Report from The ACS Leadership and Advocacy Summit
May 6-9, 2017

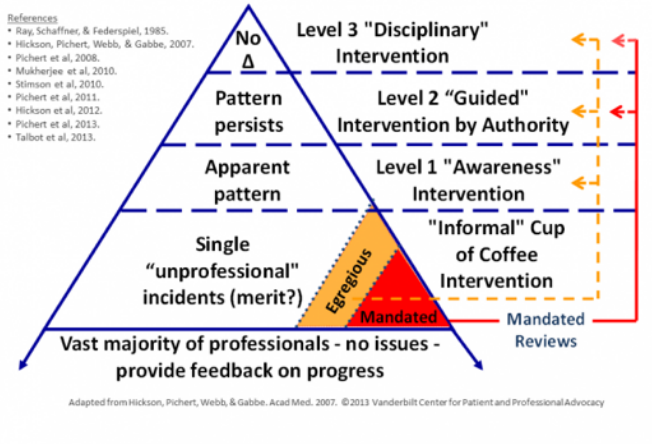
Highlights from Leadership and Advocacy days

Leadership
"Lead by example."

To open the day, Dr. Melina Kibbe, who struck me as impressively young for the number of prestigious accomplishments she has achieved, spoke to us about how to manage difficult personalities. What I appreciated most about this talk is that she focused on deliverables, which set the tone for the entire day. One of the most difficult aspects of describing optimal leadership traits, understanding emotional intelligence, or engaging others is the intangible and vague nature of these topics. Kibbe's approach to identifying disruptive behaviors or personality types and providing directives on how to directly respond gave the audience a framework to work with. First, she broke down emotional intelligence into 1.) self-regulation, or modulating and managing your *own* initial reaction first, 2.) social awareness, which involves interpreting organizational dynamics, opposing views, and furnishing empathy for each individual, and 3.) Relationship management, or mediating the dynamics between yourself and the other person or between other individuals. Once you are able to function from this standpoint, you are more able to discern the different types of difficult people, as follows with how to most effectively respond to them.

1. Passive aggressive: individuals who undercut authority and do not like being the center of attention or conflict. Respond by making them the center of attention in a constructive manner by asking them for their opinion or input.
2. Chronic whiner: disrupts the team. Respond by staying positive, but realistic; use concrete examples and ask them for a plausible solution.
3. People pleaser: tend to overcommit and are unable to deliver. Respond by becoming careful when delegating tasks to them, help them say no, and make sure to ask their opinion when the facts are clear, rather than your intentions (so their reaction is to be honest in their opinion instead of saying what you want to hear).
4. Unresponsive/ disengaged: may use silence as an aggressive device. Respond by asking open-ended questions and follow-up with their commitments.
5. Hostile: disruptive to how the entire team functions. Respond by addressing them in a transparent and consistent manner, determine their triggers, but discuss their behavior in private.

So, why is it important to learn how to intervene with these individuals, aside from establishing a positive and safe work environment? These behaviors can lead to patient safety issues, poor care outcomes, increased employee turnover, and burnout. According to Kaiser Health News (2013), 3-5% of physicians engage in disruptive behavior. In 2009, the Joint Commission mandated a Behavior Policy, ascribing the responsibility of developing a code of conduct to the administrative leader.



To further facilitate a structure to manage difficult behaviors, Kibbe provided a tool with a tiered approached, now validated by Vanderbilt (https://ww2.mc.vanderbilt.edu/cppa/45627). The first level being the "coffee cup" talk- low stakes and, as confirmed by comments from the audience, very effective, without the need to escalate most issues further. Only a minority require higher tiers, and it is possible that it is not an appropriate place for those people to work. The surprising comment which followed though was that sometimes the disciplinary action of relieving a person of their position actually allows them to exhale and begin the healing process.

