The ISCR expands scope to include emergency general surgery
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Most of you know that if you hold a word up in front of a mirror, and read from left to right, it will appear to be spelled backward, but if you read it from right to left, you find the true meaning. Likewise, sometimes musicians will record a track so that if it is played backward, listeners will hear a different message than if it’s played normally. That is called backmasking. It, too, is a deliberate process. The same purposeful technique should be applied in turning around an organization’s culture. In this column, we describe how the American College of Surgeons (ACS) turned what was erutuc into a culture that better aligns with our mission.

Why culture change is necessary
Many organizations, businesses, and institutions have sought to eliminate counterproductive behaviors that were previously ignored, especially if these behaviors were exhibited by high-ranking or top-performing employees. In today’s workplace one-upmanship, pilfering resources from others, and belittling comments are recognized as not just inappropriate but toxic.

We now recognize that hiring and retaining talented employees requires leaders to establish a diverse culture in which respect is demonstrated for each employee’s background, talents, skills, and leadership style. People, regardless of profession or trade, want to work in environments that support our productivity, encourage collaboration, and embrace our unique abilities. As leaders of health care facilities, professional associations, and teams, surgeons must be laser-focused on what will matter and how we want to define the culture to deliver value-based, patient-centric care. We must commit to doing the time-consuming work of defining the culture we aspire to lead and defining the values we can use as our guiding principles to make decisions many times each day.

Defining our culture
Approximately seven years ago, the ACS partnered with GE Healthcare Partners to evaluate how we all worked. This process allowed us to reflect on who we were as an organization, where we were, and where we wanted to go. It was about having someone hold up that mirror so we could gain a different perspective. One of the gaps we identified was that the College had never truly defined its culture. We had a mission statement, but we had yet to express our Values—the centerpiece of any culture.

The Executive Leadership Team agreed to commit to protecting time to do what initially sounded easier than it was. We spent many meetings as a leadership group and months working with our staff in focus groups to see this project through. We knew we wanted a place where intelligent, collaborative, and caring people could come together and do what they do best each day. With this goal in mind, we defined our Values as Professionalism, Excellence, Innovation, Introspection, and Inclusion. To learn more about our Values, go to facs.org/about-acs/careers-at-acs/working-at-acs.

But establishing our organizational standards was just the first step in transforming our culture.

Values in action
Values are brought to life by the people in an organization. We introduced the ACS Values to existing staff and educated them about the importance of demonstrating their alignment with these principles. We revised our performance review process to make working in ways that are reflective of our cultural mores a significant component of each employee’s overall evaluation. This strategy reinforced that demonstrating our Values was a key responsibility for all ACS staff and leaders—one that is every bit as important as completing one’s work.

For new hires, it starts with the interview process. We have guides for hiring managers to use to assess
The programs we offer are reflective of our commitment to our mission of improving the care of the surgical patient and safeguarding standards of care in an optimal and ethical practice environment. They are in line with our Values and the culture we aspire to sustain and evolve each day.

whether candidates are a good cultural fit. It would be unrealistic to assume that everyone we hire knows what we want our organization to be, so we train to it. An organization’s commitment to the culture and its aspirational qualities means that it must be willing to teach its employees what that looks like. Training that is ongoing and continually builds on cultural expectations is promoted and embraced.

At the ACS, we offer training on our Values as part of the onboarding process. We also have each staff member take a DiSC (Dominance, influence, Steadiness, and Conscientiousness) and EQi (Emotional Intelligence) assessment. These assessments provide our employees with the opportunity to learn more about who they are and what is important to them and creates an opportunity to begin to understand that other contributors to our organization have different styles and priorities. Training in these areas encourages staff to engage in some Introspection and to appreciate the importance of Inclusion—listening to and appreciating the different perspectives and skills of other team members as they innovate, create, and produce the programs and services ACS members need to thrive in today’s health care environment.

Ongoing professional and personal development

The College offers a robust set of training programs to ensure all staff can grow and develop intellectually in support of our commitment to Excellence. The Executive Leadership Team participates in ULead—four days of annual team training on key topics that align with our mission and strategic priorities. UConnect is offered 10 times a year for an hour to support the professional development of supervisors and covers topics such as becoming a manager and coaching conversations. UImprove is a multiday course that is offered to our staff to introduce how our organization has embraced Performance Improvement and Change Management techniques. ULive courses support our staff’s overall well-being, educating the team on topics such as ergonomics, managing finances, and mental health. ULearn classes are available to all staff on key topics each year, such as leading to engage, avoiding “the drama triangle” in the workplace, working and managing to individual strengths, and thinking outwardly, about the big picture.

In addition, we established a group known as Power of 8 to support our women leaders. The group meets monthly to reflect on individual challenges and success, creates an accountability framework for personal development, and contributes to each member’s professional development. This initiative provides a forum for building a greater network within the organization.

Finally, we offer tuition reimbursement, individual coaching, and support for off-site training courses and educational opportunities. Our commitment to the development of our staff is critical to the health and leadership of our organization.

The programs we offer are reflective of our commitment to our mission of improving the care of the surgical patient and safeguarding standards of care in an optimal and ethical practice environment. They are in line with our Values and the culture we aspire to sustain and evolve each day.

Culture change is no small undertaking, but we believe the benefits are evident in the programs and services we provide to College Fellows and members. This column may have offered you some ideas about how to improve the culture in your institution or practice. And maybe you have implemented some strategies that we have overlooked. If you would like to offer some suggestions or learn more about the ACS’ culture, contact Michelle McGovern, Director of Human Resources and Operations, at mmcgovern@facs.org.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
I was born at the beginning of World War II in a country halfway around the world from the fighting. As a child, I was immune to the carnage. My father was too old to be included, although his elder brother had been killed in World War I. Thousands of families in many countries lost a father, a brother, an uncle, or a friend. Today, I think about what might have been. The one great certainty over which we have no say is where and from what womb we were delivered. Then and now, I could have been born into famine and dead before the age of three. Why don’t we realize our good fortune? I never recalled being hungry or unable to go to school. I was privileged to get an education with help from a scholarship. I was healthy, got vaccinated, played sports, and had no serious illnesses. I am embarrassed to think how much I took for granted and how little I did to take advantage of the abilities and talents I was given.

False humility is wasted energy. Yesterday is gone, today is here—soon to be gone—and tomorrow is unknown. We take education for granted, and we complain about the cost, but what is the cost of never being able to read or write? But for the accident of birth, I may never have been able to read or write. I was not born deaf or blind, so I did not have the challenge that so many have overcome with grace, charm, courage, and insight, accepting their disability and contributing nonetheless.

Perhaps it is time for those of us who inherited an accident of birth and then an education to contribute to those less fortunate.

I entered a prestigious residency as a foreign graduate with some suspicion but little prejudice. To say there was no discrimination is naive. I was a white male; there were few (if any) women or people of color in surgery. I did not need a parent who was on the faculty, albeit I recognized that would have done me no harm. Today, I go to conferences every day in my own institution and watch food left over and thrown away. In our current climate, I hope it wasn’t paid for by industry.

I take for granted that I can go to the opera. A new Broadway
There is a lot of sadness in the oncologic world, but most of the time we are not the recipient but the observer. How do we balance the gift of giving against the pain and grief we see?

Time to pay it forward
This commentary should touch a chord for those reading it, but will it? It may be true for you and me, but it is not true for everyone. Perhaps it is time for those of us who inherited an accident of birth and then an education to contribute to those less fortunate. So many places to start. As a favored immigrant, I should be empathetic to a civilized immigration policy. I should not be asked to choose between “open borders” versus “circle the wagons and fight off the marauders.” There is a certain irony in the latter debate, as we now come from within the circle we created to attack a perceived enemy, forgetting how our forebears attacked the initial inhabitants of this land. Dare I even imagine a civilized debate on health care and not be asked to choose between “Medicare for all” versus “no health care for 30 million?”

True humility starts with acknowledging privilege. How can I convince my young trainees to understand their advantages? Do they realize that not just they, but their children and yet unborn grandchildren, will inherit this accident of birth and be surrounded by others of equal talent and privilege? How do I convince them to use their intelligence, their education, and their freedom from want to better other lives? How do I convince patients that I am on their side and will help them confront the tyranny of the bureaucracy in addition to the malevolence of their disease?

We should all be on the same team. And we have the ultimate privilege—we are alive, and we have time; our patients may not. We cannot do much from beyond the grave. A signed open check in a coffin is still a blank check.
AHRQ Safety Program for ISCR expands scope to include emergency general surgery in 2020

by Elizabeth Wick, MD, FACS; Chelsea Fischer, MD; Stacey McSwine, MBA; and Christina Yuan, PhD, MPH
The American College of Surgeons (ACS)—in collaboration with the Johns Hopkins Medicine Armstrong Institute for Patient Safety and Quality, Baltimore, MD—continues to support U.S. hospitals that are adopting enhanced recovery pathways. This enhanced recovery program—the Agency for Healthcare Research and Quality (AHRQ) Safety Program for Improving Surgical Care and Recovery (ISCR)—launched in the fall of 2016 with funding and guidance from AHRQ.

This article looks at the rationale for starting ISCR, where the program has been, where it’s going, and the benefits of participation. It also highlights a new opportunity to join the program and focus on improving the care of patients undergoing emergency general surgery, as well as new program enhancements designed to help hospitals improve opioid stewardship for surgical patients.

In an effort to provide health care providers and other stakeholders with examples of how ISCR is improving patient care, the experiences of three participating hospitals are described in this article.

The relevance of enhanced recovery programs

Enhanced recovery practices foster patient and family engagement, avoidance of prolonged periods of fasting, appropriate use of both multimodal analgesia and intravenous fluids, early mobility, and adherence to best practices for preventing complications, such as surgical site infection (SSI), venous thromboembolism, and urinary tract infections. The surgical community has embraced enhanced recovery techniques because they have been proven to result in better outcomes. Today, enhanced recovery is the standard of care for elective colorectal surgery, with strong evidence in support of adoption in other specialties as well. This approach to perioperative care emphasizes standardized, evidence-based care that incorporates both patients and families, as well as the entire care team. These enhanced recovery pathways have been associated with reduced surgical complications, improved patient experience, and decreased length of stay without increased readmission rates.1-5

Yet, despite the overriding support for the adoption of enhanced recovery, implementation at hospitals has been challenging for myriad reasons, including challenges related to obtaining physician buy-in and leadership support, coordinating electronic health records (EHRs), and limited resources for auditing performance and developing a data-driven improvement program.

Given the importance of ensuring consistent evidence-based perioperative care for our patients, the ISCR program launched in 2016 to accelerate adoption by disseminating easy-to-use materials and providing implementation support to U.S. hospitals that are seeking to implement enhanced recovery practices within the framework of the Comprehensive Unit-based Safety Program (CUSP). CUSP is a well-known model for sustainable safety improvement that has

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HIGHLIGHTS

• Describes the origin and future direction of the AHRQ Safety Program for ISCR
• Summarizes the benefits of program participation
• Highlights findings from three hospitals that have successfully implemented the ISCR program
• Highlights new opportunity to join ISCR to improve the care of patients undergoing emergency general surgery procedures
• Describes how ISCR participation can help hospitals improve opioid management

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been associated with preventing harm in multiple areas. Since the start of the first ISCR cohort in July 2017, the program has supported more than 300 hospitals in implementing evidence-based surgical care in four procedure areas including colorectal, orthopaedics (hip and knee repair), and gynecologic surgery. An upcoming cohort is set to start in March with a new focus on emergency general surgery, but hospitals will still be able to join and work on colorectal pathways as well.

Lessons learned
Over the last three years, ISCR program administrators have worked closely with hospitals during the implementation stage. In the process, ISCR leaders have learned some valuable lessons. What we discovered from recent site visits conducted at three ISCR hospitals follows.

Lesson one: Regularly meet as a team
Assembling a multidisciplinary perioperative team is one of the first and most critical steps in a hospital’s ISCR journey. ISCR teams at all three sites met at least monthly, providing a structured forum for solving problems, sharing data, and keeping goals front and center. Importantly, these face-to-face meetings also provided an opportunity for team members to form relationships with staff from across the continuum of care who may have had limited opportunities for engagement. In one hospital, interest in enhanced recovery pathways was cropping up in siloed efforts initiated by small groups of surgeons, with little effort to engage other staff who play an integral role in the pathway. The hospital used the ISCR program and team meetings to centralize enhanced recovery efforts across the hospital to ensure that key stakeholders were involved in all of the enhanced recovery programs in the hospital, foster the spread of best practices (both clinical and implementation), and gain efficiencies in the development of EHR order sets.

Lesson two: Provide multimodal education
A core element of enhanced recovery pathways is the use of multimodal analgesia. A nurse manager at one site noted that implementation of the pathways also requires a multimodal education component; that is, the use of education strategies that are tailored to different audiences. In the early stages of implementation, all sites emphasized the need to present their colleagues with credible evidence of the effectiveness of the pathway (particularly to physician colleagues) and the importance of explaining why the pathway is being implemented (particularly to nurse colleagues). In later stages of the implementation process, one participant described her strategy of using “pearls of wisdom” to distill new information into specific actions that staff could readily absorb. In sustaining the pathway, participants also highlighted the need to regularly provide feedback to frontline staff about their individual performance and to celebrate improvements in patient outcomes. Of interest, at a few sites, the anesthesia providers were not receiving feedback or follow-up on their efforts, and they felt they should be included in the efforts to share both process and outcome data, even if not directly related to their practice.

Lesson three: Be resilient in the face of staff turnover
Staff turnover is, unfortunately, a regular occurrence and can often stifle a project’s momentum. In all three hospitals visited, a champion or project lead left at some point in the implementation process. At one hospital, the loss of a surgeon champion meant putting the enhanced recovery pathway on hold for that surgical specialty and shifting the focus to other surgical specialties that did have an active champion. At another hospital, the departure of the ISCR project lead created an opportunity for other team members to rally around the project, leading to a more decentralized network of staff who were invested in the implementation process.

Staff turnover also can support the implementation process in unexpected ways. For example, at one
hospital, an anesthesiologist who resisted the program left the practice, and a new anesthesiologist, who embraced enhanced recovery pathways, was hired. This new anesthesia champion then was able to make significant headway in advancing the pathway’s implementation.

**How has the ISCR program helped hospitals?**
The two hospitals that were relatively new to implementing enhanced recovery pathways used ISCR program materials extensively—from learning how to structure a multidisciplinary project team to adapting patient education booklets and EHR order sets to match their local needs. The third hospital, which had implemented a pathway several years earlier, found benefit in the structured team meetings to optimize and sustain changes to the pathway, as well as the benchmarking data provided through the ISCR program. As evidenced by this small sample of sites, the ISCR program can support a hospital’s enhanced recovery implementation journey and overall comfort and skills with perioperative quality improvement in many ways.

**Introduction of emergency general surgery**
Although much of the work in enhanced recovery has focused on the elective colorectal surgery population, hospitals sometimes extend enhanced recovery care pathways to patients undergoing emergency colorectal surgery, as well as an extension of best perioperative practices. Each year, more than 900,000 patients in the U.S. undergo surgery for emergency general surgery conditions. Some of the most common procedures include laparotomies to treat diverticulitis, bowel obstructions, perforated ulcers, and incarcerated hernias, as well as cholecystectomies and appendectomies. Overall, emergency general surgery procedures are less studied than the equivalent elective procedures, but, unquestionably, emergency general surgery is performed on complex patients, with up to 50 percent of these individuals having comorbid conditions. Postoperative complications, although they vary significantly by type of procedure, can be upward of 50 percent.

Despite the tremendous potential to improve, the diverse presentation and severity of disease has made systematic quality improvement efforts in emergency general surgery challenging. Although there have been local efforts to develop clinical pathways and standardize clinical care across some emergency general surgery procedures, there are few reports of systematic and scalable efforts. More than 30 percent of ISCR hospitals have organically spread their colorectal enhanced recovery program to patients undergoing emergency colorectal procedures. With the final cohort of the ISCR program, the national project team will offer the chance to be part of a large-scale learning collaborative that will help us begin to understand how to systematically and broadly apply both enhanced recovery principles and standardized care pathways in patients undergoing emergency general surgery procedures.

These pathways—developed in conjunction with leading experts in emergency general surgery and further vetted with a large multidisciplinary group of national stakeholders—will adhere to the same common tenets that are the backbone of enhanced recovery: patient education, early mobility after surgery, reduced periods of fasting, multimodal analgesia, and health care-acquired infection processes. The recommended pathways also will highlight some of the challenges unique to emergency general surgery, including opportunities to improve antimicrobial stewardship, time to the operating room, and understanding the influence of social determinants of health in both process measure adherence and clinical outcomes.

**Introduction of discharge opioid prescribing tools**
Multimodal analgesia has been a core tenet of enhanced recovery, but discharge prescribing has been included in only a few pathways. In light of the opioid
crisis—clear evidence that patients are prescribed more opioids than needed after an operation—and the inconsistent use of nonopioid analgesia, the ISCR program has incorporated evidence-based recommendations for all pathway procedures starting in 2020.16-18 To support implementation of these recommendations, patient-facing education on safe pain control and an opportunity to track and benchmark prescribing over time using the ACS data registry will be available.

Benefits of participation
Participating hospitals receive a ready-to-use pathway developed using the latest evidence reviews, access to education materials on how to implement the pathway, access to experts in performance improvement and education who will help them troubleshoot as they implement, and inclusion in a community of surgeons and perioperative teams rolling out the same pathway. Furthermore, the program has developed an outstanding resource in the vibrant community of surgeons, nurses, and anesthesia providers committed to like-minded work.

Program support
Enrolled hospitals also have the opportunity to join monthly coaching calls that focus on learning from peers and sharing best practices, as well as special topic calls presented by national leaders who highlight best practices and encourage participants to ask specific questions about evidence. Coaching calls are conversational and have included discussions on patient and staff education about enhanced recovery and program implementation, leading and coordinating change efforts, best approaches to EHR order sets, and challenges associated with specific clinical practice changes, such as adoption of the mechanical bowel preparation with oral antibiotics for SSI prevention in colorectal surgery or nonsteroidal anti-inflammatory use as part of a comprehensive multimodal analgesia program. National leaders in quality, including Joseph Caprini, MD, FACS (venous thromboembolism); Sanjay Saint, MD (urinary

REFERENCES
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tract infections); and Chad Brumett, MD (opioids), have shared their expertise with program participants. One-on-one support for both program implementation and data collection is available to all participating hospitals.

Collecting process and outcomes data to assess adherence to pathway elements and measure improvements in patient outcomes is a key component in gaining buy-in for this program, optimizing effectiveness, and sustaining the work. All participating hospitals have access to a registry that incorporates the lessons learned from the ACS Quality Programs and is focused on the pathways process measures and key outcomes. Support is available for hospital data abstractors, and all hospitals have access to reports that benchmark their performance against other participating hospitals to help drive local conversations and engagement.

How to enroll
ISCR is especially useful to hospitals that meet the following criteria:

- Have no prior enhanced recovery implementation experience
- Have implemented enhanced recovery in one procedure area and are looking to expand to other areas
- Have attempted to implement enhanced recovery pathways but did not experience significant improvements or were unable to sustain the program

The program team is now recruiting hospitals to participate in the fourth cohort, which will focus on colorectal and emergency general surgery. Hospitals are encouraged to begin enrollment now in order to participate in the 18-month program that starts March 2020.

To enroll or learn more about the program or about participation in any of the cohorts, e-mail ISCR@facs.org.

REFERENCES (CONTINUED)

Clinical Congress 2019 highlights
The American College of Surgeons (ACS) Clinical Congress 2019 in San Francisco, CA, provided myriad opportunities for surgeons, residents, medical students, and other affiliate health care professionals to sharpen and test their surgical skills and to interact with their peers and ACS leaders and staff. A total of 12,370 surgeons, residents, medical students, affiliate health care professionals, exhibitors, staff, guests, and members of the press were in attendance.

**Highlights**

Some highlights of Clinical Congress included the opportunity to participate in The Surgical Metrics Project, three Special Sessions, and ACS Theatre offerings.

More than 100 Clinical Congress attendees at all stages of a surgical career participated in The Surgical Metrics Project, which allowed participants to explore the use of wearable technologies to measure surgical decision making and techniques. Each participant was equipped with magnetic motion-tracking technology synchronized with headgear that captured video and audio.

Three Special Sessions were once again offered at Clinical Congress. These sessions provided attendees with an in-depth look at important ACS initiatives: the ACS Academy of Master Surgeon Educators, the results of the College’s membership survey on firearm injury prevention, and the new Commission on Cancer quality metrics.

The ACS Theatre once again was the host site for three programs about timely topics. Staff from the Division of Advocacy and Health Policy led a discussion of the ACS’ response to the financial pressures facing surgeons. Three surgeons who helped lead the development of the 17th edition of the Surgical Education and Self-Assessment Program (SESAP®) led a question-and-answer session on SESAP 17, which was unveiled at Clinical Congress 2019. The third Theatre session was on getting involved in global health initiatives through Operation Giving Back.

In addition, several patient education programs were showcased through the week in the ACS Theatre. These sessions...
focused on wound assessment apps, negative pressure wound therapy, opioid-sparing pain management, central line management, feeding tubes, smoking cessation, and ostomy education and simulation.

**Convocation**

The College welcomed more than 1,990 Initiates to ACS Fellowship at this year’s Convocation, 999 of whom were in attendance. Initiates from the class of 1994 and 1969 respectively celebrated 25 and 50 years of Fellowship. Fellows who died in the last year were acknowledged.

