



Outpatient • Office Based • Non-Operating Room

A background image of the Philadelphia skyline at sunset, featuring the Liberty Bell and various skyscrapers. A blue bridge is visible on the left side.

**SAMBA 2024 ASC AND OBA
MEDICAL DIRECTORS MEETING**
FRIDAY, OCTOBER 18, 2024
W PHILADELPHIA HOTEL
PHILADELPHIA, PA

Register Online at www.sambahq.org

SYLLABUS

Jointly Provided by the American Society of Anesthesiologists (ASA) and the Society for Ambulatory Anesthesia (SAMBA).



Phone: (414) 488-3915 • Email: info@sambahq.org • www.SAMBAhq.org

PROGRAM INFORMATION

Target Audience

This meeting is designed for anesthesiologists, anesthesia providers, practitioners, nurses and administrators who work and specialize in ambulatory, office-based or non-operating room anesthesia.

About This Meeting

The purpose of this meeting is to educate and share information that is tailored to physicians, AHPs, Medical Directors, and Administrative staff who practice in Ambulatory Surgery Centers and Office Based Anesthesia. Opportunities for questions and answers will be provided at the conclusion of each panel.

Registration

Registration for the 2024 ASC and OBA Medical Directors Meeting includes access to all sessions and the program syllabus. Note that all fees are quoted in U.S. currency. Registration for the meeting is available to members and non-members via SAMBA's website at www.sambahq.org. The Non-Member registration fee includes complimentary membership in SAMBA through December 31, 2024.

Accreditation and Designation Statements

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of American Society

of Anesthesiologists and the Society for Ambulatory Anesthesia. The American Society of Anesthesiologists is accredited by the ACCME to provide continuing medical education for physicians.

Accreditation Information

The American Society of Anesthesiologists designates this live activity for a maximum of 6.00 *AMA PRA Category 1 Credits*[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosure Statement

The American Society of Anesthesiologists remains strongly committed to providing the best available evidence-based clinical information to participants of this educational activity and requires an open disclosure of any potential conflict of interest identified by our faculty members. It is not the intent of the American Society of Anesthesiologists to eliminate all situations of potential conflict of interest, but rather to enable those who are working with the American Society of Anesthesiologists to recognize situations that may be subject to question by others. All disclosed conflicts of interest are reviewed by the educational activity course director/ chair to ensure that such situations are properly evaluated and, if necessary, resolved. The American Society of Anesthesiologists educational standards pertaining to conflict of interest are intended to maintain the

professional autonomy of the clinical experts inherent in promoting a balanced presentation of science. Through our review process, all American Society of Anesthesiologists activities are ensured of independent, objective, scientifically balanced presentations of information. Disclosure of any or no relationships will be made available for all educational activities.

Disclosure information will be provided to participants before the start of the activity.

Special Needs

The Society for Ambulatory Anesthesia (SAMBA) fully complies with the legal requirements of the Americans with Disabilities Act and the rules and regulations thereof. If any attendee in this educational activity is in need of accommodations, please contact the SAMBA Executive Office at info@sambahq.org or 414-488-3915.

Cancellation Policy

Cancellations received through August 30, 2024, will receive a full refund. Cancellations received from August 31, 2024 through October 3, 2024 will receive a refund less a \$100 administrative fee. Refunds will not be given after October 4, 2024. Cancellation of a meeting registration must be submitted in writing. Refunds will be determined by date written cancellation is received at the SAMBA office in Milwaukee, WI.

OVERALL LEARNING OBJECTIVES

At the end of this activity, participants should be able to:

- Discuss current business topics such as leadership and financial understanding relevant to an ASC and OBA practice.
- Identify relevant administrative topics currently faced by medical directors in ASCs and OBA practices.
- Apply Strategies to address management issues facing ASCs and OBA practices.

PROGRAM SCHEDULE

FRIDAY, OCTOBER 18

7:00am – 8:00am

Co-Sponsored Breakfast Symposium (NON-CME): Medtronic, Inc. and Mindray North America
Or Breakfast on your own

8:30am – 9:00am

ASC Medical Director Job Description
Jarrett A. Heard, MD, MBA

9:00am – 9:30am

Adding A New Service Line
Niraja Rajan, MD, FAAP, FASA, SAMBA-F

9:30am – 10:15am

AI and the ASC Medical Director Getting Practical: How to go about Incorporating AI in your ASC Business?
Piyush Mathur MD, FCCM, FASA, FAMIA

10:15am – 10:30am

Break

10:30am – 11:00am

Recruitment and Retention: Challenges in Hiring and Keeping the Right Team Members
Alan P. Marco, MD, MMM, CPE, FAAPL, SAMBA-F

11:00am – 11:30am

Pro-Con: Mandating H and P for ASC Patients
Alan P. Marco, MD, MMM, CPE, FAAPL, SAMBA-F
BobbieJean Sweitzer, MD, FACP, SAMBA-F, FASA

11:30am – 12:00pm

Break

12:00pm – 1:00pm

Sponsored Lunch Symposium (NON-CME): PACIRA Pharmaceutical
Or Lunch on your own

1:00pm – 1:30pm

Break

1:30pm – 2:00pm

Legislative Update and CMS Inpatient List
Kara Newbury, JD

2:00pm – 2:30pm

Dealing with the Trouble Anesthesiologist
Mohsen Shabahang, MD, PhD, FACS

2:30pm – 3:30pm

OBA Director Panel

- **OBA Practice Director Overview, and Current Challenges/Solutions**
Meghan Valach, MD
- **Policies and Practice Management**
Cassie Dietrich, MD, FASA
- **Documentation, and Quality Data at the OBA**
Grace Lee Dorsch, MD

3:30pm – 3:45pm

Break

3:45pm – 4:30pm

Billing Essentials at Your ASC
Thomas Durick, MD

4:30pm – 5:00pm

The Benefits of Advanced Business Degree
Jarrett A. Heard, MD, MBA



SAMBA 2025 Annual Meeting
May 15-17, 2025
Arizona Biltmore • Phoenix, Arizona

PROGRAM PLANNING COMMITTEE

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SAMBA Meetings Committee Co-Chair
Professor of Anesthesiology
Cleveland Clinic
Cleveland, Ohio

Steven Butz, MD, SAMBA-F, FASA

SAMBA Meetings Committee
Associate Chief Medical Officer
Children's Wisconsin Surgicenter
Greenfield, Wisconsin

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Independent
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Grace Lee Dorsch, MD

Owner
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Thomas Durick, MD

Assistant Professor - Clinical
Associate Director, Ambulatory
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Anesthesia Clinical Operations
Director - Outpatient Care
New Albany
The Ohio State University
Wexner Medical Center
Lewis Center, OH

Jarrett A. Heard, MD, MBA

Associate Professor-Clinical of Anesthesiology
Medical Director of Ambulatory Perioperative
Services
Director Executive Leadership and Business
in Anesthesiology Fellowship
The Ohio State University Wexner Medical
Center
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Professor of Anesthesiology and Perioperative
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Staff Anesthesiologist and Intensivist
Associate Professor of Anesthesiology
Innovation Lead, Department of
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Kara Newbury, JD

Chief Advocacy Officer
Ambulatory Surgery Center
Association
Alexandria, Virginia

**Niraja Rajan, MD, FAAP, FASA,
SAMBA-F**

Professor of Anesthesiology
Penn State Milton S Hershey
Medical Center
President
Society for Ambulatory Anesthesia
Medical Director
Hershey Outpatient Surgery Center
Hershey, PA

**Mohsen Shabahang, MD, PhD,
FACS**

CMO/VP for Surgery, Anesthesia,
Perioperative Service Line
WellSpan Health
York, PA

**BobbieJean Sweitzer, MD,
FACP, SAMBA-F, FASA**

Systems Director,
Preoperative Medicine
Inova Health
Professor, Medical
Education
University of Virginia
Fairfax, VA

Meghan Valach, MD

Anesthesiologist-in-Chief
Mobile Anesthesiologists a
Division of Ambulatory
Anesthesia Care
Downers Grove, IL

HANDOUT



ASC Medical Director Job Description

Jarrett A. Heard, MD, MBA



Role of the Medical Director: ASC

Jarrett A. Heard, MD, MBA

The Ohio State University Wexner Medical Center

Associate Professor – Clinical Anesthesiology

Medical Director of Ambulatory Perioperative Services

Director Executive Leadership and Business in Anesthesiology
Fellowship

1

Objectives

- Review the essential role of a medical director at an ASC
- Define visionary leadership of a medical director
- Explore change management opportunities as medical director

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Role of the Medical Director: ASC



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Essential Role



- Support the **MISSION** of the ASC
 - Revenue – Gross? Operating costs? Margins?
 - Growth – Case volume? Referrals? Payor?
 - Operations – Efficiency? Outcomes?
 - Workplace – Patient satisfaction? Employee satisfaction? Reputation?
 - Case mix – Shift volume from other pavilions? Surgical access?
 - Service Lines/Physician Recruitment – HOPD only? Robotics?
- Mission depends on the governance of the ASC and the administrative/executive board

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Essential Role



- Strategic Planning - Mission
 - Attend/chair – ASC board meetings - required
 - Develop/Review Performance Metrics/KPIs
 - Review budgets, operating expenses, OR utilization
 - Discuss service lines: Improve existing ones, recruit new ones
 - Opportunities for growth, greater referrals
- Operational Efficiencies
 - Case Scheduling, Turnover times
 - Delays/Cancellations
 - Implement QI initiatives – access/throughput
 - Case length accuracy

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Essential Role



- Collaboration
 - Administrative Staff/Board
 - Surgeons
 - Anesthesia providers
 - Perioperative staff – nurses/PA's
 - Executive committees
- Integration
 - Perioperative processes – Appropriate patients, appropriate cases
 - Quality Assurance

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Essential Role



- Compliance
 - Adherence to ASC policies
 - CMS regulations
 - CLIA if applicable
 - Create/Revise/Follow ASC Scope of Care/Cases Performed
- Accreditation/Licensure
 - Follow regulations for accreditation: AAAHC vs. TJC vs. Quad A, etc
 - Conditions for Coverage - ASC
 - <https://www.cms.gov/medicare/health-safety-standards/conditions-coverage-participation/ambulatory-surgical-centers-asc>

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Essential Role



- Finances
 - Financial data – surgical/anesthesia services costs
 - Cost containment/Capital expenses
 - Vendor Contracts
 - CPT Billing/Coding Accuracy
 - Supplies
 - OR utilization
 - Payor Mix
 - Payor Contracts
 - CMS – approved cases for reimbursement

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Essential Role



- Credentialing/Privileging
 - Approve surgeons/physicians
 - Make sure no one is practicing beyond their scope
 - Performing approved cases/procedures only
 - Approve perioperative staff
 - Nurses/APPs/Anesthesia staff
- Marketing
 - Surgeons
 - Referring physicians
 - Payors
 - Patients

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Visionary Medical Director



- BIG PICTURE!!!!!!!!!!
- Have a vision and know how to fit the pieces together
- Engage staff
- Develop Leaders

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Visionary ASC Medical Director



- What is your purpose?
 - Mission Statement/Purpose
 - Create Value
 - Low Cost vs. Differentiation
- How will you measure success?
 - Performance Measures
 - Revenue
 - KPIs
- Who is your customer?
 - Patients
 - Surgeons
 - Payers

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Visionary ASC Medical Director



- Organizational Behavior
 - Promote Collaboration
 - Encourage “horizontal leadership”
 - Develop leadership from within
 - Promotes retention, trust, innovation, ownership
- Culture
 - “Just culture”
 - Incentivize

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Visionary ASC Medical Director



- 3S's
- Patient Selection
 - Throughput – reduce delays and cancellations
- Patient Safety
 - Reduce Transfers/Hospital Admissions/Sentinel Events
- Patient Satisfaction
 - Future Referrals/Revenue

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Visionary ASC Medical Director



- Innovation
 - Operational Efficiencies
 - Investments in people, equipment, technologies
 - Pushing the envelope (safely)
- Generation of Ideas
 - How can we improve performance?
 - How can we increase volume/growth/market share?

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Change Management



- Change Management Agent
 - Create a sense of urgency
 - Gather data
 - Coalition building
 - Strategic Vision
 - Enlist Volunteer Army
 - Remove Barriers
 - Generate Short Term Wins
 - Sustain Acceleration
 - Institute Change

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Change Management Opportunities



- **US News and World Report ASC ratings**
 - Endoscopy, Urology, Orthopedics/Spine, Ophthalmology
 - ED Visit Rate, Admission Rate, Cost of Complications, Mortality Rate
- Service lines
 - Robotics
 - Vascular
 - Spine
- Artificial Intelligence
 - Predictive Analytics – Preop Optimization
 - Better OR utilization
 - Billing

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Objectives



- Review the essential role/function of a medical director at an ASC
- Define visionary leadership of a medical director
- Explore change management opportunities as medical director

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Questions?



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References



- 1) Becker's ASC Review. Medical Director 101: What It Takes to Be a Great Medical Director. Oct 2010.
- 2) Guertin, M, Heard, J, Del Rosario, T. Ambulatory Surgery Center Medical Director: Visionary Leader. Anesthesiology Clinics, Ambulatory Anesthesia – Ch. 14. 2019
- 3) M.E. Porter, T.H. Lee. The strategy that will fix health care. 2013. Harvard Business Review, 91, pp. 50–70.
- 4) ASCs: A Positive Trend in Healthcare. Ambulatory Surgery Center Association. Advancing Surgical Care. www.ascassociation.org/aboutasc/industryoverview/apositivetrendinhealthcare.
- 5) Ambulatory Surgery Centers. Encyclopedia of Surgery. Ed. Anthony J. Senagore. Thomson Gale. www.surgeryencyclopedia.com.2004
- 6) 8 Ways to Enhance Patient Satisfaction in Surgery Centers. Becker's ASC Review. www.beckersasc.com/asc-turnarounds-ideas-to-improve-performance/8-ways-to-enhance-patient-satisfaction-in-surgery-centers.htm. 2011
- 7) Patient Selection for Day Case-eligible Surgery: Identifying Those at High Risk for Major Complications. Anesthesiology: The Journal of the American Society of Anesthesiologists, Inc. <http://anesthesiology.pubs.asahq.org/article.aspx?articleid=1918045>. 2013
- 8) Kotter J. The 8-Step Process for Leading Change. www.kotterinternational.com/the-8-step-process-for-leading-change

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4:30-5:30pm

Benefits of an Advanced Business Degree

Jarrett A. Heard, MD, MBA

The Ohio State University Wexner Medical Center

Associate Professor – Clinical Anesthesiology

Medical Director Ambulatory Perioperative Services

Director Executive Leadership and Business in Anesthesiology Fellowship

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Mini-MBA Graduate Healthcare Certificate

Creating visionary physician leaders

The role of physicians is evolving. The business of healthcare has changed significantly in the last decade and requires all physician leaders to develop managerial and interpersonal skills to deliver value to their patients. Business acumen will improve the leadership and decision-making skills of anesthesiologists, vital skills to improve the efficacy of healthcare delivered around the world.

The Society for Ambulatory Anesthesia, SAMBA, and The Ohio State University Fisher College of Business have partnered to create a Mini-MBA Graduate Healthcare Certificate Program for SAMBA members to meet the expanded needs of leaders in anesthesiology.





100%
online

15
credit hours

PROGRAM COMPONENTS

15 CREDIT HOUR CORE CURRICULUM

Six graduate-level courses:
 Strategy Formulation and Implementation MBA 6293
 Operations MBA 6233
 Organizational Behavior MBA 6201
 Leadership MBA 6202
 Data Analysis for Managers MBA 6273
 Finance MBA 6223

All courses are part of Fisher College of Business's Working Professional MBA program. All courses will be online.

PROGRAM OBJECTIVES

By the end of this program participants will:

- Understand the fundamentals of strategy
- Gain insight into the operations function and how it contributes to ensuring effective and efficient flow of materials and information
- Study employee interactions and organizational processes that seek to create more efficient and cohesive organizations
- Learn the factors that influence individual and team performance and techniques to improve it
- Achieve an application-oriented understanding of data-driven decision-making



"Physician leaders must be visionaries; creating collaborative culture, innovative ideas, and empowering people. Having a business acumen not only allows physicians to see things from a different perspective, but it also allows them to find creative solutions and lends them credibility in their respective organizations."

Jarrett Heard, MD, MBA
 Physician, Associate Professor of Anesthesiology, The Ohio State University Wexner Medical Center

Learn more:






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Earn an executive MBA, participate in executive-level meetings and gain expertise in OR utilization, capital expense requests, operation gains/losses and procedural reimbursement.

We've been nationally ranked as a *U.S. News & World Report* "Best Hospital" for **31 consecutive years**.



Collaboration occurs across **110+** medical center departments, divisions, institutes and centers, as well as **18** colleges and schools at The Ohio State University.



Our eighth and newest hospital, the **1.9-million-square-foot Inpatient Tower**, opens in 2026.



You'll love living in Columbus, **America's 14th largest city** and among the **Top 10** for concentration of young professionals.



Executive Leadership and Business in Anesthesiology Fellowship

- A unique, innovative Anesthesiology fellowship that provides leadership and administrative training.
- 50% of the fellow's time is spent as an attending in ORs.
- The other 50% is spent in non-clinical work, including research, administrative meetings and completion of a 17-month Executive MBA from The Ohio State University Fisher College of Business.
- Two-year commitment
- Clinical work as an attending fully funds the MBA tuition.




Executive Leadership and Business in Anesthesiology Fellowship

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HANDOUT



Adding A New Service Line

Niraja Rajan, MD, FAAP, FASA, SAMBA-F



Adding a new service at your ASC

Niraja Rajan MD FAAP FASA SAMBA-F
Professor of Anesthesiology
Penn State Milton S Hershey Medical Center
President
Society for Ambulatory Anesthesia
Medical Director
Hershey Outpatient Surgery Center

1

Objectives

- Outline some of the considerations before undertaking new procedures at the ASC.
- Develop a business plan to set up a new service line at an ASC.
- Configure parallel processes enabling a successful and sustainable implementation of the new service

2

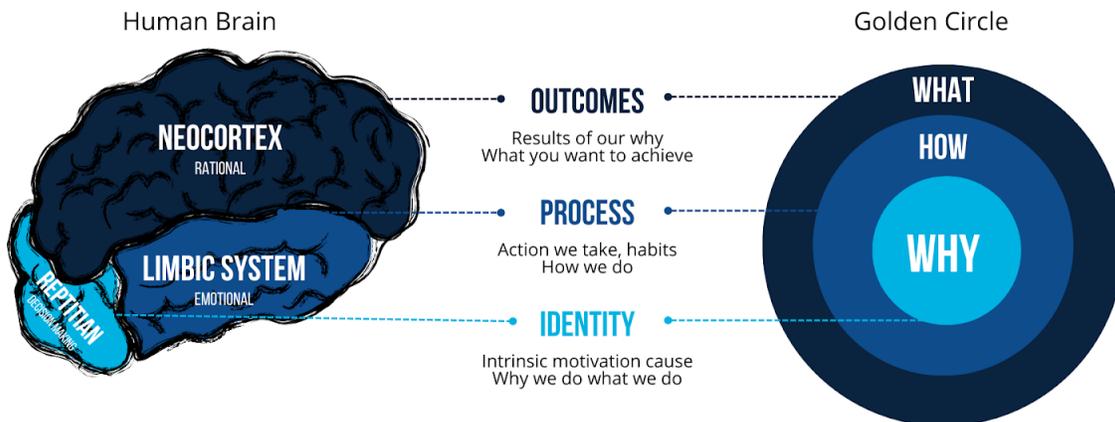
Disclosures

- None

3

THE GOLDEN CIRCLE AND THE BRAIN

As explained by Simon Sinek



4

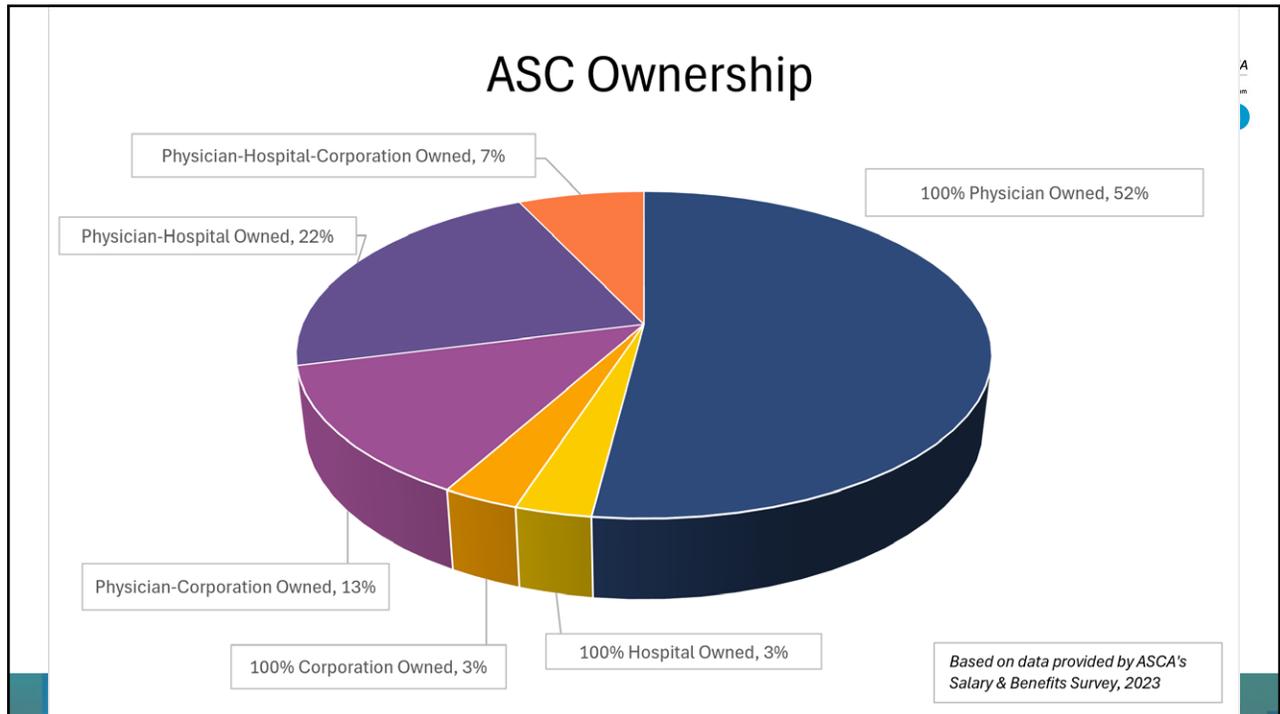


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WAIT BUT WHY

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Recently added procedures

In 2022, CMS approved four procedures for the ASC setting:

- 19307 Modified Radical Mastectomy
- 38531 Open BX/EXC Inguinofemoral Node Biopsy
- 37193 Retrieval of Intravascular Vena Cava Filter
- 43774 Laparoscopic Gastric Band/Port Removal

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Fastest Growing Specialties

Specialties with highest increase in Medicare payments in 2022:

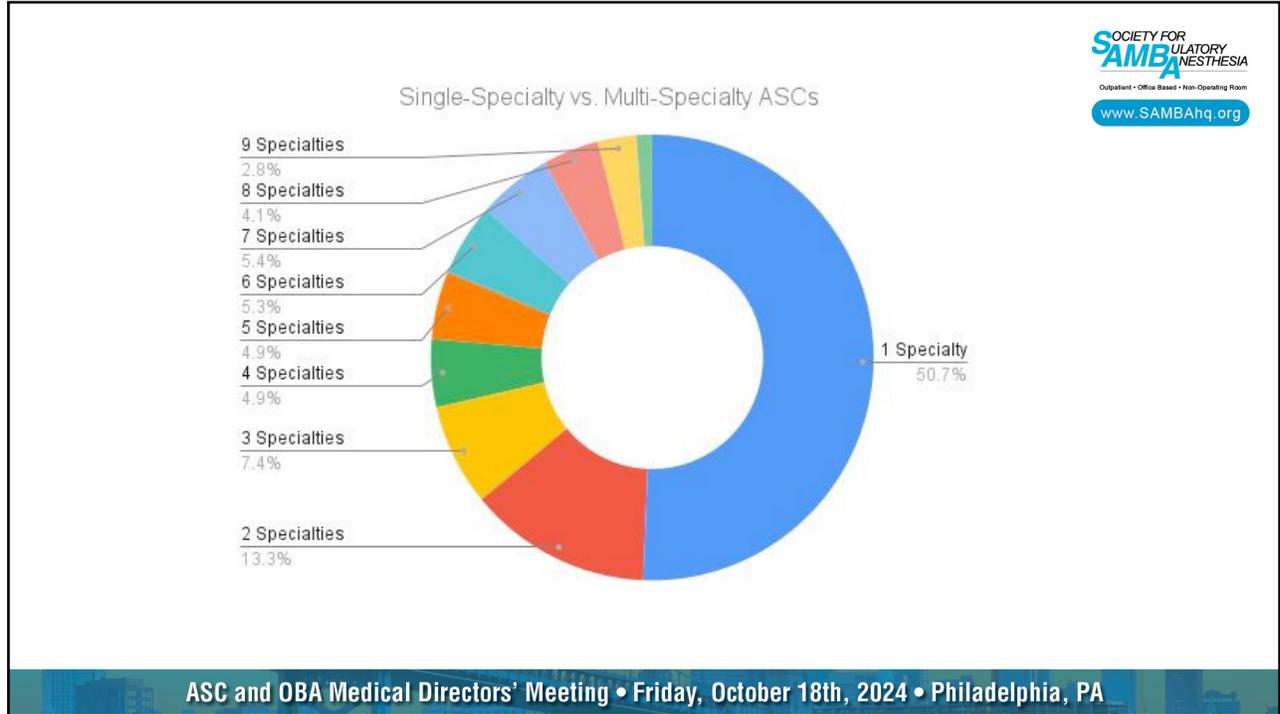
Cardiology
Musculoskeletal
Urology

Specialties with the highest anticipated facility growth in 2023-2024:

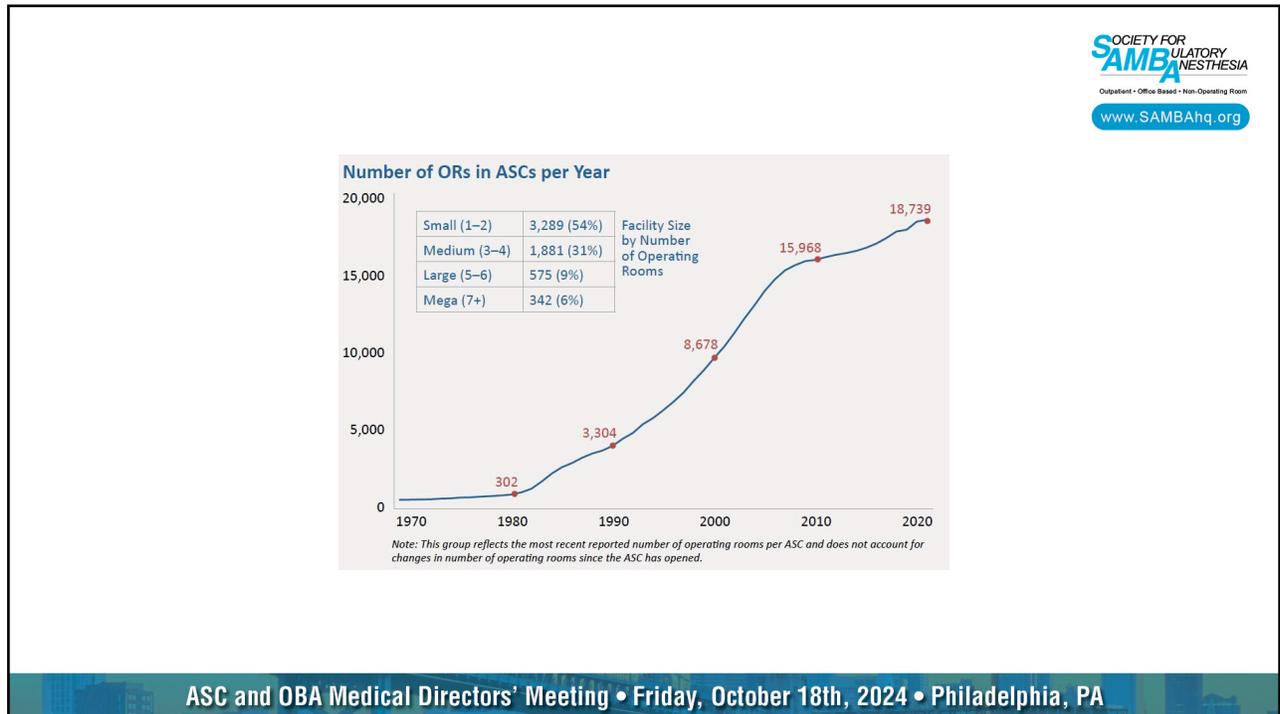
Orthopedics
Cardiovascular
Gastroenterology

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On average, Medicare reimburses ASCs **58%** of the rate it reimburses HOPDs

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Procedure	Facility Price	Doctor Price	Percentage Difference
Colonoscopy with biopsy (45380)	\$1,766	\$1,089	-38%
Cataract removal (66984)	\$3,727	\$2,410	-35%
Hernia repair (49505)	\$5,228	\$3,003	-43%
Knee arthroscopy (29881)	\$4,665	\$2,772	-41%
Ear tube insertion (69436)	\$2,262	\$1,223	-46%

Source: Mathematica's payer price analytic database.

