pembrolizumab followed by pembrolizumab. This novel trial, following complete resection of stage IB-IIIA NSCLC, requires EGFR and ALK status for eligibility and PD-L1 for stratification. The three-arm design will allow an opportunity to compare both the sequential arm and concurrent arm with standard of care chemotherapy. There also will be an opportunity to compare the two experimental arms with each other.

ALCHEMIST CHEMO-IO is a novel, high-impact trial for patients with early-stage NSCLC with the potential to change the way patients with resected NSCLC are treated. Whereas all eligible patients for this trial will have undergone resection, surgeons are the gatekeepers for identifying these patients in a timely manner and will play a crucial role in accrual to adjuvant studies.

For more information, contact Jacob Sands, MD, at jacob_sands@dfci.harvard.edu.

**Eligibility criteria:**
- Resected NSCLC enrolled on A151216
- NSCLC of any histologic subtype
- Stage IB (≥ 4 cm) or stage II–IIIA (per AJCC 7th edition)
- Complete R0 resection
- ECOG PS 0-1
- EGFR and ALK negative locally or centrally on A151216
- Candidate for adjuvant platinum-doublet chemotherapy
- Eligible for treatment with an immune checkpoint inhibitor
- 30–77 days post-surgery

**Acceptable regimens:**
- Cisplatin (or carboplatin) pemetrexed
- Cisplatin gemcitabine
- Carboplatin paclitaxel

**Each experimental arm includes a total of 17 doses of pembrolizumab**

**REFERENCES**

Gliomas are the most common form of malignant brain tumor in the U.S. They are composed of astrocytoma (including glioblastoma), oligodendroglioma, ependymoma, oligoastrocytoma, malignant glioma, and other nonspecified and rare histologies. Glioblastoma presents as the most common form of glioma—as well as one of the most lethal—with a five-year survival rate of 5 percent. This mortality rate makes assessing the treatments for glioblastoma critical. Glioblastoma incidence differs significantly within population-based analyses between age, sex, and race/ethnicity. Reports indicate that white men have the highest rates, while incidence tends to increase with age.

A National Cancer Database (NCDB) study using 2012–2014 data showed that compared with population-based national cancer registry data, the NCDB included 85.8 percent of brain/cranial nerves malignant cases, 85.6 percent of brain and other nervous system cases, and 57.8 percent of brain cranial nerves benign/borderline cases, but did not specifically analyze astrocytoma or glioblastoma. This column compares patient demographics of astrocytomas and glioblastomas from the NCDB, a hospital-based cancer registry, and the Central Brain Tumor Registry of the U.S. (CBTRUS), a population-based registry. We assessed whether the NCDB data are representative of national data for astrocytomas and glioblastomas by race, age, and sex, which are significant prognostic factors for glioblastoma. This characterization is particularly important, as NCDB data are used for analysis of treatment and survival.

Methods
NCDB and CBTRUS data on astrocytoma and glioblastoma were compared for diagnosis years 2006–2010 and 2011–2015. The International Classification of Diseases for Oncology, 3rd Edition, was used to determine primary sites (C70.0, C70.1, C70.9, C71.0–C71.9, C72.0–C72.5, C72.8–C72.9, and C75.1–C75.3) and histology/behavior codes—astrocytoma consists of pilocytic astrocytoma (9421/1) and (9425/3 only for diagnosis year group 2011–2015), diffuse astrocytoma (9400/3, 9410/3, 9411/3, and 9420/3), anaplastic...

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<tbody>
<tr>
<td>Astrocytoma</td>
<td>26.8% (18,023)</td>
<td>28.1% (19,840)</td>
<td>&lt;0.0001</td>
<td>24.8% (18,096)</td>
<td>26.4% (20,732)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Glioblastoma</td>
<td>73.2% (49,331)</td>
<td>71.9% (50,872)</td>
<td>&lt;0.0001</td>
<td>75.2% (54,880)</td>
<td>73.6% (57,805)</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

*The p-value is comparing NCDB and CBTRUS for each subgroup of cancer type.

analyses were completed with SAS (statistical analysis software) (9.4, Cary, NC) using the significance threshold of $p < 0.05$.

**Results**

**Cancer type**

The percentage of astrocytomas and glioblastomas in the NCDB was similar to that in CBTRUS, with approximately 75 percent of the cases categorized as glioblastomas in each database and set of diagnosis years. Although similar, the comparison of the NCDB and CBTRUS by each cancer type for 2006–2010 and 2011–2015 showed that the differences were statistically significant (see Figure 1, this page).

**Age at diagnosis comparison**

Age at diagnosis was categorized as 0–14 years old, 15–39 years old, and 40 years old and older. Data were obtained from NCDB for 2006–2010 and 2011–2015.

astrocytoma (9401/3), and unique astrocytoma variants (9381/3, 9384/1, and 9424/3); glioblastoma consists of (9440/3, 9441/3, and 9442/3). Percentages for the subgroups of age at diagnosis, race, and sex were calculated for each cancer type, source of data, and diagnosis year. Statistical significance for comparisons within each subgroup between NCDB and CBTRUS was performed using the z-test for proportions, using the Bonferroni method of correction. Statistical
However, CBTRUS presented only 2011–2015 data because complete data from CBTRUS for this age subgroup were not available for 2006–2010.

For 2011–2015 astrocytoma data, the age distribution was similar in NCDB and CBTRUS data, with 55 percent of cases 40 years old and older in NCDB and 50 percent 40 years old and older in CBTRUS. The percentage of cases 0–14 years old were slightly lower in the NCDB compared with CBTRUS (15 percent versus 22 percent). All age differences were statistically significant between the NCDB and CBTRUS (see Figure 2, this page).