The 100th President of the ACS, **Valerie W. Rusch, MD, FACS**, was installed at Convocation. Dr. Rusch is an esteemed thoracic surgeon and is vice-chair, clinical research, department of surgery; Miner Family Chair in Intrathoracic Cancers; attending surgeon, thoracic service, department of surgery, Memorial Sloan Kettering Cancer Center; and professor of surgery, Weill Cornell Medical College, New York, NY. In her Presidential Address, Dr. Rusch reflected on the theme, The Joys of Lifelong Learning, Collaboration, and Giving Back.

**John A. Weigelt, MD, DVM, FACS**, was installed as First Vice-President, and **F. Dean Griffen, MD, FACS**, V105 No 1 BULLETIN American College of Surgeons
was installed as Second Vice-President. Dr. Weigelt is a general surgeon with an emphasis on trauma, critical care, and acute care surgery and is on the faculty of Sanford Health System and the University of South Dakota, Sioux Falls. Dr. Griffen is clinical professor of surgery, Ochsner Louisiana State University, Shreveport. Drs. Rusch, Weigelt, and Griffen all are previous recipients of the Distinguished Service Award (DSA)—the College’s highest honor presented annually.

**R. Phillip Burns, MD, FACS,** received the 2019 DSA. Dr. Burns is professor and chairman, department of surgery, University of Tennessee College of Medicine, Chattanooga. The award acknowledges Dr. Burns’ “innovative vision as integral engineer of the College’s focused initiatives influencing general surgery training, ultimately creating better prepared general surgery residents entering practice with enhanced skills and confidence to further improve the quality of care for their patients.”

Two new awards were presented at Convocation. **Retired U.S. Army Colonel Norman M. Rich, MD, DMCC, MC, FACS,** received the inaugural Distinguished Lifetime Military Contribution Award. This award pays tribute to Dr. Rich’s outstanding contributions to surgery during his military service and his legendary advances in vascular trauma restoration techniques.

**Danielle Saunders Walsh, MD, FACS, FAAP,** received the first Resident and Associate Society (RAS-ACS) Outstanding Mentor of the Year Award. Dr. Walsh is general surgery residency program director; department of surgery vice-president for diversity and inclusion; associate professor of surgery, division of pediatric surgery, East Carolina University and Vidant Medical Center; and director of surgical quality, James and Connie Maynard Children’s Hospital, Greenville, NC.

**ACS Past-President Patricia J. Numann, MD, FACS,** was accorded the ACS Lifetime Achievement Award. Dr. Numann is the Lloyd S. Rogers Professor of Surgery Emeritus, State University of New York (SUNY) Upstate Medical University, Syracuse; SUNY Upstate Distinguished Service Professor; and SUNY Upstate Distinguished Teaching Professor Emeritus. Dr. Numann has worked tirelessly to promote diversity in the surgical professional and to advocate for surgical education and research.

The fourth annual Mary Edwards Walker Inspiring Women in Surgery Award was presented to **Vice-Admiral Raquel C. Bono, MD, FACS.** As Chief Executive Officer and Director, Defense Health Agency Medical Corps, Dr. Bono has served on the ACS Board of Governors (B/G) (2014–2016) and has been the recipient of three Defense Superior Service Medals, four Legion of Merit medals, two Meritorious Service medals, and two Navy and Marine Corps Commendation medals.

A total of 12 international surgeons were conferred Honorary Fellowship in the ACS. They are as follows:

- **Prof. Italo Braghetto, MD, MHA, FACS,** medical director, Avansalud Clinic, Santiago, and chairman, department of surgery, Universidad de Chile Clinical Hospital of Santiago
• Prof. Laurence Chiche, MD, professor of surgery and director, department of surgery, Bordeaux University, France

• Prof. Ian D.S. Civil, BSc, MBChB, FRACS, FACS, director of trauma services, Auckland Hospital, New Zealand, clinical director for the Major Trauma National Clinical Network and clinical leader for the Safe Surgery New Zealand Expert Advisory Group for the Health Quality and Safety Commission of New Zealand

• Prof. John Hyland, MCh, FACS, FRCS(Eng), FRCSI, FRCSEd(Hon), consultant general and colorectal surgeon, St. Vincent’s University Hospital, Dublin, Ireland, and founder of the hospital’s Centre for Colorectal Disease

• Prof. Yoko Kato, MD, PhD, professor and chair, department of neurosurgery, Fujita Health University Banbuntane Hotokukai Hospital, Aichi, Japan

• Prof. Marek Krawczyk, MD, PhD, professor and chairman, department of general, transplant, and liver surgery; and president, Medical University of Warsaw, Poland

• Prof. Antonio M. de Lacy Fortuny, MD, PhD, head, gastrointestinal surgery service, and chief, minimally invasive surgery department, Hospital Clinic, Barcelona, Spain

• Prof. Ari Kalevi Leppäniemi, MD, PhD, professor of surgery, abdominal center, Meilahti Hospital, and chief, division of emergency surgery and surgical critical care, University of Helsinki, Finland

• Prof. Neil Mortensen, MA, MBChB, MD, FRCSEng, FRCPSGlas(Hon), FRCSEd(Hon), FRCSI(Hon), professor of colon and rectal surgery, University of Oxford Medical School, and honorary consultant colorectal surgeon and fellow, Green Templeton College, U.K.
Named Lectures
Clinical Congress featured 11 Named Lectures, starting with the Martin Memorial Lecture, which was presented immediately following the Opening Ceremony October 28. National Public Radio legal affairs correspondent Nina Totenberg delivered the lecture, The Health of the Supreme Court, and participated in a meet and greet after the presentation.

Other Named Lectures were as follows:

- **Michael J. Mack, MD, FACC**, medical director, cardiothoracic surgery, and chair, cardiovascular service line, Baylor Scott & White Health, Dallas, TX, presented the John H. Gibbon, Jr., Lecture, Innovation: A Surgical Imperative
- **Joseph C. Maroon, MD, FACS**, clinical professor and vice-chairman, department of neurological surgery, and Heindl Scholar in Neuroscience, University of Pittsburgh Medical Center, PA, delivered the Charles G. Drake History of Surgery Lecture, From Surgical Burnout to Wellness: The Secret to a Balanced Life
- **Ronald V. Maier, MD, FACS, FRCSEd(Hon), FCSHK(Hon), FCCS(Hon)**, Immediate Past-President of the ACS, presented the I.S. Ravdin Lecture in the Basic and Surgical Sciences, Response to Injury: The Genomic Storm and Precision Medicine
- **Patricia L. Roberts, MD, FACS, FASCRS**, past-chair, department of surgery, and senior staff surgeon, department of colon and rectal surgery, Lahey Hospital and Medical Center, Burlington, MA, delivered the Herand Abcarian Lecture, How to Navigate a Second Career in Surgery
- **Steven D. Schwitzberg, MD, FACS**, professor and chairman, department of surgery, University at Buffalo Jacobs School of Medicine & Biomedical Sciences, NY, presented the Excelsior Surgical Society/Edward D. Churchill Lecture, Blood and the Moving Wheels of History
• M. Margaret Knudson, MD, FACS, Medical Director, Military Health System Strategic Partnership ACS, and professor of surgery, University of California San Francisco, delivered the Scudder Oration on Trauma, A Perfect Storm

• Carol Scott-Conner, MD, PhD, FACS, emeritus professor of surgery and emeritus chair, department of surgery, Carver College of Medicine, University of Iowa, Iowa City, presented the Olga M. Jonasson, MD, Lecture, Recapturing the Joy of Surgery

• Emmanuel M. Makasa, BSc, HB, MBCHB, MPH, MMed(orth), health and wellness expert, Office of the President of the Government of the Republic of Zambia, delivered the Distinguished Lecture of the International Society of Surgery, The Role of Surgical Care in Attaining Universal Coverage for Sustainable Development in Low- and Middle-Income Countries

• Margaret L. Schwarze, MD, MPP, FACS, associate professor of surgery and bioethics, University of Wisconsin School of Medicine and Public Health, Madison, presented the John J. Conley Ethics and Philosophy Lecture, What We Talk about When We Talk about Surgery

• Andrew L. Warshaw, MD, FACS, FRCSEd(Hon), ACS Past-President and senior consultant, international and regional clinical relations, Massachusetts General Hospital, and the W. Gerald Austen Distinguished Professor of Surgery, Harvard Medical School, Boston, delivered the Commission on Cancer Oncology Lecture, Pancreatic Cancer: Progress and Prospect
Scientific Forum

The 2019 Owen H. Wangensteen Scientific Forum Dedicatee was John C. Alverdy, MD, FACS, Sara and Harold Lincoln Thompson Professor of Surgery and executive vice chair, department of surgery, University of Chicago, IL. Dr. Alverdy is nationally recognized for introducing several new operations into the field, including minimally invasive pancreatic surgery, bariatric surgery, and surgery for disorders of the foregut.

Practicing surgeons, residents, and medical students were recognized for their contributions to advancing the art and science of surgery. Recipients honored with the 2019 Owen H. Wangensteen Scientific Forum Excellence in Research Awards included the following: Michael T. Cain, MD; Ryan A.J. Campagna, MD; Malini Chinta; Caitlin Redford Collins, MD, MPH; Naomi-Liza Denning, MD; Cale Ewald; Brian Fleischer, MD, MEng; Deshka S. Foster, MD, MA; Kyle W. Freischlag, MD; Elysia Grose, BHSc; Amna Khokar, MD; Akshita Kumar, MD; Charles Liu, MD; William Aaron Marshall, MD; Alejandro Munoz-Valencia, MD; Apoorve Nayyar, MBBS; Napat Pruekprasert, MD; Hallie J. Quiroz, MD; Arturo Jesus Rios-Diaz, MD; Simon Rodier, MD, MPhil; Christopher Scheiber, MD; Jeremy Sharib, MD; Shi Yan, MD; and Christopher J. Zimmerman, MD.

The Best 2019 Scientific Forum e-Posters of Exceptional Merit were awarded to Stephanie Cruz, MD (Domestic), for her presentation of Prospective Application of a Computational Algorithm Using Trend Analysis of Abdominal NIRS Predicts the Onset of Necrotizing Enterocolitis in Neonates with Congenital

ACS/Pfizer Volunteerism Awardees at the Board of Governors (B/G) dinner: From left: Girma Tefera, MD, FACS, Director, ACS Operation Giving Back; Terry L. Buchmiller, MD, FACS, Member Services Pillar Lead; Volunteerism awardees Drs. Meier, Furman, Saksena, and Smith; Helen Alexandra Pass, MD, FACS, Chair, B/G Surgical Volunteerism and Humanitarian Awards Workgroup; and Steven C. Stain, MD, FACS, then-Chair, B/G Executive Committee

Cancer Research Paper Competition first-place winner, Dr. Leiting

Commission on Cancer (CoC) Outstanding State Chair awardees Drs. Castaldi (second from left), Lee (center), and Lizarraga (second from right), with Timothy W. Mullett, MD, FACS (far left), former Vice-Chair, CoC Cancer Liaison Committee and CoC Chair-Elect; and Peter S. Hopewood, MD, FACS, Chair, CoC Cancer Liaison Committee
Heart Disease: From Bench to Bedside, and Pawan Singhal, MBBS, MS, DNB, FACS (International), for his presentation of A Novel Total Annulus Excision Technique of Tympanoplasty: Double Blind Randomized Controlled Trial.

Other awards and honors
The ACS Foundation Board of Directors presented the 2019 Distinguished Philanthropist Award to Christopher K. Payne, MD, FACS, a urologist at Vista Urology and Pelvic Pain Partners, San Jose, CA, whose generosity has elevated him to the Fellows Leadership Society Legacy Circle.

Recipients of the 2019 ACS B/G Surgical Volunteerism and Humanitarian Awards were recognized at the B/G annual reception/dinner. Recipients were selected by the B/G Surgical Volunteerism and Humanitarian Awards Workgroup.

Two individuals received the ACS/Pfizer Surgical Humanitarian Award, which recognizes Fellows who have dedicated much of their careers to ensuring that underserved populations have access to surgical care and have done so without expecting commensurate compensation.

Donald E. Meier, MD, FACS, a general surgeon from Dallas, TX, received the Surgical Humanitarian Award for his decades of surgical, training, and education service around the world, primarily in West Africa. Devendra S. Saksena, MBBS, FACS, a cardiothoracic surgeon in Mumbai, India, received the Surgical Humanitarian Award for his nearly 50 years of service in establishing cardiothoracic surgery services in India and Africa.

The ACS/Pfizer Surgical Volunteerism Awards recognize ACS Fellows and members who are committed to giving back to society through significant contributions to surgical care as volunteers. Three awards were granted in 2019. Steven Bolton, MD, FACS, a general surgeon in Pontiac, MI, received the Domestic Surgical Volunteerism Award for his efforts to initiate and operate a medical clinic for underserved residents of the city. Richard W. Furman, MD, FACS, a cardiothoracic surgeon from Boone, NC, received the International Surgical Volunteerism Award for providing care to underserved patients around the world and for cofounding World Medical Mission with his brother, Lowell B. Furman, MD, FACS, a 2003 recipient of the ACS Surgical Volunteerism Award. Alison Smith, MD, a general surgery resident at Tulane University, New Orleans, LA, received the Resident Volunteerism Award for her significant volunteerism efforts in Haiti.

The Commission on Cancer (CoC) recognized the winners of its annual Cancer Research Paper Competition. Jennifer Leiting, MD, a general surgery resident at the Mayo Clinic, Rochester, MN, was the 2019 first-place winner for her paper, “‘Termoriolimus Is Effective Against Patient-Derived Metastatic Fibrolamellar Hepatocellular Carcinoma In Vitro and in Vivo.” Dr. Leiting received a $1,000 honorarium plus travel expenses
to present her research at the CoC Annual Meeting. **Pamela Lu, MD**, a general surgery resident at Brigham and Women’s Hospital, Boston, MA, placed second for her paper, “Systemic Chemotherapy Does Not Prolong Survival in Patients with Metastatic Low-Grade Appendiceal Mucinous Adenocarcinoma.” **Stephen Abel, DO, MHSA**, of Allegheny Health Network Cancer Institute, Pittsburgh, PA, was awarded third place for his paper, “Utilization of Adjuvant Radiotherapy for Resected Colon Cancer and Its Effect on Outcome.” Drs. Lu and Abel each received $500 and had the opportunity to display their posters at the CoC Annual Meeting.

The CoC honored three State Chairs for their outstanding performance in 2019: **Maria Castaldi, MD, FACS**, Manhattan Council State Chair; **Susan He Lee, MD, FACS**, Brooklyn-Long Island State Chair; and **Ingrid Lizarraga, MD, FACS**, Iowa State Chair.

The 2019 National Safety Council (NSC) Surgeons Award for Service to Safety was given to **Mary E. Fallat, MD, FACS**, “for her tireless advocacy for improving the care of pediatric trauma patients.” Dr. Fallat is chief of pediatric surgery and the Hirikati S. Nagaraj endowed Professor in Pediatric Surgery, University of Louisville, KY.

The ACS Committee on Trauma (COT) presented a Special Recognition Award to **Richard J. Fantus, MD, FACS**, for his distinguished service to the COT, particularly his 200 contributions to “National Trauma Data Bank data points,” published monthly in the Bulletin for 17 years.

The Excelsior Surgical Society honored the late **Colonel Basil A. Pruitt, Jr., MD, FACS**, and the late **Donald D. Trunkey, MD, FACS**, each with a plaque and American flag.

The International Relations Committee welcomed the following International Guest Scholars and Travelers: **Mary Margaret Ajiko, MD**, Soroti, Uganda, **Baxiram S. and Kankuben B. Gelot Community Surgeons**...
Travel Awardee; Salah Eldien AlTarabsheh, MBBS, FACS, Amman, Jordan; Maria Eugenia Aponte-Rueda, MD, PhD, FACS, Caracas, Venezuela; Carlos J. Yanez Benitez, MD, FACS, Huesca, Spain, Dr. Abdol and Mrs. Joan Islami Scholar; Patrick H.Y. Chung, MBBS, MS (HK), FRCSEd (PAED), FHKAM (Surg), Hong Kong, China, Carlos Pellegrini Traveling Fellow of the ACS; Karen Hope Dalmacio, MD, Iloilo City, Philippines, Doctors Duremdes Community Surgeons Travel Awardee; Mohammad Rafi Fazli, MD, Herat, Afghanistan; Diego Lucas Fernandez, MD, Buenos Aires, Argentina; Adenauer Marinho de Oliveira Goes, Jr., MD, Belem, Brazil; Nikhil Gupta, MBBS, FALS, FACS, FRCS, Delhi, India; Vishal Gupta, MBBS, Lucknow, India; Jeremy Ming Hsu, MBBS, FACS, Gladesville, Australia; Konstantinos Kostopanagiotou, MD, PhD, Athens, Greece, Stavros Niarchos Foundation Scholar; Pawan Krainara, MD, Krabi, Thailand; Oyintonbra Funkuro Koroye, MBBS, DMAS, FWACS, FICS, FACS, Bayelsa State, Nigeria; Michael Bundepuun Ode, MBBS, Jos, Nigeria; Elena B. Rangelova, MD, Stockholm, Sweden, Dr. Murray F. Brennan Scholar; Pornthip Rattanadechapitak, MD, Khon Kaen, Thailand; Adrian M. Seifert, MD, Dresden, Germany; and Kazuki Takeishi, MD, PhD, Fukuoka, Japan.

The International Guest Scholars and Travelers, front row (from left): Drs. Goh, Goes, Gosain, Vishal Gupta, Ode, Nikhil Gupta, Fazli, Kostopanagiotou, AlTarabsheh, and Hsu


The ACS History and Archives Committee presented first- and second-place awards for the annual History of Surgery Poster Competition. The first-place winners were Tom Liu; Katherine Howe, MD; and Michael Nussbaum, MD, FACS, from Virginia Tech Carilion School of Medicine, Roanoke, for the poster, “A Long Way to Washington: Establishing Surgical Care for Black Appalachians in the Early 20th Century.” Second place was awarded to John Ernhardt, Jr., and J. Patrick O’Leary, MD, FACS, of Florida International University Herbert Wertheim College of Medicine, Miami for “Surgeons in the Colonial Development of America’s Oldest City.”

Three surgeons who serve rural or small communities attended Clinical Congress as Nizar N. Oweida, MD, FACS, Scholars—Christian Eusebio, MD, a general surgeon from Tamuning, Guam; Courtney L. Olmsted, MD, MSCI, a general surgeon from Morrisville, VT; and Wei Wei, MD, FACS, a general surgeon from Galax, VA. The three spoke at the annual meeting of the Scholarships Committee and the Rural Surgery Forum.

The 17th annual ACS Resident Award for Exemplary Teaching was presented to Courtney A. Green, MD, MAEd, a fifth-year resident in general surgery at the University of California San Francisco. The award is sponsored by the Division of Education to recognize a resident’s excellence in teaching and to highlight the importance of teaching in residents’ daily lives. Dr. Green was selected by an independent review panel of the ACS Committee on Resident Education.
The seventh annual Jameson L. Chassin, MD, FACS, Award for Professionalism in General Surgery was presented to Ruchi Amin, MD, a fifth-year chief resident in general surgery at East Carolina University in Greenville, NC. The award recognizes a chief resident in general surgery who exemplifies the values of compassion, technical skill, and devotion to science and learning. The ACS established the award with gifts from the Chassin family, colleagues, and friends of the late Dr. Chassin, who was a skilled surgeon, teacher, and scholar in New York. The award is administered by the ACS Division of Education. Dr. Amin was selected by an independent review panel of the Committee on Resident Education.

Sam C. Wang, MD, FACS, assistant professor of surgery, division of surgical oncology, University of Texas Southwestern Medical Center, Dallas, received the 15th Joan L. and Julius H. Jacobson II Promising Investigator Award administered by the ACS Surgical Research Committee. Dr. Wang received the award in recognition of his track record of producing high-impact publications and attaining extramural grant support from the National Institutes of Health, the ACS, and the Society for Surgery of the Alimentary Tract.

The Best 2019 Scientific Forum e-Posters of Exceptional Merit were awarded to Stephanie Cruz, MD (Domestic), for her presentation of “Prospective Application of a Computational Algorithm Using Trend Analysis of Abdominal NIRS Predicts the Onset of Necrotizing Enterocolitis in Neonates with Congenital Heart Disease: From Bench to Bedside,” and Pawan Singhal, MBBS, MS, DNB, FACS (International), for his presentation of “A Novel Total Annulus Excision Technique of Tympanoplasty: Double Blind Randomized Controlled Trial.”

The Committee on Medical Student Education recognized the following students as first- and second-place winners in their respective categories at the Medical Student Program ePoster Session: in the Clinical Research category, Sneha Subramaniam
(Icahn School of Medicine at Mount Sinai, NY) and a second-place tie between Randy Casals (Columbia University, New York, NY) and Mikhail Pakvasa (University of Chicago, IL); in the Basic Science category, Iris H. Liu (University of California San Francisco) and Maximilian Hawkins (University of Chicago); and in the Education, Innovation, and Outcomes Research Category, Ilaria Caturegli (University of Maryland, Baltimore) and Shawn Izadi (University of Texas Rio Grande Valley).

**Annual Business Meeting**

The Annual Business Meeting of Members convened October 30, with Dr. Rusch presiding. The following ACS officials presented reports: Gerald M. Fried, MD, FACS, FRCSC, Chair of the Board of Regents (B/R); Steven C. Stain, MD, FACS, Chair of the B/G; David B. Hoyt, MD, FACS, ACS Executive Director; Dr. McGrath, Chair of the Board of Directors of the ACS Foundation; and William G. Cioffi, Jr., MD, FACS, Chair of the Board of Directors of the ACS Professional Association Political Action Committee.

