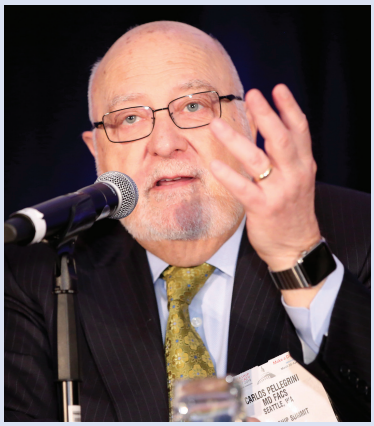

Summit attendees


Dr. Freischlag


Dr. Pellegrini

2019 Leadership & Advocacy Summit:

Ascending to the C-suite and identifying health policy priorities

by Tony Peregrin

The eighth annual Leadership & Advocacy Summit, a joint meeting featuring educational programs focused on leadership development and advocacy training, convened March 30–April 2 in Washington, DC. The Leadership Summit featured presentations intended to help surgeon leaders effectively connect with others, develop a career advancement strategy, and enhance overall leadership skills. The Advocacy Summit provided attendees with the opportunity to learn the American College of Surgeons (ACS) perspective on key topics, including surprise billing and firearm injury prevention, in preparation for organized visits to Capitol Hill.

2019 LEADERSHIP SUMMIT

"We are made stronger by those of you who give your time and talents to grow the ACS' endeavors," **Patricia L. Turner, MD, FACS,** Director, ACS Division of Member Services, said in her opening remarks. "Our goals with this meeting are to give you actionable tips to use when you return home to enhance your leadership in a complex health care environment, to lead change through information technology, and to hone the negotiation skills that are necessary to succeed."

A total of 562 surgeons, residents, medical students, chapter administrators, and affiliate members attended the 2019 Leadership Summit—a 6 percent increase from 2018.

Getting to the C-suite

In the session Getting to the C-Suite: How to Advance in Your Surgical Career, a panel of surgeon-leaders outlined productive pathways for reaching the highest level of senior management in health care institutions, including chief executive officer (CEO), chief medical officer, and so on. "How do you get in to the C-suite when you are an outsider or you're not being actively promoted? Make yourself invaluable. Find a problem and solve it," said **Julie A. Freischlag, MD, FACS, FRCSEd(Hon),**

Mr. Peck

Summit attendees

CEO, Wake Forest Baptist Medical Center, Winston-Salem, NC. She described three key strategies for becoming a C-suite leader:

- Build a team representing multiple areas of expertise
- Learn by listening to the stories of other leaders—read books and listen to podcasts
- Put patients and patience first

"Keep patients with a 't' right in front you, make them a priority, but have patience with a 'c' to get the work done," said Dr. Freischlag, who emphasized exhibiting patience with yourself and other team members.

"In order to be a strong leader, you have to be someone who expresses gratitude and celebrates the success of others," added **Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), FRCS(Hon), FRCSEd(Hon),** professor and chair emeritus, department of surgery, University of Washington, Seattle, and ACS Past-President. He also suggested surgeons avoid "playing the victim" if they want to be seen as future leaders, particularly at the senior executive level. "You need pragmatic optimism to be an effective leader," he said.

"If you want to be a leader, your reputation will get you there. You have to have honesty, integrity, and listen to others," Dr. Pellegrini said, emphasizing the importance of "consensus building over an authoritative leadership style." "In 25 years, the health care system problems may be different, but these leadership principles will be the same."

Douglas P. Slakey, MD, FACS, chief of surgical services, Advocate Christ Medical Center, Oak Lawn, IL, suggests engaging in self-reflection before taking on a C-suite role. "You have to be willing to look at yourself and ask, 'Am I willing to change my identity?'" he said. "Our training and expertise is one identity, but you have to be willing to change it to move into a C-suite role."

Surgeons are used to performing operations that have a defined beginning and end, but the work done in the C-suite has no clear end. "You have to be comfortable with the idea of moving from a defined scope of responsibilities to a C-suite with no defined end," Dr. Slakey said.