For 2011–2015 glioblastoma data, age distributions also were similar between NCDB and CBTRUS, with about 95 percent of patients age 40 and older in both databases. No statistically significant differences were found between the NCDB and CBTRUS by age for glioblastoma (see Figure 2).
Race comparison

Race was categorized as American Indian/Alaskan Native (AIAN), Asian/Pacific Islander (API), black (B), and white (W) for both sets of diagnosis years for NCDB and CBTRUS. Other and unknown race were excluded from this portion of the analysis.

For astrocytoma, the percent race distribution was similar between NCDB and CBTRUS for both 2006–2010 and 2011–2015 diagnosis years. In 2011–2015, 88 percent of NCDB patients were white, 8 percent of NCDB patients were black versus 9 percent of CBTRUS cases, and 3 percent of NCDB patients were API versus 4 percent of CBTRUS cases.

For glioblastoma cases, the race distribution also was similar between NCDB and CBTRUS for black patients, but statistically significant differences existed for all other racial subgroups (see Figure 3, this page).

For 2006–2010 and 2011–2015, no statistically significant difference was seen between NCDB and CBTRUS for black patients, but statistically significant differences existed for all other racial subgroups (see Figure 3, this page).

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**FIGURE 3.** 

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<tbody>
<tr>
<td></td>
<td>NCDB</td>
<td>CBTRUS</td>
<td>p-value*</td>
<td>NCDB</td>
</tr>
<tr>
<td>AIAN</td>
<td>0.4%   (75)</td>
<td>0.7%   (136)</td>
<td>0.0030</td>
<td>0.7%   (137)</td>
</tr>
<tr>
<td>API</td>
<td>2.2%  (387)</td>
<td>3.7%  (728)</td>
<td>&lt;0.0001</td>
<td>2.8%  (499)</td>
</tr>
<tr>
<td>B</td>
<td>7.8%  (1,363)</td>
<td>8.2%  (1,620)</td>
<td>0.4345</td>
<td>8.4%  (1,470)</td>
</tr>
<tr>
<td>W</td>
<td>89.6% (15,707)</td>
<td>87.4% (17,208)</td>
<td>&lt;0.0001</td>
<td>88.4% (15,511)</td>
</tr>
</tbody>
</table>

*The p-value is comparing NCDB and CBTRUS for each subgroup of race.*
and CBTRUS. In 2011–2015, white patients comprised 92 percent of NCDB cases and 91 percent of CBTRUS cases, black patients comprised 6 percent of NCDB cases and CBTRUS cases, while API comprised 2 percent of both databases. No statistically significant difference was detected between NCDB and CBTRUS in 2006–2010 and 2011–2015 for black patients, but statistical differences for all other race subgroups were found (see Figure 3).

Sex comparison
Sex was categorized as male and female for both sets of diagnosis years within the NCDB and CBTRUS.

For 2006–2010 and 2011–2015 astrocytoma cases, the percent distribution by sex was similar in NCDB and CBTRUS. In 2011–2015, 54 percent of cases were male in both databases. All differences in each sex between the NCDB and CBTRUS were not statistically significant (see Figure 4, this page). For glioblastoma, the
The NCDB astrocytoma and glioblastoma comparisons indicate similarities with population-based data from CBTRUS, for diagnosis years 2006–2010 and 2011–2015. Distribution by sex was similar to astrocytoma in both databases for 2006–2010 and 2011–2015. In 2011–2015, 58 percent of NCDB and CBTRUS cases were male, with all differences between the NCDB and CBTRUS for each sex not statistically significant (see Figure 4).

Discussion
The NCDB astrocytoma and glioblastoma comparisons indicate similarities with population-based data from CBTRUS, for diagnosis years 2006–2010 and 2011–2015. These trends were similar by cancer type, age at diagnosis, race, and sex, and in multiple instances no statistically significant difference was found between NCDB and CBTRUS within the subgroups analyzed. Analytic studies using NCDB astrocytoma and glioblastoma demographic data are thus representative of national data and could be used to identify trends in treatment, survival, and other factors.

Acknowledgment
Statistical support for this column was provided by Amanda E. Browner, MS, Statistician, NCDB.

REFERENCES
J. Wayne Meredith, MD, FACS, MCCM, the Richard T. Myers Professor and Chairman, department of surgery, Wake Forest School of Medicine, Winston-Salem, NC, has been elected to serve as the 2019–2020 President-Elect of the American College of Surgeons (ACS).

An esteemed trauma, thoracic, and critical care surgeon, Dr. Meredith is the chair of surgery at Wake Forest School of Medicine. Dr. Meredith and the First and Second Vice-Presidents-Elect were elected at the October 30 Annual Business Meeting of Members in San Francisco, CA, along with a new Secretary and Treasurer (see page 78).

Dr. Meredith joined the faculty of Wake Forest University Health Sciences in 1987. In his years of service at Wake Forest School of Medicine, Dr. Meredith has taken on many roles. He was director of surgical sciences through June 2014 and appointed surgeon-in-chief, Wake Forest Baptist Medical Center, in July 2019.

Dr. Meredith has served 10 years as residency program director, department of surgery, Wake Forest School of Medicine. In addition to serving as medical director of The Childress Institute for Pediatric Trauma, Dr. Meredith holds a cross-appointment at Wake Forest Institute for Regenerative Medicine, as well as a joint appointment as professor of pediatrics in the department of pediatrics.

