SOCIETY FOR AMBULATORY ANESTHESIA

Outpatient • Office Based • Non-Operating Room

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2022 SAMBA ASC Medical Directors & Leaders Summit Chat Summary

00:58:19 Arnaldo Valedon: What would you like to get out of the meeting today? Please let us know!

00:59:25 Arnaldo Valedon: Please raise your hand and we can have you talk or send it on the chat and we will mention it

01:00:02 Basem Abdelmalak, MD, FASA: What is LCD please?

01:01:32 Basem Abdelmalak, MD, FASA: Thank you!

01:05:31 Leopoldo Rodriguez: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39061&ver=27&bc=0

01:05:58 Arnaldo Valedon: Thank you DR. Chundri. We will touch on some of the aspects of business. We will bring the issues if billing coming up separately.

01:06:21 Aparna Chunduri: thankyou

01:06:22 Leopoldo Rodriguez: Local Coverage Determination. Please follow the link I placed above.

01:07:37 Leopoldo Rodriguez: LCD for Facet blocks: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=38841&ver=5&bc=0

01:08:48 Michael Hicks: Our the presentation slides going to be made available or do I need to take copious notes? 😀

01:09:25 Niraja Rajan: I can make my slides available if you want.

01:10:05 Leopoldo Rodriguez: Question asked about TJA: Today at 1pm EST, Rena Courtay MBA, VP of Duke University Ambulatory ASCs will educate us on developing this line of service.

01:10:45 Arnaldo Valedon: Yes, slides will be available to attendants

01:11:11 Leopoldo Rodriguez: All will receive a syllabus with a copy of the slides.

01:15:12 Megan Sage (SAMBA Staff): Everyone received a link to the syllabus with the Zoom link that was sent out yesterday and today. Here is a direct link to the syllabus: https://samba.memberclicks.net/assets/SAMBA_22_MedicalDirectors_Syllabus.pdf

01:26:00 karinhvangura: I was asked to be the medical director when I started my current job, but I shy away from it, because I feel, that they want me to sign off on procedures and patient selection, which I do not feel are safe for the surgery center. What are the legal implications of being a medical director for me?

01:29:22 Michael Hicks: RE: legal implications - 1) Don't sign-off on things with which you don't agree. However, make sure that your thoughts are consistent with the industry. 2) there should be written indemnification provisions in your contract for good faith efforts.

01:30:22 Arnaldo Valedon: https://www.beckershospitalreview.com/legal-regulatory-issues/how-hospital-and-physician-leaders-can-prevent-negligent-credentialing-lawsuits.html

01:32:12 Michael Hicks: Privileges are granted by the MEC. The Medical Director is an agent of the facility and should be a member of the MEC. The risk should reside with the MEC and the governing body.

01:32:46 Arnaldo Valedon: Dr. Hicks, agree!!

01:43:37 Leopoldo Rodriguez: In addition, I'd like to add, that if its a new procedure, and the MEC or Facility don't have experience, they can always hire an outside consultant with expertise on the topic, to facilitate the MEC's decision to credential or not, or to add the procedure to the DOP or not.

01:46:07 karinhvangura: If you get accused of diverting, what ways do you have to defend yourself. What actions should you take?

01:51:28 Leopoldo Rodriguez: There are many strategies that can be employed: 1. You should offer to be drug tested. 2. As stated above, each facility should have policies to address this. 3. In our facilities, we do an "End of Procedure Controlled substance time-out" where we count what has been recorded on the record, waste, and document. this is done by the Anesthesia provider and the RN circulator. This strategy has decreased the number of suspicions, as most instances are "arithmetic issues" and not missing drugs. This strategy protects everyone in the room.

01:53:32 Leopoldo Rodriguez: We routinely, send syringes to a lab to check the concentration of the drugs in the syringe to make sure the drugs are not intentionally being diluted. If not documented, it did not happen.