"Leaders are best when we hardly know they exist… When the work is done, they say, 'We did this ourselves.'" - Lao Tsu
"Leadership is about change. If you like the status quo, you are merely a manager."

Following Dr. Kibbe, Dr. Patrick Hudson rounded out the conversation on a more introspective note in his talk entitled, "Leading from Behind". The bottom line he delivered was that "it is not about you, it is about your skills". However, his opening concept was more thought-provoking: "Some people become leaders so that they can achieve things, some achieve things so they

can become leaders. Who are you?" Clearly, one of these types is detrimental to the team and the success of the individuals relying on that person for leadership. There are also different styles of leadership, which Hudson broke down into "leading from the front" and "leading from behind". There are times where, not only is it acceptable, but necessary to lead from the front: in the OR, in the trauma bay, or during times of crisis. However, because surgeons tend to have a more forthright personality, which allows/ed us to succeed through medical school and residency, and also are trained to give directive orders (captain-of-the-ship mentality), we struggle to "lead from behind" when placed in leadership positions. What Hudson meant by "leading from behind" is utilizing your skills as a leader to empower those that work for you or those around you to perform in their roles to their maximal potential. A 4000-leader survey demonstrated that the most important skill is the ability to build collaborative relationships. So, again, it is not about you (and your ego), it is about how you support and shepherd your team to thrive and to arrive together at a goal. Other terms for this style is "servant leadership" or coaching. In many ways, it is similar to parenting: allowing your team to function relatively autonomously, with the ability for them to grow into their own strengths, providing guidance along the way.

What were Dr. Hudson's deliverables? Here are his list of essential skills:

1. Avoid ego traps. Ask whether an idea or a change is good for the team.
2. Stop talking. Listen to understand (not to immediately criticize) and do this by summarizing, reflecting, then questioning.
3. Help others accomplish their tasks by coaching. Instead of "telling" them or delegating, ask, " What can I do to help you ___?" or "Who can we find to help ___?"
4. Learn vulnerable trust, not just predictive trust. Predictive trust is what is established over time with a team that you have worked with for a long time and know their moves and reactions. However, vulnerable trust allows the team to be human and admit mistakes, giving each member the ability to learn and mature.

"Everywhere you turn, someone will need you."

Dr. Scott Leckman's lecture followed a short description of Operation Giving Back by Girma Tefera, encouraging all physicians to take part in the vast surgical need abroad. Leckman's talk brought that sentiment closer to home: volunteer in your own backyard or volunteer half-way around the world, just volunteer. Listen to the voice inside you that says,"Someone needs to do something about this"- <u>you are that someone</u>. He described how this realization struck him and his subsequent involvement with Utah's Health Access Project (http://healthaccessproject.org/about-us/who-we-are/), recognizing that timely, free clinic care prevents expensive emergency department care for unfunded patients. The project was supported by the Utah medical delegation under the stipulations that patients had to be under the 50% federal poverty line and not qualify for Medicaid or government healthcare. The patients would also have to agree to 1.) follow-up with their physician, 2.) not pursue litigation, and 3.) follow up with their assigned case manager. They asked physicians to see 1 patient per month for free as a gift to that patient. They had over 600 physicians volunteer, plus PA's, NP's, and other practitioners donate their time and services in the initial round. They were so successful that when the initial federal funding ran out after 3 years, the local hospitals and Salt Lake council donated enough money to keep them operational. So far, the physicians have provided $8 million of free care and over 13,000 patients have been cared for. Leckman reported that the rate-limiting steps were the physicians' and hospitals' volunteer hours, and their ability to support the case workers. He reported that the doctors were the biggest advocates to keeping this program running- they felt that it made them much more creative and collaborative when coming up with solutions for these patients, and most importantly, it affirmed that their life had meaning.