He is a member of Wake Forest’s graduate medical education committee (1999–present), the risk and insurance management advisory council (2002–present), the faculty executive council (2002–present), the cancer center oversight committee (2004–present), the medical executive committee (2011–present), and the health system management council (2011–present). He served on the boards of North Carolina Baptist Hospital and Wake Forest Baptist Medical Center.

A Fellow of the College since 1990, Dr. Meredith has devoted much of his energy to ACS trauma-related activities. He served as Medical Director, Trauma Programs (2006–2010), and Chair, Committee on Trauma (COT) (2002–2006). He has chaired the COT’s National Trauma Data Bank Ad Hoc Committee (1997–2002) and the Trauma Registry Subcommittee (1994–2002) and continues to serve on the Verification, Review, and Consultation Committee (1996–present). In addition, he has been a liaison member of the Program Committee (2002–2006), a member of the national faculty for Advanced Trauma Life Support® (2002–present), and the ACS COT representative to the American Board of Surgery (ABS) trauma, burns, and critical Care advisory council (2005–2006).

Dr. Meredith is an ACS Governor at-Large (2017–present) and serves on the Board of Governors Surgical Training Workgroup. He previously served on the Health Policy Advisory Council (2018).

Furthermore, Dr. Meredith has played a significant role in state-level ACS activities since joining the North Carolina Chapter of the ACS in 1991. He has served as a member of the chapter’s board of directors (1994–present), member (1991–present) and Chair (1991–1997) of the North Carolina COT, and North Carolina Chapter President (2005).

The College honored Dr. Meredith for his contributions to the ACS with the 2014 Distinguished Service Award (DSA). The Board of Regents (B/R) of the ACS presented the DSA to Dr. Meredith in appreciation of “his continuous and devoted service as a Fellow” and “in recognition of his distinctive scientific contributions in cardiovascular physiology.”
A Fellow of the College since 1990, Dr. Meredith has devoted much of his energy to ACS trauma-related activities. He served as the Medical Director, Trauma Programs (2006–2010), and Chair, COT (2002–2006).

during resuscitation, trauma registries, and trauma systems.”

In addition to his previously noted service in leadership roles in ACS Trauma Programs, Dr. Meredith has been active in the field in various capacities—both nationally and globally. Dr. Meredith has been named a visiting professor or named lecturer at more than 20 institutions around the world, from Johannesburg, South Africa, to Quito, Ecuador. He is author or co-author of more than 170 scientific publications, more than 20 book chapters, and one textbook, *Trauma: Contemporary Principles and Therapy*. He also serves on the editorial boards of numerous journals.

His research interests include thoracic trauma, the biomechanics of crash injury, injury severity measures, and trauma systems development. Over the course of his career, Dr. Meredith has been awarded 10 grants for various trauma research studies. He is the principal investigator for a National Institutes of Health (NIH) grant for Integrative Training in Trauma and Regenerative Medicine, as well as a joint project with Wake Forest School of Medicine and the National Highway Traffic Safety Administration that established a Crash Injury Research and Engineering Network center at Wake Forest and Virginia Tech, Blacksburg.

Dr. Meredith has held leadership roles in other professional organizations, including president of surgical professional societies, such as the Southeastern Surgical Congress, the Eastern Association for the Surgery on Trauma, the Halsted Society, the American Association for the Surgery of Trauma, and the Southern Surgical Association. Dr. Meredith has held multiple other leadership positions including director of the ABS and the American Board of Thoracic Surgery.

Dr. Meredith graduated from Emory University, Atlanta, GA, with a bachelor of arts in physics. He earned his medical degree and completed his surgical training in general surgery and in cardiothoracic surgery at what is now Wake Forest Baptist Medical Center in Winston-Salem. He completed his trauma/critical care fellowship as visiting assistant professor of surgery/trauma under the supervision of the late Donald D. Trunkey, MD, FACS, at Oregon Health Sciences University Hospital, Portland.

**First Vice-President-Elect**

The First Vice-President-Elect is H. Randolph Bailey, MD, FACS, FASCRS, a respected colon and rectal surgeon who practices at the University of Texas (UT)/McGovern Medical School, Houston. Dr. Bailey is professor of surgery and emeritus program director of the UT colon and rectal surgery residency training program. He is chief, division of colon and rectal surgery, Memorial Hermann Hospital–Texas Medical Center, and deputy chief of surgery, Houston Methodist Hospital, TX.

A Fellow of the ACS since 1976, Dr. Bailey has served on the ACS B/R (2003–2012). As a Regent, he served on the following B/R committees: Executive Committee (2011–2012), Finance Committee (2010–2011), Finance Committee Investment Subcommittee (2006–2011), and Communications Committee (2003–2004). He is a member of the Board of Directors of the ACS Foundation. He was an ACS Governor (2002–2004) and served in various capacities on the ACS Advisory Council for Colon and Rectal Surgery (1995–2012) and was its chair (1996–2001), and chaired the ACS Advisory Council Chairs (2000–2001). He was Vice-Chair of the Legislative Committee (2011–2016). He also has been a member of the Health Policy and Advocacy Group (2012–2015) and has served on the Member Services Liaison

Dr. Bailey is a past-president of the American Society of Colon and Rectal Surgeons and the American Board of Colon and Rectal Surgery. He is a member of the American Surgical Association, the Texas Surgical Society, and the Society of American Gastrointestinal Endoscopic Surgeons.

He earned his medical degree from the UT Southwestern Medical Center, Dallas; completed his internship at Parkland Memorial Hospital, Dallas; completed his general surgery training at the UT Houston; and did his fellowship training at Ferguson Hospital, Grand Rapids, MI.