The two keys to effective leadership are emotional intelligence and the ability to "bask in the glory of others' successes," according to **Michael J. Zinner, MD, FACS,** CEO and executive medical director, Miami Cancer Institute, FL, and Past-Chair, ACS Board of Regents. It also is important to take advantage of a program that virtually all hospitals have—executive coaching. "Be aware of what you know, be aware of what you don't know, and be aware of who and when to ask to get that information," Dr. Zinner said.

"Go lead—especially if you are underrepresented in medicine," Dr. Freischlag said. "Whether you are in private practice or academia—go lead. We need you to be there. We need more diverse opinions to make health care better."

Situational leadership enhances team performance

"When I meet with a manager, I walk away feeling that they're important. But when I meet with a leader, I walk away feeling important," said **Gary Peck,** a senior executive coach. "Leaders adjust their style to fit the development level of the follower," he said. They apply situational leadership, adjusting their style and delegation of duties to the needs and abilities of the follower. "The one-size-fits-all

Dr. Turner (seated) greeting a Summit attendee

Dr. Telem

leadership style compromises performance, but with situational leadership, it is more about the members of the team and less about you, the leader," he said.

"There are a handful of steps to maximize your ability to lead and to provide great coaching," he said. "Put people in a safe, challenging, positive environment; take time to learn how your employees learn; and then listen more, talk less. You should also remember that 'the how' matters—it is not just what you ask, but how you ask that matters. How people perceive you, as a leader, clearly affects how they go about their daily work," Mr. Peck said.

Mr. Peck cited studies that suggest fostering a positive mindset results in team members who exhibit the following:

- Superior productivity
- Increased resilience
- Decreased levels of burnout
- Lower turnover rates

Chapter success stories

Officers of the Delaware, Indiana, and Virginia Chapters of the ACS shared their success stories in an effort to inspire other chapter leaders to boost member engagement. Examples included developing inclusive approaches to membership recruitment and retention in Virginia, where the chapter initiated programming and council roles for members of the Young Fellows Association and the Resident and Associate Society, as well as women surgeons. The Delaware Chapter enhanced surgical trainee chapter participation by designing a regional review course for the American Board of Surgery In-Training Examination, which evolved into a national offering via word of mouth. In Indiana, the chapter provided leadership and support for a bill that would call for Stop the Bleed® training in public schools, with three kits donated to every school by the Indiana Hospital Association.

Mentorship malpractice

"I define mentorship as a collaborative, mutually beneficial partnership in a work environment between a mentor and a mentee for career development," said **Dana A. Telem, MD, FACS,** associate chair for clinical affairs, quality; director, Michigan Women's Surgical Collaborative; and associate professor, department of surgery, University of Michigan, Ann Arbor.

Because of the complex nature of the mentor-mentee relationship, problems or missteps may occur. According to Dr. Telem, some "phenotypes of active mentorship malpractice" include the following:

- Hijackers: Take mentees' ideas and claim them as their own or uses them for self-gain
- Exploiters: Diminish mentees' success by assigning them low-yield activities
- Possessors: Dominate mentees, including isolation from collegial interactions

Similarly, mentees may exhibit their own negative phenotypes, including conflict-averse mentees and mentees who lack confidence. An example of a conflict-averse mentee is The Overcommitter, who says yes to everything resulting in high output failure, which results from a lack of prioritization. An example of a mentee lacking confidence is The Vampire—someone who "drains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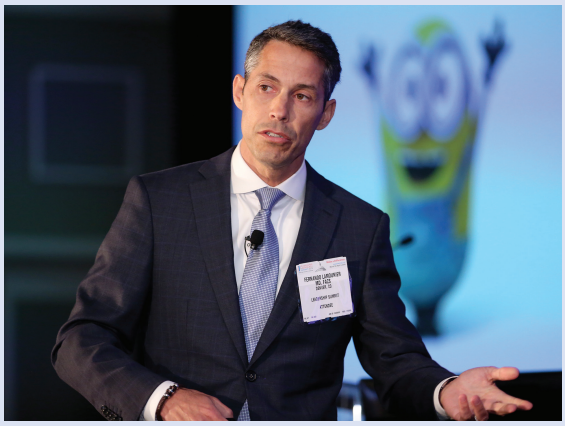
Dr. Lamounier

the lifeblood of the mentor by sending numerous e-mails, meeting requests," and so on.