01:55:14 Leopoldo Rodriguez: in HCA facilities, Propofol is considered a Controlled Substance. This is something the DEA allows facilities to do. We also treat Ephedrine as a controlled substance.

01:59:56 karinhvangura: In my facility nurses know the code to my anesthesia cart, should I carry my drugs in a bag with me?

02:03:07 karinhvangura: How many places do have a so called zero tolerance policy and is that legal?

02:09:47 Leopoldo Rodriguez: In our facilities, we use fire safe boxes in the anesthesia cart, which are left in the lower drawer of the cart, each box has a unique lock/key to prevent others from entering it. The provider carries the key with them. So even if an RN has the code, they don't have the key.

02:23:45 Basem Abdelmalak, MD, FASA: I recommend using med machine if feasible, like Pyxis (there are smaller versions of it for small ORs with space limitations. it shows exactly who pulled what and at what time and so forth, and you can co sign for drug waste there as well

02:29:28 Basem Abdelmalak, MD, FASA: is there a " a legal level" for cannabis?

02:30:42 Basem Abdelmalak, MD, FASA: That is a tough one,

02:30:57 Basem Abdelmalak, MD, FASA: what would be a cannabis sobriety test??

02:42:37 Leopoldo Rodriguez: In regards to patients and Cannabis. If a person has signs of acute intoxication, which are: slow speech, tachycardia, we question them about the use of cannabis. My facility tells patients not to smoke cannabis for 24hrs before the procedure. In reality, the acute phase lasts 8hrs in average, but I find these patients to be unreliable and numerous patients have shown up impaired.

02:43:53 Leopoldo Rodriguez: The AHA published in "Circulation Journal" an AHA SCIENTIFIC STATEMENT
Medical Marijuana, Recreational Cannabis, and Cardiovascular Health
A Scientific Statement From the American Heart Association. Circulation. 2020;142:e131–e152. DOI: 10.1161/CIR.0000000000000883

02:44:45 Leopoldo Rodriguez: Cannabis is a risk factor for Acute Myocardia Infarction.

02:46:05 Leopoldo Rodriguez: Cannabis Use Disorder and Perioperative Outcomes in Major Elective Surgeries A Retrospective Cohort Analysis
Akash Goel, M.D., M.P.H., et al. Anesthesiology 2020; 132:625–35
02:48:26 Leopoldo Rodriguez: In Forensic Science International, Acute cardiovascular fatalities following cannabis use
Liliana Bachs*, Henning Mørland
National Institute of Forensic Toxicology, P.O. Box 495, Sentrum, N-0105 Oslo, Norway.
Reporting the death of young healthy patients after use of cannabis.

02:49:45 Leopoldo Rodriguez: International Journal of Cardiology: International Journal of Cardiology 104 (2005) 230–232
Letter to the Editor
Cannabis as a precipitant of cardiovascular emergencies, Alistair C. Lindsay et al.

03:01:41 Arnaldo Valedon: Thanks Leo. We will bring this topic back at other meetings and should address through publications as well.

03:12:30 Leopoldo Rodriguez: If you look at the chat box, there is a page, a happy face and three dots. If you click on the three dots, there's an option to "save chat" in your hard drive.

03:18:40 Leopoldo Rodriguez: OK, I will ask our staff to save the chat and share.

03:19:17 Megan Sage (SAMBA Staff): For anyone interested, we will be sending out the chat transcript next week along with the syllabus.

03:28:58 Anna Penna: no

03:29:11 Arnaldo Valedon: no

03:29:28 Leticia Otchere-Darko: what is the rationale behind having them take Gatorade

03:30:03 Leticia Otchere-Darko: wow

03:30:25 Basem Abdelmalak, MD, FASA: The ASA has a task force currently working on coming up with recommendations on different types of clear liquids preoperatively, stay tuned.

03:32:33 Arnaldo Valedon: For those using gastric ultrasound, are you billing for it?

03:32:39 Anna Penna: we still use 15/kg of Ofirmev for the pedi tonisil

03:33:53 Anna Penna: how much fentanyl in pacu for post op pain?