In addition, Fellows were elected to serve as ACS officials in 2019–2020. The President-Elect is J. Wayne Meredith, MD, FACS, MCCM, the Richard T. Myers Professor and Chairman, and residency program director, department of surgery, Wake Forest University School of Medicine; medical director and professor of pediatrics, department of pediatrics, The Childress Institute for Pediatric Trauma; and medical director, Wake Forest Institute for Regenerative Medicine, Winston-Salem, NC. The First Vice-President-Elect is H. Randolph Bailey, MD, FACS, FASCRS, professor of surgery,
and emeritus director of the colon and rectal residency training program, University of Texas (UT) McGovern Medical School, Houston; chief, division of colon and rectal surgery, Memorial Hermann Hospital Texas Medical Center, Houston; and deputy chief of surgery, Houston Methodist Hospital. 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 Breast Cancer Subtypes, Weill Cornell Medicine-New York Presbyterian Hospital Network, NY, as well as adjunct professor breast surgery, UT MD Anderson Cancer Center, Houston.

A new Secretary and Treasurer were elected this year. Tyler G. Hughes, MD, FACS, clinical professor of surgery and director medical education, Kansas University School of Medicine, Salina, was elected Secretary, and Don K. Nakayama, MD, MBA, FACS, clinical professor, division of pediatric surgery, department of surgery, University of North Carolina at Chapel Hill School of Medicine, was elected Treasurer.

Two surgeons were elected to the ACS B/R. Diana L. Farmer, MD, FACS, FRCS, is a highly regarded pediatric and fetal surgeon and the Pearl Stamps Stewart Endowed Chair and Distinguished Professor and Chair, department of surgery, University of California (UC) Davis School of Medicine; surgeon in chief, UC Davis Children’s Hospital; and chief of surgery, Shriners Hospitals for Children, Sacramento. Dr. Stain, an esteemed general surgeon, is professor of surgery and Henry and Sally Schaffer Chair, department of surgery, Albany Medical College, NY.

In addition, three surgeons were reelected to the B/R: Anthony Atala, MD, FACS, director, Wake Forest Institute for Regenerative Medicine, and the W. Boyce Professor and Chair, department of urology, Wake Forest University; James W. Gigantelli, MD, FACS, ophthalmology chair and professor of ophthalmology, Joan C. Edwards School of Medicine, Marshall University, Huntington, WV; and 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.

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

• Chair: Ronald J. Weigel, MD, PhD, FACS, professor and chair of surgery, and associate vice-president, UI Health Alliance; and professor of surgery-surgical oncology and endocrine surgery, professor of biochemistry, professor of anatomy and cell biology, and professor of molecular physiology and biophysics, University of Iowa

• Vice-Chair: Taylor Sohn Riall, MD, PhD, FACS, professor and chief, division of general surgery and surgical oncology, University of Arizona College of Medicine, Tucson

• Secretary: Mika Sinanan, MD, PhD, FACS, general surgeon, UW Medical Center and Seattle Cancer Care Alliance; and professor of general surgery and adjunct professor of electrical engineering, University of Washington, Seattle

continued on page 34
A panel discussion of ACS membership survey results on firearm injury prevention. From left: Ronald M. Stewart, MD, FACS, Medical Director, ACS Trauma Programs; Deborah A. Kuhls, MD, FACS, FCCM, director, University Medical Center of Southern Nevada, Las Vegas, trauma intensive care unit, and Chair, ACS COT Injury Prevention and Control Committee; and Brendan T. Campbell, MD, MPH, FACS, the Donald W. Hight Endowed Chair in Pediatric Surgery, Connecticut Children’s Medical Center, Hartford, and Vice-Chair, ACS COT Injury Prevention and Control Committee.

The ACS Division of Education welcomed more than 380 medical students to the Clinical Congress 2019 Medical Student Program.
Recipients of the ACS Distinguished Service Award (DSA) gathered at Clinical Congress. Front row, from left (all MD, FACS): Mary H. McGrath; Valerie W. Rusch; 2019 DSA R. Phillip Burns; F. Dean Griffen; and Barbara Lee Bass. Back row: David B. Hoyt; Sir Murray F. Brennan; Patricia J. Numann; and Richard J. Finley.

Past-Presidents of the ACS gathered at Clinical Congress. Pictured here (all MD, FACS) with 2019 DSA recipient R. Phillip Burns (front row, center), are (front row, from left): John L. Cameron; W. Gerald Austen; Kathryn D. Anderson; and Barbara Lee Bass. Back row: Ronald V. Maier; Gerald B. Healy; Patricia J. Numann; R. Scott Jones; and Andrew L. Warshaw.
FOR MORE INFORMATION

For more details on the information presented in this article, refer to previous issues of the Bulletin at bulletin.facs.org as follows:

September 2019
R. Phillip Burns, MD, FACS, to receive the 2019 ACS Distinguished Service Award

October 2019
Surgeons honored for volunteerism and humanitarianism

November 2019
Valerie W. Rusch, MD, FACS, installed as 2019–2020 ACS President
Patricia J. Numann, MD, FACS, receives ACS Lifetime Achievement Award
Colonel Norman M. Rich, MD, FACS, receives inaugural Distinguished Military Lifetime Achievement Award
12 prominent surgeons awarded Honorary Fellowship in the ACS

December 2019
J. Wayne Meredith, MD, FACS, MCCM, is 2019–2020 ACS President-Elect
New ACS Secretary and Treasurer elected
New Regents, Board of Governors’ Executive Committee members elected

The following surgeons have been elected to the B/G Executive Committee:

Andre Campbell, MD, FACS, FACP, FCCM, has been reelected to the B/G Executive Committee. Dr. Campbell is professor of surgery, division of general surgery, director, surgery 110 clerkship, and director, surgical critical care fellowship, University of California San Francisco.

Mark A. Dobbertien, DO, FACS, is a minimally invasive surgeon affiliated with Naval Hospital Jacksonville, and Flagler Hospital, St. Augustine, FL.

Nancy L. Gantt, MD, FACS, is professor of surgery, Northeast Ohio Medical University, Rootstown, OH, and co-medical director, Janie Abdu Comprehensive Breast Care Center, St. Elizabeth Youngstown Hospital Center, OH.

Dhiresh R. Jeyarajah, MD, FACS, is head of surgery, Texas Christian University and University of North Texas Health Science Center, Fort Worth; program director, hepatopancreato-biliary and advanced gastrointestinal fellowship; and associate program director, general surgery residency, Methodist Richardson Medical Center, TX.

Martin A. Schreiber, MD, FACS, is professor and chief, division of trauma and critical care, Oregon Health & Science University, Portland. He is past-Chair, Grassroots Advocacy Engagement Workgroup, and Lead, Health Policy and Advocacy Pillar.

Member engagement activities
Clinical Congress 2019 provided attendees and their guests with opportunities to participate in wellness activities, including 5K running tours and yoga. The annual Taste of the City on the last night of the conference provided an informal venue for attendees, their families, and guests to experience San Francisco’s unique dining and cultural scene.

To provide a more family-friendly meeting environment, parents and guardians were able to bring infants to scientific sessions for the first time when carried in the arms of a parent or adult guardian. The ACS also partnered with ACCENT on Children’s Arrangements Inc. to provide an on-site children’s program known as Camp ACS, and the Little Medical School gave children ages two and older a chance to explore the world of medicine.

Clinical Congress 2020
This year’s Clinical Congress will take place October 4–8 in Chicago. Details regarding the educational program, registration, housing, and transportation will be posted as they become available on the ACS website.
Editor’s note: In 2019, the American College of Surgeons (ACS) Division of Member Services announced a new travel award for Student Members transitioning into residency to attend Clinical Congress. Michael Visenio, MD, an intern at the University of Nebraska Medical Center, Omaha, was the inaugural recipient of the award. In the following report, he describes how attending Clinical Congress 2019 provided him with an opportunity to access the many learning and networking opportunities available at the meeting.

Even before arriving in San Francisco, CA, for Clinical Congress 2019, Twitter had given me a glimpse of what was to come: fellow surgical residents discussing their upcoming research, several faculty members creating buzz about their podium presentations, leaders in the profession foreshadowing upcoming debates and panels. For myself, I was excited to be involved in the ACS Resident and Associate Society (RAS-ACS) Advocacy and Issues Committee meeting leading up to the conference and the thought-provoking programming that the RAS-ACS had planned for the Clinical Congress.

Attending Clinical Congress proved to be a five-day rush of meetings, networking, and, most importantly, learning. As an intern five months into surgical training, it was easy to feel torn over which sessions to attend. Plenary sessions in general surgery, surgical education, health services research, trauma, and critical care all appeared fascinating, but time was limited. Thus, I found it beneficial to have a Resident Track with focused programming. What can otherwise be an overwhelming experience was improved by having the resident sessions to facilitate meeting other attendees in similar stages of training and serving as a launch pad for further exploring surgical interests.

Past-Chair of the ACS Board of Regents and Surgery Resident Program Chair Leigh Neumayer, MD, FACS, encouraged residents to “bloom where you are planted” as our surgical careers begin. Craig J. Baker, MD, FACS, professor of clinical surgery and chief, division of cardiac surgery, University of California Los Angeles, gave a financial presentation that served as an eye-opening reminder that it is never too early to begin saving for retirement—especially given the long

First recipient of Clinical Congress travel award for Student Members reflects on his experience

by Michael Visenio, MD
educational paths physicians take. A session on implicit bias by Dana A. Telem, MD, FACS, associate chair for clinical affairs and quality director, Michigan Women’s Surgical Collaborative, and associate professor, department of surgery, University of Michigan, Ann Arbor, emphasized the many ways gender bias can affect faculty development and patient care alike. Quick-fire Town Hall topics ranged from effective mentorship to leveraging social media.

The Resident Symposium, sponsored by the RAS-ACS Advocacy and Issues Committee, tackles contemporary issues in medicine. This year's topic was shift work surgery, with thoughtful pro and con arguments from residents and faculty. Lively debate ensued between Sharmila Dissanaike, MD, FACS, professor and Peter C. Canizaro Chair, department of surgery, and assistant medical director, Timothy J. Harnar Burn Center, Texas Tech University Health Sciences Center, Lubbock; and Kenneth Mattox, MD, FACS, Distinguished Service Professor, Baylor College of Medicine, and chief of staff and surgeon-in-chief, Ben Taub Hospital, Houston, TX. Both speakers made crucial points regarding continuity of care, physician wellness, and accountability for patient care.

Business sessions revealed the behind-the-scenes work that makes Clinical Congress and the ACS run. The dedicated work of RAS members showed that young surgeons seek out every opportunity to be at the table when decisions are made regarding surgical training and the future of surgery. Individual committees continually pursue opportunities to elevate programming and ensure that ACS meetings remain relevant to residents, fellows, and early-career surgeons.

For example, the Education Committee hosted a skills competition, “So You Think You Can Operate,” that combined competitive spirit with exposure to cutting-edge surgical technology. Within the Advocacy and Issues Committee, I had the opportunity to assist in a podcast episode interviewing leaders in trauma surgery and firearm injury prevention on their diverse approaches to addressing this prevalent form of trauma. For residents looking to become more involved in the ACS, there seemed to be a committee or group to fit any interest.

At the end of the day, I find that national meetings such as Clinical Congress stimulate the field of surgery by melding together surgeons of diverse interests, practice settings, and geography. Through the sharing of ideas and dissemination of knowledge, the hope is to solve clinical problems and improve patient outcomes. Encouragingly, I found that we also use this opportunity to diligently seek out creative ways to improve surgical education, the training environment, and, ultimately, physician well-being.

♦
The 2020 Medicare physician fee schedule:

An overview of provisions that will affect surgical practices

by Lauren Foe, MPH,
and
Vinita Mujumdar, JD
ew payment policy, coding, and reimbursement changes set forth in the 2020 Medicare physician fee schedule (MPFS) final rule took effect January 1. The MPFS, which the Centers for Medicare & Medicaid Services (CMS) updates annually, lists payment rates for Medicare Part B services and introduces or modifies other regulations that affect physician reimbursement and quality measurement.

The American College of Surgeons (ACS) submitted comments September 10, 2019, in response to the CMS MPFS proposed rule issued earlier in the year.* Some provisions in the final rule, released November 1, incorporate changes that the ACS recommended. Although the final rule includes important payment and policy changes that affect all physicians, this article focuses on updates that are particularly relevant to general surgery and its related specialties.

E/M office/outpatient visits

CMS finalized changes to its coding and reimbursement policies for office/outpatient evaluation and management (E/M) visits to align with those developed by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel.† Beginning in calendar year (CY) 2021, the agency will retain the five-level office/outpatient E/M coding system for established patients and reduce the number of levels to four for new patient visits. CMS will adopt revised E/M code definitions created by the CPT Editorial Panel, which eliminate history and physical exam as elements for E/M code selection and allow physicians to choose the E/M visit level based on the extent of their medical decision making or on time spent with the patient. The agency also will implement an add-on code for office visits that are part of ongoing primary care and/or management of patients with serious or complex conditions.

Additionally, CMS accepted the AMA Specialty Society Relative Value Scale Update Committee’s (RUC)-recommended payment rates for office/outpatient E/Ms for CY 2021, which will increase the values of most of these services. However, the agency will not apply such increases to postoperative E/M visits that are bundled into 10- and 90-day global surgical packages.

The ACS commented extensively on this proposal and expressed its opposition to CMS’ failure to apply increases to standalone office/outpatient E/Ms to global surgical packages. The College’s comments stressed that this revaluation will disrupt the relativity of the MPFS because it will increase payment to certain specialties but not to others that provide the same services. CMS’ policy also will pay different specialties different amounts for the same work, which is prohibited by law. In addition, the agency ignored the recommendations of nearly all medical specialties when this policy was discussed at the RUC, which voted overwhelmingly to recommend that the full increase of work and physician time for standalone office/outpatient E/Ms be included in global codes. The College opposes any policies that unfairly result in lower reimbursement for surgeons and will continue to contest CMS’ failure to increase values for the E/M portion of 10- and 90-day global surgical packages.

Review and verification of medical records

CMS modified its existing medical record documentation regulations to specify that, when furnishing and billing for their professional services, physicians, physician assistants (PAs), and advanced practice registered nurses (APRNs) may review and verify (that is, sign and date) notes in a patient’s medical record that other physicians, residents, nurses, students, or other members of the medical team have made rather than fully redocumenting the information. This policy is applicable across the spectrum of Medicare-covered services paid under the MPFS in all settings.

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In its comments on the proposed rule, the ACS supported this revision to physician medical record documentation requirements. However, the College also asked CMS to withhold changes to such requirements for PAs and APRNs until the agency established guidelines that clarify the circumstances in which these nonphysician providers (NPPs) would be permitted to review and verify medical records, such that NPPs may only sign off on notes made in the medical record by clinicians of the same provider type (for example, a PA may only review and verify information that another PA or PA student has included in a patient’s chart). The final rule indicates that CMS will not restrict the scope of medical record documentation that the billing provider may review and verify.

**Coinsurance for colorectal cancer screening tests**

CMS solicited comments on a proposal that would require physicians to give advance notice to patients scheduled for screening colonoscopies that coinsurance may apply should the “screening” procedure turn into a “diagnostic” procedure if polyps are discovered and removed during the service.

The ACS recognized CMS’ efforts to educate physicians and patients about cost-sharing obligations in order to mitigate instances of surprise billing but did not support the agency’s proposal to add to physicians’ administrative burdens with a new reporting requirement. The ACS said that the onus is on CMS—not on physicians—to inform its beneficiaries about any potential out-of-pocket expenses and encouraged the agency to develop resources that physician offices can distribute to inform patients about Medicare preventive services benefits, the information about colorectal cancer screening, and relevant details on cost sharing. The final rule indicates that CMS will conduct a comprehensive review of its outreach materials to determine whether Medicare policies on payment and coverage for screening colonoscopies can be made clearer and more accessible.

**Medicare enrollment denial and revocation**

Under existing law, CMS may revoke a physician’s Medicare enrollment if he or she has a pattern or practice of prescribing Part D drugs that is abusive, represents a threat to the health and safety of beneficiaries, or fails to meet Medicare requirements.

### TABLE 1.
**2020 MPFS ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES FOR SURGICAL SPECIALTIES**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Impact of work RVU changes</th>
<th>Impact of PE RVU changes</th>
<th>Impact of MP RVU changes</th>
<th>Combined impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total—all providers</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Cardiac surgery</td>
<td>-1</td>
<td>-1</td>
<td>0</td>
<td>-2</td>
</tr>
<tr>
<td>Colon and rectal surgery</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>General surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hand surgery</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0</td>
<td>0</td>
<td>-1</td>
<td>-1</td>
</tr>
<tr>
<td>Obstetrics/gynecology</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>-2</td>
<td>-2</td>
<td>0</td>
<td>-4</td>
</tr>
<tr>
<td>Orthopaedic surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Thoracic surgery</td>
<td>-1</td>
<td>0</td>
<td>0</td>
<td>-1</td>
</tr>
<tr>
<td>Urology</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>0</td>
<td>-2</td>
<td>0</td>
<td>-2</td>
</tr>
</tbody>
</table>
The proposed rule called for expanding this law to ensure patient safety. The final rule permits CMS to revoke or deny a physician’s Medicare enrollment if he or she has been subject to prior action from a state oversight board, federal or state health care program, independent review organization, or any equivalent government body or program that oversees, regulates, or administers the provision of health care services if the underlying facts reflect improper physician conduct that led to patient harm. The agency specified that this policy would apply to all physicians in all settings under all Medicare programs for cases in which the physician’s behavior and the consequent patient harm was significant.

In its comments on the proposed rule, the ACS expressed concern that CMS’ patient harm provisions are inconsistent with the nationwide effort to reduce physician burnout, career changes, suicide, and the stigma associated with seeking treatment for substance abuse. The College noted that this policy might discourage physicians from self-reporting to medical boards because they may be reluctant to disclose behavior (such as drug use and alcoholism) that could result in action leading to a Medicare revocation. CMS acknowledged the ACS’ feedback and removed “required participation in rehabilitation or mental/behavioral health programs” and “required abstinence from drugs or alcohol and random drug testing” from its list of applicable actions under its policy.

The agency provided the following examples to illustrate how these new Medicare enrollment denial and revocation provisions would be enforced:

- **Example 1:** In a case involving patient harm, a state oversight board requires Dr. X to enter a rehabilitation program. The state’s order contains no other sanctions. Therefore, CMS’ denial and revocation policies would not apply because no patient harm was present.

- **Example 2:** In a case involving patient harm, a state oversight board requires Dr. X to enter a rehabilitation program and imposes a fine on the physician. CMS’ denial and revocation policies would apply because patient harm was present.

- **Example 3:** In a case involving patient harm, a state oversight board issues a decision pertaining to Dr. X that requires him or her to enter a rehabilitation program and restricts his license for a 60-day period because of sexual misconduct. CMS would consider the board decision, under its denial and revocation policies, as applicable because of the license restriction based on sexual misconduct.

### Overall impact on surgery

Table 1, page 39, shows the combined effect on total allowed charges of the changes in the work, practice expense (PE), and malpractice (MP) RVUs for all providers and various surgical specialties. The policies finalized for 2020 will have a 0 percent impact on payment for general surgery services.

### Conversion factor

The 2020 MPFS conversion factor (CF) is approximately $36.09, a 0.5 percent increase from the 2019 MPFS CF of $36.04. The 2020 CF reflects a statutory update factor and a budget-neutral adjustment as set forth in section 1848 of the Social Security Act (see Table 2, this page).

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**TABLE 2.**

**CALCULATION OF THE 2020 MPFS CONVERSION FACTOR**

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019 conversion factor</td>
<td>$36.0391</td>
</tr>
<tr>
<td>Statutory update factor</td>
<td>0.00%</td>
</tr>
<tr>
<td>2020 RVU budget neutrality adjustment</td>
<td>0.14%</td>
</tr>
<tr>
<td>2020 conversion factor</td>
<td>$36.0896</td>
</tr>
</tbody>
</table>
2020 CPT coding changes

by Samuel Smith, MD, FACS;
Megan McNally, MD, FACS;
and Jan Nagle, MS
Numerous changes in Current Procedural Terminology (CPT)* coding will be implemented in 2020. This article provides reporting information about the codes that are relevant to general surgery and its related specialties.

Revision of guidelines for repair (closure)
The introductory guidelines in the CPT Integumentary System, Repair (Closure) subsection have been revised to provide more descriptive language to clarify that intermediate repair includes limited undermining. The guidelines also clarify that complex repair includes all the requirements listed for intermediate repair plus at least one of the following: exposure of bone, cartilage, tendon, or named neurovascular structure; debridement of wound edges; extensive undermining; involvement of free margins of the helical rim, vermillion border, or nostril rim; or placement of retention sutures. References to stents and scar revision have been removed from the complex repair guidelines. The guidelines also will include a definition and an illustration (see Figure 1, page 43) of extensive undermining. Please refer to the CPT code book for detailed definitions of intermediate and complex repair.