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HOW? **HOW?** **HOW?**

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S STRENGTHS **W** WEAKNESSES Where do you need to improve?

O OPPORTUNITIES **T** THREATS What obstacles do you face?

What do you do well? What are your goals?

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Which service line?

- Procedure list
- Reimbursement
- Complementary
- Landscape

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SWOT analysis

Below is the analysis conducted by Marlon Hospital before adding a bariatric service line.

Strengths	Weaknesses	Threats	Opportunities
<ul style="list-style-type: none"> *Highly engaged workforce *Availability of resources *Skilled surgical services team *Senior administration support 	<ul style="list-style-type: none"> *Need additional surgeons *Lack of dedicated bariatric rooms, equipment, focus *Lack of growth readiness 	<ul style="list-style-type: none"> *Aggressive competitors performing bariatric surgeries *Savvy bariatric patients who do their homework on surgeon, procedure, and hospital selection *New ambulatory competition *Hospital mergers *Innovative payment models 	<ul style="list-style-type: none"> *Hospital's current lack of market share *Morbidity on the rise nationally *Accreditation *Expansion of existing service lines *Expansion of reputation

Source: Tammy Huster, MBA, MAS, BSN, RN, NE-BC. Used with permission.

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SWOT analysis

Strengths	Weaknesses	Opportunities	Threats
New high volume surgeon Growing need for procedure Favorable reimbursements Skilled surgical team Administrative support Patient population ideal for outpatient surgery	Lack of surgeon OR size Equipment acquisition Ancillary services Staff training	Market share Community needs Growth and expansion Enhancing reputation Referral base increase	ROI Patient suitability Regulatory burden Equipment costs Training costs Local competition Payment models Poor outcomes

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Six Areas for Consideration



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Finances

Patient

Emergency

Physician

Equipment

Regulations

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Business plan

- A clear business plan can help break down the task into parallel processes.

Key stakeholders

- Involve key stakeholders from the outset, such as service line coordinators, the chief financial officer, and leaders from the OR and inpatient units.

Feasibility study

- If the new service line requires significant capital costs, a feasibility study is needed to assess capital, supply, and staff needs.

Market analysis

- Consider how well the new service will fit within your market, and if there's enough patient volume to support it.

Partnering with surgeons

- Surgeons can be a valuable resource in building your business, and doctor-to-doctor recruiting can be especially effective.

State rules

- Consider state rules to ensure that the procedures you want to offer can be performed at your ASC.

Equipment and space

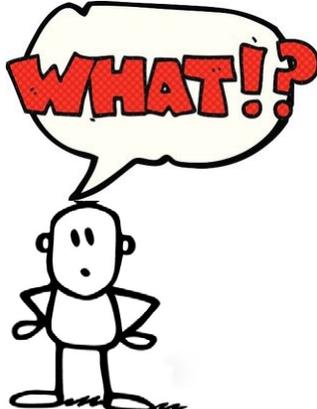
- Equipment and space requirements can be extensive, and capital equipment and supplies can cost upwards of \$1 million.

Marketing

- Develop a target list of other physicians in your specialty and regularly market your center to them.

Return on investment

Expenditure	Revenue
Equipment	Case Volume
Implants	Revenue per case
Staff	Total revenue is the product of the above
Supplies	
Maintenance	
Divide the total cost per year by the revenue per year to determine the time to recoup equipment costs	



A cartoon drawing of a stick figure with a speech bubble above its head that says "WHAT!?" in large, bold, red letters. The figure has a simple, minimalist design with a round head, two dots for eyes, and a small smile. The speech bubble is yellow with a black outline and contains the text in a bold, sans-serif font.

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Checklist

- Regulatory compliance
- Contracts
- Equipment/Pharmaceuticals
- Infrastructure
- Training for staff
- QAPI including benchmarks
- Credentialing and privileging
- Transfer agreement

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Patient care



- Patient selection
- Enhanced recovery pathways
- Evidence based guidelines and best practices
- Proctoring program
- Discharge protocols

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Pearls



- You don't want to be the last ASC adding a new service line.
- If you don't have a reimbursement plan, you don't have a growth plan.
- Don't forget SPD
- Renegotiate contracts
- Budget for ramp up
- Prepare for drop in utilization
- Should not disrupt existing patient care

ASC and OBA Medical Directors' Meeting • Friday, October 18th, 2024 • Philadelphia, PA

24

Be a part of the fastest growing sub-specialty in clinical anesthesia practice, network with your peers and expand your expertise.



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HANDOUT

AI and the ASC Medical Director Getting Practical: How to go about Incorporating AI in your ASC Business?

Piyush Mathur MD, FCCM, FASA, FAMIA

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ASC and OBA Medical Directors' Meeting Friday, October 18th, 2024 • Philadelphia, PA

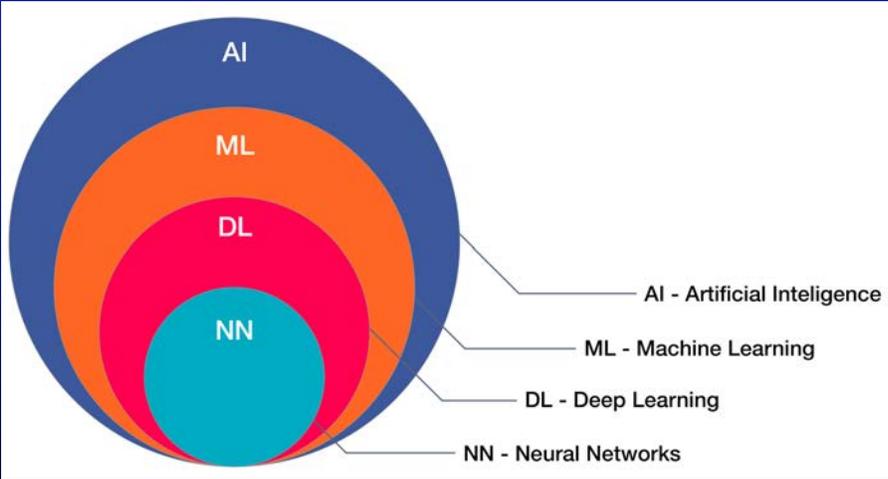
Getting Practical: How to go about Incorporating AI in your ASC Business?



Piyush Mathur MD, FCCM, FASA
Anesthesiologist & Intensivist
Innovation Lead
Department of Anesthesiology
Cleveland Clinic
Co-Founder, BrainX

1

Artificial Intelligence and deeper



AI - Artificial Intelligence
ML - Machine Learning
DL - Deep Learning
NN - Neural Networks

2

ChatGPT: What is Anesthesia?

P What is anesthesia?

G Anesthesia refers to the administration of drugs or techniques to induce a temporary state of unconsciousness, loss of sensation, or analgesia (pain relief) during medical procedures. Its primary goal is to ensure patient comfort and safety during surgical or diagnostic interventions. Anesthesia allows for painless surgery, minimizes patient movement, and helps control vital functions such as heart rate, blood pressure, and breathing.

Anesthesia can be administered in various forms, including:

1. General Anesthesia: This type of anesthesia renders the patient completely unconscious and eliminates all sensation and awareness. It involves the use of intravenous drugs and inhaled

Anesthesia is typically administered by an anesthesiologist, a medical doctor specializing in anesthesia, or by a certified registered nurse anesthetist (CRNA) under the supervision of a physician. These professionals carefully monitor the patient's vital signs and adjust the anesthesia dosage throughout the procedure to maintain the desired level of unconsciousness and pain control. After the procedure, the anesthesia is gradually discontinued, allowing the patient to wake up and recover.

spinal cord, numbing a larger area of the body. Epidurals are commonly used during childbirth to relieve pain in the lower body.

3

Instruct GPT: Reinforcement learning

Prompts Dataset

Sample many prompts

Initial Language Model

Train on (sample, reward) pairs

Reward (Preference) Model

π_{θ}

r_{θ}

Generated text

Human Scoring

Outputs are ranked (relative, FLO, etc.)

Reinforcement learning (RL). Once again following Stiennon et al. (2020), we fine-tuned the SFT model on our environment using PPO (Schulman et al., 2017). The environment is a batch environment which presents a random customer prompt and expects a response to the prompt. Given the prompt and response, it produces a reward determined by the reward model and ends the episode. In addition, we add a per-token KL penalty from the SFT model at each token to mitigate over-optimization of the reward model. The value function is initialized from the RM. We call these models "PPO."

We also experiment with mixing the pretraining gradients into the PPO gradients, in order to fix the performance regressions on public NLP datasets. We call these models "PPO-ptx." We maximize the following combined objective function in RL training:

$$\text{objective}(\theta) = E_{x \sim \pi_{\theta}} [r(x, y) - \beta \log(\pi_{\theta}^{\text{SFT}}(y | x) / \pi_{\theta}^{\text{PPO}}(y | x))] + \gamma E_{x \sim \pi_{\theta}} [\log(\pi_{\theta}^{\text{RM}}(x))] \quad (2)$$

where $\pi_{\theta}^{\text{SFT}}$ is the learned RL policy, $\pi_{\theta}^{\text{PPO}}$ is the supervised trained model, and $D_{\text{KL}}(\pi_{\theta}^{\text{SFT}} \| \pi_{\theta}^{\text{SFT}})$ is the pretraining distribution. The KL reward coefficient, β , and the pretraining loss coefficient, γ , control the strength of the KL penalty and pretraining gradients respectively. For "PPO" models, γ is set to 0. Unless otherwise specified, in this paper InstructGPT refers to the PPO-ptx models.

Baselines. We compare the performance of our PPO models to our SFT models and GPT-3. We also compare to GPT-3 when it is provided a few-shot prefix to "prompt" it into an instruction-following mode (GPT-3 prompts). This prefix is prepended to the user-specified instructions.

We additionally compare InstructGPT to fine-tuning 175B GPT-3 on the FLAN (Wei et al., 2021) and TO (Sesh et al., 2021) datasets, which both consist of a variety of NLP tasks, combined with natural language instructions for each task (the datasets differ in the NLP datasets included, and the style of instructions used). We fine-tune them on approximately 1 million examples respectively and choose the checkpoint which obtains the highest reward model score on the validation set. See Appendix C for more training details.

arXiv:2203.02155

4

AI based research in healthcare

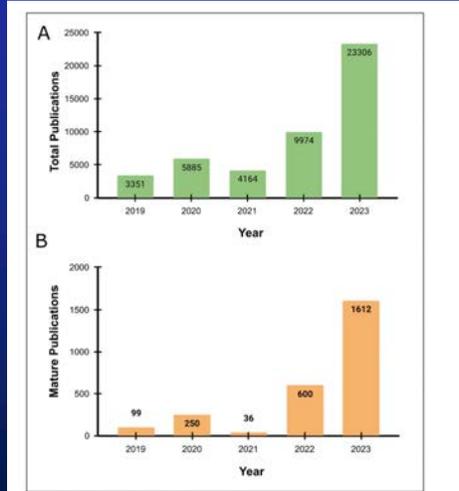
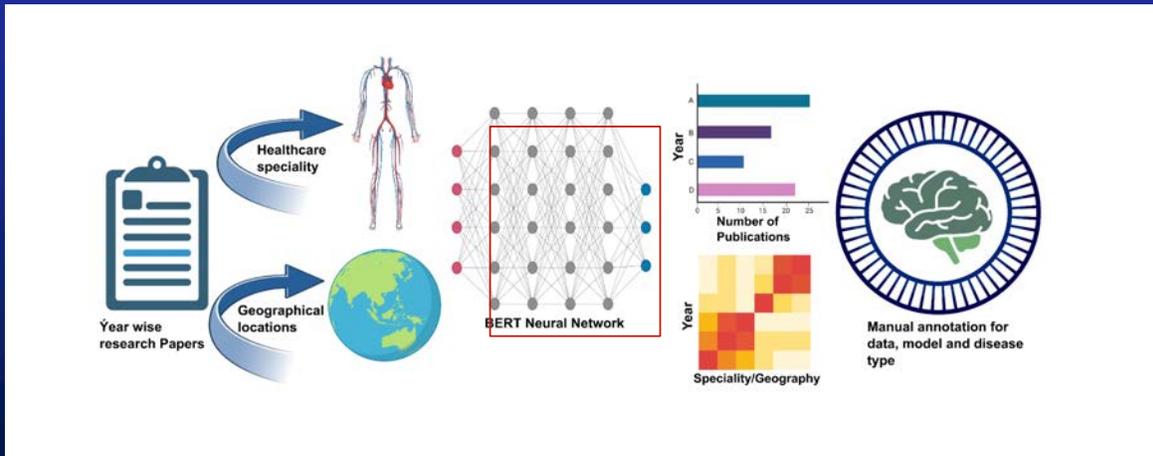


Figure 2: A) Bar plot showing the total number of publications from 2019-2023. B) Bar plot showing the number of mature publications from 2019-2023.

Awasthi, R., et al. (2024). "Artificial Intelligence in Healthcare: 2023 Year in Review." [medRxiv. 2024.02.02.2028.24303482](https://doi.org/10.1101/2024.02.02.2028.24303482).

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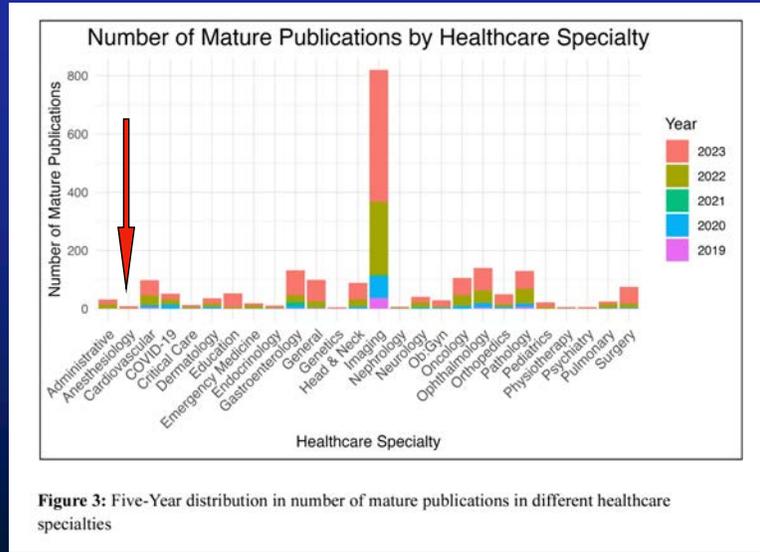
Using AI to assess AI based publications for maturity



Awasthi R, et al. Quantitative and Qualitative evaluation of the recent Artificial Intelligence in Healthcare publications using Deep-Learning. medRxiv. 2023:2022.12.31.22284092.

6

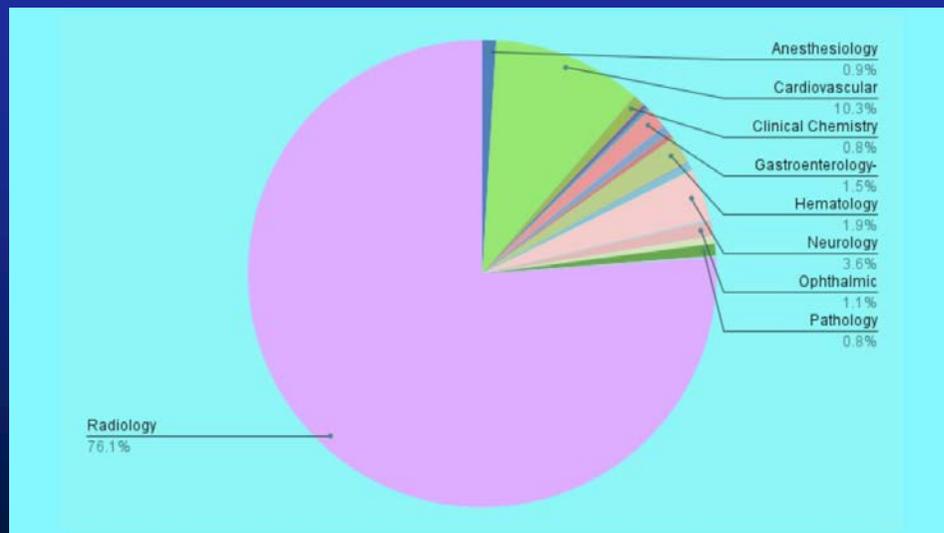
AI publications (mature) in healthcare per speciality



Awaathi, R., et al. (2024). "Artificial Intelligence in Healthcare: 2023 Year in Review." [medRxiv.2024.2002.2028.24303482](https://doi.org/10.2196/medRxiv.2024.2002.2028.24303482).

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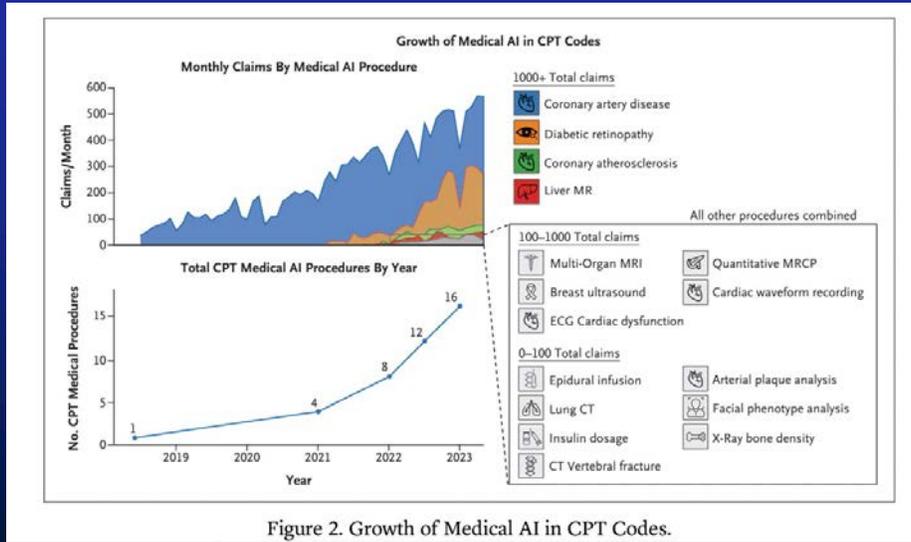
950 FDA approved AI algorithms



Source: Margareta Colangelo and Lambert Leong

8

AI examples from the real world



Characterizing the Clinical Adoption of Medical AI Devices through U.S. Insurance Claims. [Kevin Wu, M.D., NEJM AI 2023;1\(1\)](https://doi.org/10.1093/aje/kwz111)

9

What are the patients asking for?

- **80%** Americans believe that AI had the potential to improve care
- **25%** Americans are more likely to talk to an AI chatbot instead of attending a therapy
- **25%** would not visit a healthcare provider who refuses to embrace AI

<https://www.medicaleconomics.com/view/ai-special-report-what-patients-and-doctors-really-think-about-ai-in-health-care>

10

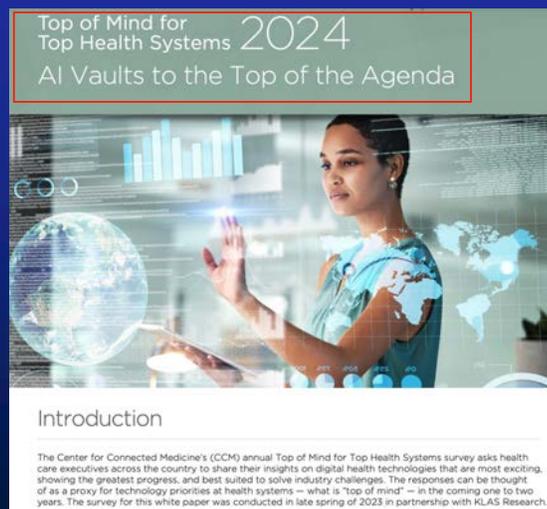
What are the clinicians asking for?

- **10%** healthcare professionals use AI technologies
- **50%** expressed interest to adopt it in future
- **95%** have a positive perspective

<https://www.medicaleconomics.com/view/ai-special-report-what-patients-and-doctors-really-think-about-ai-in-health-care>

11

What are the healthcare executives planning for?



https://info.connectedmed.com/l/689353/2023-08-30/2ld521/689353/1693403930sCnDbt8/Top_Of_Mind_For_Top_Health_Systems_2024_CCM_Reports.pdf

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10 key opportunities for AI applications in an ASC



1. Schedule the appointment
2. Review of records
3. Assess the patient
4. Evaluate the options
5. Discuss the options with the patient
6. Order tests or assist with procedures
7. Generate diagnosis
8. Document the conversation
9. Provide patient with education
10. Communicate with all the teams

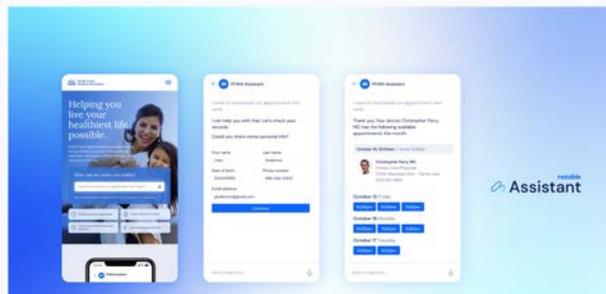
<https://www.aha.org/aha-center-health-innovation-market-scan/2024-01-16-5-ways-hospitals-can-integrate-ai-and-automation-surgical-care>

13

AI assisted appointment scheduling

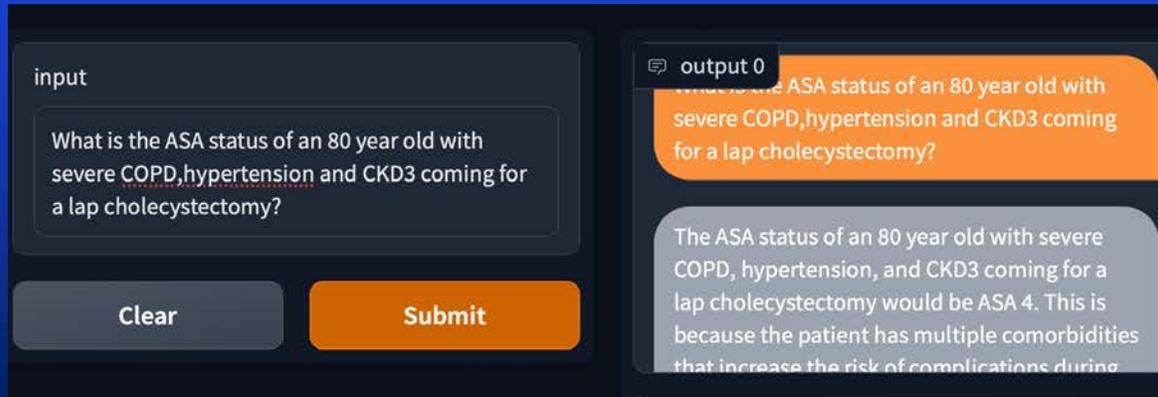
Introducing Notable Assistant, a ChatGPT-like innovation that patients can use to manage everything from appointment scheduling to bill payments

Notable Assistant makes it easy for health systems to rapidly deliver concierge care for every patient



14

ChatGPT Diagnose: Tell me the ASA score



Turan EI, et al. Evaluating the accuracy of ChatGPT-4 in predicting ASA scores: A prospective multicentric study ChatGPT-4 in ASA score prediction. J Clin Anesth. 2024 PMID: 38657530.