Second Vice-President-Elect
The Second Vice-President-Elect is Lisa A. Newman, MD, MPH, FACS, FASCO, director, interdisciplinary breast program; chief, division of breast surgery, and medical director, International Center for the Study of Breast Cancer Subtypes, Weill Cornell Medicine-New York Presbyterian Hospital Network, NY. She also is an adjunct professor of breast surgery at UT MD Anderson Cancer Center, Houston.

An ACS Fellow since 1994, Dr. Newman has been an active member of the Commission on Cancer (CoC) (2001−2009), serving on the CoC Scientific Review Subcommittee (2005−2007) and as a CoC Liaison (2001−2009). She also has been a member of the Scholarships Committee of the Fellows (2009−2010), and the Committee on Diversity Issues (2005−2008).

Dr. Newman’s research interests include cancer incidence and outcome disparities, with a focus on breast cancer disparities related to racial/ethnic background and socioeconomic resources; triple-negative breast cancer; neoadjuvant systemic therapy for breast cancer; lymphatic mapping and sentinel lymph node biopsy for breast cancer; and breast cancer risk assessment. She has been awarded 13 research grants from the NIH, the Susan G. Komen Foundation, and other funders. She has authored or co-authored 142 peer-reviewed publications. She serves on the editorial board for JAMA Surgery and is a Komen Scholar as well as a scientific advisory board member for the Susan G. Komen Breast Cancer Foundation. At present, she is a peer reviewer for Annals of Surgical Oncology, JAMA Surgery, Journal of Clinical Oncology, and Clinical Oncology.

In addition to the ACS, Dr. Newman is a member of the Association of Women Surgeons, American Society of Clinical Oncology, American Society of Breast Surgeons, Society of Surgical Oncology, Society of Black Academic Surgeons, and American Surgical Association, among others.

Dr. Newman earned a bachelor of arts degree from Harvard University, Cambridge, MA, and her medical degree from State University of New York (SUNY) Downstate Medical Center, Brooklyn. She completed her general surgery residency at SUNY Downstate Medical Center and her surgical oncology fellowship at the UT MD Anderson Cancer Center, Houston. Her master of public health degree is from the Harvard School of Public Health, Boston, MA. ♦
Two new Officers of the American College of Surgeons (ACS) were elected at the October 30 Annual Business Meeting of the Members in San Francisco, CA. Tyler G. Hughes, MD, FACS, a general surgeon from Salina, KS, will replace Edward E. Cornwell, MD, FACS, FCCM, as Secretary, and Don K. Nakayama, MD, MBA, FACS, a pediatric surgeon from Chapel Hill, NC, will replace William G. Cioffi, Jr., MD, FACS, as Treasurer.

Dr. Hughes is a general surgeon in McPherson, KS, and is clinical professor of surgery and director, medical education, Kansas University School of Medicine Salina. A Fellow of the College since 1986, Dr. Hughes has served in several ACS leadership positions and is presently Editor, ACS Communities. He was instrumental in establishing the Advisory Council for Rural Surgery and chaired the council (2012–2016). He also has served on the Board of Governors (B/G) (2009–2015) and was a member of the B/G Committee on Socioeconomic Issues (2010–2013), Communications Pillar (2013–2015), Continuing Education Workgroup (2013–2015), Newsletter Workgroup (2013–2015), and Surgical Volunteerism and Humanitarian Awards Workgroup (2013–2015).

At the local level, Dr. Hughes is Past-President, Kansas Chapter of the ACS (2006–2007), and Past-Chair, Kansas Credentials Committee (1999–2012).

Dr. Nakayama is clinical professor, division of pediatric surgery, department of surgery, University of North Carolina at Chapel Hill School of Medicine. An ACS Fellow since 1990, he also has been active in the Advisory Council for Rural Surgery (2013–2017) and the Board of Governors (2011–2013), serving on the Governors Committee to Study the Fiscal Affairs of the College (2012–2013) and Committee to Restructure B/G Committees (2012–2013).

Dr. Nakayama has been Chair of the History and Archives Committee since 2016.

He has been active at the state level as well and is a Past-President, Georgia Society of the ACS (2008–2010), and has served on the Georgia Credentials Committee (2011–2013). ♦
The Board of Governors (B/G) of the American College of Surgeons (ACS) has elected two new members of the Board of Regents—Diana L. Farmer, MD, FACS, FRCS, and Steven C. Stain, MD, FACS. In addition, new B/G Executive Committee members have been elected.

**Regents**

Dr. Farmer, a highly regarded pediatric and fetal surgeon, is the Pearl Stamps Stewart Endowed Chair and Distinguished Professor and Chair, department of surgery, University of California (UC) Davis School of Medicine. She is surgeon-in-chief, UC Davis Children’s Hospital and Chief of Surgery, Shriners Hospitals for Children, Sacramento.


At the local level, Dr. Farmer has been a member of the Northern California Chapter of the ACS since 1998, serving on the chapter’s Executive Council (2011–2013) and the Northern California Credentials Committee (2012–2015).

She is Past-President of the Society of Surgical Chairs (2016–2017), which the ACS manages, and a member since 2010. In 2015, Dr. Farmer cohosted an ACS Surgical Quality Forum at the
Sacramento Health Foundation and UC Davis Medical Center. A distinguished fetal stem cell scientist, she was the 2017 Owen Wangensteen Surgical Forum Dedicatee. She is a Life Member of the ACS Foundation Fellows Leadership Society and was the recipient of the 2017 ACS Professional Association Political Action Committee (ACSPA-SurgeonsPAC) Warshaw Award-PAC MVP.