Dr. Telem highlighted the importance of diverse mentor-mentee relationships, citing a 2018 *New England Journal of Medicine* article that revealed some men in positions of power are hesitant to participate in mentoring relationships with women in response to the #MeToo and Time's Up movements. "Inequities in mentorship perpetuate the achievement gap for women and underrepresented minorities and affect patient outcomes, workforce diversity, health care policy, and research/innovation. Diversity improves our ability to do big-scale problem solving."

Fixing a broken health care system

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane," said **James K. Elsey, MD, FACS,** Vice-Chair, ACS Board of Regents, quoting Martin Luther King, Jr., PhD. "Today, as we grapple with our stale health care system, we need to think anew and act anew and invent a new system."

In the U.S., health care spending accounts for approximately 20 percent of the gross domestic product, said Dr. Elsey. Other developed countries spend about half that amount. Nonetheless, the U.S. ranks 37 out of 191 countries in terms of overall population health status, access to care, distribution of financial burden, and other factors, according to the World Health Organization. Dr. Elsey called for attendees to actively engage in solutions tethered to allocation of surgeons, a payment system that rewards quality over volume, and greater transparency from pharmaceutical companies.

Contract negotiation: Listen with intention

"When it comes to negotiating, the number one challenge holding you back is confidence," said **Fernando N. Lamounier, MD, FACS,** a thoracic surgeon and leadership coach based in Denver, CO. "We get anxious about negotiation because we don't have the confidence—but confidence only comes once we stick our neck out." Dr. Lamounier cited "Four Cs" of effective negotiation espoused by strategic coach Dan Sullivan—commitment, courage, capability, and confidence.

"When it comes to successful negotiating, the 'f word' often comes to mind: fairness. There is no fairness in negotiating because what might be fair for me may not be fair to the other side. Listen with the intention of truly understanding. Seek to understand first and to be understood second," he said.

"Keep in mind, you will not get what you deserve—you will get what you negotiate," Dr. Lamounier added. "You have to negotiate a contract that reflects your values."

Pointing to a survey sent to Leadership Summit attendees before the meeting, Dr. Lamounier revealed that 71 percent of the respondents had "talked to a colleague or winged it" regarding a recent contract negotiation, with 68 percent noting that the process could have been improved. Only 7 percent of survey respondents hired a lawyer, consultant, or coach to assist with contract negotiation. "What is cheap now can be very expensive later. I urge you to consult with an attorney when dealing with any issue that involves legal matters," he said, emphasizing attendees should pay particular attention to what he called the "hidden

Dr. Hoyt

Dr. Mason

pillars" of a contract: term, exit, and lifestyle (that is, your health, the health of those around you, and personal satisfaction).

ACS update

"The barriers we are dealing with—including insurance coverage, maintaining autonomy, and information and change overload—can be overcome by using many of the leadership skills we talked about today," said **David B. Hoyt, MD, FACS,** ACS Executive Director. "There is something special that we do as surgeons that is essential to the future of health care," he said, which is focusing on quality improvement.

Dr. Hoyt called education "our professional responsibility" and outlined several College initiatives aimed at expanding surgical training and education, including the ACS Academy of Master Surgeon Educators, which focuses on advancing the science and practice of education across all surgical specialties; Clinical Congress programming, which has increased its scientific offerings from 986 presentations accepted in 2017 to 1,307 accepted in 2018; and other programs under development that address resident assessment, operative decision making, mentoring and coaching, and senior surgeon involvement.

Another focus of the College in 2019, according to Dr. Hoyt, is implementing a new communications strategy, including e-newsletter content driven by artificial intelligence that tailors content based on user experience and a redesign of the ACS website.