15

Review of literature or patient information

```

1 ## Llama QA for the first question
2 question = examples["input"][0]
3 print(question)
4 print("")
5 print("Correct answer:", examples["output"][0])
6 print("")
7 vectordb.max_marginal_relevance_search(question, k = CFG.k)

Q: A 23-year-old pregnant woman at 22 weeks gestation presents with burning upon urination. She states it started 1 day ago and has been worsening desp
('A': 'Ampicillin', 'B': 'Ceftriaxone', 'C': 'Ciprofloxacin', 'D': 'Doxycycline', 'E': 'Nitrofurantoin'),

Correct answer: E: Nitrofurantoin

[Document(page_content='by progesterational effects on ureteral and bladder smooth muscle and later in pregnancy due to compression effects of the
enlarging uterus. In itself, this condition is not associated with an adverse outcome of pregnancy. However, if asymptomatic bacteriuria is left
untreated, symptomatic pyelonephritis may occur. Indeed, ~75% of pregnancy-associated pyelonephritis cases are the result of untreated asymptomatic
bacteriuria. All pregnant women should be screened with a urine culture for asymptomatic bacteriuria at the first prenatal visit. Subsequent screening
with nitrite/leukocyte esterase strips is indicated for high-risk women, such as those with sickle cell trait or a history of urinary tract
infections. All women with positive screens should be treated. Pregnant women who develop pyelonephritis need careful monitoring, including inpatient
IV antibiotic administration due to the elevated risk of urosepsis and acute respiratory distress syndrome in pregnancy. Abdominal pain and fever
during pregnancy create a clinical dilemma. The diagnosis of greatest concern is intrauterine amniotic infection. While amniotic infection most
commonly follows rupture of the membranes, this is not always the case. In general, antibiotic therapy is not recommended as a temporizing measure in
these circumstances. If intrauterine infection is suspected, induced delivery with concomitant antibiotic therapy is generally indicated. Intrauterine
amniotic infection is most often caused by pathogens such as Escherichia coli and group B Streptococcus (GBS). In high-risk patients at term or in
preterm patients, routine intrapartum prophylaxis of GBS disease is recommended. Penicillin G and ampicillin are the drugs of choice. In penicillin-
allergic patients with a low risk of anaphylaxis, cefazolin is recommended. If the patient is at high risk of anaphylaxis, vancomycin is recommended.
If the organism is known to be sensitive to clindamycin, this antibiotic may be used. For the reduction of neonatal morbidity due to GBS, universal
screening of pregnant women for GBS between 35 and 37 weeks of gestation, with intrapartum antibiotic treatment of infected women, is
recommended. Postpartum infection is a significant cause of maternal morbidity and mortality. Postpartum endomyometritis is more common after cesarean
delivery than vaginal delivery and develops in 2% of women after elective repeat cesarean section and in up to 10% after emergency cesarean section
following prolonged labor. To reduce the risk of endomyometritis, prophylactic antibiotics should be given to all patients undergoing cesarean
section, and administration 30-60 min prior to skin incision is preferable to administration at the time of umbilical cord clamping. As most cases of
postpartum endomyometritis are polymicrobial, broad-spectrum antibiotic coverage with a penicillin, an aminoglycoside, and metronidazole is
recommended (Chap. 201). Most cases resolve within 72 h. Women who do not respond to antibiotic treatment for postpartum endomyometritis should be
evaluated for septic pelvic thrombophlebitis. Imaging studies may be helpful in establishing the diagnosis, which is primarily a clinical', metadata=
{'page': 139, 'source': '/content/drive/MyDrive/InternalMed_Harrison.pdf'})]

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{'page': 139, 'source': '/content/drive/MyDrive/InternalMed_Harrison.pdf'}}

16

Multimodal Machine Learning for Automated ICD Coding

Proceedings of Machine Learning Research 106:1-17, 2019

Keyang Xu¹, Mike Lam¹, Jingzhi Pang¹, Xin Gao¹, Charlotte Band¹,
Piyush Mathur MD², Frank Papay MD², Ashish K. Khanna MD², Jacek B. Cywinski MD²,
Kamal Maheshwari MD², Pengtao Xie¹, Eric Xing¹
¹Petuum Inc., Pittsburgh, Pennsylvania, USA
²Cleveland Clinic, Cleveland, Ohio USA

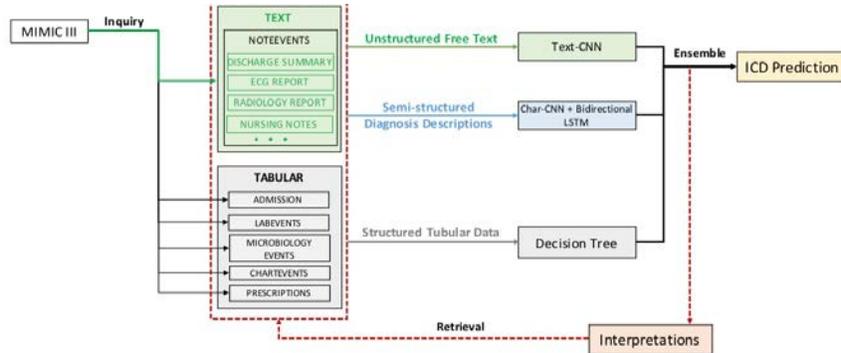


Fig. 1. Model architecture for ICD code prediction based on multimodal data, where each prediction is interpreted using retrieval-based methods.

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Automated echocardiography

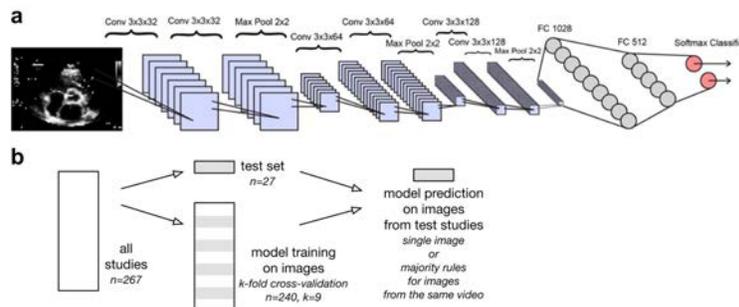


Fig. 1 Convolutional neural net architecture for image classification. **a** The neural network algorithm used for classification included six convolutional layers and two fully-connected layers of 1028 and 512 nodes, respectively. The softmax classifier (pink circles) consisted of up to 15 nodes, depending on the classification task at hand. **b** Training, validation, and test data were split by study, and test data was not used for training or validating the model. The model was trained to classify images, with video classification as a majority rules vote on related image frames. Conv convolutional layer, Max Pool max pooling layer, FC fully connected layer

npj Digital Medicine (2018) 6

Published in partnership with the Scripps Translational Science Institute

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Can algorithms democratize key skills?

Table 2. Comparison of Nurse-Acquired and Sonographer-Acquired Studies for Primary and Secondary Clinical Parameters^a

Image No.	Clinical parameter examined by qualitative visual assessment	No. (%) [95% CI]		Nurse-sonographer difference, percentage points
		Nurse examination	Sonographer examination	
1	Left ventricular size	232 (98.7) [96.3-99.7]	235 (100) [98.4-100.0]	-1.3
2	Global left ventricular function	232 (98.7) [96.3-99.7]	235 (100) [98.4-100.0]	-1.3
3	Right ventricular size	217 (92.3) [88.2-95.4]	226 (96.2) [92.9-98.2]	-3.9
4	Nontrivial pericardial effusion	232 (98.7) [96.3-99.7]	234 (99.6) [97.7-100.0]	-0.9
5	Right ventricular function	214 (91.1) [86.7-94.4]	226 (96.2) [92.9-98.2]	-5.1
6	Left atrial size	222 (94.5) [90.7-97.0]	234 (99.6) [97.7-100.0]	-5.1
7	Aortic valve	215 (91.5) [87.2-94.7]	228 (97.0) [94.0-98.8]	-5.5
8	Mitral valve	226 (96.2) [92.9-98.2]	233 (99.1) [97.0-99.9]	-2.9
9	Tricuspid valve	195 (83.0) [77.6-87.6]	217 (92.3) [88.2-95.4]	-9.3
10	Inferior vena cava size	135 (57.4) [50.9-63.9]	215 (91.5) [87.2-94.7]	-34.1

Narang A, Bae R, Hong H, et al. Utility of a Deep-Learning Algorithm to Guide Novices to Acquire Echocardiograms for Limited Diagnostic Use. *JAMA Cardiol.* 2021;6(6):624-632

19

ANESTHESIOLOGY

The Journal of the American Society of Anesthesiologists, Inc.

From: Machine-learning Algorithm to Predict Hypotension Based on High-fidelity Arterial Pressure Waveform Analysis
Anesthes. 2018;129(4):663-674. doi:10.1097/ALN.0000000000002300

Hypotension prediction
(minutes before event)

5 mins:0.95 AUC
10 mins:0.95 AUC
15 mins:0.97 AUC



Machine-learning Algorithm to Predict Hypotension Based on High-fidelity Arterial Pressure Waveform Analysis

Hypotension Prediction Index – Development, Validation, and Performance

The machine-learning algorithm was developed with two different data sources from surgical and intensive care unit patients:

	Number of arterial waveform recordings	Number of hypotensive events
Training cohort	1,334 intraoperative patient records	540,959
External validation cohort	224 postoperative records	33,234
		1,923

- The algorithm relates a large set of features calculated from the high-fidelity arterial pressure waveform to the prediction of an upcoming hypotensive event.
- Receiver-operating characteristic curve analysis evaluated the algorithm's success in predicting hypotension.

Algorithm prediction of hypotension based on 3,022 features per cardiac cycle

Minutes before event	Sensitivity	Specificity	Area under curve
15	0.95 (0.93-0.97)	0.75 (0.73-0.77)	0.93 (0.92-0.94)
10	0.95 (0.93-0.97)	0.75 (0.73-0.77)	0.93 (0.92-0.94)
5	0.97 (0.95-0.99)	0.75 (0.73-0.77)	0.97 (0.96-0.98)

A machine-learning algorithm can be trained with large data sets of high-fidelity arterial waveforms to predict hypotension in surgical patients' records.

Hartig F, et al. *ANESTHESIOLOGY*. October 2018.

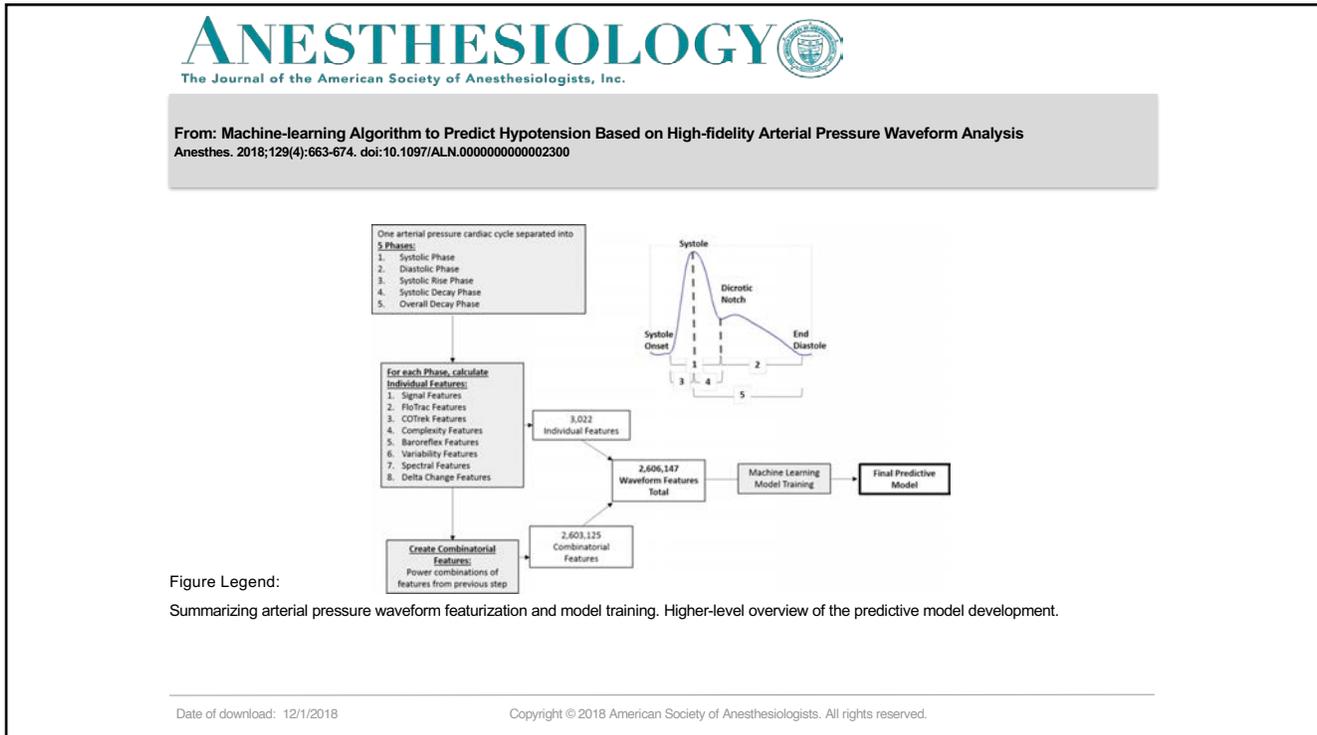
ANESTHESIOLOGY
The Journal of the American Society of Anesthesiologists, Inc. • www.anesthesiology.com

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Date of download: 12/1/2018

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Will clinicians follow algorithm's guidance?

Hypotension Prediction Index for Prevention of Hypotension during Moderate- to High-risk Noncardiac Surgery

A Pilot Randomized Trial

Kamal Maheshwari, M.D., M.P.H., Tetsuya Shimada, M.D., Ph.D., Dongsheng Yang, M.S., Sandeep Khanna, M.D., Jack B. Dwyanski, M.D., Samuel A. Inefin, M.D., Sabry Ayad, M.D., Alparslan Turan, M.D., Kurt Ruetzler, M.D., Yuwei Qiu, M.D., Partha Saha, M.D., Edward J. Mascha, Ph.D., Daniel I. Sessler, M.D.

ANESTHESIOLOGY 2020; 133:1214-22

EDITOR'S PERSPECTIVE

What We Already Know about This Topic

- Hypotension prediction algorithms commonly use arterial waveform features derived from arterial blood pressure monitoring. Whether they reduce the duration and severity of hypotension, especially in noncardiac surgery, is unknown.

What This Article Tells Us That Is New

ABSTRACT

Background: The Hypotension Prediction Index is a commercially available algorithm, based on arterial waveform features, that predicts hypotension defined as mean arterial pressure less than 65 mmHg for at least 1 min. We therefore tested the primary hypothesis that index guidance reduces the duration and severity of hypotension during noncardiac surgery.

Methods: We enrolled adults having moderate- or high-risk noncardiac surgery with invasive arterial pressure monitoring. Participating patients were randomized to hemodynamic management with or without index guidance. Clinicians caring for patients assigned to guidance were alerted when the index exceeded 85 (range, 0 to 100) and a treatment algorithm based on advanced hemodynamic parameters suggested vasopressor administration, fluid administration, inotrope administration, or observation. Primary outcome was the amount of hypotension, defined as time-weighted average mean arterial pressure less than 65 mmHg. Secondary outcomes were time-weighted mean pressures less than 60 and 55 mmHg.

Results: Among 214 enrolled patients, guidance was provided for 105 (49%) patients randomly assigned to the index guidance group. The median (first quartile, third quartile) time-weighted average mean arterial pressure less than 65 mmHg was 0.14 (0.03, 0.37) in guided patients versus 0.14 (0.03, 0.39) mmHg in unguided patients; median difference (95% CI) of 0 (-0.03 to 0.04), $P = 0.757$. Index guidance therefore did not reduce amount of hypotension less than 65 mmHg, nor did it reduce hypotension less than 60 or 55 mmHg. Post hoc, guidance was associated with less hypotension when analysis was restricted to episodes during which clinicians intervened.

Conclusions: In this pilot trial, index guidance did not reduce the amount of intraoperative hypotension. Half of the alerts were not followed by treatment, presumably due to short warning time, complex treatment algorithm, or clinicians ignoring the alert. In the future we plan to use a lower index alert threshold and a simpler treatment algorithm that emphasizes prompt treatment.

(ANESTHESIOLOGY 2020; 133:1214-22)

- Half of alerts were not followed by clinicians
- When intervened by clinicians, guidance associated hypotension was decreased

22

ANESTHESIOLOGY
Trusted Evidence: Discovery to Practice

From: Performance of the Hypotension Prediction Index May Be Overestimated Due to Selection Bias
Anesthesiology. 2022;137(3):283-289. doi:10.1097/ALN.0000000000004320

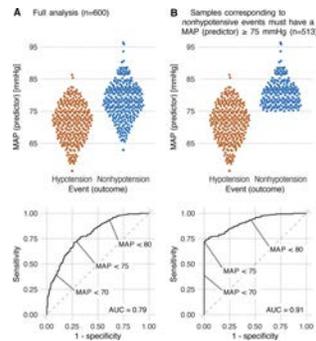


Figure Legend:

Simulation of the selection problem. Columns, A and B, illustrate different data selection strategies. Upper panels show simulated mean arterial pressure (MAP; mmHg) values for samples corresponding to hypotensive events and nonhypotensive events. Lower panels are receiver operating characteristics curves showing MAP's ability to discriminate hypotensive events from nonhypotensive events. The simulation is not an attempt to produce realistic data. It only serves to illustrate how the selection problem can result in a "skewed" receiver operating characteristics curve with very high specificity.

Date of download: 8/30/2022

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Evaluate the options

Journal of Clinical Monitoring and Computing
https://doi.org/10.1007/s10877-018-0200-x

ORIGINAL RESEARCH

Identify and monitor clinical variation using machine intelligence: a pilot in colorectal surgery

Kamal Maheshwari^{1,2} · Jacek Cywinski¹ · Piyush Mathur¹ · Kenneth C. Cummings III¹ · Rafi Avitsian¹ · Timothy Crone³ · David Liska⁴ · Francis X. Campion⁵ · Kurt Ruetzler^{1,2} · Andrea Kurz^{1,2}

Received: 12 February 2018 / Accepted: 17 September 2018
© Springer Nature B.V. 2018

Abstract
Standardized clinical pathways are useful tool to reduce variation in clinical management and may improve quality of care. However the evidence supporting a specific clinical pathway for a patient or patient population is often imperfect limiting adoption and efficacy of clinical pathway. Machine intelligence can potentially identify clinical variation and may provide useful insights to create and optimize clinical pathways. In this quality improvement project we analyzed the inpatient care of 1786 patients undergoing colorectal surgery from 2015 to 2016 across multiple Ohio hospitals in the Cleveland Clinic System. Data from four information subsystems was loaded in the Clinical Variation Management (CVM) application (Ayasdi, Inc., Menlo Park, CA). The CVM application uses machine intelligence and topological data analysis methods to identify groups of similar patients based on the treatment received. We defined "favorable performance" as groups with lower direct variable cost, lower length of stay, and lower 30-day readmissions. The software auto-generated 9 distinct groups of patients based on similarity analysis. Overall, favorable performance was seen with ketorolac use, lower intra-operative fluid use (< 2000 cc) and surgery for cancer. Multiple sub-groups were easily created and analyzed. Adherence reporting tools were easy to use enabling almost real time monitoring. Machine intelligence provided useful insights to create and monitor care pathways with several advantages over traditional analytic approaches including: (1) analysis across disparate data sets, (2) unsupervised discovery, (3) speed and auto-generation of clinical pathways, (4) ease of use by team members, and (5) adherence reporting.

Cohort analysis

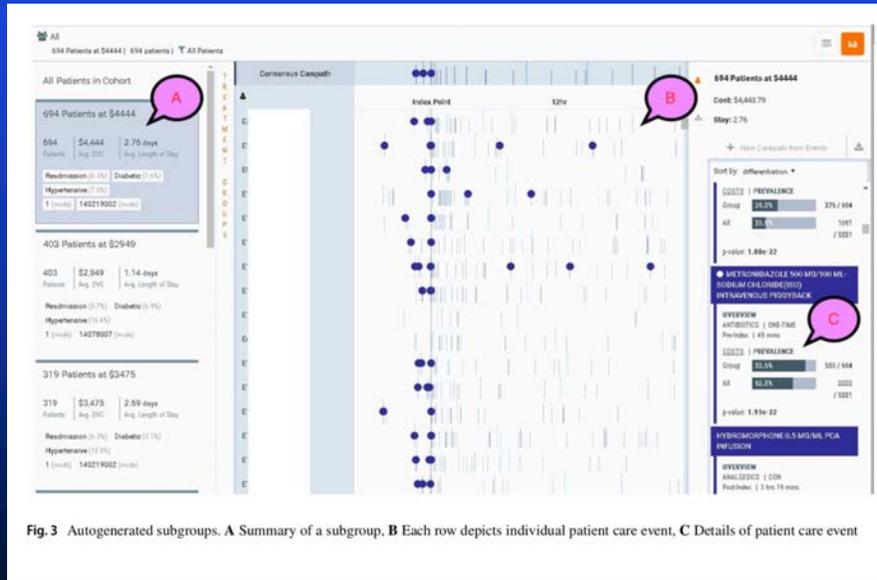


Fig. 3 Autogenerated subgroups. A Summary of a subgroup, B Each row depicts individual patient care event, C Details of patient care event

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AI Scribe



Radar Plot of Modified PDQI-9 (10 Domains) Based on Physicians' Review of Ambient Artificial Intelligence (AI) Scribe Transcripts and Notes

Our analysis of the quality of the ambient AI-generated summaries of the visit transcripts showed high levels of performance across all 10 of our metrics on a subsample of 35 randomly assessed notes across multiple clinical specialties. Our regional pilot phase suggests that using AI scribes resulted in high-quality — but not perfect — notes generated by the technology.



AI = artificial intelligence.
Source: The authors.
NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

Ambient Artificial Intelligence Scribes to Alleviate the Burden of Clinical Documentation. <https://doi.org/10.1056/CAT.23.0404>

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Discuss options with the patient

Key Points

Question Can an artificial intelligence chatbot assistant, provide responses to patient questions that are of comparable quality and empathy to those written by physicians?

Findings In this cross-sectional study of 195 randomly drawn patient questions from a social media forum, a team of licensed health care professionals compared physician's and chatbot's responses to patient's questions asked publicly on a public social media forum. The chatbot responses were preferred over physician responses and rated significantly higher for both quality and empathy.

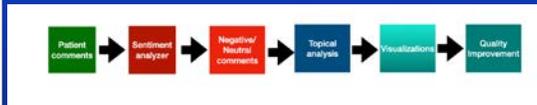
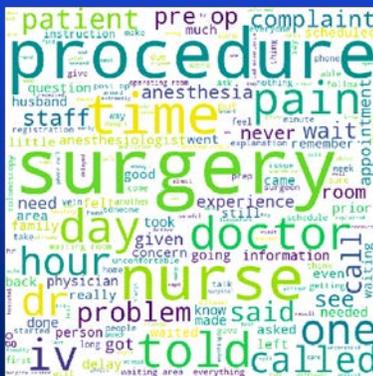
Meaning These results suggest that artificial intelligence assistants may be able to aid in drafting responses to patient questions.

liak A, Dredze M, et al. Comparing Physician and Artificial Intelligence Chatbot Responses to Patient Questions Posted to a Public Social Media Forum. *JAMA Intern Med.* 2023;18

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Can algorithms help us listen to our patients better? (15000+ comments analysis in less than one minute)



Topic	Related words*	Themes
1	room (0.029) surgery (0.025) hour (0.025) waiting (0.022) wait (0.019)	Wait times
2	area (0.046) waiting (0.030) staff (0.021) cold (0.019) professional (0.017)	Facilities
3	procedure (0.035) surgery (0.031) day (0.031) time (0.023) call (0.022)	Explanation
4	remember (0.029) surgery (0.019) am (0.014) dr (0.012) pm (0.012)	Doctor communication
5	desk (0.014) clinic (0.013) registration (0.012) experience (0.011) person (0.011)	Friendliness
6	nurse (0.034) iv (0.021) pain (0.020) procedure (0.016) surgery (0.012)	Pain control

Mathur, Piyush, et al. "Automated analysis of ambulatory surgery patient experience comments using artificial intelligence for quality improvement: A patient centered approach." *Intelligence-Based Medicine* (2021): 100043.

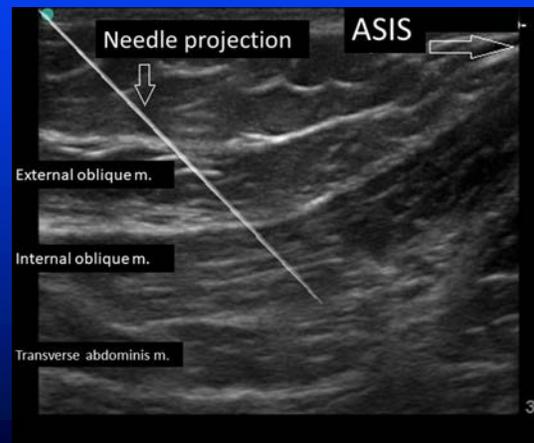
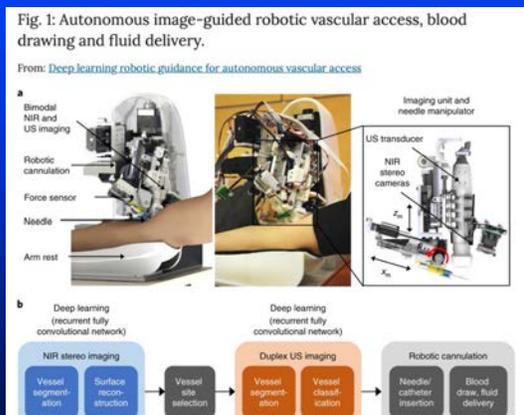
28

Communicate with all the teams

The image displays two overlapping screenshots. The background screenshot shows the MyChart patient portal interface with a list of active communications and a contact card for Stephanie McMahon, including her phone number (+1 (415) 123-4567), email (stephanie@gmail.com), and location (United States). The foreground screenshot shows the Rad AI Continuity interface, which features a section titled "Automate your patient follow-ups" and a "Closing the loop" button. The interface also displays a "Follow-up History" table with columns for High, PCP, and Exam status, and a "Report" section.

29

Can AI help do procedures more safely and effectively?



[Ultrasound Robotics, volume2, pages 104-115 \(2020\).](#)

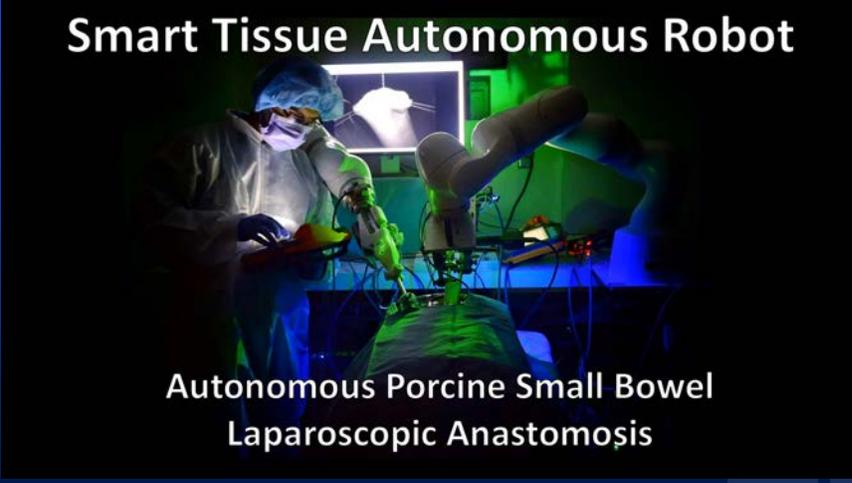
Jon D. Klingensmith, Asher L. Haggard, Jack T. Ralston, Beidi Qiang, Russell J. Fedewa, Hesham Elsharkawy, David G. Vince, "Tissue classification in intercostal and paravertebral ultrasound using spectral analysis of radiofrequency backscatter," *J. Med. Imag.* 6(4) 047001 (7 November 2019) <https://doi.org/10.1117/JMI.6.4.047001>

30



Imagine the future...

Smart Tissue Autonomous Robot



Autonomous Porcine Small Bowel Laparoscopic Anastomosis

Courtesy: Axel Krieger, PhD, JHU
 Source: <https://brainxai.org/connect/brainx-community-live-february-2022artificial-intelligence-and-robotics-in-surgery/>

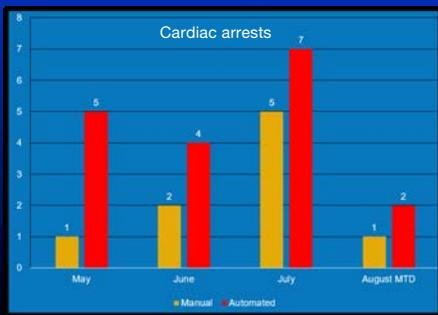
31

Can algorithms help improve safety event reporting?

Algorithms

Cardiac Arrest	Hypotension	Airway Event
<ul style="list-style-type: none"> 1mg epinephrine IV Text string search: ventricular fibrillation, V. fib, chest compressions, pulseless electrical activity, PEA, cardiac arrest 	<ul style="list-style-type: none"> Mean arterial pressure < 65mmHg for cumulative time >15 minutes for anesthetic time CMS QCDR approved metric 	<ul style="list-style-type: none"> Airway trauma Failed airway Esophageal intubation Laryngospasm Pneumothorax Bronchospasm Aspiration Unintended extubation