Dr. Stain is professor of surgery and Henry and Sally Schaffer Chair, department of surgery, Albany Medical College, NY. An esteemed general surgeon, he has been a Fellow of the ACS since 1994.

Dr. Stain has served in several ACS leadership positions. He has served on the B/G since 2013 and the B/G Executive Committee since 2014, most recently as Chair (2018–2019), Vice-Chair (2016–2018), and Secretary (2015–2016). Actively involved in the ACS Foundation, Dr. Stain has been a member of the Fellows Leadership Society since 2002 and has served on the Foundation’s Committee on Major Gifts (2009–2015) and Board of Directors (2012–2015). He has been the ACS Representative to the Accreditation Council for Graduate Medical Education Residency Review Committee for Surgery (2011–2017). He served on the ACS Health Policy and Advocacy Group (2014–2016).

He has been heavily involved in the ACS chapters in the states where he has practiced, including the Southern California Chapter (Membership Committee, 1997–2000; Assistant Chairman, Program Committee, 1998–1999; Associate Chairman Program Committee, 1999–2000; and Committee on Applicants, 1996–2000); the Tennessee Chapter (2001–2005, Committee on Applicants, 2003–2005); and New York Chapter (2005–present, Committee on Applicants, 2014–present, Chair, Committee on Applicants, 2019–present).

In addition, the following individuals have been reelected to serve three-year terms on the Board of Regents:

- Anthony Atala, MD, FACS, director, Wake Forest Institute for Regenerative Medicine, and the W. Boyce Professor and Chair, department of urology, Wake Forest University, Winston-Salem, NC

- James W. Gigantelli, MD, FACS, ophthalmology chair and professor of ophthalmology, Joan C. Edwards School of Medicine, Marshall University, Huntington, WV

- Fabrizio Michelassi, MD, FACS, Lewis Atterbury Stimson Professor and chairman, department of surgery, Weill Cornell Medical College; and surgeon-in-chief, New York Presbyterian/Weill Cornell Medical Center, New York, NY

B/G Executive Committee
The B/G elected the following Officers of the B/G Executive Committee:

- Chair: Ronald J. Weigel, MD, PhD, FACS, professor and chair of surgery, associate vice president for the University of Iowa (UI) Health Alliance, professor of surgery-surgical oncology and endocrine surgery, professor of biochemistry, professor of anatomy and
cell biology, and professor of molecular physiology and biophysics, UI, Iowa City. He has served on the Executive Committee since 2018.

• Vice-Chair: Taylor Sohn Riall, MD, PhD, FACS, professor and interim chair, department of surgery, University of Arizona College of Medicine, Tucson. Dr. Riall is the outgoing Quality, Research, and Optimal Patient Care Pillar Lead.

• Secretary: Mika Sinanan, MD, PhD, FACS, a general surgeon, University of Washington (UW) Medicine and the Seattle Cancer Care Alliance (SCCA) and professor of general surgery and adjunct professor of electrical engineering, UW, Seattle. Dr. Sinanan is the outgoing Advocacy and Health Policy Pillar Lead.

• Andre Campbell, MD, FACS, FACP, FCCM, has been re-elected to the B/G Executive Committee. Dr. Campbell is professor of surgery, division of general surgery, director, surgery clerkship, and director, surgical critical care fellowship, University of California-San Francisco. Dr. Campbell is the Education Pillar Lead.

New members of the B/G Executive Committee elected to serve one-year terms include the following:

• Mark A. Dobbertien, DO, FACS, is a minimally invasive surgeon in Jacksonville, FL. He is affiliated with Naval Hospital Jacksonville, and Flagler Hospital, St. Augustine, FL. He is Vice-Chair, Surgical Volunteerism and Humanitarian Awards Workgroup, Member Services Pillar, and is a member of the Health Policy and Advocacy Workgroup, Advocacy and Health Policy Pillar, and co-chair, Opioid Use/Abuse Subcommittee of the Workgroup. He will serve as the Member Services Pillar Lead.

• Nancy L. Gantt, MD, FACS, is professor of surgery, Northeast Ohio Medical University, Rootstown, and co-medical director, Joanie Abdu Comprehensive Breast Care Center, St. Elizabeth Youngstown Hospital Center, OH. She is Vice-Chair of the Surgical Care Delivery Workgroup, Quality, Research, and Optimal Patient Care Pillar. She will now serve as the Quality Pillar Lead.

• Dhiresh R. Jeyarajah, MD, FACS, is head of surgery, Texas Christian University, and University of North Texas Health Science Center, Fort Worth. He is program director, hepatopancreato-biliary (HPB) and advanced gastrointestinal fellowship, and associate program director, general surgery residency, Methodist Richardson Medical Center, TX. He is an HPB and foregut surgeon in Dallas, TX. He is outgoing Chair, Newsletter Workgroup, Communications Pillar, and will now serve as Communications Pillar Lead.

• Martin A. Schreiber, MD, FACS, is professor and chief, division of trauma and critical care, Oregon Health & Science University, Portland. He is Chair, Grassroots Advocacy Engagement Workgroup, Health Policy and Advocacy Pillar.
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Visit facs.org/ftl100 to donate. You can also text FTL100 to 41444.
Call for nominations for ACS Officers-Elect and ACS Board of Regents

The American College of Surgeons (ACS) 2020 Nominating Committee of the Fellows (NCF) and the Nominating Committee of the Board of Governors (NCBG) will be selecting nominees for leadership positions in the College as follows.

**Call for nominations for Officers-Elect**
The 2020 NCF will select nominees for the three Officers-Elect positions of the ACS: President-Elect, First Vice-President-Elect, and Second Vice-President-Elect. The deadline for submitting nominations is February 21, 2020.