EHR adoption

The Health Information Technology for Economic and Clinical Health Act of 2009 directed the Office of the National Coordinator (ONC) for Health Information Technology to promote the adoption and meaningful use of electronic health records (EHRs). According to **Thomas A. Mason, MD, FACP,** Chief Medical Officer, ONC, in 2009, 12 percent of hospitals nationwide had a basic EHR system, and today 96 percent of hospitals have a certified EHR system. With this significant increase in EHR adoption nationwide, new ONC "priority areas" are interoperability and decreasing physician administrative burden, as outlined in the 21st Century Cures Act.

"APIs [Application Programming Interfaces] are really driving interoperability because this technology allows one software program to access the services provided by another software program," Dr. Mason said, noting that many other sectors, such as personal banking, have been successfully using this technology, but that "health care has been lagging behind in this area." The ONC Cures Notice of Proposed Rulemaking (NPRM) calls on the health care industry to adopt APIs, which will allow individuals to securely and easily access structured electronic health information using smartphone applications. The NPRM also proposed replacing the Common Clinical Data Set with U.S. Core Data for Interoperability, which includes new required data classes and data elements including smoking status, lab test results, and other patient health care information. The proposed rule also seeks to implement the information blocking provisions of the Cures Act, which would prohibit the entities from knowingly inhibiting the exchange of health information, with several exceptions, such as blocking information that could lead to patient harm.

Mr. Berke

Mr. Coffron (far left) moderating a panel session

As previously noted, the 21st Century Cures Act calls for the Secretary of the Department of Health and Human Services to develop this goal, strategy, and recommendations in consultation with providers of health services, health care service suppliers, payors, professional societies, and other appropriate entities. "The ONC has the responsibility of drafting the Clinical Burden Reduction Report. We have gone on listening sessions with Frank G. Opelka, MD, FACS, ACS Medical Director of Quality and Health Policy, and others, and we've organized town hall meetings, webinars, and public comment through rulemaking to determine the chief burdens physicians are facing," Dr. Mason said

He noted that stakeholders report the following burdens:

- Billing-related documentation "note bloat"
- Prior authorization
- Quality measurement
- Time spent outside of patient care on EHRs

"The issue of 'pajama time'—the time that is spent in the evenings and on the weekend catching up on documentation—was a big complaint," he said.

Strategies to reduce EHR reporting burden include simplifying program reporting and participation requirements, reducing financial burdens associated with quality and EHR reporting programs, and improving electronic clinical quality measures.

2019 ADVOCACY SUMMIT

The advocacy program of the 2019 Leadership & Advocacy Summit provided 356 attendees with the information and skills necessary to help shape health policy efforts in Washington, DC, and across the country. A total of 293 Advocacy Summit attendees representing 47 states participated in 253 meetings April 2 on Capitol Hill.

Keynote speaker **David Berke,** a retired U.S. Marine Corps Officer, fighter pilot, ground combat leader in Iraq and Afghanistan, and now an instructor and speaker with Echelon Front, Kent, WA, a leadership development company, spoke about his combat experience in Iraq and Afghanistan, noting that humility, ownership, and teamwork are essential for successful leadership.

The Advocacy Summit included several educational sessions on the College's legislative priorities. "We've done webinars, chapter meetings, and conference calls to hear about the issues surgeons are facing every day—including Medicare physician reimbursement, measuring for surgical quality, surprise billing, prior authorization, and firearms research and injury prevention," said **Christian Shalgian,** Director, ACS Division of Advocacy and Health Policy (DAHP). "We want you to be able to go back to your practice and be able to say that you were in Washington making a difference."

Medicare physician reimbursement

"Congress should take steps now to ensure the long-term stability of MACRA [the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act]," said **Matt Coffron,** Manager, Policy Development, ACS DAHP. "This includes accounting for the effects of inflation on physician practice, improving

Ms. Sage (far left) moderating a panel session with Dr. Michelassi (second from right)


Gun control panel participant Jennifer Goedke, Deputy Chief of Staff, Rep. Mike Thompson (D-CA)

MIPS [Merit-based Incentive Payment System] measurement, implementing new APMs [Alternative Payment Models], and providing opportunities to succeed through innovation and quality improvement."