Dr. Krista Kaups led the afternoon with a discussion on physician burnout, identifying the predictors, common signs, tools and interventions to combat this now pervasive issue among our colleagues. She reported the following predictors: age under 50 years, proportional to the greater the number of hours worked- particularly on call, being female, being a trauma or transplant surgeon (whereas pediatric and colorectal surgeons tended to have the lowest levels), lack of autonomy, increased feeling of isolation (aggravated by hours on call away from family and friends), and being self-critical or a perfectionist. So, essentially, all of us as surgeons are at risk. Common signs of burnout were: emotional withdrawal, disruptive behavior- which were then associated with medical errors, physical exhaustion, workforce turnover, depression/anxiety, and alcohol or substance abuse. <u>Work performance tends to be preserved and is the last aspect to be affected.</u> As for residents, a study found that there are higher than average levels of distress in the 4th year, likely due to the combination of new senior responsibilities and determining their path for their fellowship and future career.

We have to move past using the coping strategies of "I just need to make it through ___, then things will be better." Resilience has to focus on a balance between detachment and over-involvement. The first intervention that was mentioned was self awareness, which can be accomplished by asking a friend or by an evaluation tool. The American College of Surgeons provides an anonymous surgeon wellbeing self-assessment tool which identifies specific areas of risk and provides targeted

access to local and national resources (https://www.facs.org/member-services/surgeon-wellbeing). Other interventions mentioned were exercise, having a personal physician other than yourself or a close colleague, and actually stopping to ask the big questions. What brings meaning or a sense of calling to you in your work? What brings joy? What are your values? How can these things be incorporated into your practice? Can things that are less enjoyable be reduced? For example, incorporate the use of scribes during clinic. Lastly, continue your hobbies, volunteer, and cultivate your relationships; the biggest defense these things provide is preventing the loss of identity.

"When educated physicians lead, good things happen."

Dr. Bhagwan Satiani demonstrated the data that while hospital quality scores are 25% higher in physician run hospitals than manager-run hospitals, only 3% of hospitals are physician run.

It is time to reclaim our administrations as clinically experienced physician leaders.

Advocacy and The Hill

Speaker, Chuck Todd, opened the Advocacy piece of the Summit at the Sunday night reception, immediately engaging his audience by describing physicians as "fishes out of water in DC" because we operate using facts. Following with, "You are in the problem solving business, we do not look like we are a town that wants to do that." Which set up his launching point to appeal to the need for physicians in the capital city. "If you have any inkling for public service, we need you. There are poor incentives for the best and the brightest to want to come to Washington. It is expensive. You'll encounter pressure by superPACs to support issues that aren't your primary endeavor. You'll drag your reputation through the mud." But indeed, it is one of the only ways to impact change at the federal level.

He described middle America as disenfranchised because they, the media, are more likely to tell stories from the coasts that impact only their lives, like the dreamer who had to watch their parent be deported, rather than the 19-year-old in Missouri that dies from an opioid overdose. He believed this was a major factor in the results of our last presidential election. But he did provide hope. He believes that the millennial generation has seen enough economic and political uncertainty, like the depression era generation, to be able to develop a comfort with disruption- and one desperately needed in politics now.

The ACS's four key principles on health care reform:

- *Quality and safety*
- *Appropriate and timely access to care*
- *Reduction of health care costs*
- *Medical liability reform*

The first session in the morning opened with a panel on healthcare reform, a timely discussion considering the passing of the American Health Care Act (AHCA) four days prior. The most constructive speech was delivered by James Capretta, who listed 6 ways the new bill could be fixed. He first laid out the background expenditure of government entitlement programs (Medicare, Medicaid, Social Security) by stating that the federal debt from these programs made up 40% of the GDP in 2008, 80% in 2016, 100% in 2017, and are projected to make up 150% of the GDP in less than thirty years. The additional problem is that other programs, like the military and FBI, require allocation from the GDP as well. His recommendations were:

1. Fix medicaid. Develop a compromise between medicaid expansion (3/5th) and non-expansion (2/5th) states by determining an income level threshold, with a safety net underneath that level and incentivize states to get up to that level over X number of years.
2. Raise tax credits for lower income populations to 250%, over merely age-adjusting.