Results

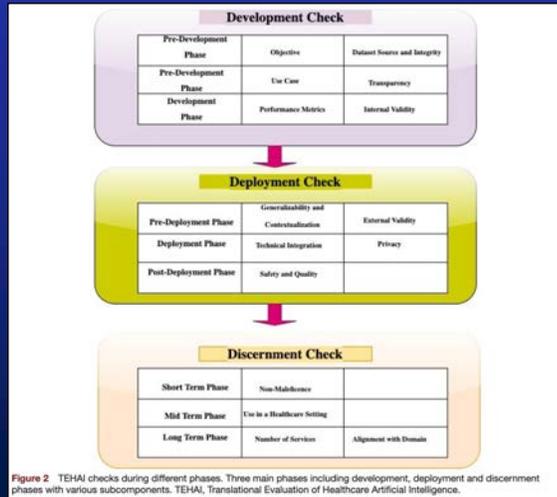


Month	Manual	Automated
May	1	5
June	2	4
July	5	7
August MTD	1	2

Unpublished data

32

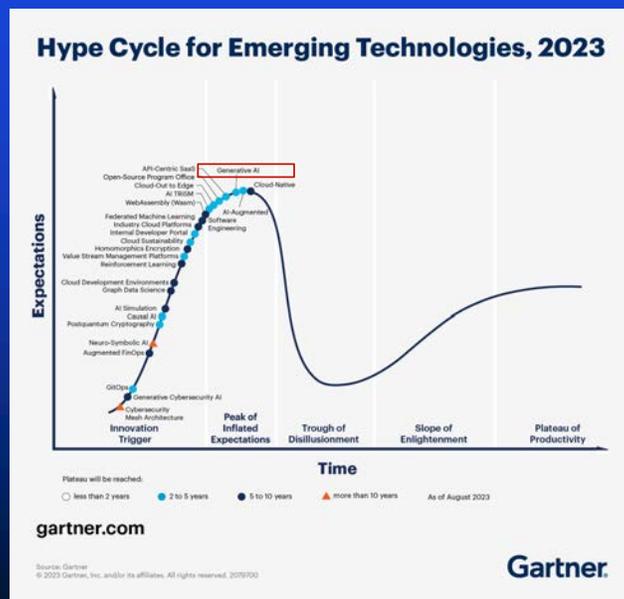
Evaluation framework - TEHAI



Reddy, Sandeep, et al. "Evaluation framework to guide implementation of AI systems into healthcare settings." *BMJ Health & Care Informatics* 28.1 (2021): e100444

33

Beware of the hype

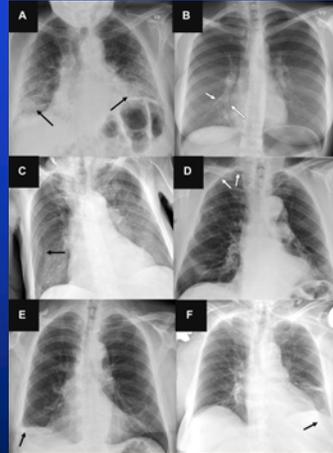


34

Does AI outperform radiologists?

“Current-generation AI tools showed moderate to high sensitivity for detecting airspace disease, pneumothorax, and pleural effusion on chest radiographs.

However, they produced more false-positive findings than radiology reports, and their performance decreased for smaller-sized target findings and when multiple findings were present.”



[Commercially Available Chest Radiograph AI Tools for Detecting Airspace Disease, Pneumothorax, and Pleural Effusion](#)
Louis Lind Plesner, et al. Radiology 2023 308:3

35

Will I lose my job?

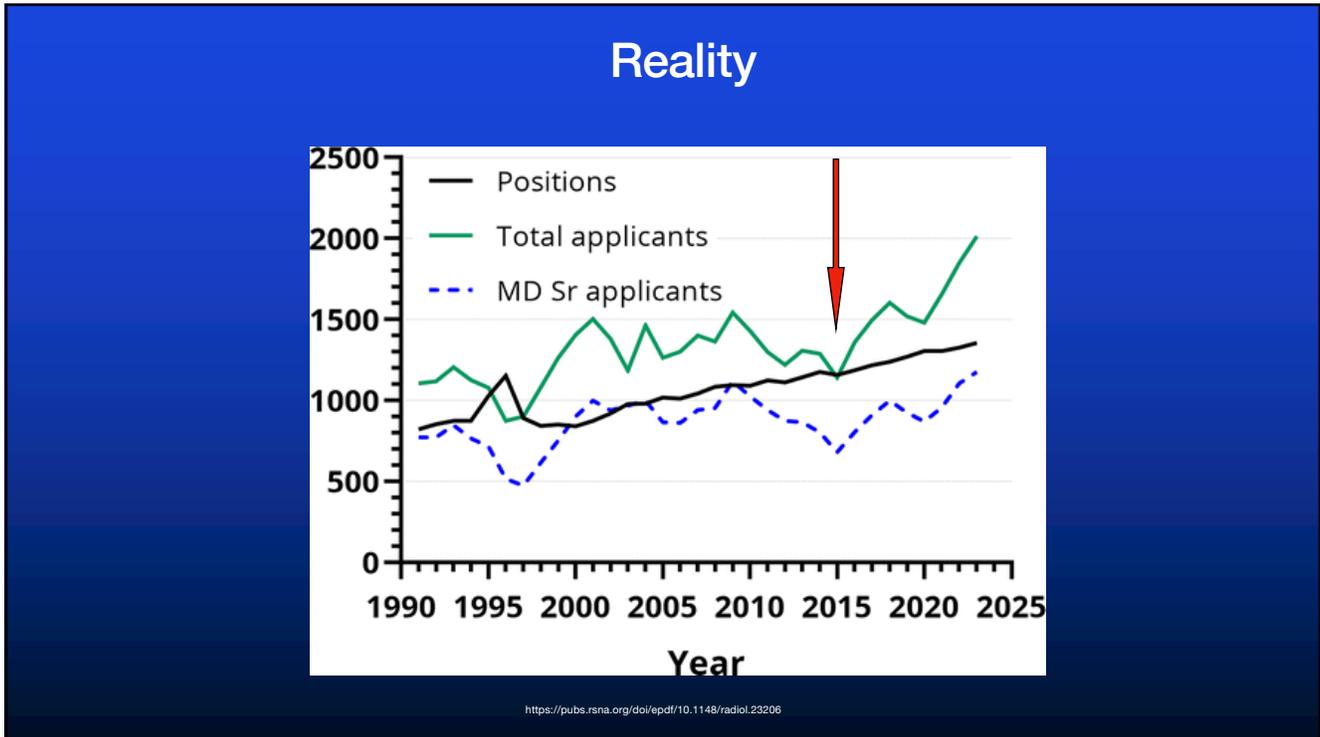
...ing radiologists now. It's just completely obvious that, within five years, deep learn

Geoffrey Hinton, British cognitive psychologist and “godfather” of AI (2016)



<https://www.politico.com/news/2022/08/15/artificial-intelligence-health-care-00051828>

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The opportunity

Research

“AI is the new electricity”
- Andrew Ng, Professor, Stanford

Market

“We need to build Energy companies” - Piyush Mathur

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Challenges

- Big data-segregated across hospitals
- Poor quality of data
- Regulatory concerns(HIPAA)
- Lack of knowledge
- Lack of unified approach
- Ethical and legal concerns



Nazer LH, Zatarah R, Waldrip S, et al. Bias in artificial intelligence algorithms and recommendations for mitigation. *PLoS Digit Health*. 2023;2(6):e0000278. Published 2023 Jun 22. doi:10.1371/journal.pdig.0000278

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Multimodal Future state

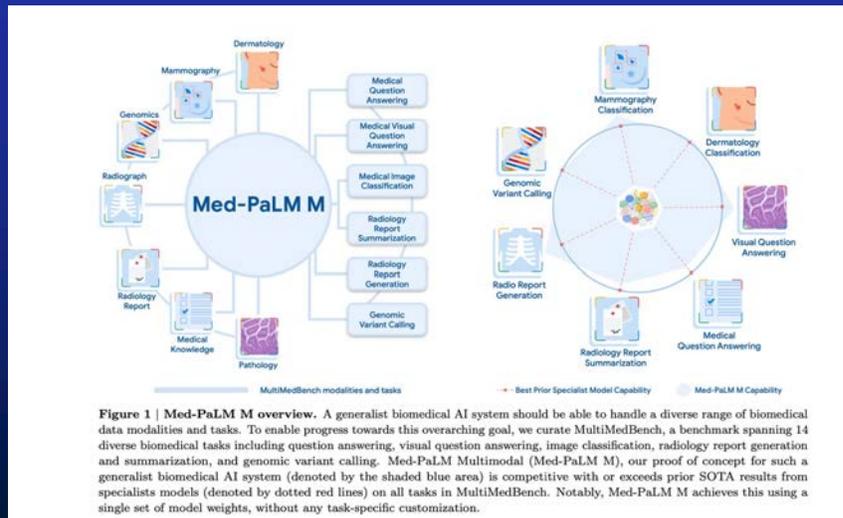
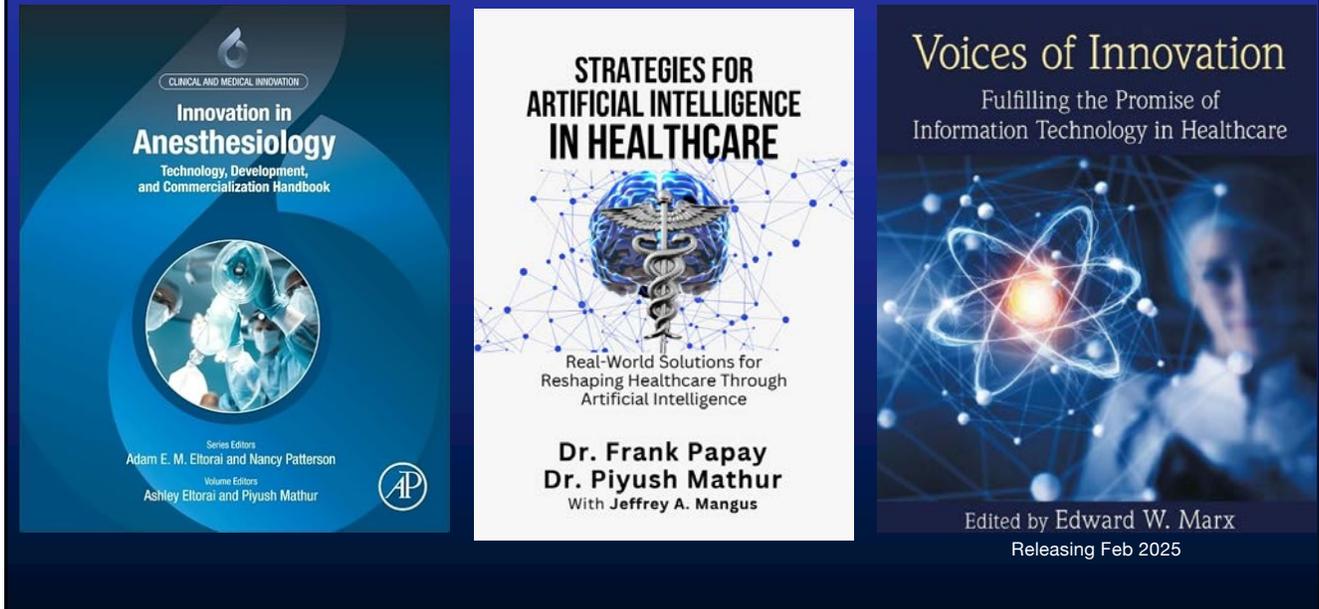


Figure 1 | Med-PaLM M overview. A generalist biomedical AI system should be able to handle a diverse range of biomedical data modalities and tasks. To enable progress towards this overarching goal, we curate MultiMedBench, a benchmark spanning 14 diverse biomedical tasks including question answering, visual question answering, image classification, radiology report generation and summarization, and genomic variant calling. Med-PaLM Multimodal (Med-PaLM M), our proof of concept for such a generalist biomedical AI system (denoted by the shaded blue area) is competitive with or exceeds prior SOTA results from specialists models (denoted by dotted red lines) on all tasks in MultiMedBench. Notably, Med-PaLM M achieves this using a single set of model weights, without any task-specific customization.

arXiv:2307.14334 (cs)

40

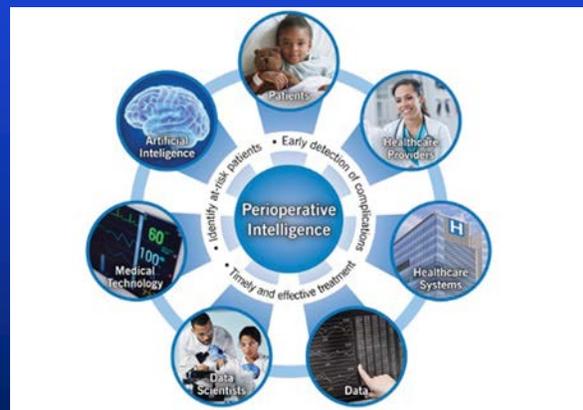
What you need is a strategy



41

Recommendations for adoption of AI

- Education
- Collaboration
- Data quality and access
- Algorithm validation
- AI Implementation
- Regulatory advocacy



Maheshwari, et al. Artificial Intelligence for Perioperative Medicine: Perioperative Intelligence. Anesthesia & Analgesia 136(4):p 637-645, April 2023.

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HANDOUT



Recruitment and Retention: Challenges in Hiring and Keeping the Right Team Members

Alan P. Marco, MD, MMM, CPE, FAAPL, SAMBA-F

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Recruitment and Retention

Alan P. Marco, MD, MMM, CPE FAAPL

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Disclosures

- I have no real or potential conflicts of interest to disclose.

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Learning Objectives



- At the conclusion of this session, the participant will be able to
 - List factors important to candidates during recruitment
 - Apply these factors when developing recruitment and retention strategies
 - Plan improved recruitment and retention processes

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3

Who Are You Recruiting?



- Physicians
 - Specialty?
- Advanced Practice Providers
- Nurses
- Medical Assistants
- Front Office
- Back Office

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Real costs of physician recruiting

- Salary
- Bonuses
- Benefits costs
- Health insurance
- Relocation costs
- Continuing medical education
- Trainings/onboarding
- Recruitment fees
 - Recruiter 15-30% or more of annual salary
- Attorneys' and accountants' fees
- Malpractice insurance
 - Anything in the history that would result in a surcharge?
- The interview process
- Office space (depending on subspecialty)
- Software, office and medical supplies
- Hidden costs
 - Lost referrals
 - Pain medicine vs ORs not covered
 - Gaps in patient care
 - Interrupted work flow
 - Low employee morale from high turnover

<https://www.healthcareers.com/employer-resources/physician-recruitment/the-real-costs-of-hiring-a-new-physician>
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Provider credentialing and privileging

- 7% say credentialing and privileging takes less than a month;
- 67% say it takes 1-3 months;
- 24% say it takes 4-6 months; and
- 2% say it takes six months or more.
- It takes an average of 120 days after acceptance to get a physician started

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Pay Transparency Laws

- Actualizing equal pay for equal work across genders, races, and nationalities is to pass laws requiring disclosure of pay scales
- California, Colorado, Connecticut, Maryland, Nevada, Rhode Island, and Washington.
- Cincinnati, Ohio, Westchester County, New York, Ithaca, New York, Jersey City, New Jersey, New York City, Toledo, OH
 - document retention obligations
 - pay equity reporting
 - requirements for equal pay regardless of gender.
- National Labor Relations Act (NLRA)
 - Covered employees have the right to communicate with their coworkers about their wages

<https://www.klgates.com/Help/Articles/What-Employers-Need-to-Know-About-Pay-Transparency-Requirements-in-Job-Postings-10-28-2022>

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Recruiting Strategies

- Treat candidates like customers
 - Be respectful of their time
 - Be hospitable
 - Make yourself available
- Use social media
- Utilizing Job Boards
- Implement an employee referral program
- Create compelling job descriptions
 - Make titles as specific as possible
 - Open with a captivating summary
 - Include the essentials: core responsibilities, hard and soft skills, day-to-day responsibilities
 - Highlight your culture
- Streamlining Your Hiring Process
- Consider past candidates
 - May be a better fit now

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Recruiting Strategies continued

- Industry networking
 - Professional society meetings, training programs
 - Building Partnerships
- Include peers in the interview process
- Participating in Recruitment Events
 - Build rapport with the closest residency and fellowship programs
 - offer career-focused guidance
 - career services at local colleges and universities
 - Connect with potential candidates
 - Identify new talent for open positions
 - Ensure access to a diverse pool of candidates
 - Establish a strong presence on college campuses
 - Enhance recruitment efforts

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Approaches to Improve Recruitment

- Use Data Driven Approaches
 - identify the most effective recruitment channels, such as job boards or social media platform
- Create a Targeted Candidate Pool
 - Analyze Previous Candidates: what motivates a physician to seriously consider your organization.
 - Segment and Target: Use data to segment your target candidate pool
 - Source of Hire Analysis: Analyze which recruitment channels and capture the % yield of each
- Identify Recruitment Bottlenecks and Process Inefficiencies
 - Collect and Organize Relevant Data: Gather data related to your organization's recruitment process.
 - Utilize Applicant Tracking Systems (ATS)
 - Identify Recruitment Bottlenecks
 - Feedback Analysis: Gather feedback from both successful recruits and those who didn't join your organization.

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Readiness of the Candidate

- Personal—such as feelings of anxiety or exclusion, and individual control around work.
- Workplace—such as company culture and management.
- Environmental—such as worries about flexible working/hybrid working, a lack of job opportunities, general health and safety (such as COVID–19) concerns, and the impact of automation on jobs.
 - For physicians, “wellness” and scope-of-practice expansion
- Organizations need to ensure younger employees are given opportunities to build stronger relationships with their managers, peers and employers
 - Mentoring of new graduates who have less clinical experience than decades ago
- One-on-one coaching is one way to bridge this confidence and readiness gap

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Use of AI in Recruiting

- Targeted Advertising:
 - can help physician recruiters create targeted advertisements to attract the right candidates.
- Candidate Screening:
 - can help recruiters screen candidates to identify the most qualified and suitable ones for the job.
 - can help recruiters identify candidates who may be a good fit for the job but may not have the exact experience or qualifications listed in the job description.
- Chatbot for Candidate Engagement:
 - can help physician recruiters create a chatbot that engages with candidates and answers their questions.
 - can help recruiters save time and resources by automating the candidate engagement process and ensuring that candidates have access to the information they need to make informed decisions about the job.
- Social Media Marketing:
 - can help physician recruiters create social media marketing campaigns
- Content Creation:
 - can help physician recruiters create relevant and engaging content for their recruitment marketing efforts...create blog posts or articles that provide insights into the job or industry trends

<https://www.practicenurse.com/employers/employee-assistance/recruitment-ai-desk-chatbot-for-physician-recruitment.cfm>

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AI Disruption in Recruiting

- use of AI to create resumes and have bots rapidly submit them, which has increased the number of resumes submitted
- use of AI in interviews — such as using technology to receive answers to questions in live time — has allowed unqualified candidates to be hired
- Make mandatory previously optional questions on applications, such as asking candidates to list why they are interested in the role.
- The ability to articulate in an interview your competencies and your skills still is what's driving a lot of hiring.
- Requiring candidates record a video answering preliminary questions to weed out applicants who might not actually be interested in the role.
- “... what is most important is what is someone looking for from a perspective of growth and development? Are they looking for an organization that's very mission driven?” Maria Zangardi, SVP HR, Universal Health Services

[https://www.beckershospitalreview.com/workforce/how-ai-is-disrupting-the-hiring-](https://www.beckershospitalreview.com/workforce/how-ai-is-disrupting-the-hiring-process.html)

[process.html](https://www.beckershospitalreview.com/workforce/how-ai-is-disrupting-the-hiring-process.html) | [https://www.beckershospitalreview.com/workforce/how-ai-is-disrupting-the-hiring-](https://www.beckershospitalreview.com/workforce/how-ai-is-disrupting-the-hiring-process.html)

13

AI Lowers the Cost of Entry for Candidates

- AI and virtual interviews have lowered the cost of applying to programs/jobs
 - This may be good or bad
 - Increased number of residency applications but not an increased number of interviews
 - Meyer AM, Hart AA, Keith JN. COVID-19 Increased Residency Applications and How Virtual Interviews Impacted Applicants. *Cureus*. 2022 Jun 19;14(6):e26096. doi: 10.7759/cureus.26096. PMID: 35875277; PMCID: PMC9298600.

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Lost Candidates

- Most smaller businesses are not prepared to move quickly
- If they don't offer the job fast enough, the candidates are snapped up by another employer.
- Do you wait for the ideal candidate or take the first one who fits your needs?

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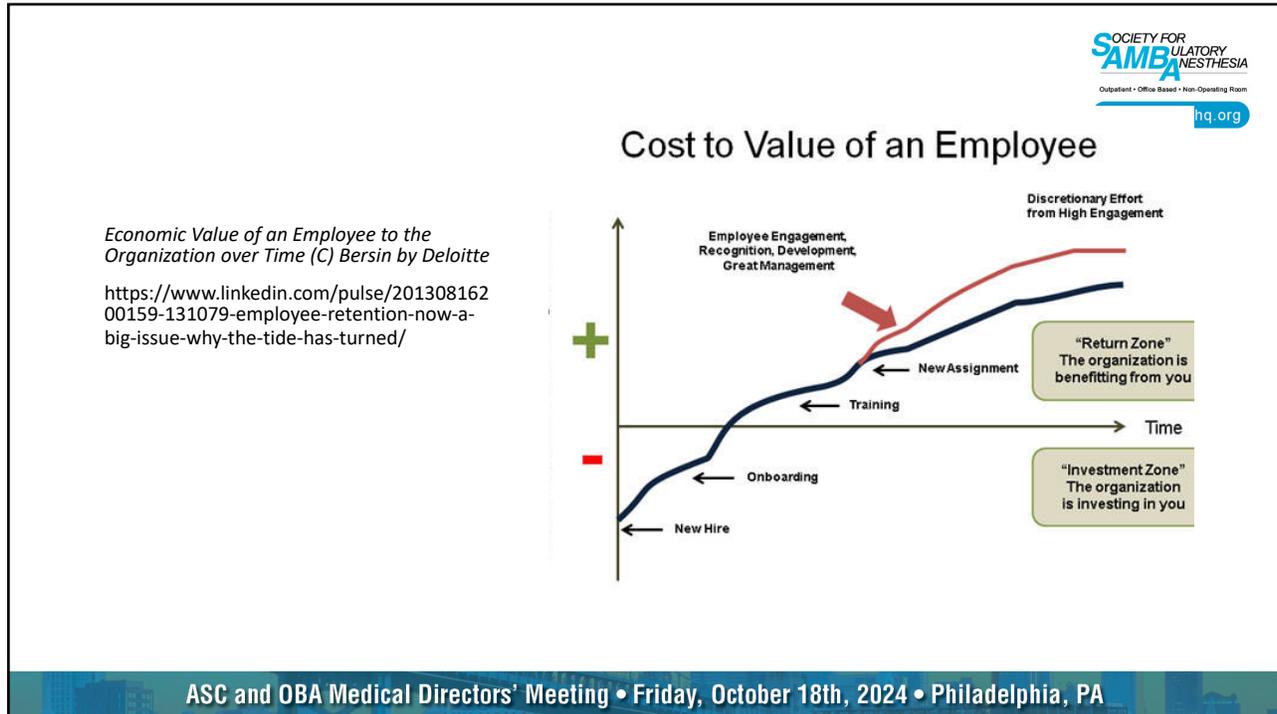
15

The Best Recruitment is Retention

- Make the job worth keeping
- Build retention into your recruiting strategy
- 50% of hourly employees quit before their 100-day anniversary. For non-hourly or salaried employees, it's 20%.
- (9%) leave because of money
 - <https://www.forbes.com/sites/shephyken/2023/07/09/beyond-money-the-real-reasons-employees-stay-or-leave/>

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- ## Top Reasons Why Employees Will Leave Their Jobs in 2024
1. Lack of career growth opportunities
 2. Inadequate compensation and benefits
 3. Issues with company culture
 4. Burnout, overworked, or overstressed
 5. Unhealthy work environment
 6. Insufficient recognition and appreciation
 7. Ineffective and poor leadership
 8. Lack of work-life balance
 9. Issues with commutes
 10. Absence of training and development
 11. Other "good" employees are leaving
 12. Organization's instability or restructuring
 13. Unfulfilled (or bored) in current role
 14. There's a change in their personal life
 15. They feel a lack of trust and independence
- <https://www.keystonepartners.com/resources/reasons-why-employees-leave/>
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Cost of Turnover

- The cost of replacing an employee = one-half to two times the annual salary
- Fifty-two percent of voluntarily exiting employees say their manager or organization could have done something to prevent them from leaving their job.
- Over half of exiting employees (51%) say that in the three months before they left, neither their manager nor any other leader spoke with them about their job satisfaction or future with the organization.
 - <https://www.gallup.com/workplace/247391/fixable-problem-costs-businesses-trillion.aspx>
- “the cost to train, credential, market and onboard a physician” at \$200,000 to \$300,000
 - Frenz DA. The staggering costs of physician turnover. Today’s Hospitalist. 2016
- voluntary turnover is highest during the first three years of a physician joining a practice, amounting to an aggregate turnover of 25 percent
 - <https://www.nejmcareercenter.org/minisites/rpt/physician-recruitment-trends-that-can-help-shape-a/>

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What Matters in Keeping Employees

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The New Focus in Recruiting

- Growth
- Impact
- Care

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Growth

- Growth is fundamental to human happiness
 - The hedonic treadmill - the observed tendency of humans to quickly return to a relatively stable level of happiness despite major positive or negative events or life changes.
- Younger workers are more easily able to prioritize things like personal growth and career opportunity over income and job security.
 - Have you had conversations with your employees about their long-term personal goals?
 - When a capable person on your team wants a role bigger than her past experience, do you give her a shot or do you simply hire someone with more experience?
 - When people need to acquire new skills to advance their careers, what do you do to help them?

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Impact



- People want to know that what their company is working on matters
 - For-profit vs Not-For-Profit
 - Payer mix (charitable care)

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Care



- creating a workplace that cares
- build a culture where people respect and appreciate each other
 - doesn't mean throwing around constant, meaningless praise
- surrounded by people who don't just want something out of them, but want something for them

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Physician Recruitment



- ranging from \$180,000 to \$250,000 and encompassing both direct and optional expenses
- replacing a physician can cost anywhere from \$1.8 million to \$2.8 million, depending on the specialty
 - <https://www.practicematch.com/employers/employer-resources/recruitment-articles/the-actual-cost-to-recruit-a-physician-in-2024.cfm#:~:text=The%20cost%20of%20recruiting%20a,both%20direct%20a,nd%20optional%20expenses.>

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Emotional Intelligence in Physician Recruitment



- Practice Active Listening
 - listening more than you are speaking which makes the other person feel as if you are fully engaged instead of simply waiting for an opportunity to reply.
- Study Body Language
 - Body language, facial expressions and tone of voice can reveal far more about what an individual is truly feeling.
- Trust Your Instinct
 - If something about their demeanor seems to be disconnected, trust your instincts.
- Empathy
 - taking an interest in other people. Build stronger, more meaningful relationships ... manifest a more authentic personality

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Emotional Intelligence in Physician Recruitment continued



- **Self-Awareness**
 - Be in touch with your own behavior
- **Welcome Constructive Criticism**
 - The ability to process and improve upon constructive criticism is indicative of an individual grounded in emotional intelligence
- **Accountability**
 - personal accountability allows for future correction of past mistakes
- **Source for Emotionally Intelligent Candidates**
 - Include key elements of emotional intelligence in the job description such as explaining your company culture and how it is based on compassion for patients or rooted in empathy.
 - observing the candidate outside of any professional setting such as how they interact with staff at a restaurant

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Physician Recruitment and Stark Law



- **Fair Market Value (FMV)**
 - compensation offered to physicians should reflect the fair market value for the services provided and must not exceed what is commercially reasonable.
- **Commercially Reasonable Terms:**
 - recruitment arrangements be commercially reasonable, taking into account the specific needs and circumstances of the healthcare organization.
 - recruitment incentives are justifiable from a business perspective.
- **Written Agreements:**
 - recruitment arrangement in writing.
 - services to be provided
 - compensation structure
- **Exemptions and Safe Harbors:**
 - certain exemptions and safe harbors that allow for specific financial relationships without violating the law.

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Attracting Top Talent

- An attractive salary
- Loan repayment incentives
- An equitable and sustainable workload
- Available access to community based colleagues and specialists for consultation
- Community educational opportunities for their children
- Local available opportunities for spousal employment
- Adequate clinical coverage and staffing
- Opportunities for professional development
- Practice autonomy
- Community need and appreciation for its healthcare providers
- Community activities and a more relaxed lifestyle

Mbemba, G. I. C., Gagnon, M., P., & Hamelin-Brabant, L. (2016). Factors Influencing Recruitment and Retention of Healthcare Workers in Rural and Remote Areas. *Journal of Rural Health*, 31(1), 1-10.

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What New Physicians Want

- Geographic location
- Call schedule
- Practice setting
- Compensation
- Professional growth/opportunities
- Spouse/family opportunities

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Rural vs. Urban