**Criteria for consideration**
The NCF will use the following guidelines when considering potential candidates:

- Nominees must be loyal members of the College who have demonstrated outstanding integrity and an unquestioned devotion to the highest principles of surgical practice.
- Nominees must have demonstrated leadership qualities, such as service and active participation on ACS committees or in other areas of the College.

- The ACS encourages consideration of women and underrepresented minorities for all leadership positions. All nominations must include the following:
  - A letter/letters of nomination
  - A current curriculum vitae (CV)
  - The name of one individual who can serve as a reference

In addition, nominations for President-Elect must include the following:

- A personal statement from the candidate detailing their ACS service and interest in the position
- Further details
  - Entities such as surgical specialty societies, ACS Advisory Councils, ACS Committees, and ACS chapters that provide a letter of nomination must provide a description of their selection process and the total list of applicants reviewed.
  - Any attempt to contact or influence members of the NCF by a candidate or on behalf of a candidate will be viewed in a negative manner and may result in disqualification.

Applications submitted without the requested information will not be considered.

Nominations must be submitted to officerandbrnominations@facs.org. If you have any questions, contact Emily Kalata, staff liaison, NCBG, at 312-202-5360 or ekalata@facs.org.

**Call for nominations for Board of Regents**
The 2020 NCBG will select nominees for four pending vacancies on the Board of Regents (B/R) to be filled at Clinical Congress 2020. The deadline for submitting nominations is February 21, 2020.

**Criteria for consideration**
The NCBG will use the following guidelines when considering potential candidates:

- Nominees must be loyal members of the College who have demonstrated outstanding integrity and an unquestioned devotion to the highest principles of surgical practice.
- Nominees must have demonstrated leadership qualities, such as service and active participation on ACS committees or in other areas of the College.

Applications submitted without the requested information will not be considered.
The ACS encourages consideration of women and underrepresented minorities for all leadership positions.

Only individuals who are in and expected to remain in active surgical practice for their entire term may be nominated for election or reelection to the Board of Regents.

The NCBG recognizes the importance of the B/R representing all who practice surgery in both academic and community practice, regardless of practice location or configuration. Nominations are open to surgeons of all specialties, but particular consideration will be given in this nomination cycle to the following specialties:

• Burn and critical care surgery
• Gastrointestinal surgery
• General surgery
• Surgical oncology
• Transplant surgery
• Trauma surgery
• Vascular surgery

Note that during this nomination cycle, two of the seats are Bylaws-designated Canadian seats and, therefore, only Canadian Fellows will be considered for these vacancies.

All nominations must include the following:

• A letter of nomination
• A personal statement from the candidate detailing their ACS service and interest in the position
• A current CV
• The name of one individual who can serve as a reference

Further details
Entities such as surgical specialty societies, ACS Advisory Councils, ACS Committees, and ACS chapters who wish to provide a letter of nomination must provide at least two nominees, and a description of their selection process, along with the total list of applicants reviewed.

Any attempt to contact or influence members of the NCBG by a candidate or on behalf of a candidate will be viewed in a negative manner and may result in disqualification. Applications submitted without the requested information will not be considered.

Nominations may be submitted to officerandbrnominations@facs.org. If you have any questions, contact Emily Kalata, staff liaison, NCBG, at 312-202-5360 or ekalata@facs.org.

For information only, the current members of the B/R who will be considered for re-election are Gary L. Timmerman, MD, FACS, and Douglas E. Wood, MD, FACS.
The American College of Surgeons (ACS), in association with Pfizer, Inc., will begin accepting nominations for the 2020 Surgical Volunteerism and Surgical Humanitarian Awards December 16, 2019. Nominations will be accepted through February 15, 2020.

Volunteerism Awards
The ACS/Pfizer Surgical Volunteerism Award—offered in four potential categories annually—recognizes surgeons who are committed to giving back to society by making significant contributions to surgical care through organized volunteer activities. The awards for Domestic, International, and Military* are intended for ACS Fellows in active surgical practice who engage in volunteer activities that go above and beyond their usual professional commitments or retired Fellows who have been involved in volunteerism during their active practice and into retirement. Resident Members and Associate Fellows (members of the Resident and Associate Society of the ACS) who have been involved in significant volunteer activities during their postgraduate surgical training are eligible for the Resident award†. Surgeons in any surgical specialty are eligible to be nominated in each category.

For the purposes of these awards, “volunteerism” is defined as professional work donated for charitable clinical, educational, or other worthwhile activities related to surgery. Volunteerism does not necessarily require that care is uncompensated. Instead, volunteerism should be characterized by prospective, planned surgical care to underserved patients with no anticipation of commensurate reimbursement.

Humanitarian Award
The ACS/Pfizer Surgical Humanitarian Award is given in recognition of a Fellow who has dedicated the majority of their career to ensuring the provision of surgical care to underserved populations without expectation of commensurate reimbursement.

This award is intended to honor an ACS Fellow who has dedicated his or her surgical career to full-time or near full-time humanitarian efforts, rather than routine surgical practice. Examples include a career dedicated

The nomination website will be open for electronic submission on December 16 and can be accessed through the OGB section of the ACS website at facs.org/ogb. For more information, contact OGB at ogb@facs.org.
to missionary surgery, the founding and ongoing leadership of a charitable organization dedicated to providing surgical care to the underserved, or a retirement characterized by surgical volunteer outreach. Having received compensation for this work does not preclude a nominee from consideration and, in fact, may be expected based on the extent of the professional obligation.