Mr. Coffron noted that Medicare payment rates are about to enter a six-year period of 0 percent updates, during which early MACRA incentives also are set to expire, meaning many surgeons will receive lower payment rates based on factors out of their control, rather than the quality of care they are providing. The Medicare conversion factor over the next several years is likely to decline because of budget neutrality rules and changes in care patterns as the U.S. population ages.

"For surgeons and their patients, MACRA has failed to deliver on its promise" of creating a value-based payment system, said **Linda Barney, MD, FACS,** Chair, ACS General Coding and Reimbursement Committee. Instead, most surgeons have their MIPS Quality score calculated using broad, primary care-focused measures that have little relationship to surgical outcomes. Dr. Barney noted that there are similar issues for Cost measurement in MIPS, which doesn't allow for a comparison of cost and quality for the same patient or same episode of care.

"Medicare's number one need right now is information, and that is where PTAC [the Physician-focused Payment Model Technical Advisory Committee] comes in," said **Robert Horne,** principal, Leavitt Partners, noting that the Centers for Medicare & Medicaid Services (CMS) has failed to test or implement a single PTAC-recommended Advanced-APM, forcing surgeons to continue to participate in the flawed MIPS program.

Measuring surgical quality

Surgeons are scored on primary care measures reported through their group: diabetes control, immunization, tobacco cessation, and so on, said **Jill Sage, MPH,** Manager, Quality Affairs, ACS DAHP. The ACS believes that in order to be effective, measurement should help to inform patient decision making, as well as provide actionable information for surgeons to improve clinical outcomes. The College supports surgical quality measurement that includes a combination of three elements: standards-based facility-level verification programs, patient-reported outcome measures, and traditional clinical quality measures, including registry- and claims-based measures.

"Primary care measures are important, but we need risk-adjusted specific measures to assess the quality of surgical care," added ACS Regent **Fabrizio Michelassi, MD, FACS,** Lewis Atterbury Stimson Professor of Surgery and chair, department of surgery, Weill Cornell Medicine; surgeon-in-chief, New York-Presbyterian/Weill Cornell Medical Center, New York, NY. He called for the continued use and evaluation of quality improvement initiatives such as the ACS National Surgical Quality Improvement Program. "Good quality leads to improved outcomes and lower cost," he said, noting that over the last 25 years, bariatric surgery has experienced a significant drop in postoperative mortality as a result of the efforts of the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program and invested surgeons.

"The ACS has a long history of outstanding registries," added **Michelle Schreiber, MD,** Director, Quality

Ms. Ollapally (far left) moderating a panel session with Dr. Opelka (second from left)


Summit attendees

Measurement and Valued-Based Incentives Group, CMS, who stressed the importance of bundling measures together so that they are more closely aligned, particularly with respect to preventive care.

Surprise billing

"Surprise medical billing results from interactions with providers that patients reasonably assumed would be in-network but were not or when patients have no real choice of provider," said **Kevin Lucia, JD, MHP,** research professor of health law and project director, Georgetown University Health Policy Institute, Washington, DC. According to Mr. Lucia, settings with the potential for a surprise or unanticipated bill include: ambulance services (51 percent); inpatient emergency department (20 percent); outpatient emergency department (14 percent); and elective inpatient care (9 percent).

"Patients are vulnerable because the system is so incredibly complex," said **Beth Sutton, MD, FACS,** ACS Regent. "We all have to work together so that the insurance companies, the legislators, the hospitals, and the surgeons can resolve this problem."

Patrick V. Bailey, MD, MLS, FACS, Medical Director, Advocacy, ACS DAHP, also called for a coordinated approach to remedy the surprise billing issue, noting that Congress should address network adequacy, increase the transparency of insurance plans, and provide alternate dispute resolution for certain cases.