New graft codes
The American Medical Association (AMA) Specialty Relative Value Scale (RVS) Update Committee (RUC) identified code 20926, Tissue grafts, other (eg, paratenon, fat, dermis), as potentially misvalued. The stakeholder societies determined that this code represented many different types of tissue grafts that required different physician work. For 2020, code 20926 will be deleted and replaced with five new codes (15769–15774) in the Integumentary System, Other Flaps and Grafts subsection. Table 1, page 44, provides the new code descriptors and relative value units (RVUs) for 2020.

Breast guidelines
The “Incision” and “Excision” subheadings will be deleted from the CPT Integumentary System, Breast subsection. The guidelines preceding the breast biopsy codes (previously under the deleted “Excision” subheading) have been extensively revised, including the addition of clear instructions for reporting percutaneous and image-guided breast biopsy, open incisional breast biopsy, and open excision of a breast lesion. Similarly, the guidelines under the “Breast, Introduction” subheading have been extensively revised to provide clear instructions for reporting percutaneous image-guided placement of breast localization device(s). Instructions also have been added for correct reporting of bilateral procedures, and new introductory text has been added to the Breast, Mastectomy Procedures subsection that describes and differentiates mastectomy procedures.

Nipple- and skin-sparing mastectomy
In 2017, the CPT Assistant Editorial Board requested clarification for coding nipple- and skin-sparing mastectomy procedures. Upon review, the stakeholder specialties determined that code 19304, Mastectomy, subcutaneous, has been misreported for a mastectomy procedure that included a nipple- or skin-sparing technique, which should have correctly been reported as a mastectomy procedure using code 19303, Mastectomy, simple, complete. A subcutaneous mastectomy (that is, removing some breast tissue) is a technique introduced in the 1960s that is no longer standard of care; therefore, code 19304 will be deleted for 2020.

Breast reduction
New instructional parentheticals were added to direct reporting code 19300, Mastectomy for gynecomastia, for breast tissue removed for breast reduction for gynecomastia and code 19318, Reduction mammoplasty, for breast tissue removed for breast size reduction for other than gynecomastia.

*All specific references to CPT codes and descriptions are © 2018 American Medical Association. All rights reserved. CPT and CodeManager are registered trademarks of the American Medical Association.
Chest wall procedures
Stakeholder specialties determined that codes 19260, 19271, and 19272, which describe the radical resection of a chest wall tumor involving and/or including rib(s), were misplaced in the Integumentary System, Breast subsection. As a result of this review, these codes were renumbered 21601–21603 and relocated to the Musculoskeletal System, Neck (Soft Tissues) and Thorax subsection.

Exploration of artery without repair
Changes have been made to the artery exploration family of codes in the Cardiovascular System, Arteries and Veins subsection. One code (35701) has been revised, two new codes (35702, 35703) have been added, and three codes (35721, 35741, 35761) have been deleted. Prior to CPT 2020, the code descriptors for exploration of artery included the language “with or without lysis of artery.” Since lysis of the artery during exploration rarely is performed, this language has been removed from the code descriptors. The revised code and new codes continue to indicate that an artery is explored and “not followed by surgical repair.” Existing code 35701 has been revised to describe exploration of artery in the neck. New code 35702 was established to report exploration of an upper extremity artery and new code 35703 was established to report exploration of a lower extremity artery. The code descriptors include examples of typical arteries. Codes 35721 (exploration of femoral artery) and 35741 (exploration of popliteal artery) were deleted with directions to report exploration of a lower extremity artery with code 35703. Code 35761 (exploration of other artery) was deleted with directions to use 37799 to report vascular exploration not followed by surgical repair, other than neck artery, upper extremity artery, lower extremity artery, chest, abdomen, or retroperitoneal area.

When artery exploration is performed on the same side of the neck as blood vessel repair; exploration for postoperative hemorrhage, thrombosis, or infection; or flap or graft procedures in the neck, code 35701 may not be reported separately. When artery exploration is performed on the same extremity as blood vessel repair, code 35702 or 35703 may not be reported separately. Importantly, codes 35701, 35702, and 35703 may only be reported with a surgical procedure performed by the same surgeon if the other procedure is a nonvascular surgical procedure and the artery exploration is performed through a separate incision. Table 2, page 44, provides the new and revised code descriptors and RVUs for 2020.
Transanal hemorrhoidal dearterialization (THD)
CPT Category III code 0249T, Ligation, hemorrhoidal vascular bundle(s), including ultrasound guidance, has been deleted and converted to CPT Category I code 46948, Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy, when performed. THD is a nonexcisional surgical technique developed for the treatment of internal hemorrhoids. This technique is based on the identification and ligation of the terminal branches of the superior rectal artery through a specially developed anoscope equipped with an ultrasound probe that allows localization of arteries that are individually ligated as needed to interrupt hemorrhoid blood supply. When required, a ring of sutures also will be deployed to pull up a prolapse (mucopexy). Family codes 46945 and 46946 were revised to differentiate the work from new code 46948. Separately, all parenthetical references to deleted code 0249T also will be revised. New code 46948 indicates that at least two columns/groups must be treated to report this code. If only one column/group is treated, then code 46999, Unlisted procedure, anus, should be reported. Table 3, page 45, provides the new and revised code descriptors and RVUs for 2020.

Radiofrequency spectroscopy at time of mastectomy
New CPT Category III code 0546T, Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report, may only be reported with codes 19301 or 19302 (partial mastectomy) and only once for each partial mastectomy site. Code 0546T may not be reported for re-excision.
The term “with report” indicates that a written report (for example, handwritten or electronic) signed by the interpreting individual is required. CPT Category III codes do not have assigned RVUs and are considered emerging or evolving procedures or services. CPT Category III code eligibility for payment, as well as coverage policy, is determined by each individual third-party payor. For specific details about payment for this procedure, physicians should contact their local third-party payors because reimbursement varies.

Cryoablation of malignant breast tumors
Cryoablation of malignant breast tumor(s) will now be reported with a new code, 0581T, Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral. Physicians should continue to report cryoablation of “fibroadenomas” with code 19105, Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma. Note that code 0581T includes any imaging modality for guidance, whereas code 19105 only includes ultrasound guidance. In addition, code 0581T may be reported only once per breast treated no matter how many tumors are ablated, whereas code 19105 should be reported for each fibroadenoma ablated. CPT Category III code eligibility for payment, as well as coverage policy, is determined by each individual third-party payor. Physicians should contact their local third-party payors for specific reimbursement policies.

Preperitoneal pelvic packing
The Military Health System Strategic Partnership American College of Surgeons (MHSSPACS) was established in 2014 to improve educational opportunities, inform systems-based practices, and drive surgical research capabilities. Although some trauma injuries are uncommon in the U.S., members of the MHSSPACS U.S. military medical personnel use CPT codes to indicate work performed at military bases and on the battlefield around the world. These procedures also may be performed for battle wound-type injuries, such as the pelvic damage that runners and bystanders sustained at the Boston Marathon in 2013 when angioembolization services were unavailable or inaccessible in a timely manner for all patients needing immediate treatment.

<table>
<thead>
<tr>
<th>TABLE 3. HEMORRHOIDECTOMY</th>
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<tbody>
<tr>
<td>CPT code</td>
</tr>
<tr>
<td>#▲46945</td>
</tr>
<tr>
<td>#▲46946</td>
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<tr>
<td>●46948</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>TABLE 4. PREPERITONEAL PELVIC PACKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT code</td>
</tr>
<tr>
<td>●49013</td>
</tr>
<tr>
<td>●49014</td>
</tr>
</tbody>
</table>
For CPT 2020, a new CPT Category I code (49013) was approved to report preperitoneal pelvic packing without a laparotomy. A second code (49014) was approved for packing removal that will occur on a subsequent day. These two new codes differ from other exploratory procedures in that a laparotomy is not performed. Instead, a Pfannenstiel low horizontal incision is made just above the pubic rim, with dissection carried out until the urinary bladder is identified, without opening the peritoneum. Table 4, page 45, provides the new code descriptors and RVUs for 2020.

**Orchiopexy**

Code 54640 is a CPT legacy code (pre-1990). The inclusion of “with or without” terminology in the code descriptor did not mean “includes when performed.” This verbiage was clarified with the addition of a parenthetical note in 2001 that stated, “For inguinal hernia repair performed in conjunction with inguinal orchiopexy, see 49495–49525.” The AMA CPT 2001 Changes publication provided the following rationale for the revision: “To allay misinterpretation that inguinal hernia repair is an inclusive procedure of the orchiopexy code 54640, a cross-reference was added directing users to the appropriate hernia repair code (49495–49525). When an inguinal hernia repair is performed in addition to an orchiopexy, both code 54640 and the appropriate inguinal hernia repair code 49495–49525, should be reported.” However, coding confusion developed after an erroneous CPT Assistant was published in 2008, and further coding changes were necessary. For CPT 2020, the code descriptor has been revised. Although the revision was editorial, the AMA RUC required review of physician work. Table 5, this page, provides the updated code descriptor and RVUs for 2020.

**Vessel assessment prior to creation of hemodialysis access**

In 2005, CMS created Healthcare Common Procedure Coding System (HCPCS) code G0365, *Vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow)*, to report venous mapping for hemodialysis access placement to allow tracking of venous mapping for quality improvement purposes and to analyze the relationship between venous mapping utilization and fistula formation. The AMA RUC identified code G0365 as potentially misvalued because it never was reviewed for physician work and had Medicare utilization greater than 30,000. The stakeholder specialties agreed to create CPT Category I codes to replace this HCPCS code. For CPT 2020, two new CPT Category I codes will be available to report a duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access. Code 93985 describes a complete bilateral study and code 93986 describes a unilateral study. In addition

### TABLE 5. ORCHIOPEXY

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Descriptor</th>
<th>Global period</th>
<th>Work RVU</th>
<th>Total FAC-RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲54640</td>
<td>Orchiopexy, inguinal or scrotal approach</td>
<td>090</td>
<td>7.73</td>
<td>12.55</td>
</tr>
</tbody>
</table>

### TABLE 6. VESSEL ASSESSMENT FOR HEMODIALYSIS ACCESS

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Descriptor</th>
<th>Global period</th>
<th>Work RVU</th>
<th>Total NF-RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>●93985</td>
<td>Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study</td>
<td>XXX</td>
<td>0.80</td>
<td>1.10</td>
</tr>
<tr>
<td>●93986</td>
<td>complete unilateral study</td>
<td>XXX</td>
<td>0.50</td>
<td>0.71</td>
</tr>
</tbody>
</table>

XXX = global period does not apply  
NF = Non-facility (for example, office)
to creating the two new codes, new subsection guidelines will be added to the codebook to instruct users when to report the new codes or other related codes depending on the type of vessel study performed. New parenthetical notes further instruct users on the restrictions of reporting related vessel study codes on the same extremity. Table 6, page 46, provides the new code descriptors and RVUs for 2020.

### eVisit

The expansion of electronic health record use with associated Health Insurance Portability and Accountability Act (HIPAA)-compliant patient portals has resulted in the creation of three new online digital evaluation and management (E/M) codes—sometimes referred to as an eVisit. Codes 99421–99423 are reported once for the physician’s or other qualified health care professional’s cumulative time devoted to the digital E/M service during a seven-day period. This codeset includes significant restrictions and instructions for correct reporting. The patient must be an established patient, although the problem may be new. The patient must initiate the eVisit, and communication platforms must comply with HIPAA. These codes may not be reported if a separately reported E/M visit occurs within seven days of the first day of patient inquiry. Refer to the CPT code book for detailed guidelines and coding instructions. Table 7, this page, provides the new code descriptors and RVUs for 2020.

### Deletion of rarely used or outmoded procedure codes

The AMA CPT Editorial Panel annually screens the codeset for codes that are rarely or never used. Stakeholder societies and manufacturers are able to provide a rationale for maintaining the code. For CPT 2020, code 43401, *Transection of esophagus with repair, for esophageal varices*, will be deleted as it is no longer standard practice. Code 0377T, *Anoscopy with directed submucosal injection of bulking agent for fecal incontinence*, also will be deleted because no party expressed an interest in maintaining it.

#### Learn more

Learn more about correct coding at an ACS General Surgery Coding Workshop. Physicians receive up to 6.5 AMA PRA Category 1 Credits™ for each day of participation.

The ACS will offer the following workshops in 2020:

- Las Vegas, NV, January 30–31
- Dallas, TX, March 19–20
- Nashville, TN, August 6–8 (third day focuses on trauma)
- Chicago, IL, November 12–14 (third day focuses on trauma)

For more information about the 2020 ACS General Surgery Coding Workshops, visit the ACS website at [facs.org/advocacy/practmanagement/workshops](http://facs.org/advocacy/practmanagement/workshops).

---

**TABLE 7. eVISIT**

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Descriptor</th>
<th>Global period</th>
<th>Work RVU</th>
<th>Total NF-RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>●99421</td>
<td>Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes</td>
<td>XXX</td>
<td>0.25</td>
<td>0.43</td>
</tr>
<tr>
<td>●99422</td>
<td>11–20 minutes</td>
<td>XXX</td>
<td>0.50</td>
<td>0.86</td>
</tr>
<tr>
<td>●99423</td>
<td>21 or more minutes</td>
<td>XXX</td>
<td>0.80</td>
<td>1.39</td>
</tr>
</tbody>
</table>
What to expect from the 2020 Quality Payment Program

by
Haley Jeffcoat, MPH;
Molly Murray;
and Jill Sage, MPH
The Centers for Medicare & Medicaid Services (CMS) updated its policies for the 2020 Quality Payment Program (QPP) as part of the calendar year (CY) 2020 Medicare Physician Fee Schedule (MPFS) final rule released November 1, 2019. This article highlights the finalized policies of the QPP and select American College of Surgeons (ACS) positions, and offers important information and guidelines to help surgeons successfully participate in the QPP’s Merit-based Incentive Payment System (MIPS).

Background
The QPP was implemented in 2017 as part of the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA) of 2015, which replaced the sustainable growth rate (SGR). The QPP offers two pathways for participation—MIPS and qualifying participation in an advanced Alternative Payment Model (APMs). MIPS consolidated three legacy programs—the Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBM), and the Electronic Health Record (EHR) Incentive Program—and recast them as the Quality, Cost, Improvement Activities (IA) and Promoting Operability (PI) (formerly known as Advancing Care Information) performance categories.

Overview of important QPP and MIPS policies for the 2020 performance year
The MPFS final rule comprises the following key policy changes:

• CMS finalized the implementation of the MIPS Value Pathways (MVPs)—a new framework intended to streamline the program starting with the 2021 performance year.

• The MIPS performance threshold required to avoid a penalty increased from 30 points in 2019 to 45 points in 2020.

• As required by MACRA, the 2020 performance may result in a Medicare payment adjustment of up to +/− 9 percent in 2022.

• The performance category weights are unchanged from 2019 to 2020—Quality: 45 percent, Cost: 15 percent, IA: 15 percent, PI: 25 percent.

• For 2020, CMS increased the data completeness threshold for the Quality category by 10 percentage points; clinicians will now need to report each measure for at least 70 percent of applicable patients.

• Starting in 2020, groups can attest to an IA only if at least 50 percent of the clinicians in the group or virtual group complete the same activity during any continuous 90-day period. Previously, at least one clinician in the group needed to complete the activity for the group to receive credit.

• The Cost category includes 10 new episode-based measures for a total of 18 episode-based Cost measures.

• CMS reduced the threshold for a group to meet the definition of hospital-based and qualify for reweighting of the PI component. Instead of 100 percent of clinicians, more than 75 percent of the clinicians in a group must meet the definition of hospital-based for the group to have this category reweighted for the 2020 performance year/2022 payment year.

MVPs: New MIPS participation option for 2021
CMS finalized the implementation of MVPs, which is designed to align measures and activities across Quality, Cost, PI, and IA to simplify MIPS; create a more meaningful participation experience with a set of measures tailored to an episode of care or condition; include population health measures; reduce clinician burden; and better align with APMs to help ease the transition between the two tracks.
In this year’s proposed rule, CMS sought public feedback on MVPs in the form of a Request for Information (RFI), and although the agency finalized the start of the program in 2021, CMS will propose additional program details and plans to implement MVPs in next year’s 2021 rulemaking cycle. See Figure 1, this page, for an example of what a surgical MVP might look like.

The ACS supported the new MVP framework and emphasized that CMS’ willingness to allow for innovation and a truly patient-centric program will be critical to the success of MVPs as it moves away from the siloed structure of MIPS and past legacy programs. The College provided guiding principles for the development of MVPs and supported an MVP framework that includes the following: participation in a verification or accreditation program, such as Commission on Cancer Accreditation; conformance quality, which includes clinical standards and monitoring high-risk events related to preventable harms; and performance quality as measured through condition- or procedure-specific patient reported outcomes (PROs). This framework includes measures that are actionable to clinicians and meaningful to patients, which could increase value for stakeholders. The ACS believes that verification or accreditation programs should be a key component to MVPs because they are rooted in the assurance that the systems in which clinicians practice pursue excellence and avoid errors by verifying that the resources, staff, and infrastructure are in place to provide the highest quality patient care. The College
stressed the need to test MVPs before national implementation. The ACS will track the development of the MVP program and will be working with CMS to develop surgical MVPs.

In addition, the ACS has partnered with the Harvard Business School (HBS) Institute for Strategy and Competitiveness to create ACS THRIVE (Transforming Health care Resources to Increase Value and Efficiency). This initiative will help inform the development of Surgical MVPs. The goal of THRIVE is to define value based on health care outcomes that matter to patients and the costs of delivering those outcomes. THRIVE will help hospitals and surgical practices improve patient outcomes while lowering the cost of delivering care as reimbursement shifts toward APMs and away from fee-for-service care—an approach that increases transparency and accountability. For more information on THRIVE, visit facs.org/quality-programs/acs-thrive.

Data submission requirements
CMS finalized a 10 percentage point increase in the data completeness threshold, which means surgeons or groups must report Quality data for 70 percent of all patients to whom the measure is applicable, regardless of payor. To achieve the maximum points available in the Quality category, surgeons should report at least six Quality measures, including one outcome measure.

The ACS opposed the increase in the data completeness threshold because CMS has not demonstrated statistical reliability supporting this policy, which could result in misclassification of care. Based on its last two decades of experience in quality measurement development and analytics, the College has demonstrated that reliability must be determined on a measure-by-measure basis and account for event rates for a specific surgical procedure. The ACS warned that it is very difficult to measure surgical outcomes at the individual level and is more reliably determined at the hospital or system level.

Quality
For performance year 2020, the Quality category is the most heavily weighted component of the MIPS final score and measures health care processes, outcomes, and patient experience.* The College continues to oppose the constructs of the Quality category because it neither measures health outcomes that matter to patients nor provides actionable quality improvement metrics to surgeons.

CMS finalized notable changes to the MIPS Quality category in the 2020 final rule, including updates to the general surgery specialty measure set and a 10 percentage point increase in the data completeness threshold. CMS did not finalize a proposed increase in the Quality category weight; therefore, Quality is weighted at 45 percent of the MIPS final score for the 2020 performance year, which is unchanged from 2019.


2020 MIPS Specialty Measure Sets
CMS offers many specialty measure sets that provide recommendations on MIPS quality measures most relevant to certain specialties. In the 2020 final rule, CMS finalizes updates to many of the specialty measure sets, including the General Surgery measure set. Surgeons can report these measures through the ACS Surgeon Specific Registry or through other registries listed in the QPP resource library on the CMS website.

Table 1, page 52, shows the finalized general surgery specialty measure set. For the most part, surgeons will receive three to 10 points for Quality measures that have a benchmark when they report at least 20 cases and meet 70 percent data completeness. However, to receive the full weight of the MIPS points available for the Quality category, a surgeon must earn 60 points (10 points for each measure). If a surgeon chooses to report a quality measure that does not have a benchmark or does not meet the 20-case requirement, the measure can receive only three points. Measures that don’t meet data completeness will earn zero points.
Another factor important to understand to optimize your MIPS score is that some of the measures in the general surgery set are considered topped-out, which CMS defines as measures with a median performance score of 95 percent or higher where performance is “so high and unvarying that meaningful distinctions and improvement in performance can no longer be made.” The maximum amount of points clinicians can earn on topped out measures is seven out of 10 points. When measures are extremely topped out, surgeons may need to achieve a performance score of 100 percent performance to receive the maximum amount of points available for the measure. For example, when reporting on Quality Measure #021, Perioperative Care: Selection of Prophylactic Antibiotic—First- OR Second-Generation Cephalosporin, if a surgeon performs less than 100 percent on this measure, the surgeon would only receive three points, even with a performance score of 99.99 percent.