- 3% of “newly trained physicians prefer a community of 25,000 or less, while the majority (84%) prefer a community of 100,000 or more

https://www.ASCandOBAMedicalDirectorsMeetingFridayOctober18th2024PhiladelphiaPA

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Rural Recruiting

- nine in 10 physicians surveyed said they would consider a rural position
 - 64% higher compensation, bonuses and benefits;
 - 47% ability to work part-time or flexible hours;
 - 46% improved work/life balance;
 - 33% strong organizational culture;
 - 29% affordable cost of living;
 - 20% additional paid time off;
 - 18% offer of loan repayment;
 - 17% ability to use telehealth;
 - 15% to meet preferences of family/better place for children;
 - 15% ability to spend more time with patients;
 - 14% proximity to family/friends;
 - 14% increased access to hobbies/interests;
 - 10% leadership opportunities.
 - 10% nothing would prompt me to consider;

2022 Rural Physician Recruitment and Staffing Survey Results via Jackson Physician Search and LocumTenens.com

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Advocacy and Recruitment

- Impact of Residency Slot Limitations
 - stagnation in residency slots, primarily due to funding limitations
 - significant barrier to entry for new physicians
 - cap on federal funding for physician residency training programs since 1997
- The Resident Physician Shortage Reduction Act
 - Providing 14,000 new Medicare-supported GME positions over seven years
 - Increasing the number of trained physicians entering the workforce
 - Ultimately improving access to healthcare services across the country
- Proactive Measures for Recruitment
 - Engagement with educational institutions and advocacy for increased funding
 - work closely with policymakers to address the healthcare needs of the population.

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Some Strategies for Retention and Recruitment

- Offering flexible working conditions, such as
 - part-time positions and customizable schedules,
 - retain aging physicians
 - appealing to the new generation's work-life balance preferences.
- Embracing the Four-Day Workweek Trend
 - four-day workweek is gaining traction
 - improved work-life balance
 - increased productivity
 - enhances job satisfaction among healthcare providers
 - positions organizations as forward-thinking and adaptable employers.
 - promotes a culture of wellness and efficiency.

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The Essence of Personal Interaction

- Nothing beats the efficacy of direct communication
 - merit to be found in phone calls, video chats, and face-to-face meetings
 - one-to-one interactions significantly enhance candidate engagement
 - maximize any opportunity to be in front of your candidate audience.
 - specialty conferences and in-person career fairs to build valuable rapport in person
 - Host happy hours and cocktail parties before or after these events to maximize your time with your desired candidate audience.
- Getting in front of early-career residents and fellows
 - Residents and fellows remember who helped them.
 - career guidance, advice, and resources when it comes time to search for their first opportunity
 - didactic courses where you can offer education on career pathing, interviewing skills, CV writing, financial management, and any other topic you can gather expertise and create content on
 - Partner with local resume writers or financial planners if you need assistance developing content

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Retain Important Members of Your Team

- Functional hospital management and infrastructure support
- Access to social and professional networking opportunities
- Community safety
- Easy access to larger cities or attractions

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Getting Rid of Stupid Stuff

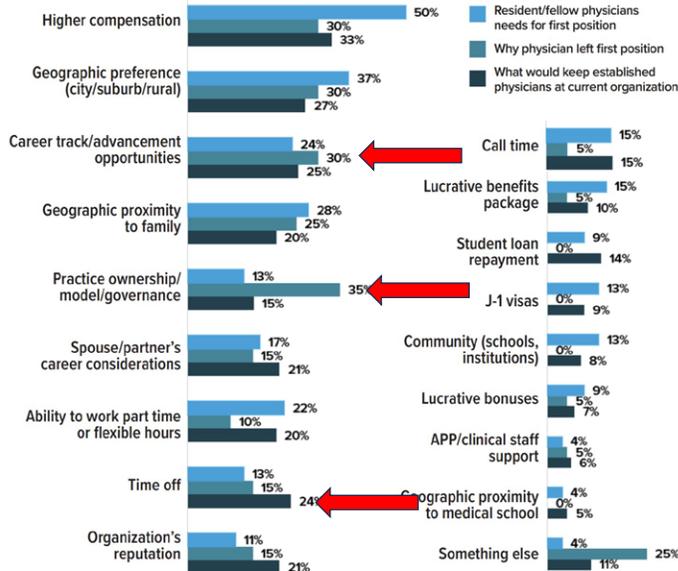
<https://edhub.ama-assn.org/steps-forward/module/2757858>

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Department	Role	Potential "Stupid Stuff" That Can Be Addressed
Information Technology (IT)	Design, build, and maintain/improve the EHR	EHR inefficiencies
Risk Management	Advocate for liability reduction	Processes implemented to mitigate risk that may be well-intentioned but not useful
Legal	Oversee compliance and risk management activity	Processes implemented to mitigate risk that may be well-intentioned but not useful
Compliance	Interpret regulatory requirements	Misunderstandings about regulatory requirements
Quality	Provide expertise on process improvement and understanding regulatory requirements	Misunderstandings about regulatory requirements
Health Information Management (HIM)	Provide information on documentation, coding requirements, and coding	Overinterpretation of requirements (especially HIPAA rules)
Revenue Cycle	Provide information on payer requirements	Misunderstandings about requirements for accurate billing
Mandatory education	Provide mandatory physician (and other clinician) training	Irrelevant training requirements
Nursing leadership	Represent nurses and provide expertise on nursing workflow	Documentation requirements that are variably determined by managers, rather than standardized. Documentation of nurse activities, rather than patient care provided.
Physician executive leadership	Represent physicians and provide expertise on physician workflow	Medical executive committee requirements that create extra work
Specific departmental leadership (eg, radiology, ER, hospitalist, OB/GYN, pediatrics, surgery, pharmacy)	Provide expertise on specialty-specific workflow	Specialty-specific requirements that create extra work (often thought to be necessary for that specialty, but may not actually be)
Laboratory services	Provide expertise on appropriate lab ordering practices	Unnecessary clicks to accomplish appropriate ordering

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TOP THREE FACTORS FOR PHYSICIANS LOOKING FOR THEIR FIRST JOB, WHEN LEAVING A FIRST POSITION, AND WHAT WOULD KEEP THEM AT THEIR CURRENT ORGANIZATION



It's the job, not the money!

<https://www.jacksonphysiciansearch.com/white-papers/white-paper-early-career-physician-recruiting-and-retention-playbook/>

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Summary



- We have discussed
 - What factors are important to candidates during recruitment
 - How to apply these factors when developing recruitment and retention strategies
 - Issues to address when planning improved recruitment and retention processes

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Questions?



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HANDOUT



Pro-Con: Mandating H and P for ASC Patients

Pro: Alan P. Marco, MD, MMM, CPE, FAAPL, SAMBA-F

Con: BobbieJean Sweitzer, MD, FACP, SAMBA-F, FASA

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We Need the Comprehensive H&P!

Alan P. Marco, MD, MMM, CPE, FAAPL

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Disclosures

- I have no real or potential conflicts to disclose

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Learning Objectives



- At the conclusion of this session, the participant will be able to:
 - Recognize the updated regulations requiring ASC comprehensive H&Ps
 - Describe the rationale for such H&Ps
 - Appraise the need for detailed policies on H&Ps
 - Summarize why I am right and my opponent is wrong
 - Distinguish between my superbly crafted argument and the unsubstantiated views of my opponent

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Red Tape



- On September 26, 2019, the Centers for Medicare & Medicaid Services (CMS) took action at President Trump's direction to "cut the red tape,"
- Removed requirements that a physician or other qualified practitioner conduct a complete comprehensive medical history and physical assessment on each patient not more than 30 days before the date of the scheduled surgery.
- Requirement that each ASC establish and implement a policy that identifies patients who require an H&P prior to surgery.

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Other components to Consider

- **§ 416.42 Condition for coverage—Surgical services.**
- Surgical procedures must be performed in a safe manner by qualified physicians who have been granted clinical privileges by the governing body of the ASC in accordance with approved policies and procedures of the ASC.
- (a) **Standard: Anesthetic risk and evaluation.**
- (1) Immediately before surgery—
- (i) A physician must examine the patient to evaluate the risk of the procedure to be performed; and
- (ii) A physician or anesthesiologist as defined at [§ 410.69\(b\) of this chapter](#) must examine the patient to evaluate the risk of anesthesia.

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Current Requirements

- **§ 416.52 Conditions for coverage—Patient admission, assessment and discharge.**
- The ASC must ensure each patient has the appropriate pre-surgical and post-surgical assessments completed and that all elements of the discharge requirements are completed.
- (a) **Standard: Patient assessment and admission.**
- (1) The ASC must develop and maintain a policy that identifies those patients who require a medical history and physical examination prior to surgery. The policy must—
- (i) ~~Include the timeframe for medical history and physical examination to be completed prior to surgery.~~
- (ii) Address, but is not limited to, the following factors: Patient age, diagnosis, the type and number of procedures scheduled to be performed on the same surgery date, known comorbidities, and the planned anesthesia level.
- (iii) ~~Be based on any applicable nationally recognized standards of practice and guidelines, and any applicable State and local health and safety laws.~~
- (2) Upon admission, each patient must have a pre-surgical assessment completed by a physician who will be performing the surgery or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and ASC policy.
- (3) The pre-surgical assessment must include documentation of any allergies to drugs and biologicals.
- (4) The patient's medical history and physical examination (if any) must be placed in the patient's medical record prior to the surgical procedure.

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Let's Look at § 416.52.a.1.ii

- Patient age, diagnosis, the type and number of procedures scheduled to be performed on the same surgery date, known comorbidities, and the planned anesthesia level
 - Doesn't "known comorbidities" mean the same as PMH, Allergies, Medications, directed ROS?
- Or is this another version of "Don't Ask, Don't Tell"?
 - If I don't ask about that heart transplant, then it's not a "known comorbidity"
- Isn't knowing something about medical conditions and medications part of the surgical assessment and the discussion of risks and proposed benefits of the procedure?
 - i.e. informed consent

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Why Do We Want to Bother?

- The purpose of a preoperative evaluation is not to "clear" patients for elective surgery, but rather to evaluate and, if necessary, **implement measures to prepare higher risk patients for surgery.**
 - Preoperative Evaluation, MITCHELL S. KING, M.D. Am Fam Physician. 2000;62(2):387-396
- The preoperative evaluation offers physicians and other health care professional a unique opportunity to help patients **optimize their health prior to surgery.**
 - O'Donnell FT. Preoperative Evaluation of the Surgical Patient. Mo Med. 2016 May-Jun;113(3):196-201. PMID: 27443045; PMCID: PMC6140067.
- A detailed history of prior medical problems, any previous surgical procedures, family, personal, and social history, any chronic medications and allergies or addictions needs to be obtained...Any medical history **questionnaire can either be extremely useful or totally worthless** and its ultimate **value depends upon the ability of the surgeon to interpret** the significance of the answers and to elicit additional information through physical examination and dialogue history
 - Krishnan, B., Parida, S. (2021). Preoperative Evaluation and Investigations for Maxillofacial Surgery. In: Bonanthaya, K., Panneerselvam, E., Manuel, S., Kumar, V.V., Rai, A. (eds) Oral and Maxillofacial Surgery for the Clinician. Springer, Singapore. https://doi.org/10.1007/978-981-15-1346-6_2

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How About a “Day of” Note Since That’s Required Anyway?



- preadmission preoperative assessment was more effective than the option of an inpatient medical assessment in reducing the frequency of unnecessary admissions with significantly fewer surgical cancellations
 - Pham CT, Gibb CL, Fitridge RA, et al. Effectiveness of preoperative medical consultations by internal medicine physicians: a systematic review BMJ Open 2017;7:e018632. doi: 10.1136/bmjopen-2017-018632

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But I’m Not Qualified to Do an H&P...



- Q My hospital has asked me to update the patient’s preoperative history and physical examination by conducting a physical assessment prior to surgery. I haven’t done a preoperative H&P since my residency years ago, and I don’t feel competent to do one now. What should I do?
- A There is no way to truthfully sign a reassessment form without conducting a history and physical examination, however brief. **Ophthalmologists** whose **current competency does not include these skills** should decline such requests and work with the hospital administration to find alternative solutions
 - <https://www.omic.com/who-can-perform-preop-history-physical-exams/>

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Why Do We Want to Let the Surgeon Off the Hook?

- Isn't the ability to perform a History & Physical Exam a Core Entrustable Professional Activity?
- The AAMC thinks so
 - EPA 1: Gather a History and Perform a Physical Examination
 - EPA 5: Document a Clinical Encounter in the Patient Record
 - <https://www.aamc.org/media/20211/download>

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What Does The American College of Surgeons Say?

- Oversee proper preoperative preparation of the patient
 - Statement on Patient Safety in the Operating Room: Team Care
<https://www.facs.org/about-acsc/statements/patient-safety-in-the-operating-room/>
- The surgeon is responsible for the proper preoperative preparation of the patient.
 - Statement on Principles Underlying Perioperative Responsibility
<https://www.facs.org/about-acsc/statements/principles-underlying-perioperative-responsibility/>
- "Preoperative evaluation of the surgical patient begins with a thorough history and physical examination."
 - ACS/ASE Medical Student Core Curriculum,
https://www.facs.org/media/ucgfkicy/perioperative_care.pdf

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Does the Surgeon/Proceduralist Have to Personally Do the H&P?



- No, they can have team members (APPs) do it
 - Ah, but they can't charge for it- 90 day global likely applies
- PCP can do it
- Urgent Care places often do this
 - Don't get me started on the quality of that
- Shouldn't their own office note (which should have PMH, meds, allergies, etc.) suffice?
 - See the last bullet point on the preceding slide
- Don't you need this to decide if the patient is suitable for ambulatory... and meets the requirements the ASC sets?

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Some Recent Studies



- risk ...not higher after the omission of the conventional preoperative H&P in patients **screened** to be low risk by a **validated preoperative questionnaire**.
 - Benoit, et al. Does eliminating the preoperative history and physical make a difference in low-risk cataract surgery patients? A before and after study of 30-day morbidity and mortality, Canadian Journal of Ophthalmology, Volume 54, Issue 5, 2019, Pages 529-539, ISSN 0008-4182, <https://doi.org/10.1016/j.jcjo.2018.12.001>.
- retrospective cohort study was performed using claims data from a hospital value collaborative in Michigan from January 2015 to June 2019
 - visits being more common for patients with **increased comorbidities**
 - associated with higher rates of low-value preoperative testing
 - Metz, et al. Comprehensive History and Physicals are Common Before Low-Risk Surgery and Associated With Preoperative Test Overuse, Journal of Surgical Research, Volume 283, 2023, Pages 93-101, ISSN 0022-4804, <https://doi.org/10.1016/j.jss.2022.10.019>.

Study was BEFORE the change. Sicker patients more likely to be evaluated. Pre-op testing overused. Shocking

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7 Reasons the PE Remains Important

- Contributes to diagnosis
- Prognosis and ongoing care
- Patient Safety
- Patient contact
- Teaching observation
- Teaching clinical reasoning
- Reducing over-investigation
 - Garibaldi BT, Elder A. Seven reasons why the physical examination remains important. J R Coll Physicians Edinb. 2021 Sep;51(3):211-214. doi: 10.4997/JRCPE.2021.301. PMID: 34528605.

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Future Steps?

- the PE... actually is an extremely powerful (and under-appreciated) clinical tool.
- Developing hardware and software solutions that can replace and recreate the experience of an in-clinic PE and capture the same data as an in-clinic PE.
 - https://www.ekohealth.com/blogs/eko-blog/why-the-physical-exam-is-an-opportunity?gad_source=1&gclid=Cj0KCQjw4a2BhD6ARIsALgH7Dqtf2LTtRkp_h3bvS4smCAEzrXhm_suV73N9-zsbbmBtjV8xwgbhZoaAnr_EALw_wcB

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Not “If” but “How”

- Develop systems to get this information in advance
 - Coordinate with PCP/referral source
 - Artificial Intelligence
 - Zhakhina G, Tapinova K, Kanabekova P, Kainazarov T. Pre-consultation history taking systems and their impact on modern practices: Advantages and limitations. J CLIN MED KAZ. 2023;20(6):26-35. <https://doi.org/10.23950/jcmk/13947>
 - Computerized history taking may be better than people
 - Computerized history-taking improves data quality for clinical decision-making— Comparison of EHR and computer-acquired history data in patients with chest pain
 - David Zakim ,Helge Brandberg ,Sami El Amrani ,Andreas Hultgren ,Natalia Stathakarou ,Sokratis Nifakos ,Thomas Kahan ,Jonas Spaak ,Sabine Koch ,Carl Johan Sundberg . September 27, 2021. <https://doi.org/10.1371/journal.pone.0257677>

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Let's Eliminate More Red Tape

- Do we really need a pre-flight checklist and sign-off?
- It's just a short flight
- The weather's not that bad
- The plane is pretty new
- Just ask the 737-Max passengers
- Have you checked your door plug recently?

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Patient Safety vs. Surgeon Convenience

- If we frame the question as “How do we promote patient safety?” the answer becomes clear.
 - Evidence that pre-op preparation improves outcome
 - No evidence that it can be safely skipped
 - What would you want for your mother?

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And Now, The Loyal Opposition...

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Preoperative H&Ps: Con

BobbieJean Sweitzer, MD, FACP, F-SAMBA,
FASA
Past President, SAMBA
Systems Director, Perioperative Medicine,
Inova Health
Professor, University of Virginia

Bobbiejean.sweitzer@inova.org

1



Objectives

Audience members will:

- ✓ Go home and do whatever it takes to eliminate requirements for preoperative H&Ps for patients having ambulatory procedures

Disclosures

- ✓ I receive funding from UptoDate, IARS and Medtronic

2

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**Centers for Medicare & Medicaid
Services**



The current regulations at § 416.52 require ASCs to ensure that a physician or other qualified practitioner provide a comprehensive medical history and physical assessment (H&P) completed not more than 30 days before the date of the scheduled surgery.

We proposed to remove the current requirements at § 416.52(a) and replace

3

There are, however, no known studies supporting the proposition that H&P procedures should be performed within 30 days of surgery to avoid adverse consequences to patients.