3. Fix the 1-year penalty. The fee should be commensurate with the amount of time not covered by health insurance. This provides incentive to have continuous coverage, rather than to avoid reinstating coverage after being out for a period of time because the fee is mandated at that point.
4. Auto-enrollment in health insurance for all eligible.
5. Tax health benefits for high-income individuals and limit tax preference for employer-based premiums.
6. Fix health savings accounts. Enrollees should spend 20% less than those not enrolled. This should present the ability to buy high-quality/ low-cost pre-packaged care along with the HSA.

The majority of the day was tailored to informing us on the ACS positions and specific "asks" of our representatives. We were addressed by a presentation coach who gave specific tips on how to communicate our requests to staffers in the clearest and most effective manner. The most pertinent points were:

1. Be declarative. Tell the staffer to circle or underline or star something important; they will do it because you told them to and their eyes will catch on their markings as they are sifting through their hundreds of papers later.
2. Essentially create a "problem sandwich" (my words, not hers). First state the problem, provide an example story, then restate the problem by saying, "…you see why this needs to be fixed now."
3. Use powerful statements, like "Imagine that you ___" (places them in the center of the issue) or "Remember when ___".
4. Use SODAR to structure your presentation
   - Subject: I am ____. My patients are ____.
   - Opportunity: If we had [this resource or ability], we would [action]. OR
   - Decision: Because we did not have [this resource or ability], we decided to [alternative action].
   - Action
   - Results of that action. If no results are available yet, set up a specific date and method of providing your representative with that data.
5. The most impactful technique is to clearly outline the issues/asks for them by saying, "I have 3 items to go over. One… Two… Three…" They will write the list down.

Representatives (or their staff) visited by our team

Senator Elizabeth Warren (Julia Frederick, LC)
Senator Edward Markey (Taylor Winkleman, DVM, MPH; AAAS Congressional Fellow)
Rep. Richard Neal (Lizzy O'Hara, COS)
Rep. James McGovern (Mike Cusher, LA)
Rep. Michael Capuano (Robert Primus, COS and HLA)

The American College of Surgery Congressional "Asks" which our team brought to the Hill and their responses

1. **MIPS.** Provide greater flexibility during implementation of the Merit-based Incentive Payment System (MIPS)
   - Composite score of 4 categories (Quality, Cost, Advancing Care Information, Improvement Activities) compared to a threshold
   - Threshold is determined by the Secretary of HHS for 2017 and 2018, but starting in 2019, the threshold is set at the mean or median composite score
     - Half of providers will be penalized with payment cuts
     - PQRS are not reliable or valid measures on which to base performance
     - Not possible to achieve case volume within two years to show statistical significance at the mean or median threshold
     - Many providers have already maximized their quality measures, meaning that other providers must be near 100% performance as a minimum score

Additional team input: this legislation will inadvertently harm independent and rural practitioners who do not have access to the same resources as their counterparts at larger institutions. By charging them a fee, they will be forced to further cut back on the parts of their practice that allow them to provide quality care, creating a downward cycle. These are the physicians that are already essential for patient care in underserved or poor-access areas.

Ask: *Allow for an additional 3-year period of flexibility to determine the threshold score and verify that the quality measures being used to calculate that score are appropriate.*

Staffer response: All felt that the extended period of flexibility was reasonable and logical, particularly that an insufficient amount of data would be collected at two years to inform the threshold appropriately. There was also general agreement that PQRS was likely not going to be the final set of metrics used to determine performance. We did have one chief of staff (for Rep. Neal) attempt to explain that we did not understand the concept of how the score was being calculated- that half of physicians would not be penalized because they would be scored across four different categories. Our understanding was that the four categories create a composite score against which physicians are evaluated; however, we had no other way to dispute what the staffer was explaining to us, which left us feeling like we should have been better prepared.