### TABLE 1. GENERAL SURGERY SPECIALTY MEASURE SET FOR REGISTRY REPORTING

<table>
<thead>
<tr>
<th>Measure #</th>
<th>Measure title</th>
<th>Measure type</th>
<th>Maximum points available*</th>
</tr>
</thead>
<tbody>
<tr>
<td>021</td>
<td>Perioperative Care: Selection of Prophylactic Antibiotic—First- OR Second-Generation Cephalosporin</td>
<td>Process</td>
<td>7</td>
</tr>
<tr>
<td>023</td>
<td>Perioperative Care: Venous Thromboembolism Prophylaxis (When indicated in all patients)</td>
<td>Process</td>
<td>7</td>
</tr>
<tr>
<td>047</td>
<td>Advance Care Plan</td>
<td>Process</td>
<td>10</td>
</tr>
<tr>
<td>128</td>
<td>Preventative Care and Screening: Body Mass Index Screening and Follow-Up Plan</td>
<td>Process</td>
<td>10</td>
</tr>
<tr>
<td>130</td>
<td>Documentation of Current Medications in the Medical Record</td>
<td>Process</td>
<td>7</td>
</tr>
<tr>
<td>226</td>
<td>Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>Process</td>
<td>10</td>
</tr>
<tr>
<td>264</td>
<td>Sentinel Lymph Node Biopsy for Invasive Breast Cancer</td>
<td>Process</td>
<td>7</td>
</tr>
<tr>
<td>317</td>
<td>Preventative Care and Screening: Screening for High Blood Pressure and Follow-Up Documented</td>
<td>Process</td>
<td>10</td>
</tr>
<tr>
<td>354</td>
<td>Anastomotic Leak Intervention</td>
<td>Outcome</td>
<td>10</td>
</tr>
<tr>
<td>355</td>
<td>Unplanned Reoperation within the 30 Days of Postoperative Period</td>
<td>Outcome</td>
<td>10</td>
</tr>
<tr>
<td>356</td>
<td>Unplanned Hospital Readmission within 30 Days of Principal Procedure</td>
<td>Outcome</td>
<td>10</td>
</tr>
<tr>
<td>357</td>
<td>Surgical Site Infection</td>
<td>Outcome</td>
<td>10</td>
</tr>
<tr>
<td>358</td>
<td>Patient-Centered Surgical Risk Assessment and Communication</td>
<td>Process</td>
<td>7</td>
</tr>
<tr>
<td>374</td>
<td>Closing the Referral Loop: Receipt of Specialist Report</td>
<td>Process</td>
<td>10</td>
</tr>
<tr>
<td>402</td>
<td>Tobacco Use and Help with Quitting Among Adolescents</td>
<td>Process</td>
<td>10</td>
</tr>
</tbody>
</table>

*This column indicates the maximum available points for each measure in the general surgery specialty measure set for registry reporting. As mentioned in the Quality section, some measures in the set are topped-out and subject to a seven-point scoring cap. The values in this column are based on 2019 benchmarks, and CMS was scheduled to release the 2020 Quality measure benchmarks in December 2019. The benchmark values for all MIPS measures can be found at [https://qpp.cms.gov/about/resource-library](https://qpp.cms.gov/about/resource-library).
In short, it is very difficult to earn 60 points in the Quality category. Therefore, when planning for 2020 Quality reporting, surgeons may want to report measures with 10 maximum points available and be prepared to report more than six Quality measures to receive the full amount of MIPS Quality points. While CMS will only provide performance scores for a physician’s top six performing measures, CMS will allot two bonus points for reporting additional outcome measures and one bonus point for reporting additional high priority measures beyond what is required for full Quality reporting. Even if these measures are not included in the surgeon’s top six measures, it is still possible to receive the bonus points as long as the measure meets case minimum and data completeness requirements. In addition to these possible bonus points, surgeons also can receive up to 10 bonus points for demonstrating an improvement in overall performance in the quality category from the previous year.

Cost
The MIPS Cost performance category measures resources clinicians use in patient care, providing MIPS participants insight on how their care decisions result in spending and how their outcomes differ from similar clinicians’ outcomes.† Cost measures are calculated using Medicare Part B claims data; therefore, clinicians have no reporting requirements. The ACS has continued to question the utility of the cost measures in MIPS. For several years, the ACS has commented that the Cost measures provide inaccurate, unactionable information, making it difficult for surgeons and other participating clinicians to reduce costs and improve the value of care.

In response to ongoing concerns about the measures used in this category and the feedback provided on these measures, CMS opted to maintain the Cost category weight at 15 percent of the MIPS final score for 2020, rather than increase it to 20 percent as originally proposed. CMS also maintained the Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Cost (TPCC) measures in this category from previous years but made some important updates to these measures. Of note, CMS finalized a change in the attribution methodology of the MSPB measure to distinguish between medical episodes (where the index admission has a medical Medicare Severity-Diagnosis Related Group [MS-DRG]) and surgical episodes (where the index admission has a surgical MS-DRG). The updated methodology attributes specialists who are more likely to be involved in managing the patient’s care for which they are being attributed. CMS also changed the name from MSPB to Medicare Spending Per Beneficiary Clinician (MSBC) to distinguish this version of the measure from its use under other CMS programs. CMS also revised the TPCC measure so that it does not attribute costs that occurred before a clinician sees a patient, and generally excludes specialists who are not providing primary care. Although the revisions to these measures may improve appropriate attribution overall, the ACS continues to oppose the use of broad cost metrics such as these because they do not break down all the services billed related to the patient’s experience and are generally not actionable for surgeons.

Episode-based cost measures
CMS also finalized the addition of 10 new episode-based measures for a total of 18 applicable episode-based measures for 2020. The following 12 episode-based measures are relevant to surgeons in 2020:

- Knee arthroplasty
- Revascularization for lower extremity chronic critical limb ischemia

The College commented that MIPS-eligible clinicians and physicians should be free to choose which IAs are most meaningful to their practice.

- Routine cataract removal with intraocular lens implantation
- Screening/surveillance colonoscopy
- Elective primary hip arthroplasty
- Femoral or inguinal hernia repair
- Hemodialysis access creation
- Lower gastrointestinal hemorrhage (applies to groups only)
- Lumbar spine fusion for degenerative disease, 1–3 levels
- Lumpectomy partial mastectomy, simple mastectomy
- Non-emergent coronary artery bypass graft
- Renal or ureteral stone surgical treatment
- Procedural episode-based measures attribution: Episode is attributed to each MIPS eligible clinician who renders a trigger service as identified by Healthcare Common Procedure Coding System/CPT procedure codes.

ACS initiatives to improve value

The ACS’ comments highlight that to achieve value-based care, quality measurement and cost measurement should occur or the same episode of care. Yet, many of the MIPS episode-based cost measures do not have complementary, actionable, and meaningful quality measures. Instead, the ACS supports the CMS Episode Grouper for Medicare and tools capable of producing a patient-specific expected price with a breakdown for all services assigned to the episode within the following phases of care: prehospital, in hospital, and postdischarge. To move from fee-for-service to value-based care, delivery systems need to understand both the cost and price aspects of care. As discussed previously, ACS THRIVE is designed to help surgical teams understand the cost of delivering outcomes for an episode and the price to patients so they can make more informed decisions. While this approach does not appear feasible under the current MIPS structure, the ACS is hopeful that the newly proposed MVP option would allow for measurement of both Cost and Quality across a single episode of care.

Although surgeons are not required to report data to CMS to receive points for Cost, the College recommends that surgeons become familiar with their 2018 MIPS performance feedback reports, which include confidential performance feedback on these measures, to get a sense of how they may score in this category in 2020 and beyond. CMS plans to release the 2019 MIPS performance feedback reports by July 2020, and surgeons can access them by logging on to https://qpp.cms.gov with their Enterprise Identity Data Management credentials. CMS also offers more information about the episode-based cost measures on the MACRA Feedback page, and...
IA

The IA performance category will continue to be weighted at 15 percent of the MIPS final score. As in 2019, most surgeons must select and attest to having completed up to four activities in at least 90 consecutive days within a 12-month period to achieve full credit in this category. For 2020, CMS has revised the list of activities in the IA inventory by consolidating and removing closely related activities, and adding new activities. For example, CMS finalized the removal of eight IAs related to participation in a Qualified Clinical Data Registry (QCDR) and consolidated the activities into two medium-weighted encompassing activities: Participation in a QCDR that promotes use of patient engagement tools and use of QCDR data for ongoing practice assessment and improvement. The College supported the consolidation of these activities to reduce complexity in MIPS but advocated for the new activities to be high-weighted so that surgeons who have reported multiple QCDR-related IAs and will now have only two to choose from could still receive full IA credit. The ACS strongly encouraged CMS to recognize participation in nationally validated and risk-adjusted clinical data registries, such as the ACS National Surgical Quality Improvement Program (NSQIP®), as an activity that could achieve the full IA score, but CMS did not expand the definition beyond QCDRs or did it increase the weight of QCDR-related activities.

CMS also removed many other activities because they duplicate existing measures and are less robust. For the 2020 Performance Year, CMS finalized removal of the annual registration in the Prescription Drug Monitoring Program (PDMP) activity but retained the Consultation of the PDMP. Based on reporting trends from the ACS Surgeon Specific Registry (SSR™) in 2018, many Fellows attested to the annual registration in the PDMP activity. Therefore, surgeons who reported the Annual Registration in the PDMP IA should report the Consolidation of the PDMP IA in 2020 instead.

CMS also finalized a revision to the group reporting policies for the IA category. Starting in 2020, group practices (that is, TINs) can only attest to an improvement activity if at least 50 percent of the clinicians in the group or virtual group complete the same activity in any continuous 90-day period in the performance year. This requirement calls for a significant increase in reporting from past years’ policy, which required only one clinician in the group to attest to the completion of an activity for the group to receive credit.

The College opposed this new policy because it greatly reduces the number of meaningful IAs available to surgeons, especially individuals in multispecialty groups, and increases administrative burden on practices. The College commented that MIPS-eligible clinicians and physicians should be free to choose which IAs are most meaningful to their practice.

PI

The PI category was finalized with few significant changes. The PI category is composed of four broad objectives, each containing a set of measures: public health and clinical data exchange, electronic prescribing health information exchange, and provider to patient exchange. Minor changes have been made to several of the measures within the objectives, but of particular note is the continuation of the Query of the PDMP measure, which is optional and worth five bonus points. CMS also finalized that, beginning with the 2019 performance year, this optional measure will only require a yes/no response instead of the submission of a numerator/denominator. If a surgeon is using a PDMP, attesting to this optional measure is a low-burden way to earn five additional points, particularly as the overall performance threshold increases to 45 points.
If you are interested in reporting through the College, the SSR is the QR option for MIPS reporting. In CY 2020, the SSR will include the measure sets for general surgery and for plastic surgery.

The other measure changes for the CY 2020 PI category are within the e-prescribing and health information exchange objectives. CMS finalized that the Verify Opioid Treatment Agreement measure has been eliminated. The ACS supported the removal of this measure, as it required manual documentation and created undue reporting burden. Within the Health Information Exchange objective, CMS clarified that any participant who is exempt from the Support Electronic Referral Loops measure(s) will have the points (20 points if excluded from one measure, 40 points if excluded from both) redistributed to the Provide Patients Electronic Access to their Health Information measure. The College agreed with the clarification of this redistribution, because surgeons often are exempt from both of the measures in the Health Information Exchange Objective, making it necessary to redistribute points to another objective. This change will be applied retroactively in the 2019 performance year.

Surgeons who meet CMS’ definition of hospital-based clinician or hospital-based group are eligible to have the PI category weight redistributed to the quality category (making the quality weight 70 percent, instead of 45 percent). It is important to note that the criteria for a hospital-based group changed for 2020, so even surgeons who did not meet the definition in the past may now be eligible for an automatic exemption from the PI category in 2020.

To qualify as a hospital-based group in 2020, more than 75 percent of the NPIs in the group must meet the definition of a hospital-based MIPS eligible clinician (that is, the clinician furnishes 75 percent or more of his/her services in a hospital setting). The College supported this change, as it will expand the group definition to additional physicians who work primarily within a hospital, which will reduce reporting burden. To check if your practice qualifies as part of a hospital-based group, use the NPI look-up on the QPP Participation Status website (https://qpp.cms.gov/participation-lookup).

The proposed rule included multiple RFIs, but CMS has yet to address all of the responses. Additional information and feedback may be included in future policy.

**MIPS registry reporting**

Options for registry reporting through MIPS include Qualified Clinical Data Registries (QCDRs), Qualified Registries (QRs), and other health information technology vendors, such as EHR or data analytics vendors. CMS finalized several changes that affect these organizations in an effort to streamline and consolidate reporting mechanisms and options. Beginning in performance year 2021, physicians will be able to report all three performance categories (Quality, IA, and PI) through QCDRs and QRs. In the rule, CMS proposed that registries make these functionalities available to clinicians starting with the 2020 program year. The College encouraged CMS to delay it for at least a year to allow for development and implementation within registry systems. Although surgeons are not required to report all MIPS categories via a QCDR or QR, it will be an option for surgeons who prefer to report from a single source starting in 2021. Surgeons who currently use their EHR and/or Health Information Exchange to report PI can continue to use this method of submission in performance year 2021.

If you are interested in reporting through the College, the SSR is the QR option for MIPS reporting. In CY 2020, the SSR will include the measure sets for general surgery and for plastic surgery.

**Facility-based scoring**

For the first time, in 2019 CMS will automatically use the Hospital Value-Based Purchasing (VBP) Program score of a facility-based clinician or group in lieu of a MIPS score if the VBP score is higher than the clinician’s combined Quality and Cost score under MIPS. CMS calculates the facility-based score automatically using the facility’s Total Performance Score determined through the Hospital VBP Program. Surgeons are not required to opt-in or take any specific action to
be eligible, but should use the QPP Participation Look-Up Tool (https://qpp.cms.gov/participation-lookup) to determine whether they meet the definition of “facility-based” and to which facility they are attributed. Surgeons who are eligible for facility-based scoring can still report MIPS Quality measures, but CMS will automatically use the facility’s score if it is higher than their individual Quality and Cost MIPS scores. CMS will provide details about how surgeons were scored for MIPS in 2019 MIPS feedback reports, which are expected to be released in July 2020.

Individual clinicians are considered facility-based if they meet all the following criteria:

- Billed at least 75 percent of covered professional services in a hospital setting.
- Billed at least one service in an inpatient hospital or emergency room and can be attributed to a facility with a Hospital VBP score.
- If a clinician works at multiple facilities, CMS will attribute the clinician to the hospital where they provided services to the greatest number of Medicare beneficiaries during the determination window using the same TIN/NPI combination.
- A group practice would be considered facility-based if 75 percent or more of the MIPS eligible clinicians in a group are deemed facility-based. CMS will attribute the group to the hospital where the plurality of clinicians in the group were attributed as individuals.

In October 2019, CMS released the results of the FY 2020 Hospital VBP Program and indicated that 55 percent of hospitals will receive positive adjustments. Facility performance scores associated with the FY 2020 Hospital VBP Program results will be posted on the Hospital Compare website as part of the January 2020 update. Some surgeons are tied to high-performing facilities and could rely on the facility score to achieve a high MIPS score, but that may not be the case for all, making it important to understand how your facility has historically scored and compared with other facilities in the Hospital VBP Program.

Note that hospital-based status is different than facility-based status. Hospital-based status has different eligibility criteria and is used to determine if a clinician or group is exempt from the PI category. As mentioned, facility-based status is used to determine whether the clinician or group is eligible for facility-based scoring. Although the statuses are different, it is possible to fall into both categories. Surgeons who are considered both hospital-based and facility-based will receive an automatic reweighting of PI to Quality and are also eligible to have their facility’s Hospital VBP Program score applied to Quality and Cost.

APMs

The final rule also included policies related to Alternative Payment Models (APMs), but CMS did not finalize many significant changes to the APM track for 2020. For surgeons who are part of APMs or may be in the future, it is important to remember that surgeons who provide a sufficient number of services (that is, payments or patients) through what CMS defines as an Advanced APM (A-APM) are exempt from MIPS and qualify for a 5 percent lump sum Medicare bonus payment. However, absent any legislative changes to the MACRA statute, the 5 percent bonus for APMs will no longer be available after the 2024 payment year (that is, 2022 will be the last year that participation in an A-APM will qualify for a 5 percent bonus). CMS determines eligibility for the APM track of the QPP based on the number of patients or revenue earned through the A-APM. Beginning with the 2019 performance year, these eligibility determinations may take into account participation in a combination of both Medicare and

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QUALIFYING FOR AN EXEMPTION
- Small practices and clinicians that are part of a hospital-based group could qualify for a PI exemption
- A small practice is defined as surgeons in solo practice or a practice of 15 or fewer MIPS eligible clinicians reporting under the same TIN
- A hospital-based group is defined as a group in which more than 75 percent of the NPIs in the group meet the definition of a hospital-based MIPS eligible clinician (that 75 percent of their services are hospital-based)

How to avoid a penalty
There are many ways to achieve a MIPS Final Score of 45 points in 2020 and avoid a payment penalty in 2022. However, unlike past years where reporting in only one performance category could yield enough points to avoid negative payment adjustments, for 2020 most surgeons will need to participate across all reportable MIPS performance categories to earn enough points to avoid a penalty.

Tips for successful 2020 MIPS reporting
Following are tips for successful 2020 MIPS reporting:

- As a first step toward successful 2020 reporting, the College recommends checking your participation status using the QPP Participation look-up on the CMS website at https://qpp.cms.gov/participation-lookup to determine whether you are required to report MIPS or are eligible for special statuses. Surgeons who qualify for special statuses may receive bonus points or exemptions and have certain performance categories reweighted.

- When selecting quality measures, it is important to remember that many measures have benchmarks that could limit the number of points that you may earn on the measure. For example, many surgery-focused measures are topped-out and subject to a scoring cap of seven points, which may necessitate reporting other measures or reporting on additional outcome or high priority measures that may earn you bonus points.

The following are scoring examples for clinicians who meet a special status category that exempts them from PI. None of these scenarios includes points for the Cost category because CMS calculates Cost using claims data, and scores are difficult to predict.

- Scoring example for physicians who qualify for PI exemptions (see sidebar, this page, for information regarding physicians who may qualify for an exemption):
  - The 25 percent weight allotted to the PI category is reweighted to Quality, making Quality worth 70 percent of the overall MIPS score
  - (26 measure points in Quality = approximately 30 MIPS points) + (fully reporting IA = 15 MIPS points) = 45 MIPS points

- Scoring example for small practices (groups of 15 or fewer MIPS eligible clinicians):
  - Small practices receive six bonus points in the Quality performance category if they report at least one quality measure and may apply for an exemption from the PI category.
  - (20 measure points + 6 bonus points in Quality = approximately 30 MIPS points) + (fully reporting IA = 15 MIPS points) = 45 MIPS points
  
  Note: This scenario applies if your PI score is reweighted to the quality category.

- Scoring example for physicians who qualify for PI exemptions (see sidebar, this page, for information regarding physicians who may qualify for an exemption):
  - The 25 percent weight allotted to the PI category is reweighted to Quality, making Quality worth 70 percent of the overall MIPS score
  - (26 measure points in Quality = approximately 30 MIPS points) + (fully reporting IA = 15 MIPS points) = 45 MIPS points

- Scoring example for small practices (groups of 15 or fewer MIPS eligible clinicians):
  - Small practices receive six bonus points in the Quality performance category if they report at least one quality measure and may apply for an exemption from the PI category.
  - (20 measure points + 6 bonus points in Quality = approximately 30 MIPS points) + (fully reporting IA = 15 MIPS points) = 45 MIPS points
  
  Note: This scenario applies if you report in PI and it is not reweighted to Quality.

Surgeons seeking assistance in planning for 2020 QPP and MIPS participation or understanding their 2019 MIPS feedback reports should e-mail qualityDC@facs.org. ♦
The American Society of Breast Surgeons (ASBrS) released consensus guidelines February 10, 2019, regarding testing for hereditary breast cancer syndromes.1 The major takeaway from these guidelines is that germline genetic testing should be available to every breast cancer patient; however, the consensus statement also discusses many of the challenges related to germline genetic testing, presents an unbiased review of the literature, and suggests appropriate management strategies. This article summarizes background information pertaining to expanded genetic testing, presents the five major points contained in the ASBrS guidelines, highlights the importance of germline genetic mutation detection, and discusses the implications this practice change will have for surgical management.

HIGHLIGHTS
• Describes the evolution of genetic testing for breast cancer patients
• Identifies the five major points of the ASBrS consensus guidelines
• Summarizes the implications of germline genetic mutation detection and implications on surgical management

Editor’s note: This article was developed and written as part of a series of feature stories by members of the American College of Surgeons Clinical Research Program to inform Bulletin readers about issues that affect cancer surgeons and patients.
Background

Approximately 10 to 15 percent of breast cancers are attributable to an inherited genetic mutation. According to the National Comprehensive Cancer Network (NCCN) guidelines, clinicians should consider genetic testing for breast cancer patients who are 50 years old or younger, have triple-negative breast cancer at an age younger than 60 years old, are male with breast cancer, have bilateral or a second primary breast cancer, or also have had ovarian cancer. For individuals without this personal history, additional family history criteria must be met: At least one relative with breast cancer diagnosed at 50 years old or younger; one relative with ovarian cancer; and more than two relatives with breast cancer, prostate cancer (Gleason score ≥7 or metastatic disease), or pancreatic cancer. However, these guidelines are cumbersome for providers and may lead to lapses in identifying patients who can be considered for genetic testing. In fact, only one in five patients who meets these guidelines is referred for genetic testing. A cross-sectional look at the National Health Interview Survey Cancer Control Supplement in 2005, 2010, and 2015 estimated that at least 1.2 million patients never underwent genetic testing.

Many groups internationally have recognized the problem of not testing a significant proportion of patients with genetic mutations in breast cancer predisposition genes and have started to provide evidence for broadening their nations’ genetic testing guidelines to simplify the process and capture more genetic mutation carriers. A group in Norway tested all breast cancer patients for BRCA1/2 mutations and found that 3 percent of the 1,371 patients tested had a BRCA1 or BRCA2 mutation and that existing guidelines were insufficient to identify all BRCA1/2 mutation carriers. A group in the U.K. conducted a study that used broadened and simplified guidelines. The researchers tested patients with breast cancer who were younger than 45 years old, had two primary breast cancers before the age of 60, had triple-negative breast cancer at any age, had ovarian cancer at any age, were men of any age, or any breast cancer patient in whom genetic testing would affect their cancer management. They found that 117 of 1,184 people tested had BRCA mutations, which represented 50 percent more mutations detected than would have been found if they had used their prior guidelines.