Nominations will be evaluated by the ACS Board of Governors’ Surgical Volunteerism and Humanitarian Awards Workgroup and their selections will be forwarded to the Board of Governors’ Executive Committee for final approval.

**Nominations**
The following conditions apply to the nominations process:

- Self-nominations are permissible and encouraged. Such nominations require at least two outside letters of recommendation. One of the letters must be submitted by a Fellow of the College. In addition, self-nominators must submit three references. It is required that at least one reference also be a Fellow of the College.

- Re-nomination of previous nominees is acceptable and encouraged. A resubmission requires completion of a new application. Applicants are encouraged to consider adding additional details and supporting narratives to strengthen their application.

- The Workgroup reserves the right to move a nominee from one category to another based on a review of the application.

- Detailed, precise information must be included in the application for nominees to have the best chance of success. Specific information for inclusion is as follows:
  - Demographic information about the nominee and nominator.
  - Details about the nominator’s relationship to the nominee, along with background information on the nominee’s surgical career.
  - Quantifiable time spent participating in volunteer activities, including: number of trips per year, length of each trip, and the number of years that the nominee has been engaged in this work.
  (Note: Resident nominees are not expected to have the same quantity of volunteer experience as nominees in other categories.)

- Completion of narrative sections requesting detailed information about the nominee’s volunteerism or humanitarian work, including the type of service they provide(d), the sustainability of the programs in which they are involved, any advocacy efforts in which they may have been involved, and additional roles they have played, among other items.

- It helps to tell a story with your nomination. Specific examples and anecdotes are encouraged.

- The information you provide will be shared with your nominee during our verification process. It may be worthwhile to obtain input from the nominee in advance.

- The nomination form does not need to be completed in one sitting and usually requires a significant time commitment. You can save and return to an application with additional information you have obtained about the nominee.

The nomination website will be open for electronic submission on December 16 and can be accessed through the Operation Giving Back (OGB) section of the ACS website at facs.org/ogb. For more information, contact OGB at ogb@facs.org.
Heller School Executive Leadership Program in Health Policy and Management 2020 scholarships available

The American College of Surgeons (ACS) is offering scholarships to subsidize attendance and participation in the Executive Leadership Program in Health Policy and Management at the Heller School for Social Policy and Management at Brandeis University, Waltham, MA. The course takes place June 14–20, 2020, and the $8,000 award is intended to cover the cost of tuition, travel, housing, and subsistence during the period of the course and the postcourse follow-up period. The closing date for receipt of all application materials is February 1, 2020.

Two scholarships, reserved for general surgeons, are fully funded by the College. The ACS also has partnered with a number of surgical specialty societies to cosponsor a scholarship for a member in good standing of both the College and their society to take part in this intensive program. Participating societies include the following: American Association of Neurological Surgeons, American Academy of Otolaryngology–Head & Neck Surgery, American Association for the Surgery of Trauma, American Pediatric Surgical Society, American Society of Breast Surgeons, American Society of Colon and Rectal Surgeons, American Society of Plastic Surgeons, American Surgical Association, American Urogynecologic Society, American Urological Society (via its Gallagher Scholarship program), Americas Hepato-Pancreato-Biliary Association, Eastern Association for the Surgery of Trauma, New England Surgical Society, Society for Surgery of the Alimentary Tract, Society of Thoracic Surgeons, and the Society for Vascular Surgery.

Requirements for these scholarships are posted on the ACS website at facs.org/member-services/scholarships/health-policy. All applicants will be notified of the outcome of the selection process in April 2020. Questions may be directed to the ACS Scholarships Administrator at scholarships@facs.org or 312-202-5281. ♦
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Chapter news

by Luke Moreau and Brian Frankel

Domestic and international chapters of the American College of Surgeons (ACS) met in the last several months to host a variety of activities, including annual meetings, skills competitions, award ceremonies, and more. Following are highlights and photos from these programs.

DOMESTIC CHAPTERS

Connecticut Chapter: The Connecticut Chapter congratulates the 2019 state Surgical Skills Competition winning team from the UCONN (University of Connecticut) Health, Farmington, general surgery residency program. The Surgical Skills Competition, the first of its kind in the U.S., was created in Connecticut 12 years ago. The chapter works with its industry partners to use game theory to enhance surgical training.

Photo, from left: Austin Healy, MD, postgraduate year (PGY)-1; Anthony Tran, MD, PGY-4; and Constantine “Dean” Poulos, MD, PGY-2.

Florida Chapter (FL-ACS): 2019 Florida Medical Association (FMA) Annual Meeting, August 11–13, Orlando. The chapter helped move two resolutions through the FMA House of Delegates: FMA Support for Removing Barriers for Medicare Patients to Colorectal Cancer Screening Act and FMA Support of Bleeding Control Kits in Schools and Public Spaces.

Photo, from left: Vic Velanovich, MD, FACS, Governor; Danielle Henry, MD; John Armstrong, MD, FACS, President; William Liston, MD, FACS; Jay Redan, MD, FACS, Governor and President-Elect; Patricia Byers, MD, FACS, Governor; Mark Soliman, MD, FACS; and Mark Dobbertien, DO, FACS, Treasurer and Governor.

Massachusetts Chapter (MCACS): State Lobby Day, October 8, Boston. More than 50 health care professionals and political leaders participated in the annual tradition, including seven surgery residents. MCACS members met their state legislators and staff to further discuss key issues including the availability of trauma kits in public buildings, access to patient-centered care for opioid use disorders, and coverage for breast and colorectal screenings.