We are unaware of any study or body of opinion suggesting that 30 days or any such arbitrary time limit can be medically justified, or that any providers would adhere to such a limit if not a regulatory requirement.

4

follows that the persistence of low-value testing may simply be due to our requirement for what are often low-value H&Ps, as opposed to an indication



estimate of the annual costs of the current regulatory requirement, as shown in Table 15, could be as much as \$908 million for ASCs and a similar amount for hospital outpatient surgery.

5

Association of Preoperative Medical Consultation With Reduction in Adverse Postoperative Outcomes and Use of Processes of Care Among Residents of Ontario, Canada

Weiwei Beckerleg, MD, MPH; Daniel Kobewka, MD, MSc; Duminda N. Wijeyesundera, MD, PhD;
Manish M. Sood, MD, MSc; Daniel I. McIsaac, MD, MPH



- ✓ Echocardiograms
- ✓ Stress testing
- ✓ Pharmacologic interventions
- ✓ LOS



- ✓ Costs
- ✓ Stroke
- ✓ Postoperative ventilation
- ✓ 30-day ED visits
- ✓ **Deaths** (both 30-day and 1 yr)

6



Effective date: These regulations are effective on November 29, 2019. The



proposal to replace the requirement that every patient have a comprehensive H&P within 30 days prior to surgery in an ASC with a requirement that allows the operating physician and ASC to determine which patients would require more extensive testing and assessment prior to surgery.

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Centers for Medicare & Medicaid Services

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decreasing the amount of time that ASC personnel spend following up on patient visits to obtain the necessary H&P information and that it will provide for an increase in scheduling flexibility for the facility. We believe these changes may have the effect of improving patient satisfaction and increasing positive patient referrals for the ASC.



8

• For PCPs:

- Reduce unnecessary exams
- Reduce administrative and paperwork
- Reduce testing requirements
- Increased access for other patients
- More income from better payer mix

• For Patients

- Reduces time to prepare for surgery
- Reduces costs
- Reduces missed time from work

For Payers:

- Reduces expenses
- Increases access to providers for Medicare patients






9

Association of preoperative anaesthesia consultation prior to elective noncardiac surgery with patient and health system outcomes: a population-based study



- ✓ Days alive at home at 90 days
- ✓ Significantly more days at home:
 - ✓ Frail
 - ✓ ASA-PS ≥ 4
 - ✓ Ischemic heart disease
 - ✓ Vascular surgery



- ✓ 30-day mortality
- ✓ 1 year mortality
- ✓ LOS
- ✓ 30-day costs

10

Did I Meet My Objective?



Audience members will/must:

Go home and do whatever it takes to eliminate requirements for preoperative H&Ps for patients having ambulatory procedures

Bobbiejean.Sweitzer@inova.org

HANDOUT



Legislative Update and CMS Inpatient List

Kara Newbury, JD

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ASCA Federal Update

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Learning Objectives

- Explore the history of ASCs and projected trends for the future.
- Analyze the ASC Medicare payment system, including the ASC Quality Reporting Program, highlighting 2025 proposed rule developments.
- Discuss federal legislation being considered that would impact ASCs.

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History of ASCs

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1970s & 1980s

- First ASC - February 12, 1970
- 1974 - Society of Freestanding Ambulatory Surgical Care incorporated
- 1976 - Omnibus Budget Reconciliation Act of 1980 officially provides Medicare reimbursement
- 1982 - Medicare approves payment for ~200 ASC procedures
- 1988 - ASC industry passes milestone of 1000 facilities

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1990s & 2000s

- 1995 - Founding of International Association for Ambulatory Surgery (IAAS)
- 1995 - Medicare expands ASC list to 2000 procedures
- 2000 – 3000 ASCs
- 2004 – 4000 ASCs
- 2008 – Medicare implements new payment system linking ASC rates to hospital outpatient prospective payment system (OPPS)
- 2008 – Conditions for Coverage overhauled

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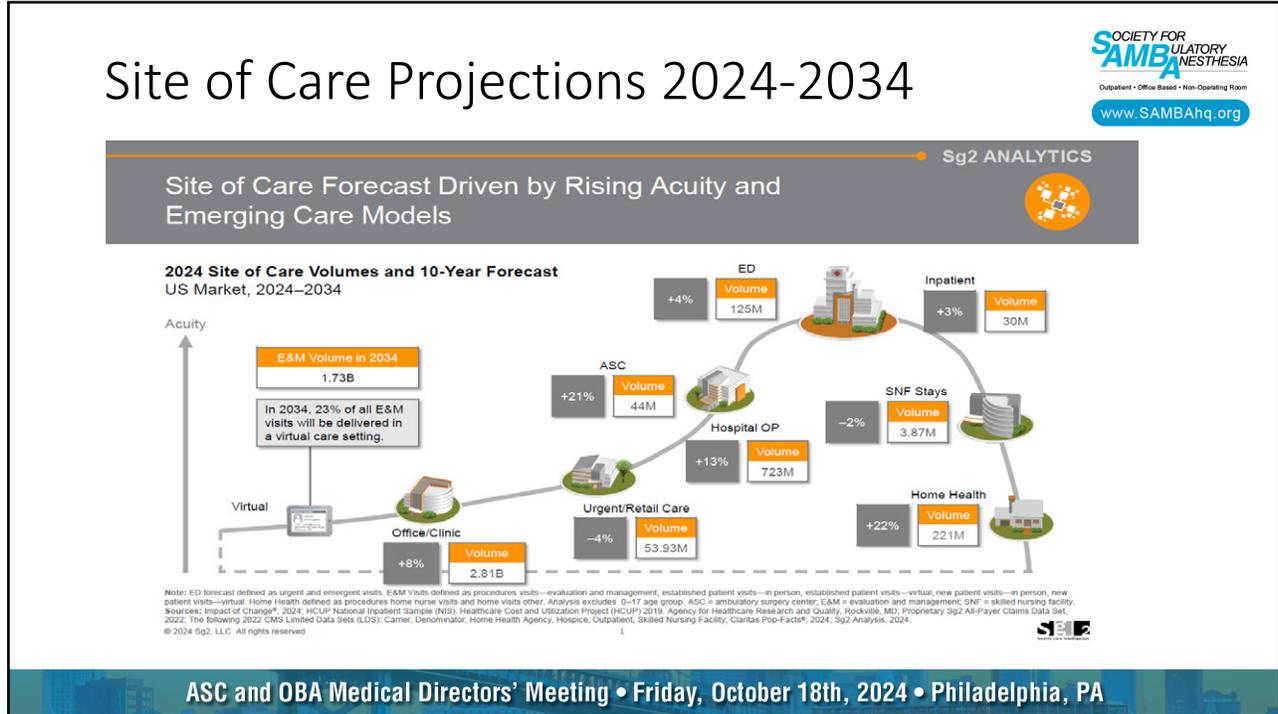
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Today

- 2024 – 6,377 Medicare certified ASCs
- More than 4,000 surgical codes on Medicare's ASC list
- 2022
 - 6.2 million FFS Medicare procedures
 - \$6.1 billion in FFS Medicare reimbursement

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Medicare Payment Policy

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Medicare Reimbursement

§ 416.61 Scope of facility services.

- (a) **Included services.** Facility services include, but are not limited to -
- (1) Nursing, technician, and related services;
 - (2) Use of the facilities where the surgical procedures are performed;
 - (3) Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures;
 - (4) Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
 - (5) Administrative, recordkeeping and housekeeping items and services; and
 - (6) Materials for anesthesia.
 - (7) Intra-ocular lenses (IOLs).
 - (8) Supervision of the services of an anesthesiologist by the operating surgeon.

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Hospital Outpatient Prospective Payment System (OPPS) / ASC Payment Rule Timeline

- **Proposed rule:** Usually early July
- Comments due 60 days after proposed rule
- **Final rule:** Typically issued 60 days prior to January 1 effective date
- Payment Rates Effective January 1
 - Correction Notices
 - Quarterly Updates

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2025 Proposed Payment Update

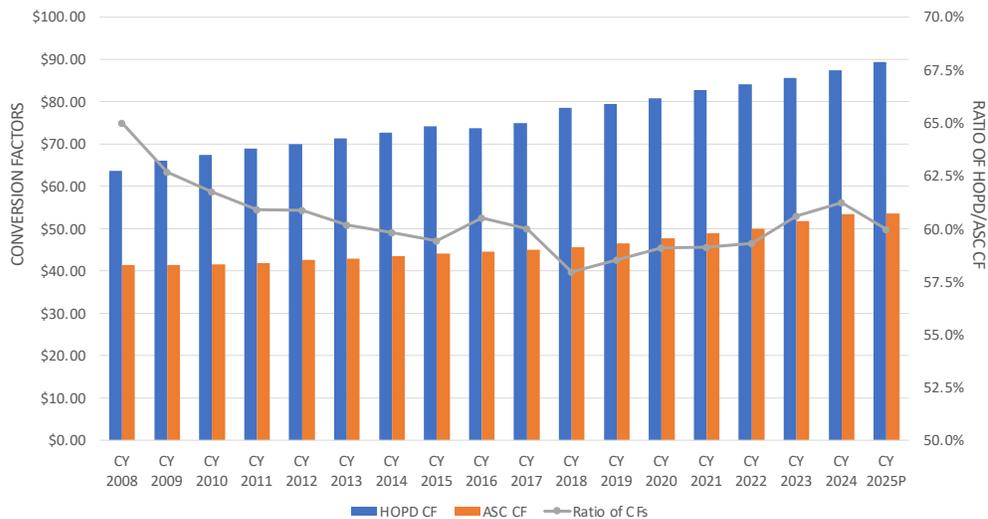


- **ASC Effective Inflation Update: 2.6%**
 - CMS to use hospital market basket index through 2025
 - Hospital Market Basket: 3.0%
 - Multi-factor productivity (MFP) adjustment: 0.4%
- **HOPD Effective Inflation Update: 2.6%**
 - Hospital Market Basket: 3.0%
 - Multi-factor productivity (MFP) adjustment: 0.4%
- **Secondary Rescaling Factor: 0.876**
- **Rate change varies by procedure**

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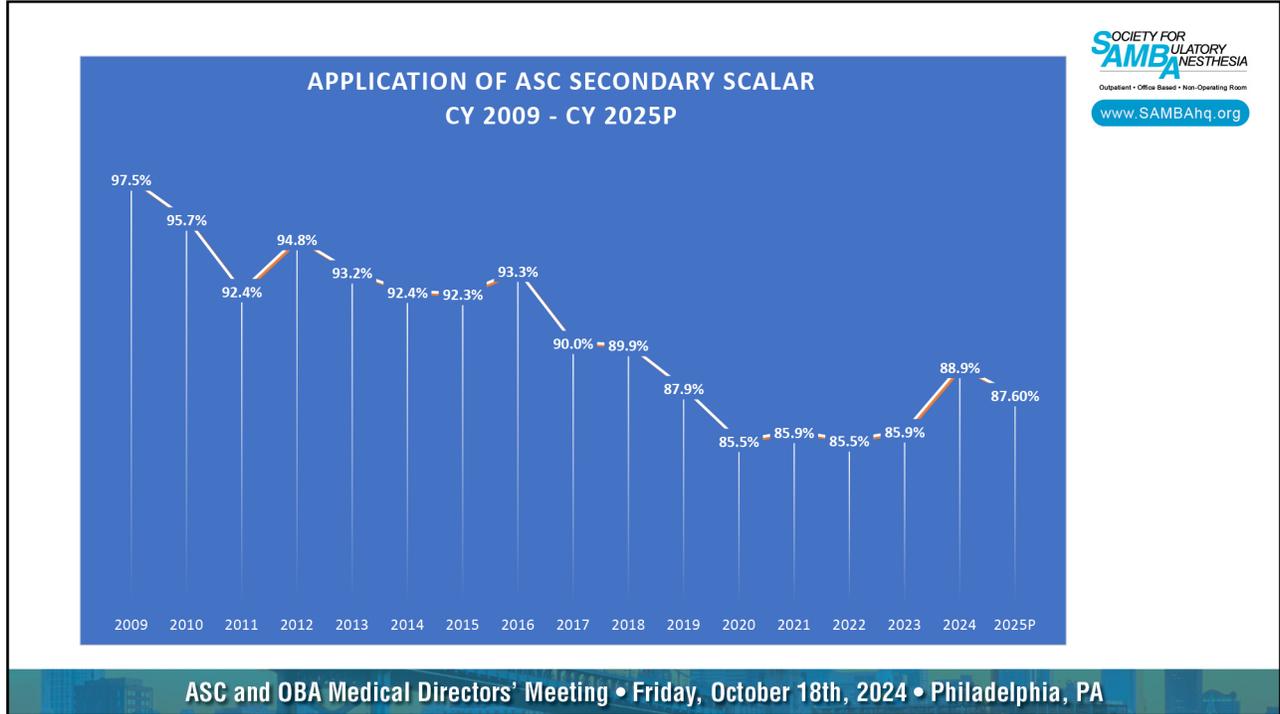
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HOPD versus ASC Conversion Factor:
2008 - 2025P



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Top 100 Procedures by Volume

Specialty	Total Codes in Top 100	2022 ASC Volume for Top 100 Codes	Δ 2024F – 2025P
Dermatology	6	50,869	3.15%
Gastrointestinal	15	1,903,049	3.05%
General	1	5,818	3.45%
Ophthalmology	22	1,803,124	2.35%
Orthopedics	21	358,553	2.18%
Otolaryngology	4	58,229	4.10%
Pain Management	15	969,018	1.74%
Spine	3	50,005	3.02%
Urology	10	169,557	2.78%
Vascular/Cardio Surgery	3	42,180	-0.55%
Grand Total	100	5,410,402	2.43%

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Top 10 Procedures by Volume

HCPCS	Descriptor	Specialty	2022 Volume	July 2024 Rate	2025 Proposed Rate	Δ 2024 – 2025 P
66984	Cataract surg w/iol 1 stage	Ophthalmology	1,165,208	\$1,183.57	\$1,205.23	1.8%
43239	Egd biopsy single/multiple	Gastroenterology	474,978	\$470.17	\$497.46	5.49%
45385	Colonoscopy w/ lesion removal	Gastroenterology	465,629	\$612.08	\$626.82	2.35%
45380	Colonoscopy and biopsy	Gastroenterology	432,508	\$612.08	\$626.82	2.35%
64483	Inj foramen epidural l/s	Pain Management	257,601	\$472.76	\$478.78	1.26%
66821	After cataract laser surgery	Ophthalmology	235,975	\$301.49	\$305.57	1.34%
64493	Inj paravert f jnt l/s 1 lev	Pain Management	189,565	\$472.76	\$478.78	1.26%
G0105	Colorectal scrn; hi risk ind	Gastroenterology	152,106	\$474.05	\$485.67	2.39%
62323	Njx interlaminar lmb/sac	Pain Management	125,844	\$358.69	\$372.04	3.59%
64635	Destroy lumb/sac facet jnt	Pain Management	106,989	\$897.67	\$920.62	2.49%
			3,606,403			2.43%

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Medicare ASC Covered Procedures List (ASC-CPL)

- Historically includes surgical procedures CPT 10000-69999 (unless excluded)
- Ancillary services (when provided in conjunction with surgical code)
- List updated annually (mid-year coding changes)
- Evaluates excluded procedures to determine if any codes currently excluded should be added to the ASC-CPL

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General Exclusions



c) *General exclusions.* Notwithstanding paragraph (b) of this section, covered surgical procedures do not include those surgical procedures that—

- (1) Generally result in extensive blood loss;
- (2) Require major or prolonged invasion of body cavities;
- (3) Directly involve major blood vessels;
- (4) Are generally emergent or life-threatening in nature;
- (5) Commonly require systemic thrombolytic therapy;
- (6) Are designated as requiring inpatient care under §419.22(n) of this subchapter;
- (7) Can only be reported using an unlisted surgical procedure code
- (8) Otherwise excluded under §411.15 of this subchapter

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ASC-CPL Nomination Process Changes for 2024



- Name Change in 2023 – “Pre-Proposed Rule CPL Recommendation Process”
- Stakeholders submit codes for consideration by March 1
- CMS will review whether codes meet exclusionary criteria

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ASC-CPL Nomination Process



- ASCA submitted the following codes:
- **Cardiovascular Codes**
 - Electrophysiology Studies and Ablations: 93613, 93619, 93620, 93623, 93650, 93653, 93654, 93655, 93656 and 93657
 - Cardioversion and TransEsophageal Echocardiogram: 92960 and 93355
- **Spine Codes**
 - Posterior Lumbar Inter-body Fusion: 22630
 - Combined Posterior Lumbar and Posterior Lumbar Inter-body Fusion: 22633

NONE were proposed for addition to ASC-CPL.

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Proposed ASC-CPL Additions for 2025



- CMS proposed the following codes:
 - **ADRC Therapy**
 - 0717T, 0718T
 - **Cardiovascular Codes**
 - Pacemakers: 0795T, 0801T
 - **Dental Codes**
 - D7251, D7280, D7410, D7411, D7412, D7413, D7414, D7415, D7450, D7451, D7460, D7461, D7485, D7521, D7530, D7540

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ASC Quality Reporting Program

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Quality Reporting in 2025 OPPS/ASC Proposed Payment Rule

CMS is proposing to add the following measures cross-program measures:

- (1) the Facility Commitment to Health Equity (FCHE) measure beginning with the CY 2025 reporting period/CY 2027 payment determination;
- (2) the Screening for Social Drivers of Health (SDOH) measure beginning with voluntary reporting in the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination; and
- (3) the Screen Positive Rate for Social Drivers of Health (SDOH) measure beginning with voluntary reporting in the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination.

CMS also requested public comment on the “potential development of frameworks for specialty focused reporting and minimum case number for required reporting under the ASCQR Program.”

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ASC 15: Outpatient/Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS)



- The five survey-based measures (ASC-15a-e) are collected via one survey {OAS CAHPS}:
- ASC-15a: About Facilities and Staff;
- ASC-15b: Communication About Procedure;
- ASC-15c: Preparation for Discharge and Recovery
- ASC-15d: Overall Rating of Facility; and
- ASC-15e: Recommendation of Facility

Voluntary reporting in CY 2024; mandatory reporting beginning in CY 2025

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OAS CAHPS Survey



- Survey has 34 questions:
 - 22 questions related to the patient, the facility, communication, and patient reported outcomes
 - 12 demographic questions
 - ASCs may add up to 15 supplemental questions
- Survey must be conducted via telephone, mail or mixed-mode (mail with telephone follow-up); electronic with phone and electronic with mail (these two modes added in 2022)
- CMS requires 200 completed surveys
- Must contract with CMS-certified vendor (currently 16)
- <https://www.ascassociation.org/asca/asc-operations/quality/oas-cahps>

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ASC-21: THA/TKA PRO-PM



- Pre-operative data collected from 0-90 days before the procedure and post-operative data collected between 300-425 days after the procedure.
- Must submit 44 to 47 data elements for each THA patient and a total of 46 to 49 data elements for each TKA patient when complete PRO data is provided by the patient.
- Has not been tested in the ASC setting
- Voluntary reporting begins with CY 2025-2027 reporting periods followed by mandatory reporting beginning with the CY 2028 reporting period.

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Public Reporting of Facility Specific Quality Reporting Data



- CMS publicly reports ASC data here:
<https://data.cms.gov/provider-data/>
- A facility comparison dashboard is available here:
<https://www.qualityreportingcenter.com/en/facility-compare-dashboard/>

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Legislative Update

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Outpatient Surgery Quality and Access Act (H.R. 5818 and S. 3132)

- CPI-U to HMB
- ASC representation on payment panel
- Comparable quality data (ASCs and HOPDs)
- Transparency re: ASC-approved procedures list
- Co-pay cap
- ASC weight scalar

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Medicare Cost Transparency Tool for Certain Surgical Procedures



- Mandated by the 21st Century Cures Act (signed into law December 13, 2016)
 - <https://www.medicare.gov/procedure-price-lookup/>
- Outpatient facility checklist: Which facility is best for my outpatient procedure? <https://www.medicare.gov/what-medicare-covers/outpatient-facility-checklist>
 - Also a hospital and ASC look up tool

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ASC to HOPD Beneficiary Comparison



Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation
Code: 66984

Patient pays (average)
\$341

Ambulatory surgical centers

This includes facility and doctor fees. You may need more than one doctor and additional costs may apply.

More cost information		^
<i>All costs are national averages</i>		
Total Cost		\$1,711
Doctor Fee	\$528	
Facility Fee	\$1,183	
Medicare Pays		\$1,368
Patient pays		\$341

Patient pays (average)
\$549

Hospital outpatient departments

This includes facility and doctor fees. You may need more than one doctor and additional costs may apply.

More cost information		^
<i>All costs are national averages</i>		
Total Cost		\$2,748
Doctor Fee	\$528	
Facility Fee	\$2,220	
Medicare Pays		\$2,198
Patient pays		\$549

Next Steps: Use this [checklist](#) to talk to your doctor about your costs and options, find [hospitals](#) in your area, or get [data](#) on ambulatory surgical centers.

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Co-Pay Cap Issue

Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
Code: 63655

Patient pays (average)

\$3,762

Ambulatory surgical centers

This includes facility and doctor fees. You may need more than one doctor and additional costs may apply.

More cost information		
<i>All costs are national averages</i>		
Total Cost		\$18,815
Doctor Fee	\$838	
Facility Fee	\$17,977	
Medicare Pays		\$15,052
Patient pays		\$3,762

Patient pays (average)

\$1,799

Hospital outpatient departments

This includes facility and doctor fees. You may need more than one doctor and additional costs may apply.

More cost information		
<i>All costs are national averages</i>		
Total Cost		\$21,680
Doctor Fee	\$838	
Facility Fee	\$20,842	
Medicare Pays		\$19,880
Patient pays		\$1,799

In hospital outpatient departments, Original Medicare caps your copayments at \$1,632. This likely applies to this procedure.

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Lower Costs, More Transparency Act (H.R. 5378) Health Care PRICE Transparency Act 2.0 (S. 3548)

Beginning January 1, 2026, ASCs would publish:

- Standard charges for each item or service furnished in the ASC;
- Information on the ASC's prices for as many of the CMS-specified shoppable services (or up to 300 shoppable services provided by facility);
- Indication of which of CMS shoppable services are not provided at the ASC;

There are penalties for non-compliance in the bill.

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Draft Site Neutral Legislation



- Evaluates HOPD, ASC and physician office volume over four-year period
 - HOPD volume highest: status quo
 - ASC volume highest: HOPDs drop to ASC rate; physician office remains on MPFS
 - physician office volume highest: all drop to MPFS

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Site of Service Facility Fee Restrictions



By: Frank H.B. No. 1692

A BILL TO BE ENTITLED
AN ACT
relating to facility fees charged by certain health care providers;
providing an administrative penalty.

19 Sec. 32B.002. PROHIBITED FACILITY FEES. (a) Except as
20 provided by Subsection (b), a health care provider may not charge a
21 facility fee, including a facility fee for:
22 (1) outpatient health care services; or
23 (2) health care services identified by the executive
24 _____.

962 (1) (1) A health care provider may only charge, bill for or collect a
963 facility fee for services provided (A) on a hospital's campus, (B) at a
964 facility that includes a hospital emergency department, or (C) at a
965 freestanding emergency department.

SENATE BILL 321
Health Care Committee Substitute Adopted 4/10/23
Third Edition Engraved 5/1/23

SENATE BILL 321-THIRD EDITION
March 20, 2023

SENATE BILL 321
Health Care Committee Substitute Adopted 4/10/23
Third Edition Engraved 5/1/23

Page 10 Senate Bill 321-Third Edition

Short Title: Medical Debt De-Weaponization Act. (Public)

Sponsors: _____

Referred to: _____

March 20, 2023

A BILL TO BE ENTITLED
PRO-FAMILY, PRO-CONSUMER MEDICAL DEBT
PROTECTION ACT TO LIMIT THE ABILITY OF LARGE MEDICAL FACILITIES TO
CHANGE UNREASONABLE INTEREST RATES AND EMPLOY UNFAIR PRACTICES IN
DEBT COLLECTION AND TO LIMIT THE ABILITY OF NON-HOSPITAL HEALTH
CARE FACILITIES TO CHARGE FACILITY FEES.

General Assembly of North Carolina
Session 2023

(1) No health care provider shall charge, bill, or collect a facility fee unless the services are provided on a hospital's main campus or at a facility that includes an emergency department.

(2) Regardless of when the services are provided, no health care provider shall charge, bill, or collect a facility fee for diagnostic, evaluation and management services, or any other outpatient, diagnostic, or imaging services identified by the Department.

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Site of Service Facility Fee Restrictions


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Facility Fee Restriction Proposals 2020-2024
■

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References



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- **2025 OPPS/ASC Proposed Payment Rule:**
- <https://public-inspection.federalregister.gov/2024-15087.pdf>

- **2025 Proposed Rule ASC Addenda:**
- <https://www.cms.gov/license/ama?file=/files/zip/2025-nprm-addendum-aa-bb-dd1-dd2-ee-and-ff.zip>

- **ASCA Payment Resources:**
- <http://www.ascassociation.org/federalregulations/medicarepayments>

- **ASC Quality Reporting Program:**
- <https://qualitynet.cms.gov/asc>
- <https://www.ascassociation.org/medicare/quality-reporting>
- <https://www.ascassociation.org/asca/asc-operations/quality/oas-cahps>

- **Legislation Links:**
- <https://www.congress.gov/bill/118th-congress/house-bill/972>
- <https://www.congress.gov/bill/118th-congress/senate-bill/312>
- <https://www.congress.gov/bill/118th-congress/house-bill/5378>
- <https://www.congress.gov/bill/118th-congress/senate-bill/3548>

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Questions?

knewbury@ascassociation.org