These studies, though, only tested for BRCA1/2 mutations; the percentage of genetic mutation carriers identified would likely have been higher had panel testing been performed. Yang and colleagues retrospectively examined deidentified data from 4,196 Medicare patients undergoing genetic testing. Rates of germline genetic mutation were similar among patients who met NCCN criteria (10.5 percent) and patients who did not meet NCCN criteria (9 percent, p = 0.26). Another group in the U.S. prospectively performed broad panel testing (80 genes) for a series of consecutive breast cancer patients and discovered that 9.65 percent of 959 tested patients carried a pathogenic germline mutation. These rates were similar among patients who met the NCCN guidelines for genetic testing (9.39 percent) and those who did not (7.9 percent; p = 0.4241).

Five points from the consensus guidelines

The ASBrS consensus guidelines include the following major take-home points:

- Health care professionals who are knowledgeable about genetic testing can discuss and arrange genetic testing for patients. It may be useful to refer complicated patients to certified genetic counselors.

- Germline genetic testing should be offered to all breast cancer patients, both newly diagnosed and those with a previous personal history.

- Patients with prior genetic testing may benefit from updated testing.
Genetic testing should be available to patients without cancer but who otherwise meet NCCN guidelines.

Variants of uncertain significance (VUS) results are not clinically actionable findings.

The importance of detecting a genetic mutation
Discovering deleterious genetic mutations in breast cancer predisposition genes can have many important implications for the breast cancer patient. These include a change in the patient’s cancer management, enhanced surveillance strategies for recurrent breast cancer, enhanced surveillance and prevention of other cancers, and cascade testing for family members.

An important reason to identify genetic mutation carriers is that different systemic therapies may be more effective in this population. There is substantial evidence that poly (ADP-ribose) polymerase inhibitors are especially effective in metastatic breast tumors with DNA-repair defects, such as those in BRCA1/2 patients,6,7 and cisplatin, an alkylating agent that disrupts DNA replication, has shown activity in BRCA1/2-mutated patients, possibly because of their impaired DNA repair mechanisms.8,9 Based on this body of work, ongoing clinical trials are examining BRCA patient-specific regimens.10,11 As certain treatments are found to be more effective in some patient populations than others and the field of cancer treatment moves toward personalized or precision medicine, the identification of genetic mutation carriers will be increasingly important.

Another reason to test breast cancer patients for genetic mutations is that germline genetic mutation carriers with residual breast tissue are at increased risk of a second primary breast cancer of both the ipsilateral and contralateral breast, and increased posttreatment surveillance should be recommended. This continuum of care involves mammogram/tomosynthesis and magnetic resonance imaging (MRI) every year. In contrast, average-risk women without a predisposition to genetic mutation require only bilateral mammogram annually.

Genetic testing results can have considerable implications for unaffected relatives, especially siblings and offspring—from improved risk stratification to specialized medical and surgical interventions for risk modification. For example, unaffected patients who are found to be genetic mutation carriers at increased risk of breast cancer are offered enhanced screening with annual MRI and mammogram for early detection of breast cancer to minimize morbidity and mortality. In addition to the higher rates of genetic mutation detected in the study by Grindedal and colleagues, the testing of relatives after the identification of a mutation resulted in, on average, one additional family member being identified as having a genetic mutation for each of the patients who tested positive. One early-stage breast cancer and one early-stage ovarian cancer were identified on average in these “unaffected” family members.5 The identification of genetic mutation carriers and early detection of breast cancer or risk reduction with surgery to prevent ovarian cancer can be lifesaving. Panel-based testing results also can detect mutations in genes that confer an increased risk of other malignancies, such as colorectal cancer. Earlier and more frequent colonoscopy screening can effectively prevent colorectal cancer if such a pathogenic mutation is discovered.

Implementation concerns
It is a common and reasonable concern that the increased demand for genetic testing will overcome the supply of genetic counselors.13 In the Surveillance, Epidemiology, and End Results (SEER) study conducted by Kurian and colleagues, half of the patients tested for a genetic mutation never saw a genetic counselor.14 Consequently, the ASBrS recommendation encourages surgeons or other clinicians experienced and knowledgeable in genetic testing to educate patients and order genetic testing for patients.1 The ASBrS cautions, however, that patients with complicated family histories or...
complex genetic mutation results would benefit from referrals to genetic counselors.

To address the genetic counselor workforce issue, expedited genetic mutation pre-counseling and testing practices are in development. One such model implemented a rapid testing practice, which included pre-test counseling and genetic testing performed by the cancer team and then cascade testing performed by genetic counselors. As at least some of the genetic testing responsibility likely will shift to surgeons; rapid genetic testing models will prove crucial in the coming years, and consideration should be given to developing such models with genetic counseling input.

Health care resource use and cost containment is another common concern regarding broadening genetic testing practices. According to the National Human Genome Research Institute, the cost of coding the human genome has dramatically declined since 2001. Also, the number of genetic tests on the market is increasing, and genetic testing is widely available to the public via direct-to-consumer saliva/cheek swabs, resulting in heightened competition between companies. For these reasons, it can be assumed that the trend of decreasing genetic testing costs will continue to align with pricing for other routine medical screening tests. Furthermore, several studies indicate that broad genetic testing applied to all breast cancer patients is cost-effective, with the prevention of breast and ovarian cancers in family members of affected individuals offsetting the costs of testing. A recent microsimulation modeling study published in JAMA Oncology examined two testing strategies among 11,836 patients in the U.S. and U.K.—testing only those with family history or clinical criteria versus testing all affected patients. This study showed that the cost of broad genetic testing would fall well below each country’s cost-effectiveness threshold and would prevent more than 2,000 breast and ovarian cancer cases and 600 deaths in the U.K. and more than 9,000 cases and 2,000 deaths in the U.S. annually. The authors concluded that broad genetic testing would be cost-effective.

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Implications for surgical practice and patient management

Genetic mutation status significantly affects surgical decision making. Even in patients who are not affected by a pathogenic genetic mutation, the rates of CPM have been on the rise for the past two decades—increasing from 2 percent in 1998 to 12.7 percent in 2012.22 Despite this more aggressive surgical treatment, bilateral mastectomy is not associated with a decreased mortality compared with breast conservation.23 Patients who have an inherited genetic mutation may be more likely to choose a mastectomy and/or CPM as their surgical procedure based on their increased risk of a second breast cancer.14

Risks of contralateral breast cancer and benefits of prophylactic surgery for BRCA germline mutation carriers are well established. Although it has not been shown to improve survival, bilateral mastectomy does reduce contralateral breast cancer risk by 95 percent among BRCA1/2 mutation carriers.24

Generally, the NCCN guidelines successfully identify many patients with BRCA mutations because the guidelines were based on clinical factors and family histories of BRCA mutation carriers; as such, the major increase in discovery of genetic mutations resulting from broad-based genetic testing will be moderate penetrance gene mutations.25,26 Unfortunately, unlike for BRCA carriers, specific estimates are not available with regard to the benefits of prophylactic surgery for carriers of mutations in other breast cancer susceptibility genes.27,28 Most of these patients are at lower risk than BRCA mutation carriers, but risk estimates are unstable because of smaller numbers, variable penetrance, and lack of long-term follow-up.

So, although we have less clear surgical guidance for these moderate penetrance genetic mutation carriers, clinicians will be identifying these patients more frequently. Hence, the ASBrS consensus guidelines made recommendations regarding prophylactic mastectomy. For the following four genes, the ASBrS recommends consideration of risk-reducing mastectomy: BRCA1, BRCA2, PTEN, and TP53. For the other germline

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continued on next page
mutations associated with increased breast cancer risk, the ASBrS recommends enhanced screening: ATM, CDH1, CHEK2, NBN, NF1, PALB2, and STK11. The authors reinforce that data are insufficient to support risk-reducing mastectomy, which is in line with other recommendations. Some patients may pursue risk-reducing surgery, regardless of genetic mutation status, based on their perceived risk of contralateral breast cancer, desire for symmetry with bilateral reconstruction, peace of mind, or to forgo future breast screening. Factors such as family history and age should play a particularly important role in an informed patient-provder discussion regarding moderate penetrance gene mutation carrier status, and though ultimately patients may opt for bilateral mastectomy, the ASBrS recommendations should be considered.

Surgeons critically influence the decisions women with early-stage breast cancer make about their surgical procedures and their satisfaction with those decisions. The ASBrS has advised against routine CPM in average-risk women without a genetic mutation. A recommendation against CPM in a SEER cohort of patients with early stage breast cancer led to only a 1.9 percent rate of CPM, whereas women who received care from surgeons who did not provide management recommendations had a tenfold higher (19 percent) rate of CPM. Furthermore, patients reported low dissatisfaction when their surgeon did not recommend against CPM but discussed it (3.9 percent), whereas dissatisfaction was substantively higher when surgeons recommended against CPM but did not discuss it (14.7 percent), highlighting the importance of informed discussion and shared decision making. In addition, women who were advised against CPM were not more likely to seek a second opinion or have a different surgeon perform the operation.

The oncology community has expressed general concern that increased genetic testing would lead to increased rates of contralateral prophylactic mastectomy. However, evidence indicates that the increase in mutations discovered by multigene panel testing has not led to a corresponding increase in rates...
of CPM. This finding is encouraging, though the rates were already high and approximately equal for women with a deleterious mutation, a VUS, and no mutation at all, which may point to overtreatment of women with negative or VUS results. Well-designed rapid genetic counseling and panel testing practices did not increase rates of mastectomy in two prospective single-institution trials. In a series of patients with VUS identified in BRCA, breast cancer patients with a known VUS in BRCA before surgery opted for CPM at a similar rate as patients who did not have preoperative knowledge of their VUS (22 percent versus 35 percent, respectively; P = 0.45); overall surgical choices made by patients with a VUS closely resembled patients with no known genetic mutation in this series from the Mayo Clinic, Rochester, MN. Patients with a VUS in BRCA but without a cancer diagnosis had high rates of bilateral prophylactic mastectomy, associated with first-degree family history and clinical risk. Over time, 22 percent of the 97 patients with BRCA VUS were reclassified (95 percent benign, 5 percent deleterious), illustrating the importance of appropriate counseling regarding VUS. Another critical aspect of the ASBrS consensus guidelines is the emphasis that a VUS result is not clinically actionable.

Conclusions
The ASBrS recently released consensus guidelines recommending genetic testing be made available for all breast cancer patients. This represents a departure from other guidelines, such as those from the NCCN. However, the statement recognizes the challenges of this practice and makes clear recommendations for clinical quandaries like VUS results and prophylactic surgery for moderate penetrance gene mutation carriers. Broad genetic testing practices should be considered and likely will become standard care in the coming years, and the ASBrS consensus guidelines are straightforward and can serve as an important resource for surgeons.

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Enhanced Recovery After Surgery (ERAS) is a multimodal approach that focuses on optimizing nutrition, early mobilization, and pain management while minimizing narcotic usage. In colorectal and general surgery, ERAS has led to improved outcomes, reduced length of stay (LOS), and lower hospital costs. Less has been published about implementing ERAS in the field of orthopaedic surgery or in geriatric patient populations; however, additional studies such as this one are looking to address the lack of literature in these groups of patients.

Kaiser Westside Medical Center (KWMC), Hillsboro, OR, had a LOS for arthroplasty patients that was significantly longer than that of Kaiser Permanente hospitals in other regions. As more patients joined our health plan, the volume of total joint replacements at the hospital increased, which led to a bottleneck in our arthroplasty service line.

A team was assembled to work on implementing ERAS principles in the care of total hip and total knee replacement patients. Until this point, no surgical services at Kaiser Permanente Northwest had implemented ERAS protocols. Certain elements of ERAS already were in place for arthroplasty patients, such as mobilization on the day of the operation and a component of multimodal pain management. However, prior to the rollout in October 2017, no clearly defined process for all joint replacement patients had been implemented. Other elements were added to the arthroplasty bundle, including a preoperative carbohydrate drink two hours before arrival (approximately four hours before scheduled operation); avoiding routine use of urinary catheters; short-acting spinal anesthesia; postoperative mobilization within 12 hours; resumption of regular diet within 12 hours; maintenance of euvolemia (minimize intraoperative fluid volume and avoiding hemodilution); and standardized postoperative nausea and vomiting prophylaxis. In addition, the orthopaedic service lacked a consistent method of documentation to identify improvements and gaps. Standardizing ERAS principles required a culture shift that included familiarizing staff with core concepts (minimizing opioids, early ambulation, optimized nutrition), as well as educating patients about expectations of early discharge and pain management.

Putting the quality improvement activity in place
KWMC is a community hospital located west of Portland. It is one of two hospitals owned by Kaiser Permanente Northwest. The service area comprises the Portland metropolitan area (including Vancouver, WA), extending south to Salem and Eugene. KWMC has 126 licensed beds, approximately 675 physicians, and more than 1,000 employees. The hospital opened in 2013 and prioritizes high-reliability organization principles in patient care. It participates in the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) Multispecialty Option, abstracting primarily orthopaedics, general surgery, and urology.
Standardizing ERAS principles required a culture shift that included familiarizing staff with core concepts (minimizing opioids, early ambulation, optimized nutrition), as well as educating patients about expectations of early discharge and pain management.

The highest volume service is orthopaedic surgery, specifically hip and knee replacement. In 2017, 2,045 total joint operations were performed at KWMC, 391 of which involved patients who were 75 years old or older. In 2018, that number increased 21 percent, bringing the annual volume to 2,496 (521 of these patients were age 75 older), making KWMC the busiest joint replacement center in the state of Oregon.

At KWMC, our total joint patients were the first population in the region for which the ERAS multimodal care pathway was implemented. It was the first step of a larger regional project to rollout ERAS across all surgical specialties. Launching this initiative required executive-level sponsorship and collaboration between physicians, nurses, and operational leaders.

This region-wide initiative provided the executive-level support needed to implement culture changes specific to KWMC arthroplasty patients. We were able to identify appropriate ERAS process measures with the input of departmental leaders and partner with our change champions in each phase of care (orthopaedic clinic, preoperative medicine clinic, preoperative holding area, operating room, postanesthesia care unit, surgical floor, and physical therapy) to facilitate meaningful discussions regarding opportunities and potential barriers. We also were able to leverage our ACS NSQIP data set for our outcome measures. This project required highly collaborative relationships between multidisciplinary workgroups throughout the hospital.

Key steps involved in the planning and development of the ERAS program were as follows:

- Determine goals for the ERAS program: reduce LOS without concomitant increase in readmissions, achieve harm-free surgery (no surgical site infection, wound dehiscence, pneumonia, sepsis, unplanned intubation, venous thromboembolism, acute renal failure or progressive renal insufficiency, urinary tract infection, cerebrovascular accident, myocardial infarction, cardia arrest, transfusions)
- Identify stakeholders and subject matter experts
- Develop dashboard team responsible for data validity and integrity for both process and outcome measures, using NSQIP data for outcomes measures
- Engage operational and clinical leaders in measuring discrete steps in the process (that is, early ambulation, last liquids, multimodal analgesia, preoperative carbohydrate drink, avoiding use of urinary catheters)
- Identify all patient touch points to ensure consistent ERAS messaging throughout their care process
- Collaborate with outpatient clinic, the preoperative medicine clinic, preoperative total joint class, surgical prep area (preoperative), intraoperative, postanesthesia care unit, hospital ward, as well as physical and occupational therapy

The planned changes largely came from Kaiser Permanente Northern California’s experience with using ERAS for elective colorectal resection and emergency hip fracture repair across 20 medical centers in their region. They published their findings from 8,770 cases, which demonstrated earlier and greater ambulation, improved nutrition, and reduced opioid use, as well as lower readmission and overall complication rates. Colorectal patients saw a decrease of in-hospital mortality, and hip fracture patients saw increased rates of home discharge. This study showed that rapid, large-scale implementation of a multidisciplinary ERAS program was feasible and cost-effective in improving surgical outcomes.

We developed the ERAS protocol for arthroplasty patients in September 2017, and implementation of new protocols began in October 2017. ERAS education materials for both staff and patients were distributed. In January 2018, we began implementation of home recovery (also known as same-day discharge, outpatient arthroplasty). We piloted the home recovery protocol among four surgeons, who closely monitored their patient outcomes.

In the second and third quarter of 2018, the remaining surgeons adopted this practice after seeing the early adopters’ initial success. In the second quarter of 2018, we also developed an ERAS rounding tool for both staff and patients. Staff education and rounding on ERAS core principles occurred quarterly, with operational leaders taking responsibility for rounding on staff, supported by their partners in hospital quality. Quarterly patient rounding focused on ERAS principles and experience (preoperative carbohydrate beverage, pain management expectations, avoidance of urinary catheters).

The following staff were involved in the program:

- Quality consultant
- Surgeon champion
- Anesthesia lead
- Hospitalist co-management program

### TABLE 1. EFFECTS OF ERAS ON ARTHROPLASTY PATIENTS AGES 75 AND OLDER

<table>
<thead>
<tr>
<th></th>
<th>Pre-ERAS (October 1, 2016–September 30, 2017) (n = 253)</th>
<th>Post-ERAS (October 2, 2017–September 30, 2018) (n = 276)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>Rate</td>
<td>Count</td>
</tr>
<tr>
<td>American Society of Anesthesiologists (ASA) 1–2</td>
<td>122</td>
<td>48%</td>
<td>134</td>
</tr>
<tr>
<td>ASA 3+</td>
<td>131</td>
<td>52%</td>
<td>142</td>
</tr>
<tr>
<td>Anesthesia–General</td>
<td>32</td>
<td>12%</td>
<td>31</td>
</tr>
<tr>
<td>Anesthesia–Spinal</td>
<td>221</td>
<td>88%</td>
<td>245</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>1</td>
<td>0.4%</td>
<td>2</td>
</tr>
<tr>
<td>Pulmonary embolism</td>
<td>1</td>
<td>0.4%</td>
<td>3</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>5</td>
<td>2.0%</td>
<td>3</td>
</tr>
<tr>
<td>Pulmonary nodular amyloidosis</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
</tr>
<tr>
<td>Cerebrovascular accident/myocardial infarction</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>LOS–0 days</td>
<td>2</td>
<td>0.8%</td>
<td>3</td>
</tr>
<tr>
<td>LOS–1 day</td>
<td>115</td>
<td>45.5%</td>
<td>178</td>
</tr>
<tr>
<td>LOS–2 days</td>
<td>83</td>
<td>32.8%</td>
<td>57</td>
</tr>
<tr>
<td>LOS–3+ days</td>
<td>53</td>
<td>20.9%</td>
<td>38</td>
</tr>
<tr>
<td>Skilled nursing facilities discharge</td>
<td>53</td>
<td>20.9%</td>
<td>43</td>
</tr>
<tr>
<td>Home discharge</td>
<td>199</td>
<td>78.7%</td>
<td>232</td>
</tr>
<tr>
<td>Unplanned return to operating room</td>
<td>5</td>
<td>2.0%</td>
<td>4</td>
</tr>
<tr>
<td>Unplanned readmit</td>
<td>14</td>
<td>5.5%</td>
<td>12</td>
</tr>
</tbody>
</table>
Nursing leadership: preoperative, intraoperative, postoperative, hospital floor

Nurse educators from perioperative and hospital floor

NSQIP surgical case reviewer

Data analytics

Physical therapy

No additional costs were incurred beyond normal hospital operations to implement and maintain the quality improvement (QI) program, and no additional funding sources were necessary to implement this program.

Results
This was a retrospective study aimed at determining the effects of ERAS on geriatric arthroplasty patients ages 75 and older. Patients were divided into two groups: pre-ERAS and post-ERAS. Each group consisted of 12 months of geriatric arthroplasty patients: October 1, 2016, to September 30, 2017, for pre-ERAS patients, and October 1, 2017, to September 30, 2018, for post-ERAS. There were 276 patients in the post-ERAS (experimental) group and 253 in the pre-ERAS (control) group.

Table 1, page 72, shows that, despite having a similar breakdown of comorbidities as measured by American Society of Anesthesiologists class, after implementation of the ERAS protocol, a significantly greater proportion of patients had a LOS of only one day (64.5 percent versus 45.5 percent; p < 0.0001) (see Figure 1, this page). Similarly, after ERAS, fewer patients had a LOS of two days (16.0 percent versus 32.8 percent, p < 0.0001) or three or more days (13.8 percent versus 21 percent, p = 0.03).

Few patients older than the age of 75 participated in the home recovery program, and no significant difference was seen in the proportion being discharged home or to a skilled nursing facility (see Figure 2, page 74). Similarly, no difference in unplanned returns to the operating room or readmissions was demonstrated.

All data were analyzed using R statistics package version 3.5.3 (R Foundation for Statistical Computing, Vienna, Austria). When comparing the proportions between groups, a t-test for proportions was used with an alpha of 0.05.

The setbacks for implementing this QI activity included the following:

- Delays in dashboard build-out from other high priorities at the regional level
- Staffing in postanesthesia care unit (PACU) for home recovery patients: procured additional full-time equivalents (FTEs) from leadership for PACU nurses
- Identification of home recovery patients: surgeon reluctance
to participate because of perceived increased workload from earlier discharge, and, related to that, the potential need for more opioid refills offered another barrier to identifying home recovery patients.

- Patient and family preference to stay longer, so it is necessary to educate them on the benefits of earlier discharge, be it same day or postoperative day one.