2. **IPAB.** Repeal the Independent Payment Advisory Board legislation
   - If the expected per capita growth rate exceeds the target rate for Medicare, an unelected panel given the provision to make funding and coverage decisions to reduce spending
   - Panel is comprised of 15 members, none of which are practicing physicians

   Ask: *Repeal the IPAB and support the Protecting Medicare from Executive Action Act of 2017.*

   Staffer response: Across the board agreement. The difficulty is that no representative can endorse repealing another piece of healthcare legislation this soon after the distress and confusion caused by the passing of the AHCA with "repeal and replace". Repealing the IPAB is now going to have to be tabled until the AHCA dust settles.

3. **Mission Zero Act.** Grant funding for military and civilian collaboration to achieve zero preventable deaths after injury
   - $40 million total (up to $1 million each) to be awarded to level I and II civilian trauma centers to host military trauma teams to identify systems to reduce mortality and train the civilian staff
     - Smaller grants ($50-100,000) to host individual military providers

   Additional team input: For military in the field, 98% of patients who make it to a care center survive. Our civilian trauma survival rates are nowhere near that high. The military has received super-specialized training in how to reduce their patient mortality, which civilians can and should benefit from. Furthermore, this provides continuous upkeep for reserve military who are not maintaining their skills at that time, as well as a purpose for veteran physicians back in civilian life.

   Ask: *Cosponsor the Mission Zero Act ($40 million grant funding).*

   Staffer response: Most staff felt this was a great idea and were excited to bring a positive piece of legislation to their representative. The chief of staff for Rep. Capuano, however, felt that there was no place to pull this grant money from at this time.

4. **Good Samaritan Health Professionals Act.**
   - While laypeople who step in to help another individual, say, found down, are protected by the Good Samaritan Act, physicians who choose to volunteer their services in disaster settings across state lines are not provided the same legal protection.

   Additional team input: Having attended medical school in New Orleans shortly after Katrina, I met a number of physicians who were held liable for their actions at Charity Hospital during the Flood. Most of them also knew other physicians who had undergone litigation and even had their medical licenses revoked because they had to make excruciating ethical decisions about which patient should be given the last oxygen tank or which patients could survive being carried to the top of the hospital towers to be evacuated. These physicians were not Louisianians. Many were Northerners or from other parts of the country who felt a duty to help and were left unprotected in the aftermath.

   Ask: *Cosponsor the Good Samaritan Health Professionals Act.*

   Staffer response: Again, most staffers felt this was very reasonable. However, when we met with Rep. Capuano's chief of staff (who had worked as his HLA for years and was extremely knowledgeable of healthcare issues), his response was

that this Act had been brought up the previous year and their office's response was that this would be imminently doable if a registry of volunteer physicians existed with their credentials to provide care. The government cannot protect a physician practicing outside of their scope of care and there would be no way of verifying their credentials in a disaster setting with the exception of a nationally kept database of those doctors that have signed up with their medical licenses and hospital credentials on file. Our team would have been more effective during this meeting if we had known about the conversation that had occurred in the previous year and what progress had been made towards creating this registry.

5. **General Surgery Act.** Ensuring adequate surgical workforce in underserved areas.
   - Health Resources Services Administration (HRSA) to conduct a study to identify general surgery shortage areas and provide a shortage designation.
   - Determining lack of access is key to being able to incentivize general surgeons to move into these geographical areas and provide equal quality care to patients in underserved areas.

Additional team input: Patients in more rural areas of even Massachusetts (Lowell, Berkshires, etc.) have to be transferred by ambulance to higher level centers to encounter appropriate level surgical care. Dr. Heena Santry told her story of treating an otherwise healthy 19-year-old patient with perforated appendicitis who would likely not have had such an advanced disease course if he was able to access basic general surgery care near his home town. This situation was now more morbid for the patient and more costly for the hospital systems.