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The central graphic features a collection of hands in various colors (blue, orange, green, brown, grey) reaching upwards. Above the hands are numerous question marks of different sizes and colors (blue, orange, green, grey) scattered across a light blue background with faint circular patterns.

HANDOUT



Dealing with the Trouble Anesthesiologist

Mohsen Shabahang, MD, PhD, FACS



Dealing with the Trouble Anesthesiologist

Mohsen Shabahang, MD, PhD
VP/CMO Surgery, Anesthesia, Perioperative Service
WellSpan Health
October 18, 2024

1

Objectives

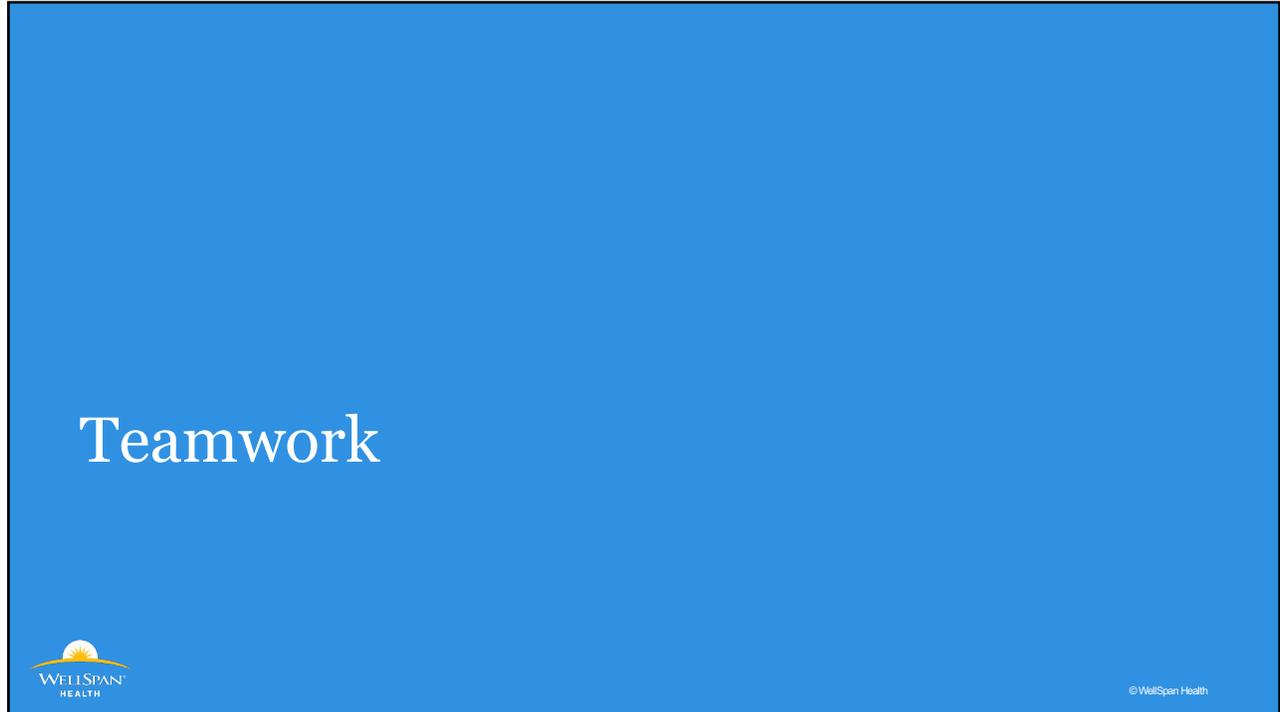
By the end of this session, participants will be able to:

- Characterize the characteristics of healthy teamwork
- Describe the concepts of conflict resolution
- Use principles of coaching and feedback to work with the providers
- Enumerate the human resource process for separation from an employee

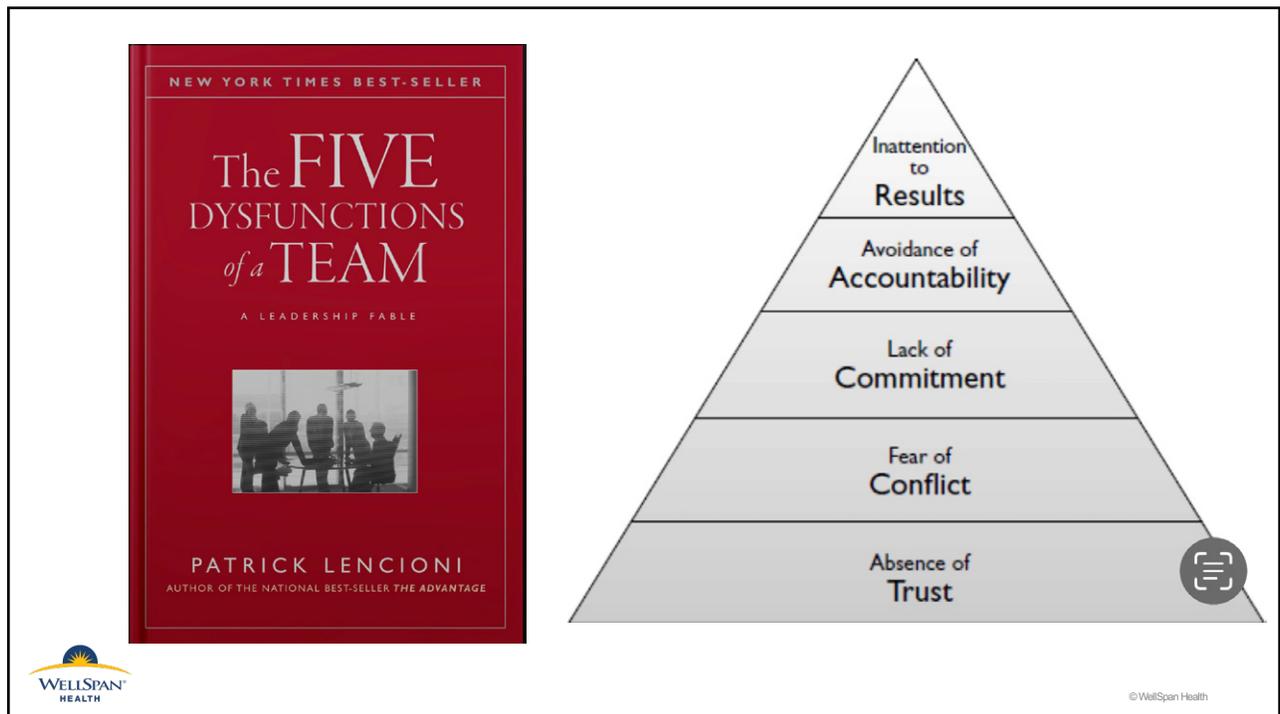


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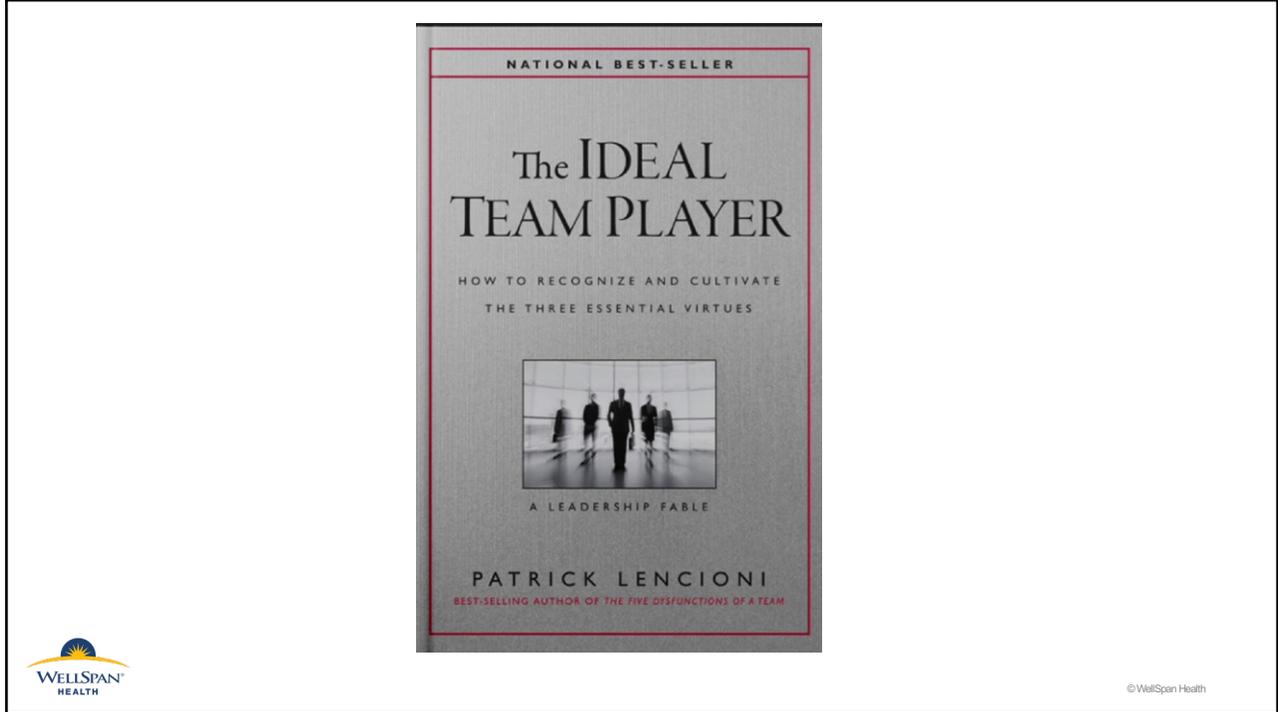
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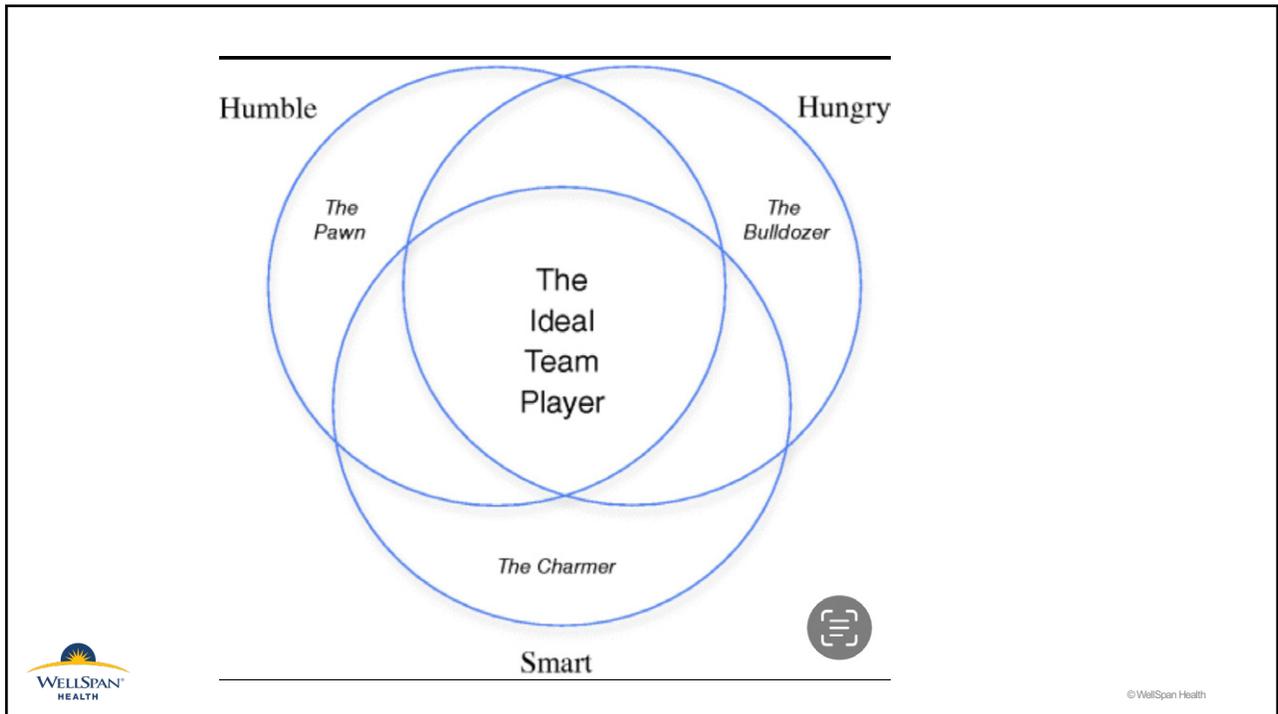
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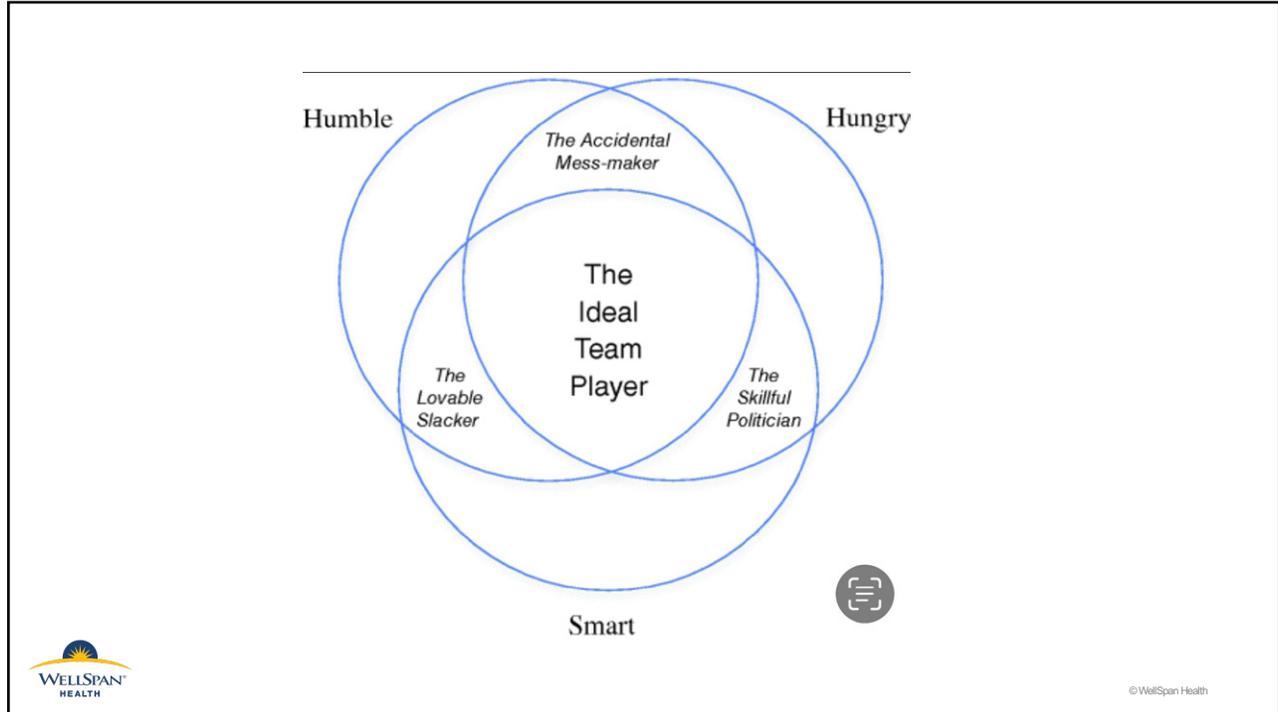
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5



6



7

Conflict Resolution



8

Getting to Yes: Fisher & Ury

- Separate the people from the problem
- Focus on interests, not positions
- Invent options for mutual gain
- Insist on using objective criteria



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Coaching & Feedback



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Principles of Coaching

- Create a safe space
- Empathy: what is the story being told by both sides
- Lack of Judgement



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Feedback

GIVE Feedback

- Ask for permission
- Say it how they can hear it
- Focus on behavior
- Just do it

RECEIVE Feedback

- Feedback is a gift
- Open to all sources
- Two response options
- Take time to process
- Assume positive intent
- Ask for feedback
- Reflection/mirroring



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Human Resources



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Human Resource Path

- Verbal Warning
- Written Warning
- Separation

- Transparency, determination, courage
- Dignity of each person



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Conclusion

- The process of dealing with a “trouble” provider would be more effective if principles of team building, conflict management, coaching & feedback are used before a decision is made to separate. However, when the decision is made to separate, it should be done with determination, transparency, courage with attention to preserve the dignity of the provider.



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HANDOUT



OBA Director Panel:

OBA Practice Director Overview, and Current Challenges/Solutions

Meghan Valach, MD

Policies and Practice Management

Cassie Dietrich, MD, FASA

Documentation, and Quality Data at the OBA

Grace Lee Dorsch, MD

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OBA practice director overview and current challenges /solutions

Meghan C Valach MD
Anesthesiologist-in-Chief
Mobile Anesthesiologists

1

Learning Objectives

- Analyze role of Office-based anesthesiology (OBA) practice director in structure in practice organization that allows for safe, efficient delivery of care in office
- Determine necessary logistical elements for a fully ambulatory anesthesia practice
- Review current challenges and potential solutions in the office-based practice including obtaining necessary medications, controlled substances, and payment for services
- Identify sources for the development of office-based anesthesia policies and review differences from ASC/Hospital policies
- Identify major components of practice management skills that are valuable to an office-based anesthesia practice, including contract negotiation, staffing, and communication.
- Participants will review documentation responsibilities of anesthesia providers including anesthesia record, machine and monitor maintenance, and controlled substances
- Participants will gain insights into role of thorough anesthesia documentation in enhancing patient safety and supporting legal defensibility
- Refresh attendees of importance of data collection including accuracy, quality assessment, outcomes, and performance improvement
- The presentation will encourage participants to promote a culture of continuous improvement in anesthesia practice

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- Business Structure
- Personnel
- Scheduling
- Medical Education
- Medical Records
- Case Review
- Quality Assurance

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Preparing team for success

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- New Environment
- New Locations
- Different Team
- New Roles
- New Responsibilities

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Logistics



- Equipment
- Supplies
- Medications

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DEA Diversion rules

- Current State
 - Scheduled narcotics including fentanyl, morphine, hydromorphone (II), ketamine (III) and midazolam (IV) must be delivered by a licensed distributor directly to the site of administration
 - A DEA registration must be held for each physical address
 - Opiates (schedule 2) must be ordered using a 222 form unique to that address
 - “Black bag exception”

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DEA Diversion Rules

- Ideal state for office-based anesthesiologists
 - DEA license held for address where narcotics are delivered by a distributor
 - Medications securely maintained
 - Licensed physicians or employees acting on their order can transport the narcotics securely to site of patient care
 - Any unused, unopened vials can be returned

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Revenue Cycle

- Patient Eligibility
- Billing
- Payment and Denial Posting
- Insurance Follow-up
- Patient Billing

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Be a part of the fastest growing sub-specialty in clinical anesthesia practice, network with your peers and expand your expertise.



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2025 ANNUAL MEETING
May 15-17, 2025
Arizona Biltmore • Phoenix, AZ

Website: sambahq.org/membership
Twitter: @SAMBAHQ
Facebook: @SAMBAHQ
Instagram: @samba_hq
LinkedIn: Society for Ambulatory Anesthesia (SAMBA)

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OBA Policies & Practice Management

Cassie Dietrich, MD, FASA
Mobile Anesthesia Care, Director
Overland Park, KS
CDietrich@macofkc.com



1

Importance

- Little or no regulation/oversight by federal, state, local laws but increasing
 - FSMB
 - JCAHO
- Safety has improved over time – patient selection, adequate protocols
- Practice standardization
 - Cognitive aids for emergencies
 - Safety checklists
 - Facility accreditation standards

2

Policies – Up to Us



- Governance and organization
- Construction and equipment
- Fire, safety, drugs, emergencies
- Staffing, training
- Unanticipated transfers
- Patient/procedure selection

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Source Material



- State licensing bodies
- National organizations (ASA)
 - Standards – Preanesthesia Care, Basic Monitoring, Postanesthesia Care
 - Guidelines for Ambulatory Anesthesia & Surgery
 - Statement on Office Based Anesthesia
- Accrediting entities (AAAASF, AAAHC, JCAHO, etc.)
- DEA website
- Other facilities
- Emergency Manuals Implementation Collaborative (EMIC)
- ISOBS

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Policies – Safe Patient Care

- Patient care based on
 - Nationally accepted standards
 - Guidelines & statements
- Consistent independent of location
- Proceduralist level of training/education
- Adequate facilities
- Patient selection
- Safety/emergency protocols

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Safety Checklist for Office-Based Surgery

from the Institute for Safety in Office-Based Surgery (ISOBS)



Introduction	Setting	Operation	Before discharge	Satisfaction
<p>Preoperative encounter, with practitioner and patient</p> <p>Patient Patient medically optimized for the procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No, and plan for optimization made</p> <p>Does patient have DVT risk factors? <input type="checkbox"/> Yes, and prophylaxis plans arranged <input type="checkbox"/> No</p> <p>Procedure Procedure complexity and sedation/analgesia reviewed? <input type="checkbox"/> Yes</p> <p>NPO instructions given? <input type="checkbox"/> Yes</p> <p>Escort and post-procedure plans reviewed? <input type="checkbox"/> Yes</p>	<p>Before patient in procedure room, with practitioner and personnel</p> <p>Emergency equipment check complete (e.g. airway, AED, code cart, MH kit)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>EMS availability confirmed? <input type="checkbox"/> Yes</p> <p>Oxygen source and suction checked? <input type="checkbox"/> Yes</p> <p>Anticipated duration ≤ 6 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No, but personnel, monitoring, and equipment available</p>	<p>Before sedation/analgesia; with practitioner and personnel*</p> <p>Patient identity, procedure, and consent confirmed? <input type="checkbox"/> Yes</p> <p>Is the site marked and side identified? <input type="checkbox"/> Yes <input type="checkbox"/> N/A</p> <p>DVT prophylaxis provided? <input type="checkbox"/> Yes <input type="checkbox"/> N/A</p> <p>Antibiotic prophylaxis administered within 60 minutes prior to procedure? <input type="checkbox"/> Yes <input type="checkbox"/> N/A</p> <p>Essential imaging displayed? <input type="checkbox"/> Yes <input type="checkbox"/> N/A</p> <p>Practitioner confirms verbally: <input type="checkbox"/> Local anesthetic toxicity precautions <input type="checkbox"/> Patient monitoring (per institutional protocol) <input type="checkbox"/> Anticipated critical events addressed with team <input type="checkbox"/> Each member of the team has been addressed by name and is ready to proceed</p>	<p>On arrival to recovery area; with practitioner and personnel</p> <p>Assessment for pain? <input type="checkbox"/> Yes</p> <p>Assessment for nausea/vomiting? <input type="checkbox"/> Yes</p> <p>Recovery personnel available? <input type="checkbox"/> Yes</p> <p><i>Prior to discharge: (with personnel and patient)</i> Discharge criteria achieved? <input type="checkbox"/> Yes</p> <p>Patient education and instructions provided? <input type="checkbox"/> Yes</p> <p>Plan for post-discharge follow-up? <input type="checkbox"/> Yes</p> <p>Escort confirmed? <input type="checkbox"/> Yes</p>	<p>Completed post-procedure; with practitioner and patient</p> <p>Unanticipated events documented? <input type="checkbox"/> Yes</p> <p>Patient satisfaction assessed? <input type="checkbox"/> Yes</p> <p>Provider satisfaction assessed? <input type="checkbox"/> Yes</p>

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged. *Adapted from the WHO Surgical Safety Checklist. © 2010 Institute for Safety in Office-Based Surgery (ISOBS), Inc. – All Rights Reserved – www.isoobs.org

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Highlights



- Quality of Care – Medical Director
- Controlled drug supply, storage, and administration
- Patient & Procedure Selection
 - BMI
 - Pregnancy test
 - Rescheduling Guidelines
 - Length/type of procedure

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Practice Management



- Many forms depending on practice arrangement
- Directs operations, administrative and business affairs
- Strategic planning and execution, in collaboration with physicians
- Workforce planning and development
- Partners with financial team
- Cultivates and develops relationships
- Team leadership
- Ensures compliance

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Data Analysis

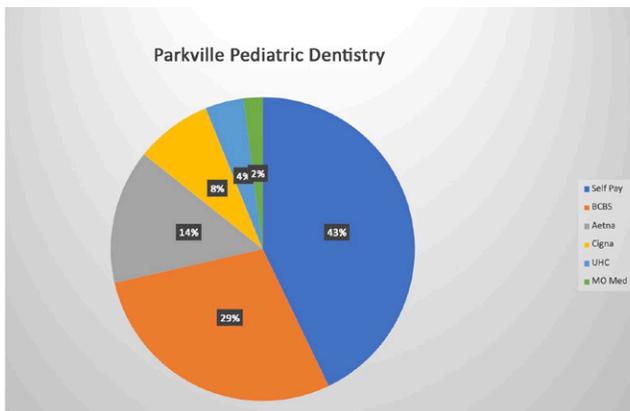
- What is useful to our practice?
- Implement changes
 - RN Health Hx Calls
 - Rescheduling guideline
 - One-week out calls
 - Text reminders
 - Highlights in email
- Track numbers monthly

Patient Cancels	
7/2/24 Expedition	no response to dental site or pre op calls
7/8/24 Spencer	child ill
7/10/24 Smile Spot	NPO violation
7/11/24 MyKids LO	parent decided to go another route
7/11/24 MYKids BS	child is ill
7/12/24 KC Braces	child in pain and going elsewhere
7/12/24 DFC KC	not wanting to wait for date
7/12/24 MyKids BS	same day cx-drunk water right before appt
7/15/24 LeBlanc	parent called day before-no ride to appt
7/15/24 LeBlanc	child ill for 7/16 appt
7/16/24 LeBlanc	same day cx-mom called day of-unable to make appt
7/16/24 MyKids LO	same day cx-showed up sick
7/18/24 Shoal Creek	same day cx-showed up sick
7/19/24 Summit	cx on pre-op call. Something came up
7/22/24 MyKids OW	parents tested positive for Covid
7/23/24 Smiles4Kids	parents moved forward w/o anesthesia
7/24/24 Ped Smiles	NPO violation
7/25/24 KC Braces	cancelled during pre-op
7/25/24 KC Kids	child bit by dog-stitches to the face
7/25/24 Summit	same day cx

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Data Analysis



Average Cases/Day		Frequency
4.5		1x/month
2 days/month in Oct and Nov		
29% Referral Increase		
Date	Total Referrals	Total Completed
2023	98	55
2022	76	46

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Data Analysis



- Discrepancies billed charges vs AR
- Billing code changes
- Errors – insurance
- Persistence required
- Teamwork required

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Contract Negotiations



- Education is critical
- Cannot settle for “standard anesthesia unit rates”
- Bundled package; stipend
- Enlist CEOs, legislative contacts, state association lobbyists, dentists/surgeons, regional practitioners
- Eventually get to the “right” person
- Have to be willing to walk away if substandard rates

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Pearls



- Shared file & calendar system
- Point of contact facilitates communication
- Create collaborative, respectful environment
- OBA offers autonomy but requires constant vigilance inside and out of OR
- Change is inevitable – personnel, regulations, insurance contracts, medication shortages

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- ASA Statement on Office Based Anesthesia. <https://www.asahq.org/standards-and-practice-parameters/statement-on-office-based-anesthesia?&ct=f10db4305faa15b301ca14ef7af6771716f0daf175659cb6b4af986e7b2aaa15c3ff5e5cb35dbe4d1b08c2da6ef5e714af4bb8d3387d798155a6562ab9efa31a> Accessed on Sept. 14, 2024.
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- ASA Statement on Sedation & Anesthesia Administration in Dental Office-Based Settings. <https://www.asahq.org/standards-and-practice-parameters/statement-on-sedation--anesthesia-administration-in-dental-officebased-settings> Accessed on Sept. 14, 2024.
- Federation of State Medical Boards Report of the Specialty Committee on Outpatient (Office-Based) Surgery. <https://www.fsmb.org/siteassets/advocacy/policies/outpatient-office-based-surgery.pdf> Accessed on Sept. 28, 2024.

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OBA Directors Panel

Grace Lee Dorsch, MD

Owner, Office Anesthesia Services, LLC

gldorsch@me.com

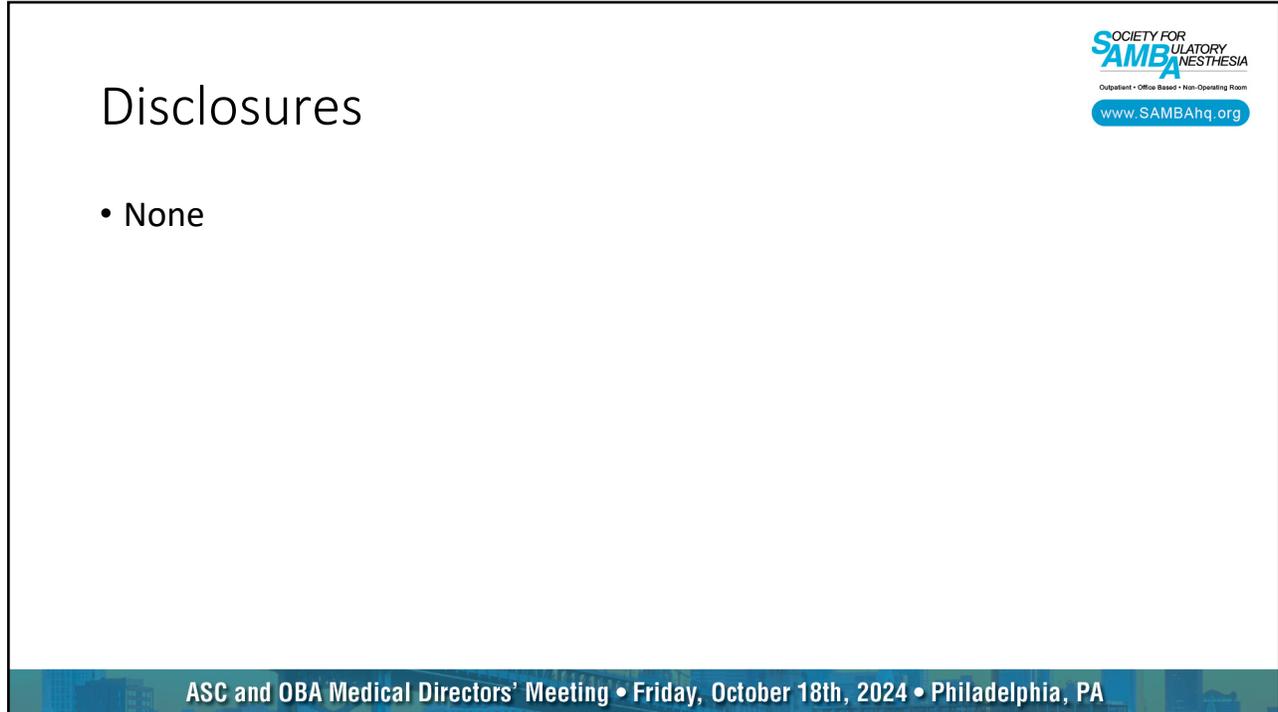
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Early in my OBA career

14 years ago



2



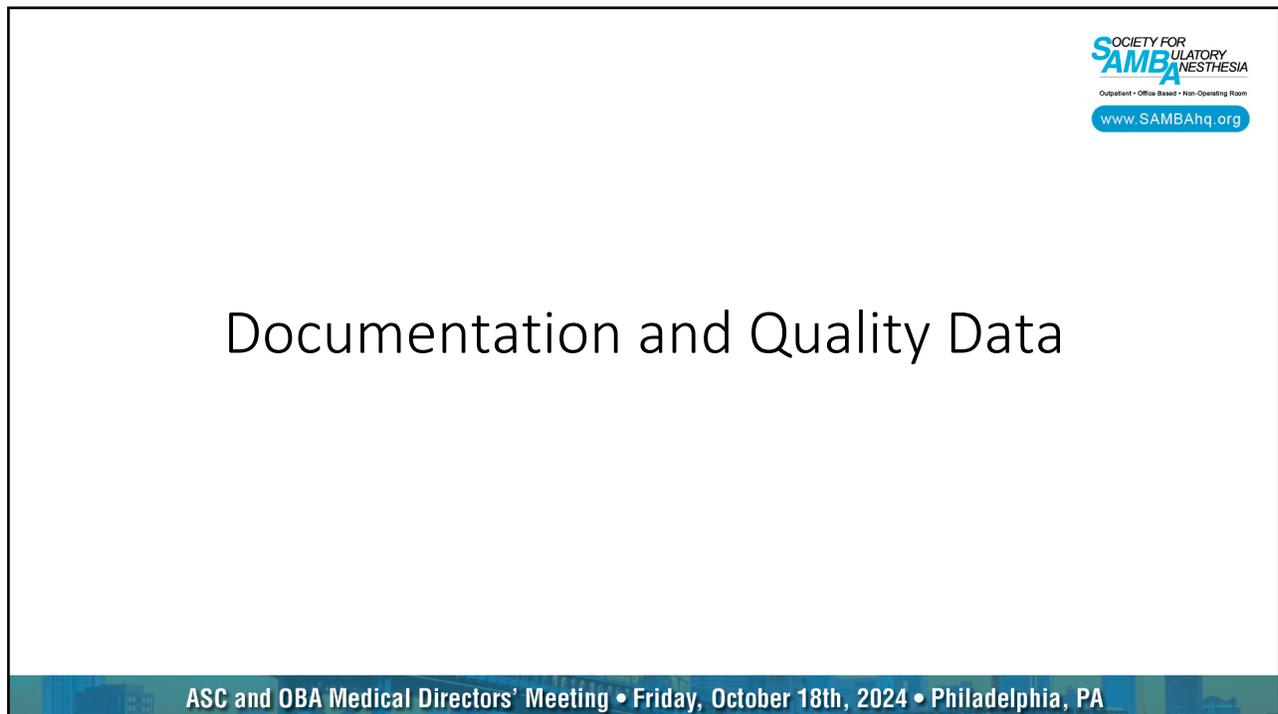
Disclosures

- None

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Documentation and Quality Data

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4

Objectives



- Review documentation responsibilities of anesthesia providers including anesthesia record, machine and monitor maintenance, and controlled substances
- Gain insights into role of thorough anesthesia documentation in enhancing patient safety and supporting legal defensibility
- Refresher of importance of data collection including accuracy, quality assessment, outcomes, and performance improvement
- Encourage participants to promote a culture of safety and continuous improvement in anesthesia practice

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Documentation



The image shows a complex, handwritten anesthesia record form. It includes sections for patient information, anesthesia details, and monitoring data. The form is filled with dense, cursive handwriting, making it difficult to read. The form is titled 'ANESTHETIC RECORD' and has a 'CHECKER' and 'DATE' field at the bottom.

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Anesthesia Record

- Pre-anesthesia Assessment: phone calls, notes from primary care visits or specialists, lab work, testing, EKG
- Intra-operative record
- Post-operative: report, vitals, discharge info, and follow-up phone call
- Paper or electronic record
- What about unusual occurrences or incidents-THOROUGHNESS

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7

Anesthesia Quality Institute(AQI)

Anesthesia Quality Institute(AQI) has Anesthesia Incident Reporting System (AIRS): collecting individual adverse events from anesthesia

The AIRS database is protected from use in legal proceedings through AQI's status as a federally listed Patient Safety Organization (PSO). As a PSO, federal law protects any patient safety work product from legal discovery and imposes strict confidentiality guidelines.

NEW website: AQIHQ.ORG

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Machines and Monitors

- Includes sequential compression devices(SCD), infusion pumps, and BIS monitors
- Annual inspection (sticker)
- Maintenance reports

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Controlled Substances

- Lockbox
- Daily Count logs



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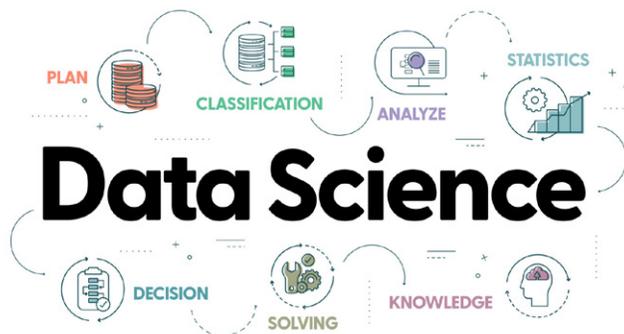
10

Licenses

- State medical license
- Business license
- Malpractice policy
- DEA license
- Accreditation

11

Quality Data



12

According to
ASA's Monitor
in August 2024

Dr. Joseph Staggenborg stated,

“ Cliches are cliches because they are true more often than not. Such is the case with ,
‘it starts with the data.’ ”



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Definitions

- Data Science: a multidisciplinary study of information and how to extract meaningful insights for decision making and strategic planning
- Benchmarking: the act of measuring the quality of something by comparing it with an accepted standard- how does your practice compare to other similar practices
- NACOR- National Anesthesia Clinical Outcomes Registry
- AQI- Anesthesia Quality Institute (AQIHQ.ORG)
- NSQIP- National Surgical Quality Improvement Program



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Data Collection/Reporting

- Internal: numbers, totals, search ability
- External: ASA's NACOR, ACS- NSQIP
- May be required by accrediting body



Data Collection

Quality Assessment/ Performance Improvement

- Patient safety
- Quality Care
- QA/QI Committee: to review incident reports, adverse events and unusual occurrences
- Identify and implement best practices
- Recommend performance improvement and educational activities



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in ASA's Monitor September 2024

"Pay to Play: Do Quality
Metrics for Anesthesiology
Improve Value?"

By Drs. Ibekwe and Gupta

- Reimbursement through Medicare/Medicaid (CMS) uses value-based payment models
- Focus moving to value based models that link "pay for performance to quality indicators"
- Limited outcomes data RESEARCH in anesthesia
- We need **anesthesia specific data** to support our value if reimbursement is going to continue to be tied to outcome data

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Data Collection

➔



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Value

According to Anesthesia Quality Institute's Strategic Plan:

"The specialty of anesthesiology is at risk of being diminished if a high-quality anesthetic is defined only by the patient's survival of induction and emergence in the PACU alive. Anesthesiologists who focus on the immediate operating room outcome are "value enabling," not "value adding." We endeavor to change that."