03:34:13 Basem Abdelmalak, MD, FASA: ENT surgeon's association just published guidelines , recommending ketorolac for tonsillectomy, they also recognize (rightfully) that intraoperative opioids is not the problem, and their recommendations aimed at reducing postoperative opioid prescription

03:42:11 Arnaldo Valedon: WE have been using IV Dex for dental patients with special needs. Works wonderful for post op delirium

03:42:33 Niraja Rajan: Agree. IV dex is great

03:47:33 Leopoldo Rodriguez: PEDIATRIC ANESTHESIOLOGY: RESEARCH REPORTS
The Effect of Intraoperative Dexmedetomidine on Postoperative Analgesia and Sedation in Pediatric Patients Undergoing Tonsillectomy and Adenoidectomy.
https://journals.lww.com/anesthesia-analgesia/Fulltext/2010/08000/The_Effect_of_Intraoperative_Dexmedetomidine_on.37.aspx

03:48:04 Rosalie Tassone: IV dexmetedomdine is very helpful, especially in the PACU

03:52:41 Rosalie Tassone: https://pubmed.ncbi.nlm.nih.gov/33201518/

03:53:40 Leopoldo Rodriguez: Predictive Risk Factors for 30-day Readmissions Following Primary Total Joint Arthroplasty and Modification of Patient Management
Samantha Tayne, BA a, Christian A. Merrill, BS a, Eric L. Smith, MD b, William C. Mackey, MD c
: While there was a trend toward increased readmission risk in patients with BMIs N 35, this did not reach statistical significance (P = 0.108).

03:58:03 Leopoldo Rodriguez: Goyal N, Chen AF, Padgett SE, Tan TL, Kheir MM, Hopper Jr RH, et al. Otto Aufranc Award: a multicenter, randomized study of outpatient versus inpatient total hip arthroplasty. Clin Orthop Relat Res 2017;475:364e72.

03:59:46 Leopoldo Rodriguez: Re: BMI > 40: Certainly, one should start their program with BMI <35, as we get experienced BMI of 40. Then on a case by cases you can decide if you want to do BMI > 40, but complication rates and readmission rates are higher in the orthopedic literature.

04:00:43 Leopoldo Rodriguez: In our AmSurg facilities we limit BMI to 40 or less.

04:01:22 Anna Penna: our limit is 35-ish. But we are new to outpatient total joint

04:01:30 Arnaldo Valedon: RISK FACTORS LINKED TO HIGHER COMPLICATIONS
AND RE-ADMISSIONS FOR THA AND TKA:
04:01:38 Arnaldo Valedon: Age > 70 y/o
ASA Physical Classification > 3
BMI >40 Kg/m2
Blood dyscrasia and use of anticoagulants
Tobacco abuse
Malnutrition
Uncontrolled diabetes
COPD
CHF
Cirrhosis

1.Who Should Not Undergo Short Stay Hip and Knee Arthroplasty? Risk Factors Associated With Major Medical Complications Following Primary Total Joint Arthroplasty, Courtney, PM et al. J arthroplasty,2015 Sep;30(9 Suppl):1-4. doi: 10.1016/j.arth.2015.01.056. Epub 2015 May 27.
2. Complications Following Outpatient Total Joint Arthroplasty: An Analysis of a National Database. P.Courtney et.al, May 2017. Volume 32, Issue 5,

04:02:37 Leopoldo Rodriguez: In AmSurg we exclude patients 80 or older. Again we start with patient age < 70, then increase with experience.

04:08:40 Basem Abdelmalak, MD, FASA: Clinical Practice Guideline: Opioid Prescribing for Analgesia After Common Otolaryngology Operations
https://journals.sagepub.com/doi/full/10.1177/0194599821996297

04:11:52 Rena Courtay: Duke currently does around 2000 TKA and THA per year

04:15:06 Rena Courtay: Typical anesthetic at Duke: • Start w/Short acting spinal
- Aductor canal Pre-op
- OR: periarticular w/bupivacaine

04:15:50 Christopher Canlas: Is there any type of block done preoperatively for total hips?