Ask: *Cosponsor the Ensuring Access to General Surgery Act of 2017.*

Staffer response: There were no disagreements with regard to this proposal, but also not a lot of enthusiasm either. Most agree that populations in more rural areas should have access to care and it seems logical that studying where physicians would need to be allocated is the next step to providing coverage.

<u>What to walk away with</u>

- Especially when speaking on a vague topic, provide concrete, objective approaches and techniques. Provide deliverables.
- There are specific and straightforward methods to diffuse difficult situations, conversations, and personalities. Most of the time these issues do not need to be escalated beyond the "coffee cup" talk. If they do reach a level that does not work for the individual or the workplace, sometimes relieving that person from their position allows them to begin the healing process.
- Lead by example and "from behind". It is difficult for surgeons not to stand at the front of the ship, but we are more effective leaders as shepherds or coaches.
- Listen to the voice that says someone should do something- you are that someone. Medical volunteerism provides reaffirmation that our lives have meaning and actually prevents burnout.
- Use your resources to identify when you are in trouble for burnout and interventions for preventing or alleviating its effects (tool provided by the ACS: https://www.facs.org/member-services/surgeon-wellbeing). Stop and take the time to ask yourself what is important to you and make sure to take the time to cultivate the things in your life that prevent loss of identity.

- In the history of healthcare and most other complex bills, each presidential administration has built on and improved the previous. "Repeal and replace" throws the baby out with the bathwater, instead of correcting the weaknesses of the ACA.
- The most effective method to "crafting the ask" is to be clear, concise, and provide the outline of issues as "One… Two… Three…" Making sure the staffer marks their page is influential too.
- Preparation. Some staffers will be extremely knowledgeable with regard to healthcare legislation (and medicine in general) and some will only know the basics. Personal stories and examples are compelling for those with less awareness, but a clear grasp of the issue, definitive agenda points, and the "ask" are most influential for chiefs of staff and health legislative aides.
- Know what the discussions with the staffers had been the previous year and what progress had been made since that time.

"For far too long surgeons have confined themselves to their own environment and ceded the conversations to others. It is our comfort zone- we take care of patients and we do it well. However, there are many issues at play now that directly impact our ability to care for patients- healthcare access, cost, quality, efficiency, need for accurate

public reporting, burdensome documentation, EHR, burnout, aging population, aging workforce, and the need for healthcare reform.

We need to get engaged at all levels of leadership and advocacy (hospital, state, national). We need to learn the necessary skills to be effective We can't afford to sit idly by any longer. And we can never forget to keep our patients at the center of all of our conversations." Tom Varghese, MD

Impact on my professional development and the potential beneficial experience for all residents

Attending the Leadership and Advocacy Summit is an incredibly empowering experience for residents, particularly those who have not previously been exposed to American College of Surgeons (ACS) leadership positions. After attending the ACS Congress in the fall, I was expecting to enter a meeting tailored to the leaders within our field feeling the same way: as a small fish in a big pond; particularly in a city that was built to intimidate visitors with its grandeur. The ACS Congress has a way of making a resident with few connections to the national community feel somewhat diminutive and inconsequential (though this effect also provides motivation to aspire to higher positions within it). However, within the first hour of the Saturday evening reception, I had been befriended by six residents- each with their own leadership roles in their institution, within their chapter, and/or within the Resident and Associate Society (RAS). By the end of the first session on Sunday, a board member of the College approached my table to thank me and my fellow residents for attending the Summit; informing us that we were essential as the future leadership of the society and that it was their honor that we were there. I was pleasantly taken back by this gesture. This meeting made the ACS leadership accessible, approachable, and relatable; it made me one of them.