Photo: Massachusetts surgeons and legislators on the grand staircase of the State House.
Germany Chapter: 136th Congress of the German Society of Surgery, March 26, Munich. The Germany Chapter sponsored the panel, Interdisciplinary Trauma Management: Establishing the ASSET Course in Germany. At the business meeting, Ankush Gosain, MD, PhD, FACS, presented his report as ACS Traveling Fellow to Germany. Photo, from left: John Armstrong, MD, FACS, President, ACS Florida Chapter; Germany Chapter members Norbert Senninger, MD, FACS, President; Ernst Klar, MD, FACS, Governor; Wolfram Knoefel, MD, FACS, Vice-President; and Dr. Gosain.

Nigeria Chapter: 2019 Clinical Congress of ACS Nigeria Chapter, July 10–13, Lagos. Pictured: Prof. Oluwole Atoyebi, MBBS, FACS, President (seated sixth from right) and Prof. Emmanuel Ameh, MBBS, FACS, Governor (seated eighth from right) with guests, dignitaries, and Congress attendees.

Minnesota Surgical Society—a Chapter of the ACS: Fall Conference, October 4–5, Minneapolis. The meeting included a session where residents presented to medical students on A Day In the Life of a Surgical Resident and Tips on Transitioning to Residency. The chapter plans to continue this initiative at future meetings. Photo: Medical students from the University of Minnesota.
United Arab Emirates Chapter: First International Congress of the American College of Surgeons United Arab Emirates Chapter, September 12–13, Dubai.

Photo (from left): Ibrahim Turki Tamur, MD, FACS, CABS, FRCS, Treasurer; Basim Alkhafaji, MD, FACS, FRCS, Events and Education Committee Chair; Patricia L. Turner, MD, FACS, Director, ACS Division of Member Services; Prof. Safwan Taha, MD, FACS, CABS, FRCS, MSMBS, Governor; Bassel Safi, MD, FACS, Membership Committee; and Associate Prof. Haytham N. Elsalhat, MD, FACS, EBSO, MBA, Secretary.

Uruguay Chapter: Annual Uruguay Chapter Meeting, August 17, Montevideo. More than 50 people attended the meeting, with many more participating via a live stream.

The main topics covered were trauma, breast, and rectal cancer treatment.

Photo: Chapter members gather together during lunch at the annual meeting.

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**Coming next month in JACS, and online now**

**Enhancing the American College of Surgeons NSQIP Surgical Risk Calculator to predict geriatric outcomes**

Melissa A. Hornor, MD, MS; Meixi Ma, MD, MS; Lynn Zhou, PhD; and colleagues in the January issue of the *Journal of the American College of Surgeons* found that the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) Surgical Risk Calculator (SRC) can predict four unique outcomes germane to geriatric surgical patients, with improvement of predictive capability after accounting for geriatric risk factors. Augmentation of ACS NSQIP SRC may enhance shared decision making to improve the quality of surgical care in older adults.

This article and all other *JACS* content is available at journalacs.org.
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*Dates and locations subject to change. For more information on College events, visit facs.org/events or facs.org/member-services/chapters/meetings.

**DECEMBER**

**Region 14 Meeting**
December 3–5
Punta del Este, Uruguay
Contact: Valentina Henderson, cirugia2019@grupoelis.com.uy

**Saudi Arabia Chapter**
December 6–8
Riyadh, Saudi Arabia
Contact: Dr. Jamal Jomah, info@saudiplasticsurgery.org, acsaudiabaria.com

**Massachusetts Chapter**
December 7
Boston, MA
Contact: Brittany Fiore, meetings@mcacs.org, meeting.mcacs.org

**New Jersey Chapter**
December 7
Iselin, NJ
Contact: Andrea Donelan, njsurgeons@aol.com

**Brooklyn & Long Island Chapter**
December 11
Uniondale, NY
Contact: Teresa Barzyz, acsteresa@aol.com, bliacs.org

**Louisiana Chapter**
January 17–19
New Orleans, LA
Contact: Janna Pecquet, janna@laacs.org, laacs.org

**Utah, Idaho, and Montana-Wyoming Chapters**
January 23–25
Snowbird, UT
Contact: Nathalia Granger, ngranger@facs.org

**Bangladesh Chapter**
January 24–25
Dhaka, Bangladesh
Contact: Prof. Choudhury, qchoudhury@yahoo.com

**FEBRUARY**

**North Texas Chapter**
February 21–22
Dallas, TX
Contact: Carrie Steffen, carrie@ntexas.org, ntexas.org

**FUTURE CLINICAL CONGRESSES**

**2020**
October 4–8
Chicago, IL

**2021**
October 24–28
Washington, DC

**2022**
October 16–20
San Diego, CA

**JANUARY 2020**

**Southern California Chapter**
January 10–12
Santa Barbara, CA
Contact: Tracey Dowden, socalsurgeons@gmail.com, socalsurgeons.org

**South Texas Chapter**
March 5–7
Houston, TX
Contact: Janna Pecquet, janna@southtexasacs.org, southtexasacs.org

**Maryland Chapter**
March 7
Annapolis, MD
Contact: Kathy Browning, kathy@marylandacs.org, marylandacs.org

**Arkansas Chapter**
March 14–15
Little Rock, AR
Contact: Linda Gist, lindac92@comcast.net

**Peru Chapter**
March 25–27
Lima, Peru
Contact: Dr. Jaime Herrera-Matta, juanjaimehpe@yahoo.com

**MARCH**

**Egypt Chapter**
March 5–6
Cairo, Egypt
Contact: Prof. Mohey Elbanna, monheyelbanna@yahoo.com, egyptianchapter-acs.com

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