Some states have successfully passed out-of-network laws that protect patients, which may provide a workable model for federal legislation. For example, a New York law holds insurers accountable for maintaining adequate networks of physicians and specialists, establishes reasonable payment benchmarks, and provides effective alternative dispute resolution for special circumstances.

PA

"Prior authorization (PA) is the number one administrative burden that we hear about," said **Vinita Ollapally, JD,** Regulatory Affairs Manager, ACS DAHP. A 2017 ACS survey of 300 surgeons and practice managers revealed that a medical practice typically receives approximately 37 PA requests per provider each week. To complete these PAs, physicians and staff must work 25 hours (about three business days)—a significant amount of time that is largely the result of a lack of automated PA processes that integrate with EHRs.

Jay D. Lieberman, MD, FACS, assistant professor of surgery, University of South Florida Morsani College of Medicine, and vice-chair, department of surgery, Lehigh Valley Health Network, Allentown, PA, works in a large, multispecialty physician group with two full-time employees devoted to completing PAs. Dr. Lieberman and other members of the panel described the PA-related challenges for surgical practices, such as providing timely patient care and difficulty determining the services that require PA, the necessary documentation, and how to submit this information.

"We should be able to come together and write clinical standards for how we interpret the evidence and put it into an implementation for authorization so that we can standardize the authorization process," added Dr. Opelka. "The ability to do

Gary Timmerman, MD, FACS, ACSPA-*Surgeons*PAC Board Member (left) and Naveen Sangji, MD, winner of the Resident Rising Star award

Dr. Michelassi (left) with a Summit attendee

this from a technology standpoint exists today, but we have to do a lot of homework on the clinical side to make it possible."

To reduce PA-related challenges, the ACS supports standardization across the industry, identification of services that no longer warrant PA, and neutral third-party engagement in appeals processes.

Firearm injury prevention research

According to Mr. Shalgian, one issue that surgeons can significantly affect is funding for firearm injury research and prevention. "Right now, the College is very much supporting a request of $50 million specifically for firearm morbidity and mortality prevention though the Centers for Disease Control and Prevention as part of the fiscal year 2020 Labor, Health and Human Services, Education and Related Agencies appropriations package," he noted.

"What we are facing related to firearm injury and death in America is a public health crisis," said **Joseph V. Sakran, MD, MPA, MPH, FACS,** director, emergency general surgery; associate chief, division of acute care surgery; and assistant professor of surgery, Johns Hopkins Hospital, Baltimore, MD. "A lot of you know that firearms killed nearly 40,000 people in the U.S. in 2017, but that's just the tip of the iceberg," Dr. Sakran, a gunshot wound survivor, said. "For every one of those deaths, we have about two to three injuries. And the reality is the nonfatal injury cases we don't really capture very well within our own registries. There's a lot of work that's left to be done."

Alex McCourt, JD, MPH, PhD, Johns Hopkins Center for Gun Policy and Research, attributed the lack of data on nonfatal firearm injuries to a lack of funding and challenges in data aggregation. "In general, we get aggregate data on mortality looking at homicides and suicides because it's much more difficult to get nonfatal data. Sometimes we can look at crime data, but that's notoriously bad because it relies on individual police department reporting, which is not so dependable," he said.

Although data on nonfatal injuries can be difficult to obtain, Mr. McCourt noted that Johns Hopkins has been able to draw conclusions from other firearm-related data, specifically the positive effect of state gun laws that require background checks and domestic violence restrictions, which have resulted in lower rates of homicide, suicide, and intimate partner violence.

Feedback from the Hill

Several invited congressional speakers underscored the importance of the College's legislative efforts regarding firearm research and violence prevention, surprise billing, Medicare physician payment, and other issues. Congressional speakers included Reps. **Michael Burgess, MD (R-TX); Debbie Dingell (D-MI); Steve Watkins (R-KS);** and **Jimmy Gomez (D-CA).**

The next ACS Leadership & Advocacy Summit will take place March 28–31, 2020, in Washington, DC. ♦