One of the most advantageous parts of attending this meeting was the ability to become involved in RAS. I generally forget as I prepare to attend a meeting that the after-hours are just as formative and vital as the daytime events. Spending the evenings with the group of residents that attended not only confirmed my sense of affiliation to the College, but opened doors I would not have even come across otherwise. I have been asked to participate in the teleconferences on at least two of the resident committees (which I plan on doing) and was invited to join workgroups. I am eager and excited to become more involved, both within the resident society and state chapter.

The Summit also made my government representatives accessible. The opportunity to visit Capitol Hill influenced my perspective as a citizen of this country. I have not had the opportunity to bring my concerns to my government prior to this experience, and certainly not at the federal level. After going through the last year, watching the campaigns leading up to the presidential election, the election itself, then the melodrama of unpredictable events over the first 100 days of President Trump's term, I- and most individuals I know- have felt helpless. We voted; we speak our minds; we post messages and articles on social media. I have participated in and watched a half-dozen protests. However, none of these things seem to have an impact on the headlines that run across our screens or, more importantly, the legislation that is now affecting our lives daily. This meeting gave me footing to stand on again. It reminded me that our government is an institution built by and for its people; that my voice is not only important, it is imperative. As physicians, we assumed for too long that policy would be made for us in our and our patients' best interests and that there would be voices of reason to protect our right to quality and timely healthcare. I learned that our voices as physicians/surgeons are powerful because we *are* the experts on the ground everyday with the insight that our representatives are seeking, and that our physician/surgeon voices are glaringly absent among policymakers even though they are sought out.

I initially wished to attend the Summit to mature the skills I would need for my career in the future, advocating as one of the only physicians in a conflict-strewn and/or resource-poor community abroad. I now see the role I can play at this time in our own community and have been met with specific ways to become engaged within our society. I look forward to partaking in these opportunities, in cultivating the same commitment from my colleagues, and continuing to grow through these leadership experiences.

Next Steps

Ideas and directions for engagement of colleague surgeons and for improvement of the Summit for the next year.

Mass Chapter

1. Develop a resident council with representatives from each institution. This council should establish a needs assessment of what services/resources residents from each program would want from the MC-ACS. They can set up opportunities for ABSITE and board study and provide guidance towards how to become more involved within the national and state ACS.

2. Further engage residents, fellows, specialists, and community surgeons. Many people do not have a sense of the ACS and/or MC-ACS leadership structure and committees, so it would be helpful to create an outline or visual map of the leadership structure.
3. Utilize novel ways to disseminate information about the Chapter's acheivements, events, and opportunities for involvement beyond email. Examples would be having a grand rounds at each institution, hosting an information session at the annual meeting, creating webcasts, and getting onto social media (Facebook, Twitter, etc.); however, social media tends to require full time personnel to continuously curate and respond.
4. Survey to all Massachusetts physicians in the state, not only MC-ACS members, to identify what issues they are concerned about and what else can be done to engender greater participation with the Mass chapter.

Recommendations for next year's Advocacy Summit

1. Have individual (~30 minute) powerpoint lectures briefing us on each ACS position statement that we will be bringing to our representative, including whether this issue has been brought to them in the prior year and what has been done since that time to work on the issue. While the majority of the Congressional "Asks" were covered in the varies panel discussions, this format made amalgamating a structured proposal more difficult for Hill day.
2. Provide optional scripts to work off of for each "Ask". I do not think our team felt that we had streamlined our proposals until the last meeting or two without our representatives. Starting with a script would have allowed us to more comfortably improvise with our own stories and examples, while staying on track.
3. Rather than having a speaking coach on stage for a whole hour, have the teams break out to practice their "Asks" with each other while the speaking coach makes recommendations and poses tips.
4. While the sheets with each "Ask" were generally very informative, breaking the facts down into bullet points, rather than large paragraphs would have made the purpose of each clearer and would have been a more useful reference tool during the discussions with the staffers.

Thank you to the MC-ACS for providing me the opportunity to attend the Leadership and Advocacy Summit!
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