Solutions for overcoming barriers to implementation included the following:

- Educate staff and surgeons about the benefits of ERAS.
- New scripting of preoperative patient education class; inform patients that discharge on postoperative day zero is the norm for healthy patients.
- Revisions in original QI plan due to limitations encountered during the process.
- Manage expectations, changing deadlines.
- Focus on patient collaboration to ensure successful change management.
- Modify protocol as needed: switched from intravenous to oral acetaminophen (because of cost issues), did not implement postoperative chewing gum protocol (used in Kaiser Northern California).

**Cost savings**

No money was directly invested in implementing the ERAS pathway for geriatric arthroplasty patients. Health plan leadership allocated 0.25 FTE of our perioperative regional QI consultant, who had the assistance of a project manager and a senior administrator to help achieve this goal. Further studies are under way to estimate direct reductions in cost from reduced LOS.

**Lessons learned**

Many variables must be considered prior to implementing a system-wide initiative like ERAS to ensure success. Early on in the process, research best practices to incorporate and identify organizational leaders to obtain buy-in. Assemble a multidisciplinary team including change champions, clinical subject matter experts, data specialists, frontline champions, and both clinical and nonclinical hospital leadership. Additional lessons learned include the following:

- Achieve consensus on measurable objective rooted in best practice.
- Establish reasonable deadlines with accountability.
- Identify change champions—subject matter experts who are respected and can solicit buy-in from peers and their groups of influence.
The success of a large-scale project like ERAS is completely dependent upon data integrity, accountability for meeting deadlines, and interdepartmental communication.

- Obtain support of executive leadership (both physicians and health plan operations)
- Reach out to other hospitals that have implemented similar programs—solicit recommendations and shortcomings
- Identify unit-based frontline champions for specific metrics
- Standardize message regarding the change to both staff and patients
- Establish clear budget and strategy for data analytics and marketing

The success of a large-scale project like ERAS is completely dependent upon data integrity, accountability for meeting deadlines, and interdepartmental communication. With this in mind, it is recommended that other institutions engage in the following:

- Monitor data through smaller monthly dashboard meetings
- Present leadership reports at quarterly meeting regarding progress on arena-specific action items
- Conduct focused ERAS rounding with staff and patients
- Share the patient voice and ERAS experience
- Solicit and share staff feedback
  
  Clear and consistent communication is required for success. Communication is facilitated through meaningful relationships across the care continuum and by the use of web-based collaborative platforms.

Additional considerations
QI program leaders also should consider the following when implementing a system-wide initiative such as ERAS:

- Develop patient education videos on what ERAS is and why it is important for their successful recovery
- Implement a web-based collaborative platform such as Microsoft SharePoint for the team to access current data and resources
- Stay flexible, as priorities may change
- Anticipate delays
- Develop meaningful relationships across multiple departments to facilitate success

Conclusion
Implementing ERAS is a safe multimodal approach when caring for geriatric total hip and knee arthroplasty patients. In our QI initiative, 66 percent of patients had a LOS of zero or one days compared with 46 percent before the intervention. We did not see a difference in the overall complication rate, readmission rate, or reoperation rate.

There are multiple elements to consider before implementing a program such as ERAS to ensure meaningful and lasting change occurs. The role of multidisciplinary teams is crucial, and much of the success of the program hinges on unwavering collaboration. Additionally, maintain clear and consistent communication with accountability to deadlines, which helps prioritize and sustain the patient-centered approach. Lastly, get buy-in at all levels within the hospital, from senior leadership to frontline staff.
Pancreatic cancer (PC) treatment continues to prove challenging. Most patients present with metastases, and even in patients with localized disease, relapse is frequent and overall survival rates are low. The European Study Group for Pancreatic Cancer (ESPAC)-1 and CONKO-001 randomized trials clearly demonstrated that surgery alone, even in resectable disease, was insufficient treatment for PC. ESPAC-1 showed a significant survival benefit in patients with resected nonmetastatic PC who received adjuvant 5 fluorouracil (5FU) plus folinic acid (leucovorin) over those who had surgery alone.1

Similarly, in the CONKO-001 trial, adjuvant gemcitabine was found to prolong survival and decrease tumor recurrence at five years when compared with curative pancreatectomy only.2,3 A subsequent comparison trial of adjuvant 5FU plus folinic acid versus gemcitabine in resected PC would show equivalent survival outcomes, but less toxicity was found in the gemcitabine arm.4 The addition of capecitabine to gemcitabine in the ESPAC-4 trial showed incremental improved survival when compared with gemcitabine alone.5 These data established gemcitabine-based treatments as the standard of care adjuvant therapy in patients with resected PC for more than a decade. However, contemporary cytotoxic combination therapies—particularly fluorouracil, leucovorin, oxaliplatin, and irinotecan (FOLFIRINOX)—have demonstrated improved efficacy over gemcitabine in metastatic PC and increased response rates in the neoadjuvant treatment of locally advanced and borderline resectable PC.6,7 Based on these data, the PRODIGE (Partenariat de Recherche en Oncologie Digestive) intergroup and the Canadian Cancer Trials Group evaluated modified (m) adjuvant FOLFIRINOX in patients who underwent curative-resection of PC and established this regimen as the new gold standard adjuvant therapy for resected PC.8

Study design and findings
Conroy and colleagues randomized 493 patients after R0 or R1 resection of nonmetastatic PC from 77 hospitals in France.
and Canada to mFOLFIRINOX versus gemcitabine for 24 weeks. Randomization was stratified by trial center, lymph node status, serum CA 19-9 levels, and final margin status. Patients enrolled in the study had to be within three months of operation. Researchers used a modified FOLFIRINOX regimen without bolus 5FU to decrease toxicity. The primary outcome was disease-free survival (DFS); secondary outcomes included overall survival (OS), toxicity, and disease-specific survival (DSS).

At a median follow-up of 33.6 months, median DFS was longer in the mFOLFIRINOX group when compared with gemcitabine (21.6 versus 12.8 months, p <0.001) with a three-year DFS rate of 39.7 percent versus 21.4 percent. Median OS also significantly improved in the mFOLFIRINOX arm (54.4 versus 35.0 months) (see Figure 1, this page). mFOLFIRINOX extended time to development of distant metastases (median 30.4 months versus 17.0 months for...
More patients experienced grade 3/4 toxicity in the mFOLFIRINOX arm, and although these side effects were manageable, only 66.4 percent of patients completed all intended therapies in the mFOLFIRINOX arm versus 79 percent in the gemcitabine arm. However, it has yet to be determined whether the inability to complete therapy led to different outcomes. Regardless, on intention-to-treat analysis, median disease-free survival was 21.6 months in the modified-FOLFIRINOX group versus 12.8 months in the gemcitabine group, establishing mFOLFIRINOX as the new standard of care in adjuvant therapy for resected PC.

The median disease-free survival was 21.6 months in the modified-FOLFIRINOX group versus 12.8 months in the gemcitabine group (Panel A). The median overall survival was 54.4 months in the modified-FOLFIRINOX group versus 35.0 months in the gemcitabine group (Panel B).

The study shows a striking median of OS of 54.4 months, significantly better than the previously reported median OS of 28 months seen with gemcitabine and capecitabine. The major limitations of this trial included the inability to capture the number of patients who were unable to...
The major limitations of this trial included the inability to capture the number of patients who were unable to recover adequately from the operation to receive adjuvant therapy and the inability to widely apply this effective but toxic regimen to all PC patients because the study was highly selective.

Future directions
Given the challenges of delivering adequate postoperative therapy with mFOLFIRINOX and the reported benefit of upfront treatment, many centers now use neoadjuvant therapy for PC to maximize receipt of all intended therapies and select patients with aggressive biology who will derive no benefit from surgical resection. To test this approach, the Alliance 021806 trial, Perioperative Versus Adjuvant Chemotherapy for Resectable Pancreatic Cancer, was designed with the schema outlined in Figure 2, page 78, and will be opening shortly. This clinical trial will determine the optimal chemotherapy sequencing strategy for resectable PC, and the results will be eagerly awaited.

For more information on the Alliance trial, contact Cristina Ferrone, MD, FACS, at cferrone@mgh.harvard.edu.

REFERENCES
The Joint Commission launched a new Speak Up campaign focusing on patients’ rights in November 2019. Speak Up For Your Rights aims to educate patients and their advocates about their rights before, during, and after receiving care. From a surgical perspective, helping patients know their rights can be beneficial to the patient and the surgical team.

Speak Up encourages patients to be their own advocates and to engage in the following activities:

• Speak up
• Pay attention
• Educate yourself
• Advocates (family members and friends) can help
• Know about your new medicine
• Use a quality health care organization
• Participate in all decisions about your care

The Speak Up For Your Rights campaign features an infographic—in both English and Spanish, and in three different sizes (8.5 x 11”, 11 x 17”, and 24 x 36”), at www.jointcommission.org/resources/for-consumers/speak-up-campaigns/for-your-rights/. The campaign also features an animated video (also available in both English and Spanish).

Patients need to know their rights
For patients, understanding their rights is key to ensuring they receive the best possible care. Those patients who are aware of their rights are better prepared to ask the right questions, helping them make informed decisions about the care and treatments that are right for them. As such, by informing patients of their rights, providers can help confirm that more patients are satisfied with their care.

The Speak Up For Your Rights infographic explains patient rights, including the following:

• Being informed and making decisions about their care
• Being treated with courtesy and respect
• Having a patient advocate with them during their care
• Privacy of their health information
• Speaking to a patient representative about their rights

Meanwhile, the Speak Up For Your Rights video provides an example of a patient and her advocates navigating the emergency room. In the video, parents Grant and Manuel seek care for their daughter after she breaks her wrist. As their daughter receives care, Grant and Manuel learn about their daughter’s rights as a patient, including their right to have an interpreter present and receive copies of their daughter’s medical records.

The Speak Up For Your Rights campaign also encourages patients to actively participate in their care. Active engagement includes asking questions about diagnoses, medicines, and treatments—
Those patients who are aware of their rights are better prepared to ask the right questions, helping them make informed decisions about the care and treatments that are right for them.

as well as informing caregivers about medicines, allergies, and lifesaving actions, such as being put on a ventilator. Additionally, the campaign explains how advocates can help a patient seek the best care and how patients can improve care or report concerns if they believe their rights as patients were violated.

Examples of questions patients should ask their surgeons include the following:

• How many operations of this type have you performed?

• Who will be involved in my care?

• Will you be performing my operation, or will an assistant be doing it? If an assistant is performing part (or all) of my operation, will you be present, or will you be scrubbed?

• Will you be doing another operation that overlaps with mine?

• Who do I call if I have pain within the first three days after the operation?

• Are you easy to contact at night? If not, is the person I speak to authorized to prescribe pain medicines, or will he or she have to contact you in the morning?

• Should I get a second opinion?

• Will I see you before and after the operation, or will your assistants see me?

Other key conversations that surgeons should consider having to help patients understand their rights while receiving care in the surgical setting include the following:

• Provide information regarding the diagnosis for which this operation is indicated, the type of operation indicated, and the overall prognosis

• Receive thorough informed consent—by discussing alternative treatments, expected benefits of the operation, and the main risks of the procedure

• Discuss how a patient can get involved in his or her own care

• Explain that patients have the right to refuse treatment

• Determine advance directives

• Describe postoperative care, rehabilitation, physical therapy, occupational therapy, and infection control plans

• Note that patients have the right to receive safe, quality care—free of abuse

• Explain how the time-out process works, its purpose, and what is expected of the patient during the time out

The Speak Up program originally was created in 2002. Since then, program materials have been used in more than 70 countries. To download Speak Up For Your Rights, visit www.jointcommission.org/topics/speak_up_patient_advocacy.aspx.

Disclaimer
The thoughts and opinions expressed in this article are solely those of Dr. Pellegrini and do not necessarily reflect those of The Joint Commission or the American College of Surgeons.
From the Archives:

Jennie Smillie Robertson, MD: One of Canada’s first women surgeons

by Robin S. McLeod, MD, FACS, FRCSC, and Heather Gardiner, MISt

Jennie Smillie Robertson, MD, was one of the first women to practice surgery in Ontario province, Canada. Dr. Smillie Robertson decided when she was five years old that she would like to be a physician. She had seen a woman physician who was planning to go to India as a missionary. When the young Jennie asked whether she could become a physician, her mother said, “Yes,” and that started her interest in medicine.

To understand Dr. Smillie Robertson’s path to becoming a surgeon, it is helpful to know a little about her personal background. She was born in 1878 on a farm in Tuckersmith Township, Huron, ON. Her family, which included seven children, were pioneers. Her father was a farmer who died when Dr. Smillie Robertson was six years old. Her oldest brother took over the farm and acted as a father to the younger children. Despite her parents having only public schooling, they were supportive of their children having secondary education. One of her sisters became a public school teacher, and the other was a nurse who worked on a hospital ship in India during World War I. One of Dr. Smillie Robertson’s brothers was a physician, and another was a missionary.

Her journey begins

Dr. Smillie Robertson made the final decision to study medicine at age 15. However, she could not start medical school until she was 25 years old because she had to earn money to pay for her education. She eventually received her teaching...
certificate when she was 18 years old. She taught school until she was 25 years old, earning $300 a year until she accumulated enough money to apply for medical school.

The University of Toronto Medical School, ON, opened in 1840. Initially, the school only accepted men. The Women’s College Medical School was established in 1883 to accommodate women who wanted to become physicians, so Dr. Smillie Robertson and two other women enrolled. However, the school closed after their first year, and the three women transferred to the University of Toronto Medical School for the rest of their training. The reason for closing the Women’s College Medical School and having the women join the men at the University of Toronto was reportedly because the professors at the University of Toronto Medical School had difficulty keeping “the mischievous and obstreperous boys” under control, and the professors noted that the young men behaved better in the presence of women. The female and male students had all classes together except for anatomy and dissection. By all accounts, the women were happy to take classes with the men and were pleased to have been admitted to the University of Toronto.

Dr. Smillie Robertson graduated from medical school in 1909. At that time, Toronto hospitals offered few internships to women. Dr. Smillie Robertson knew that the Women’s Medical College in Philadelphia, PA, was built for women physicians, so she did a one-year internship at the Women’s Hospital of Philadelphia, which is connected to the Women’s Medical College.

**Pursuing surgery**

After returning to Toronto, Dr. Smillie Robertson started a solo practice in 1910. She realized that few women were practicing medicine in Toronto, and none were surgeons. She tried to coax some of her colleagues into specializing in surgery, but no one was willing to spend the time and money to do so.
As the lone woman physician in Toronto who aspired to perform surgery, Dr. Smillie Robertson had difficulty finding a place where she could practice. She knew the chief of surgery in Philadelphia, so she contacted her to see if she could get some surgical training. She was accepted into the program, and at the end of six months Dr. Smillie Robertson was able to perform some operations independently, which boosted her self-confidence.

When Dr. Smillie Robertson returned to Toronto, she again had difficulty finding a hospital where she could practice. Thus, her first operation as an independent practice surgeon was done on a kitchen table in a house. Several women physicians and two older male physicians who were encouraging women to pursue surgery watched her perform the procedure, which was related to a “diseased ovary.”

As time went on, more women became specialists in various fields and felt they should have a hospital where women could work. Initially, they rented a house where they cared for patients, and later moved to a bigger home. Finally, the Women’s College Hospital was built with generous financial help from friends.

Dr. Smillie Robertson was associated with the Women’s College Hospital for most of the 40 years that she was a practicing physician. Dr. Smillie Robertson’s practice was mainly gynecological surgery, but she also did some maternity work and abdominal operations, such as appendectomies. She held the position of associate chief of gynecology from 1912 to 1942.

Shortly after starting her practice in Toronto, Dr. Smillie Robertson realized the importance of government-funded health care. She became a member of the Women’s Liberal Association and was a charter member of the Federation of Medical Women of Canada.

Dr. Smillie Robertson continued practicing until 1948 when she was 70 years old. She then married her childhood sweetheart, Alex Robertson, and they had 10 wonderful years together. Dr. Smillie Robertson died in 1981 at 103 years old.

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**BIBLIOGRAPHY**


Beth H. Sutton, MD, FACS, and L. Scott Levin, MD, FACS, were elected Chair and Vice-Chair, respectively, of the Board of Regents (B/R) of the American College of Surgeons (ACS) at the conclusion of Clinical Congress 2019 in San Francisco, CA.

A general surgeon in private practice in Wichita Falls, TX, Dr. Sutton has been a Fellow of the College since 1984 and has held several leadership roles within the ACS. She has been a member of the B/R since 2012 and served on the Board of Governors (B/G) Executive Committee (2008–2010) and as a Governor at-Large from the North Texas Chapter (2004–2010).

As B/R Chair, Dr. Sutton will work closely with ACS Executive Director David B. Hoyt, MD, FACS, and will chair the Regents’ Finance and Executive Committees. The College’s 23-member B/R formulates policy and is ultimately responsible for managing the affairs of the College. The Board members’ diversity and variety of experiences and interests enable the Regents to represent views related to myriad issues in contemporary surgery.

Other professional roles
At present, Dr. Sutton serves on the ACS Committee on Health Care Disparities, the Advisory Council for General Surgery, the Committee on Transition to Practice (Mastery in General Surgery), the Committee on Preceptorship for Practicing Surgeons, and the Committee on Professional Opportunities for Senior Members. She also is Regent Liaison to the Committee on Trauma and on the faculty for the ACS Surgeons as Leaders course.

Beyond her roles with the College, Dr. Sutton is a past-president of the Texas Surgical Society (2007) and the Association of Women Surgeons (1999). She is a member of the Western Surgical Association, American Association of Endocrine Surgeons, American Thyroid Association, Southwestern Surgical Congress, Society of American Gastrointestinal Endoscopic Surgeons, Southern Surgical Association, Texas Medical Association, and the Wichita County Medical Society. She has been named a Distinguished Alumna in General Surgery, Scott and White Memorial Hospital Graduate Medical Education Program (2008), and listed among the Best Doctors in America (1996–present).

Dr. Levin elected Vice-Chair
Dr. Levin is the Paul B. Magnuson Professor of Bone and Joint Surgery and chair, department of orthopaedic surgery, and professor of surgery, University of Pennsylvania School of Medicine, Philadelphia. He is medical director, Penn Musculoskeletal and Rheumatology Service Line, and director, hand transplant program, Children’s Hospital of Philadelphia.

A Fellow of the College since 1996, Dr. Levin was elected to the B/R in 2012 and has served on the B/R Executive Committee since 2018. Among his ACS leadership positions, he is Past-Chair of the ACS Advisory Council for Orthopaedic Surgery (2008–2012), served on the B/G (2006–2012), and is a member of the Health Policy and Advocacy Group (2017–present).

View the full roster of 2019–2020 Regents, Officers, and B/G Executive Committee on page 66.
The American College of Surgeons (ACS) is now accepting applications for the 2021–2023 Clinical Scholar in Residence positions. Applications will be accepted through April 1, 2020.

The ACS Clinical Scholars in Residence Program is a two-year, on-site fellowship in surgical outcomes research, health services research, and health care policy. The fellowship was initiated in 2005 to advance the College’s quality improvement initiatives and to offer opportunities for residents to work on ACS Quality Programs. More specifically, ACS Clinical Scholars in Residence perform research relevant to ongoing projects in the ACS Division of Research and Optimal Patient Care (DROP-C).

About the program
The primary objective of the fellowship is to address issues in health care quality, health policy, patient safety, and value-based care, with the goal of helping the ACS Clinical Scholar in Residence prepare for a research career in academic surgery. The ACS Clinical Scholars in Residence have worked on projects and research using data from the ACS National Surgical Quality Improvement Program, the National Cancer Database, the National Trauma Data Bank®, the Surgeon Specific Registry, the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program, and the Geriatric Surgery Verification Program. They have been involved in guideline development and accreditation programs. Scholars are assigned to the appropriate group within the ACS based on their interests and the College’s needs.

In addition, participants earn a master’s degree in health services and outcomes research or health care quality and patient safety during their two years at the ACS headquarters in Chicago, IL. The goal of this aspect of the program is to educate clinicians to become effective health services and outcomes researchers. The health services and outcomes research curriculum focuses on these issues within institutional...
A total of 21 scholars have completed the program, and four scholars are currently participating. The ACS Clinical Scholars in Residence have demonstrated great dedication to outcomes research and the improvement of the quality of surgical care.

Past successes
Since its inception, surgical residents from throughout the U.S., including Alabama, California, Colorado, Connecticut, Georgia, Illinois, Kansas, Louisiana, Michigan, and Ohio, have participated in the ACS Clinical Scholars in Residence program. These individuals say that they have had excellent, productive experiences that have been useful in launching their careers in academic surgery. A total of 21 scholars have completed the program, and four scholars are currently participating. The ACS Clinical Scholars in Residence have demonstrated great dedication to outcomes research and to the improvement of the quality of surgical care.

The ACS Clinical Scholars in Residence have presented their findings at numerous national meetings and in high-impact, peer-reviewed publications, in addition to contributing to the ACS quality improvement programs. Furthermore, scholars have gone on to attain prestigious fellowships in several fields, including surgical oncology, colorectal surgery, and pediatric surgery.

Apply now
The 2021–2023 scholars will begin their work July 1, 2021. At present, applicants are required to have funding from their institution or other grant mechanism.

For more information about the program and the application requirements, go to facs.org/quality-programs/about/clinical-scholars-program or send an e-mail to clinicalscholars@facs.org.

and health care delivery systems, as well as in the external environment that shapes health policy centered on quality and safety issues. The program takes approximately two years to complete. All coursework is done at Northwestern University’s downtown Chicago campus, one block from the ACS headquarters. The ACS also offers a variety of educational programs from which the Clinical Scholars may benefit, including the Health Services Research Methods Course.