04:16:20 Rena Courtay: We have also made exceptions on age if the patient is in great health otherwise.

04:17:23 Basem Abdelmalak, MD, FASA: Clinical Practice Guideline: Tonsillectomy in Children (Update)

04:17:24 Anameti Usoro: We've started doing PENG blocks for the THA for some of our surgeons and they've been doing well

04:17:29 Basem Abdelmalak, MD, FASA: https://journals.sagepub.com/doi/pdf/10.1177/0194599818807917

04:22:29 Arnaldo Valedon: Rena, for THA, are most practitioners doing an anterior surgical approach?

04:27:44 Leopoldo Rodriguez: Each state has different regulations. In Florida we can do overnight stay, however, it is not a widely offered service, because facilities have staffing shortages during the day. Thus, they don't want to impact the staffing further.

04:28:53 Rena Courtay: We have a mix of anterior approach and posterior. Two of our more experienced surgeons still doing posterior.

04:29:17 Leopoldo Rodriguez: If a complication happens in a CMS patient, one can transfer the patient to a Hospital. However, this is a sensitive topic, because if done routinely the ASC may lose it's license.

04:34:20 Leopoldo Rodriguez: https://www.cdc.gov/healthyweight/bmi/calculator.html

04:39:49 Niraja Rajan: Marjanovic, V., Budic, I., Golubovic, M. et al. Perioperative respiratory adverse events during ambulatory anesthesia in obese children. Ir J Med Sci (2021).

04:40:24 Niraja Rajan: BMI percentile greater than 99 is considered morbidly obese

04:54:32 Stan Plavin: How does one know when AAAHC standards have been compromised and what to do

05:04:12 Michael Hicks: Where in the AAAHC standards can I find the dantrolene requirement?

05:05:31 Anna Penna: yes, would love to see the AAAHC standard on dantrolene. Though I don't know if AAAHC certifies GI centers?

05:07:56 Leopoldo Rodriguez: RE: Where in the AAAHC standards can I find the dantrolene requirement? Dr. Hicks, the 2020 AAAHC Manual, on page 83, If anesthetic and resuscitative agents known to trigger malignant hyperthermia are available in the facility, staff are prepared to respond to an episode of malignant hyperthermia.
Elements of compliance

1. Written treatment protocols based on current, nationally recognized guidelines have been adopted.
2. The protocols include:
a. The administration of dantrolene and other medications.

05:09:30 Anna Penna: does USPI owned centers have a relationship with ASCA?

05:10:21 Arnaldo Valedon: yes indeed

05:20:25 Arnaldo Valedon: AAAHC does accredit GI centers

05:23:21 Arnaldo Valedon: www.ascassociation.org

05:59:12 abdelmb: Thank you Bobbie Jean, and all moderators and panelists, Great talks, well done! Basem Abdelmalak

06:06:16 Leopoldo Rodriguez: Very well rounded presentation, important for Medical Directors.

06:07:37 Anna Penna: how can we convince our Ophthalmology colleagues to stop sending their patients to the internist for "history and physical". They are convinced that they need to!

06:09:53 Leopoldo Rodriguez: Anna Penna: unfortunately are community practices. Internist refers to Ophtalmology, who refers back for "clearance" then do the surgery. Presenting this SAMBA paper to your ophthalmologists would serve every patient well.

06:10:01 Peter DeSocio: Thank you for a great meeting

06:10:24 Rosalie Tassone: Thanks for a great meeting!

06:10:39 Christopher Canlas: I missed the first 30 min. Is there a video link so that I can see what I missed?

06:10:48 Aparna Chunduri: nice meeting. Thankyou

06:10:52 Rena Courtay: Fantastic meeting! Thank you for having me.

06:11:26 Megan Sage (SAMBA Staff): The recording of the meeting will be posted for all attendees next week.