The ACS assigns internal mentors to meet regularly with each ACS Clinical Scholar in Residence. Scholars also have opportunities to interact with various surgeons who are affiliated with the ACS and the DROP-C. Mentorship is one of the most important aspects of this fellowship. Guidance and interaction with multiple individuals from diverse backgrounds will provide the best opportunity for success.

In addition, a core of ACS staff statisticians and project analysts serve as invaluable resources to the ACS Clinical Scholars in Residence.
CONGRATULATIONS TO THE ASSOCIATES who successfully completed the Mastery in General Surgery Program in 2019

Jessica S. Adams, DO
Metro Surgical Savannah

T. Ellis Barnes, MB BCh
Metro Surgical Savannah

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Geisinger Health System

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Stony Brook University Hospital

Clarence D. Lin, MD
Alpert Medical School of Brown University

Ronald S. Mowad, MD
Louisiana State University Health Sciences Center at Shreveport School of Medicine

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Loyola University Medical Center

James Tseng, MD
Surgical Care of the Virginias

Jesse M. Victory, DO
Montefiore Medical Center

David A. Vivas, MD
Stony Brook University Hospital

WELCOME TO THE FOLLOWING ASSOCIATES participating in 2019–2020

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Wake Forest University School of Medicine

Gifty S. Abraham, MD
Loyola University Medical Center

Akram Ahmed, MBBS
Geisinger Health System

Jonathan S. Chun, MD, FACS
Oregon Health and Science University

Herminio Diaz, MD
Stony Brook University Hospital

Starr Eads, MD
Arizona Premier Surgery

Grace Hsiung, MD
University of Texas Health Science Center at San Antonio, University of Texas School of Medicine

Viola Huang, MD
Stony Brook University Hospital

Mallory Lara, MD
University of Texas Health Science Center at San Antonio, University of Texas School of Medicine

Katherine A. Petersen, MD
Metro Surgical Savannah

Jennifer G. Rodgers, MD
Oregon Health and Science University

Dana-Rachael Smith, MD
Arizona Premier Surgery

Shirley Xing, DO
Kaiser Permanente, Mid-Atlantic Permanente Medical Group

Min Li Xu, MD
University of Florida/St. Vincent’s Health Center
ACS and APSA address pain control after surgery for children and teens

The American College of Surgeons (ACS) and American Pediatric Surgical Association (APSA) recently released patient education resources on the ACS website to inform parents and teens about safe pain control after an operation.

The Safe and Effective Pain Control After Surgery for Children and Teens brochure was researched using the best evidence available and developed as a resource for surgeons to address appropriate pain management options for young surgical patients who have unique pain relief needs. The brochure features a guide for parents and children/teens to help them decide when to take medications based on the types of activities performed in the days following an operation.

The brochure includes information to help young patients and their parents lower the risk of misuse and diversion of opioids to inappropriate persons, understand the proper use of these medications for severe pain, and safely store and dispose of prescription medications. It also includes an insert that describes nonmedication therapies, commonly prescribed medications and their side-effects, and a customizable form for patients to list their medications, doses, and times of administration following an operation.

“APSA is proud to have collaborated with the ACS on these important parent resources. Our care goes beyond the operating room to ensure pediatric patients are comfortable after surgery and, equally important, that we create a space where families are comfortable asking about and understanding pain medication use, options, and risks,” said APSA President Joseph P. Vacanti, MD, FACS.

“These new resources are a vital tool that will help surgeons work with parents to safeguard children’s care during the postsurgery phase and also provide a framework for a presurgery discussion between parents, young patients, and surgeons,” said ACS Executive Director David B. Hoyt, MD, FACS.

“We’ve made these resources publicly available for free on our website so everyone who needs this information has access to it. We encourage all to take advantage of it.”

View the brochure and other resources on the ACS website at facs.org/pedssafepaincontrol.
The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) has recognized 88 of 592 eligible hospitals participating in the adult program for achieving meritorious outcomes for surgical patient care in 2018. A list of the recognized hospitals is available online at facs.org/quality-programs/acs-nsqip/meritorious.

ACS NSQIP participating hospitals are required to track the outcomes of inpatient and outpatient surgical procedures; the ACS then analyzes these outcomes and reports back to hospitals. Hospitals use these data to direct patient safety initiatives and improve the quality of surgical care.

The ACS NSQIP recognition program commends a select group of hospitals for achieving a meritorious composite score determined through a different weighted formula combining eight outcomes. Outcomes in the eight clinical areas were evaluated (see sidebar, this page).

The 88 hospitals achieved the distinction based on an outstanding composite quality score. Risk-adjusted data from the July 2019 ACS NSQIP Semiannual Report, which presents data from the 2018 calendar year, were used to determine which hospitals demonstrated meritorious outcomes. Seventy-two hospitals were recognized on the “All Cases” list and 72 hospitals were recognized on the “High-Risk” list; the 72 hospitals represent 10 percent of the 722 calendar-year 2018 ACS NSQIP hospitals.* A total of 56 hospitals were recognized on both the “All Cases” and “High-Risk” lists, 16 other hospitals were on just the “All Cases” list, and 16 other hospitals were on the “High Risk” list only—yielding 88 hospitals in total. These meritorious hospitals are eligible to display these achievements among their staff and within their institutions.

PATIENT MANAGEMENT: CLINICAL AREAS

- Mortality
- Cardiac arrest and myocardial infarction
- Pneumonia
- Unplanned intubation
- Ventilator care exceeding 48 hours
- Kidney failure
- Surgical site infection (SSI): superficial incisional SSI, deep incisional SSI, and organ/space SSI
- Urinary tract infection

* A total of 592 of the 722 ACS NSQIP hospitals participating in 2018 met the three-year criteria to be eligible for meritorious consideration.
The American College of Surgeons (ACS) has issued a call for abstracts to be presented at its 2020 Quality and Safety Conference, July 19–22 at the Walter E. Washington Convention Center, Washington, DC. The deadline for submitting abstracts is February 2.

Individuals at participating sites are encouraged to submit a 250-word abstract for a poster and/or podium presentation. The abstract should relate to surgical quality improvement initiatives, including the development, implementation, or validation of best practices. The ACS also is interested in operational best practices relating to workflow around collecting data and reporting.

Medical students and medical/surgical trainees are encouraged to submit research for the Best Trainee Abstract Competition. The primary author will be awarded a prize and invited to present at the conference.

Submissions from the following Quality Programs are welcome:

- ACS National Surgical Quality Improvement Program (ACS NSQIP®)
- ACS Children’s Surgery Verification, as well as ACS NSQIP Pediatric
- Cancer Programs, including the Commission on Cancer and National Accreditation Program for Breast Centers
- Geriatric Surgery Verification
- Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program
- Trauma Quality Programs, including Pediatrics, Verification, Trauma Quality Improvement Program, and Performance Improvement and Patient Safety

Note that abstracts that have been submitted or recently presented at other meetings are eligible for presentation at the ACS Quality and Safety Conference. In the view of the ACS, previous presentation of a paper does not prohibit the presentation or publication of the material at the Quality and Safety Conference.

If you have an idea for an abstract, the ACS encourages you to begin reaching out to your colleagues soon. Get your team together, and start planning your projects now.

For more information or to submit an abstract, visit the Quality and Safety Conference web page at facs.org/quality-programs/quality-safety-conference/call-for-abstracts. Inquiries may be directed to acsqsconference@facs.org or 312-202-5319.

•
You are your best advocate.

Meeting with elected officials is a powerful way to raise the profile of issues you care about and to effect change. Through the Division of Advocacy and Health Policy’s (DAHP) Advocate at Home program, staff can assist with planning, preparing for, and executing a successful meeting or event that will leave your lawmaker wanting to know more about issues of importance to surgeons and patients.

- Develop relationships with lawmakers via in-district meetings
- Leverage your expertise with your representative or senators by offering to serve as their trusted resource
- Allow policymakers a unique opportunity to hear your story and learn more about issues important to you
- Continue to advocate for meaningful change at home
- Elevate the College’s health policy agenda at the local and state levels

To learn more:
Contact Katie Oehmen, Manager, ACSPA-SurgeonsPAC and Grassroots, at koehmen@facs.org.

facs.org/advocacy/surgeonsvoice
Applications for Jacobson Award accepted through February 21

The American College of Surgeons (ACS) is accepting applications for the 2020 Joan L. and Julius H. Jacobson II Promising Investigator Award (JPIA) through February 21, 2020.

The JPIA was established to recognize outstanding surgeons who are engaging in research, advancing the art and science of surgery, and demonstrating early promise of significant contribution to the practice of surgery and the safety of surgical patients. The award is supported through a generous endowed fund established by the donors and administered by the ACS Surgical Research Committee.

**Award criteria**
The criteria for selection of the JPIA winner are as follows:

- Candidate must be a Fellow or an Associate Fellow of the ACS.
- Candidate must be board certified in a surgical specialty and must have completed surgical training, including fellowship, in the last six years, excluding military, medical, or family leave.
- Candidate must hold a faculty appointment at a research-based academic medical center or hold a military service position.
- Candidate must have received peer-reviewed funding, such as a K-series award from the National Institutes of Health (NIH), Veterans Administration, National Science Foundation, or U.S. Department of Defense merit review award to support their research effort. Surgeon-scientists who are well established (for example, recipients of NIH R01 and Veterans Affairs Merit grants or equivalent grants from other agencies) are ineligible.
- Only one application per surgical department will be accepted.

Nomination documentation must include the following:

- A one-page essay to the committee explaining why the candidate should be considered for the award and describing the importance of their past and current research.
- Copies of the candidate’s three most significant publications from their current faculty position.
- A letter of recommendation from the candidate’s department chair. Up to three additional letters of recommendation will be accepted.
- An NIH-formatted biographical sketch through the electronic application system.

Special consideration will be given to surgeons who are at the tipping point of their research careers, with a track record indicative of early promise and potential (for example, a degree program in research or a K-award).

To be considered for the award in 2020, applications must be submitted to facs.org/jpia through the February 21 deadline.

**Additional details**
For more information about the award, go to facs.org/jpia.

View a list of all past recipients at facs.org/quality-programs/about/cqi/jacobson/past-recipients.

Send comments and inquiries to Jorge Hernandez, Project Coordinator, Division of Research and Optimal Patient Care, Continuous Quality Improvement, at jacobsonpia@facs.org, or call 312-202-5319.
2020 Nizar N. Oweida, MD, FACS, Scholarships available

The Scholarships Committee of the American College of Surgeons (ACS) has announced the availability of the Nizar N. Oweida, MD, FACS, Scholarships for surgeons who serve small communities. The Oweida Scholarships provide up to three awards of $5,000 each to subsidize the participation of a Fellow or Associate Fellow serving a small community at the ACS Clinical Congress 2020 in Chicago, IL; alternatively, applicants may propose a plan for additional training or research appropriate to a rural surgeon. Applications are due to the ACS Scholarships Administrator no later than March 1, 2020.

Requirements
The Oweida Scholarship is available to an ACS member in any surgical specialty who meets the following requirements:

• Is a Fellow or Associate Fellow younger than age 55 on the date the application is filed

• Serves a small town or rural community in the U.S. or Canada

Activities
Awardees may use their award stipend to do one of the following:

• Attend the ACS Clinical Congress.

• Execute a well-defined proposal for travel or research to improve a rural surgeon’s performance.

Applicants must provide information regarding their work setting, including their hospital and the patients they see, as well as their participation in quality improvement activities in this setting. They also must indicate their career goals, explaining how they plan to transfer their newly acquired learning to their current situation.

Financial Support
Successful applicants will receive the sum of $5,000 to be used to defray expenses for attendance at the Clinical Congress or for the approved training or research opportunity. Cost categories include travel expenses, lodging and per diem, registration, and course fees.

• Scholars will make their own travel arrangements

• Awardees will be selected following review and evaluation of applications received

General application information
Applicants must submit a fully completed online application form provided by the College on its website. Applications must include the following:

• A copy of the applicant’s current curriculum vitae, no more than 10 pages in length

• Applicants must attach a one- to two-page essay discussing the following topics:
  − The opportunity for which the applicant is applying (Clinical Congress attendance or a personal training or research project)
  − The applicant’s reasons for submitting an application
  − The applicant’s qualifications for the scholarship
  − The applicant’s current practice in a rural or small community

All applicants will be notified of the outcome of the selection process in May 2020.

Award obligations
The Oweida Scholars will provide a narrative and financial report of their experiences at the conclusion of their awarded activity. All applicants will be notified of the outcome of the selection process in May. Questions can be directed to the ACS Scholarships Administrator at scholarships@facs.org or 312-202-5281.
The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) and the International Relations Committee offer International ACS NSQIP Scholarships for three surgeons from countries other than the U.S. or Canada who demonstrate a strong interest in surgical quality improvement.

The scholarships, in the amount of $10,000 each, provide the scholars with an opportunity to attend the 2020 ACS Quality and Safety Conference, July 24–27 in Minneapolis, MN, and meet with program leadership and surgeon champions from ACS NSQIP-participating hospitals. Following the conference, the candidate is encouraged to visit one or two hospitals reflecting the candidate’s specific clinical interests. These hospitals should have strong quality programs.

The International ACS NSQIP Scholarship requirements are as follows:

• Applicants must be graduates of schools of medicine.
• Applicants must submit their applications from their intended permanent institution.
• Applications will be accepted for processing only when the applicants have been in surgical practice, teaching, or research for a minimum of one year at their intended permanent location, following completion of all formal training (including fellowships and scholarships).
• Applicants must be younger than 55 years old at the time of application.
• Applicants must have demonstrated a commitment to surgical quality improvement.
• Applicants must submit a fully completed online application form provided by the College on its website. The application and accompanying materials must be prepared in English. Submission of a curriculum vitae only is not acceptable.
• Applicants must provide information regarding their work setting, including their hospital and the patients they see, as well as their participation in quality improvement activities in this setting. They must also indicate their career goals, indicating how they plan to transfer their newly acquired learning to their present situation.
• Applicants must submit letters of recommendation from three of their colleagues. One letter must be from the chair of the department of their hospital in which they hold academic appointment, or an ACS Fellow residing in their country. The chair’s or the Fellow’s letter should include a specific statement detailing the nature and extent of the quality improvement involvement of the applicant. Letters of recommendation should be submitted by the person making the recommendation.
• The International ACS NSQIP Scholarships must be used in the year for which they are designated. They cannot be postponed.
• Applicants who are awarded scholarships will submit a full written report of the...
The scholarships, in the amount of $10,000 each, provide the Scholars with an opportunity to attend the 2020 ACS Quality and Safety Conference, July 24–27 in Minneapolis, MN, and meet with program leadership and surgeon champions from ACS NSQIP-participating hospitals.

Experiences provided through the scholarships upon completion of their scholarships.

- An unsuccessful applicant may reapply only twice and only by completing and submitting an application provided by the College, together with new supporting documentation.

- The scholarships provide successful applicants with the privilege of participating in the ACS NSQIP Quality and Safety Conference. Assistance will be provided in arranging hotel accommodations in the conference city.

More information regarding the ACS NSQIP can be found at acsnsqip.org.

All of the requirements must be fulfilled for consideration by the Selection Committee. The International ACS NSQIP Scholarship requirements and application form are available at facs.org/isnsqip.

Completed applications for the International ACS NSQIP Scholarships for the year 2020 and all supporting documentation must be received by the International Liaison Section before March 1, 2020. All applicants will be notified of the selection committee’s decision in May 2020. Questions should be directed to scholarships@facs.org.

The scholarships, in the amount of $10,000 each, provide the Scholars with an opportunity to attend the 2020 ACS Quality and Safety Conference, July 24–27 in Minneapolis, MN, and meet with program leadership and surgeon champions from ACS NSQIP-participating hospitals.
Apply for 2020 international chapter opportunity to develop an ACS-based education course

The International Relations Committee of the American College of Surgeons (ACS) offers a special opportunity for international ACS chapters to create a local educational course that includes faculty from the College. The application deadline is March 1, 2020. The goals of this competitive grant program are as follows:

• To promote surgical education to the international surgical community

• To encourage the active involvement of the international chapters in ACS activities

A total of $25,000 per year will be made available to international chapters to develop courses in their own countries. Subject to the quality, merit, and requirements of each proposal, either a single grant up to $25,000 or two grants up to $12,500 each will be awarded.

Preference will be given to developing nations as defined by the World Bank. An international chapter may use the grant to present the ACS General Surgery Review Course or to develop other surgery-focused courses in its home country. The grant is intended to cover necessary costs, such as the travel expenses of ACS faculty who will teach the course. The grant is not to be used to cover all expenses related to course material, venue rental, AV equipment, or food. Chapter funds should be used to support those expenses.

All proposals must be made by an officer of an international ACS chapter and should be submitted electronically to the International Liaison at scholarships@facs.org. All applicants will be notified of the outcome in May.

For more information and to apply, visit the program web page at facs.org/member-services/chapters/intl-opportunity.

Apply for ACS/AAST International Scholarship 2020

The American College of Surgeons (ACS) and the American Association for the Surgery of Trauma (AAST) are cosponsoring a scholarship for international surgeons specifically working in acute care surgery—trauma and emergency general surgery—to improve the quality of acute care surgical services. Preference will be given to applicants from developing nations.

The scholarship, in the amount of $5,000, provides the scholar with an opportunity to attend the annual meeting of the AAST and to visit the Trauma Quality Improvement Program (TQIP®) at the ACS headquarters in Chicago, IL, to learn about the standards for a trauma program/database and the importance of multidisciplinary acute care surgery care.

The awardee will receive gratis registration to the 2020 annual meeting of the AAST, September 9–12, Waikoloa, HI, and to one available postgraduate course at the meeting. See the full requirements and link to the application form on the ACS/AAST International Scholarship web page at facs.org/acsaaast.

Applications and all the supporting documentation must be received by the ACS International Liaison at scholarships@facs.org no later than March 16, 2020, for an applicant to receive consideration by the selection committee.
Our mission is to help you celebrate this marvelous life achievement of becoming a Fellow of the American College of Surgeons by offering the highest quality and most unique jewelry and accessories. Designed expressly for the American College of Surgeons, these emblematic items are crafted to perfection in the Jim Henry tradition of excellence.

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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.
NEWS

• 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.

• 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 B/R.

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 negatively 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.
Nominations for 2020 ACS/Pfizer Volunteerism and Humanitarian awards due February 15

The American College of Surgeons (ACS), in association with Pfizer, Inc., is accepting nominations for the 2020 Surgical Volunteerism and Surgical Humanitarian Awards. 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 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.

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

*Military nominees: Describe how the nominee participated in service above and beyond his or her assigned military duties.
†Resident nominees will be evaluated among other trainees; they are not expected to have the same experience as more senior nominees.
Influence of student loan debt on general surgery resident career and lifestyle decision making

Kelsey Gray, MD; Amy H Kaji, MD, PhD; Mary Wolfe, MD, FACS; and colleagues in the February issue of the Journal of the American College of Surgeons (JACS) report that surgical residents consider their debt a significant financial burden. Furthermore, high debt significantly influences their financial security, practice location, and salary goals.

This article and all other JACS content is available at journalacs.org. ♦
Surgeons and Engineers:
A Dialogue on Surgical Simulation

The American College of Surgeons (ACS) Surgeons and Engineers full-day meeting on March 11 will serve as a venue for surgeons, academic and industry engineers, scientists, and surgical educators to continue the dialogue between the medical simulation and engineering communities.

It will provide opportunities for the exchange of ideas and potential solutions to address needs in surgical education through the engagement of existing engineering technologies as well as those technologies that are in development.

*The ACS Annual Surgical Simulation Summit will directly follow this meeting on March 12.

TO REGISTER, VISIT facs.org/surg-eng.

Questions? Please contact Gyusung Lee, PhD, at glee@facs.org or 312-202-5782.
Calendar of events

*Dates and locations subject to change. For more information on College events, visit facs.org/events or facs.org/member-services/chapters/meetings.

**JANUARY**

Southern California Chapter
January 10–12
Santa Barbara, CA
Contact: Tracey Dowden, socalsurgeons@gmail.com, socalsurgeons.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. Murtuza Choudhury, qchoudhury@yahoo.com

**FEBRUARY**

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

**MARCH**

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

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

**APRIL**

120th Annual Congress of the Japan Surgical Society
April 16–18
Yokohama, Japan
Contact: Congress Secretariat, 120jss@convention.co.jp, jssoc.or.jp/jss120/

Annual Congress of the German Society of Surgery
April 21–24
Berlin, Germany
Contact: Dr. Ernst Klar, Ernst.Klar@med.uni-rostock.de

Trinidad and Tobago Chapter
April 26
Piarco Trinidad, West Indies
Contact: Dr. Lakhan Roop, acs.chapter.tt@gmail.com

Puerto Rico Chapter
April 30–May 2
San Juan, Puerto Rico
Contact: Aixa Velez-Silva, acspuertoricochapter@gmail.com, acspuertoricochapter.org

**FUTURE CLINICAL CONGRESSES**

2020
October 4–8
Chicago, IL

2021
October 24–28
Washington, DC

2022
October 16–20
San Diego, CA

Make a Difference.


Advocate to improve health care

Engage influential decision makers

Connect with ACS leaders and learn how to get involved

Lead discussions on innovative ways to face leadership and surgical challenges

Enhance your leadership skills by attending professional development sessions

facs.org/summit
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