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Individual Value



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Anesthesia Team/Practice Value



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TEAMWORK INTEGRITY CONTRIBUTION

CONNECTION QUALITY FOCUS

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Patient Centered Care



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- Patient satisfaction
- Patient feedback
- Patient follow-up

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ASA's Enhancing Patient Communications Program (EPCP)



- Strategies and tools to establish meaningful relationships with patients
- Helps increase patient satisfaction scores
- Improve outcomes
- Increase reimbursement
- Ensure better patient care

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Saturday, Oct. 19, 1:30pm

ASA's CME Course and Toolkit



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SAFETY CULTURE

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Personal touch

I challenge you to think
outside the box!

You can practice the way you
want.... Don't settle for less.



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Resources



ASA's Anesthesia Quality Institute (AQI) Strategic Plan 2021
ASA Podcast. Central Line Episode 17: Quality Improvement, August 2020.

[‘Helping’ Your Hospital Partner with Quality and Performance Metrics](#)

[Joseph L. Staggenborg, MD, MBA, FASA](#)

ASA Monitor August 2024, Vol. 88, 17–19. <https://doi.org/10.1097/01.ASM.0001027540.50857.25>

[Pay to Play: Do Quality Metrics for Anesthesiology Improve Value?](#)

[Stephanie Opusunju Ibekwe, MD, MBA, MPH, MS; Anita Gupta, DO, MPP, GMP, PharmD, FASA](#)

ASA Monitor September 2024, Vol. 88, 24–25. <https://doi.org/10.1097/01.ASM.0001050684.87003.9a>

ASA Enhancing Patient Communications Program: New Strategies for Improving Outcomes and Patient Satisfaction

David Matthews, MD, MBA, FASA
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Contact:
gldorsch@me.com



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Documentation and Quality Data

Objectives

- Review documentation responsibilities of anesthesia providers including anesthesia record, machine and monitor maintenance, and controlled substances
- Gain insights into role of thorough anesthesia documentation in enhancing patient safety and supporting legal defensibility
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Documentation

Anesthesia Record

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- Intra-operative record
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- Paper or electronic record
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The AIRS database is protected from use in legal proceedings through AQI's status as a federally listed Patient Safety Organization (PSO). As a PSO, federal law protects any patient safety work product from legal discovery and imposes strict confidentiality guidelines.

Equipment

- Machines, monitors, and other devices (including sequential compression devices) SCD, infusion pump and BIS
- Annual inspection (sticker)
- Maintenance reports

Controlled Substances

- Lockbox
- Daily Count logs

Licences

- State medical license
- Business license
- Malpractice license
- DEA license

Quality Data

According to ASA's Monitor in August, Dr. Joseph Staggenborg stated, " Cliches are cliches because they are true more often than not. Such is the case with , 'it starts with the data.' "

Definitions:

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Data Collecting and Reporting

- Internal (using own EMR): numbers, totals, search ability
- External: ASA's NACOR, ACS-NSQIP
- May be required by accrediting body

Quality Assessment/Performance Improvement

- Patient safety
- Quality Care
- QA/QI Committee: to review incident reports, adverse events and unusual occurrences
- Identify and implement best practices
- Recommend performance improvement and educational activities

What is on the horizon?

According to Dr. Ibekwe and Gupta, in ASA's September Monitor, there is:

- Limited research on anesthesia outcomes data
- We need **anesthesia specific data** to support our value if reimbursement is going to continue to be tied to outcome data

Value

According to Anesthesia Quality Institute's Strategic Plan:

"The specialty of anesthesiology is at risk of being diminished if a high-quality anesthetic is defined only by the patient's survival of induction and emergence in the PACU alive. Anesthesiologists who focus on the immediate operating room outcome are "value enabling," not "value adding." We endeavor to change that."

Patient Centered Care

Patient satisfaction, feedback, and followthrough

Value as an individual:

Sincerity, respect, ethics, integrity, trust, honesty

Value as part of the Anesthesia Team or Practice Team:

Teamwork, integrity, contribution, connection, quality, focus

What VALUE do you bring to your practice? What VALUE do you offer your patients? How can you capture it?

What is next?

How is your practice using its data?

Is it usable?

Are you using it?

Can we use technology to aid us?

Are you maintaining SAFETY and Quality focus?

Are you promoting a SAFETY CLUTURE?

Resources

ASA's Anesthesia Quality Institute (AQI) Strategic Plan 2021

ASA Podcast. Central Line Episode 17: Quality Improvement, August 2020.

'Helping' Your Hospital Partner with Quality and Performance Metrics

[Joseph L. Staggenborg, MD, MBA, FASA](#)

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HANDOUT



Billing Essentials at Your ASC

Thomas Durick, MD



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Billing Essentials at Your ASC

Thomas Durick, MD

Assistant Professor - Clinical

Anesthesia Clinical Operations Director – Outpatient
Care New Albany Ambulatory Surgery Center

Associate Director, Ambulatory Anesthesia Division



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Disclosures

- Fisher & Paykel Healthcare, Inc.: consultant/speaker's bureau
- Butterfly, Inc.: consultant/speaker's bureau

2

Objectives

- Understand HOW the ASC facility gets reimbursed
- Learn why case costing is critical in maintaining a profitable business model
- Learn what WE can control regarding getting
 - The RIGHT patient
 - With the RIGHT insurance
 - Into the RIGHT OR/procedure room
 - In the RIGHT pavilion/building/facility/site
 - At the RIGHT time
 - In the RIGHT order

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HOW the ASC facility gets reimbursed

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HOW the ASC facility gets reimbursed

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- SIMPLE: Submit claims to insurance companies, collect reimbursements for procedures or services performed in the ASC or doctor's office.
- REALITY: Coding, claims submission, reimbursement, denials and appeals



CODING CLAIMS SUBMISSION REIMBURSEMENT DENIAL & APPEAL

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HOW the ASC facility gets reimbursed

Abbreviations and Acronyms: CPT

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- CPT® (Current Procedural Terminology)
 - Codes offer doctors, health care professionals and facilities a uniform language for coding medical **services and procedures** to streamline reporting, increase accuracy and efficiency.
 - CPT codes are also used for administrative management purposes such as claims processing and developing guidelines for medical care review.

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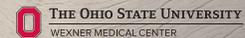
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HOW the ASC facility gets reimbursed: CODING



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- Determines the sum of money one is going to be reimbursed and makes sure that all regulatory standards are being met
- Necessitates the utilization of International Classification of Diseases (ICD) and Current Procedural Terminology (CPT) codes to precisely delineate the diagnoses and procedures done on the patient.
- Can only have ONE fee schedule for insured patients



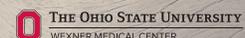
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HOW the ASC facility gets reimbursed Abbreviations and Acronyms: ICD-10-CM



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- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes
 - The standard transaction code set for diagnostic purposes under the Health Insurance Portability and Accountability Act (HIPAA).
 - It is used to track health care statistics/disease burden, quality outcomes, mortality statistics and billing.
 - ICD-10-CM codes are used to describe **why** a service or procedure was performed.



8

HOW the ASC facility gets reimbursed Abbreviations and Acronyms: HCPCS



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- Healthcare Common Procedure Coding System (HCPCS)
 - A set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT).
 - HCPCS includes three levels of codes:
 - Level I consists of the American Medical Association's Current Procedural Terminology (CPT) and is numeric.
 - Level II codes are alphanumeric and primarily include non-physician services such as ambulance services and prosthetic devices, and represent items and supplies and non-physician services, not covered by CPT-4 codes (Level I).
 - Level III codes, also called local codes, were developed by state Medicaid agencies, Medicare contractors, and private insurers for use in specific programs and jurisdictions



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HOW the ASC facility gets reimbursed Abbreviations and Acronyms



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- CPT and HCPCS codes and modifiers describe a **service** and how it was performed. ICD-10-CM codes are used to show **why** a service was performed.
- If CPT/HCPCS predicate **how much** a physician or other qualified provider (facility) will be paid for a service, ICD-10-CM predicates **IF** s/he/it will get paid as these codes establish medical necessity and are used to confirm whether the scenario in which the service was provided conforms with the payer's coverage policies.



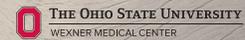
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HOW the ASC facility gets reimbursed: CLAIMS SUBMISSION



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- Essential to ensure that the claims have all the necessary details and are in compliance with the applicable standards.
- The claims should contain all of the patient data, as well as the correct diagnosis and procedure codes for services rendered and the associated charges.
- Accurate claim submission is paramount to ensure timely and accurate payments for services provided.



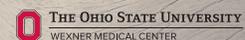
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HOW the ASC facility gets reimbursed: REIMBURSEMENT



Outpatient • Office Based • Non-Operating Room

- The payer will assess the accuracy of the claim and either approve or deny the request for reimbursement.
- Determines whether the provider receives payment for services rendered.
 - Preauthorization may be required for some insurers and procedures
- Reimbursement rates for ASCs are typically lower than those of inpatient or hospital settings.
- To ensure that providers receive adequate reimbursement, it is essential for them to understand the reimbursement process and work with payers to negotiate favorable rates.



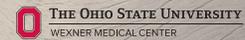
12

HOW the ASC facility gets reimbursed: REIMBURSEMENT



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- Common Payers:
 - Medicare
 - Medicaid
 - Workers' Compensation
 - Private Insurance
 - Self Pay
 - Personal Injury (Lien cases)



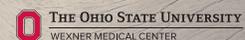
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HOW the ASC facility gets reimbursed: REIMBURSEMENT



Outpatient • Office Based • Non-Operating Room

- Common Payers: Medicare
 - Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category).
 - National coverage determinations (NCDs) are made through an evidence-based process, with opportunities for public participation.
 - In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors based on a local coverage determination (LCD).
 - <https://www.cms.gov/medicare/coverage/determination-process>



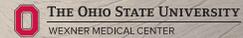
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HOW the ASC facility gets reimbursed: REIMBURSEMENT



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- CMS (Centers for Medicare & Medicaid Services):
 - CMS.gov ASC Payment Rates can be found at <https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-payment-rates-addenda>
 - Covered Procedures List
 - Procedure codes which may be performed in an ASC under the Medicare program as well as the ASC payment group assigned to each of the procedure codes.
 - The ASC payment group determines the amount that Medicare pays for facility services furnished in connection with a covered procedure.
 - No significant additions or changes for 2025



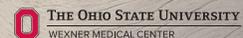
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HOW the ASC facility gets reimbursed: REIMBURSEMENT



Outpatient • Office Based • Non-Operating Room

- CMS (Centers for Medicare & Medicaid Services):
 - Facilities are paid on the “100-50-25-25-0” rule
 - Also known as “Subject to Multiple Procedure Discounting”
 - Device intensive procedures may pay differently from year to year
 - J8 payment indicator: Device-intensive procedure; paid at adjusted rate.
 - CPT 63650 Percutaneous implantation of spinal neurostimulator electrode array: 49.02% of the payment offsets device cost
 - J7 payment indicator: OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.



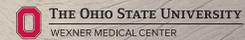
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HOW the ASC facility gets reimbursed: REIMBURSEMENT



Outpatient • Office Based • Non-Operating Room

- CMS
 - Also available on The Ambulatory Surgery Center Association (ASCA) website under "Medicare Resources" Medicare Rate Calculator:
 - A members-only resource that clearly and easily shows your Medicare payment rates for ASC-payable procedures.
 - By selecting your state and county from the drop-down menus, the calculator automatically finds your local wage index and calculates the total payment, Medicare payment and beneficiary copayment for each procedure.
 - The calculator is made available when new rates are released by the Centers for Medicare & Medicaid Services (CMS), most notably in the summer for the proposed payment rule and in the fall for the final payment rule.
 - New calculators are also posted for regular quarterly updates, as well as any ad hoc updates to the payment rates at other times
 - <https://www.ascassociation.org/medicare/rate-calculator>



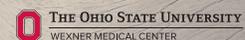
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HOW the ASC facility gets reimbursed: REIMBURSEMENT



Outpatient • Office Based • Non-Operating Room

- CMS (Centers for Medicare & Medicaid Services):
 - Prior Authorization Demonstration for Certain Ambulatory Surgical Center (ASC) Services (CMS-10884)
 - These targeted services can potentially be provided as cosmetic procedures, rather than medically necessary procedures, resulting in improper or fraudulent payments.
 - Blepharoplasty, botulinum toxin injections, rhinoplasty, panniculectomy, and vein ablation.
 - California, Florida, Texas, Arizona, Ohio, Tennessee, Pennsylvania, Maryland, Georgia, and New York.
 - <https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pa-listing/cms-10884>



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HOW the ASC facility gets reimbursed: REIMBURSEMENT

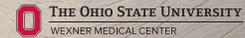


Outpatient • Office Based • Non-Operating Room

- Common Payers: Medicaid
 - A program that is jointly funded by the federal government and individual states, which provides health insurance to individuals with limited financial resources.
 - The services that are covered and the amount of reimbursement for these services differ depending on the state in which the patient resides



**Department of
Medicaid**



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HOW the ASC facility gets reimbursed: REIMBURSEMENT

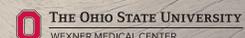


Outpatient • Office Based • Non-Operating Room

- Common Payers: Workers' Compensation
 - Usually state run
 - Reimbursement for the same procedure differs by state
 - Usually a predetermined facility payment per CPT code
 - Cannot balance bill the worker



**Bureau of Workers'
Compensation**



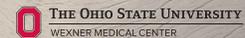
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HOW the ASC facility gets reimbursed: REIMBURSEMENT



Outpatient • Office Based • Non-Operating Room

- Common Payers: Private Insurance
 - Reimbursement and coverage levels depend on the individual's policy.
 - Certain private health insurance plans may need pre-approval for specific treatments or have constraints regarding the site at which the procedure is carried out.



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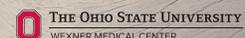
HOW the ASC facility gets reimbursed: REIMBURSEMENT



Outpatient • Office Based • Non-Operating Room

- Common Payers: Private Insurance
 - IN versus OUT of network FACILITY and/or PROVIDERS
 - The federal No Surprises Act (NSA) became effective Jan. 1, 2022
 - When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.
 - This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services.
 - These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

<https://www.cms.gov/medical-bill-rights>



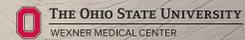
22

HOW the ASC facility gets reimbursed: REIMBURSEMENT



Outpatient • Office Based • Non-Operating Room

- Common Payers: Self-Pay
 - Uninsured
 - Insurance does not cover the requested procedure
 - Prices and payment structure should be established well in advance to cover all costs (staffing, implants, disposables, etc.) and overhead.
 - Often includes presumed anesthesia fees
 - Often based on estimated surgical and anesthesia times
 - Keep on top of case length accuracy!
 - Are ultrasound-guided blocks common and included in the fee?



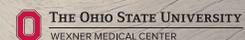
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HOW the ASC facility gets reimbursed: REIMBURSEMENT



Outpatient • Office Based • Non-Operating Room

- Common Payers: Personal Injury (Lien cases)
 - A lien is a legal right to a portion of an asset.
 - When physicians/facilities provide services to treat patients on a lien, it means the patient immediately receives treatment, and payment of the bill is deferred.
 - The treating physician/facility then waits to be paid until the personal injury claim is settled or resolved.
 - After the personal injury attorney has obtained a verdict or a settlement, the personal injury lawyer will pay that medical bill directly from the amount obtained.
 - Financing companies that buy liens from doctors and facilities before litigation is complete are also becoming more common with the practice.



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HOW the ASC facility gets reimbursed: REIMBURSEMENT



Outpatient • Office Based • Non-Operating Room

- Common Payers: Personal Injury (Lien cases)
 - The largest risk for physicians/facilities is that the plaintiff will not win the lawsuit or receive a settlement, and the provider will be uncompensated or 50% of the award will not fully compensate the provider.
 - Physicians/facilities also cannot be certain if they will be paid the entire portion of the bill for their services.
 - An additional risk is that providers must wait sometimes six months to a year (or years) for the resolution of a plaintiff's case.



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HOW the ASC facility gets reimbursed: DENIAL AND APPEAL



Outpatient • Office Based • Non-Operating Room

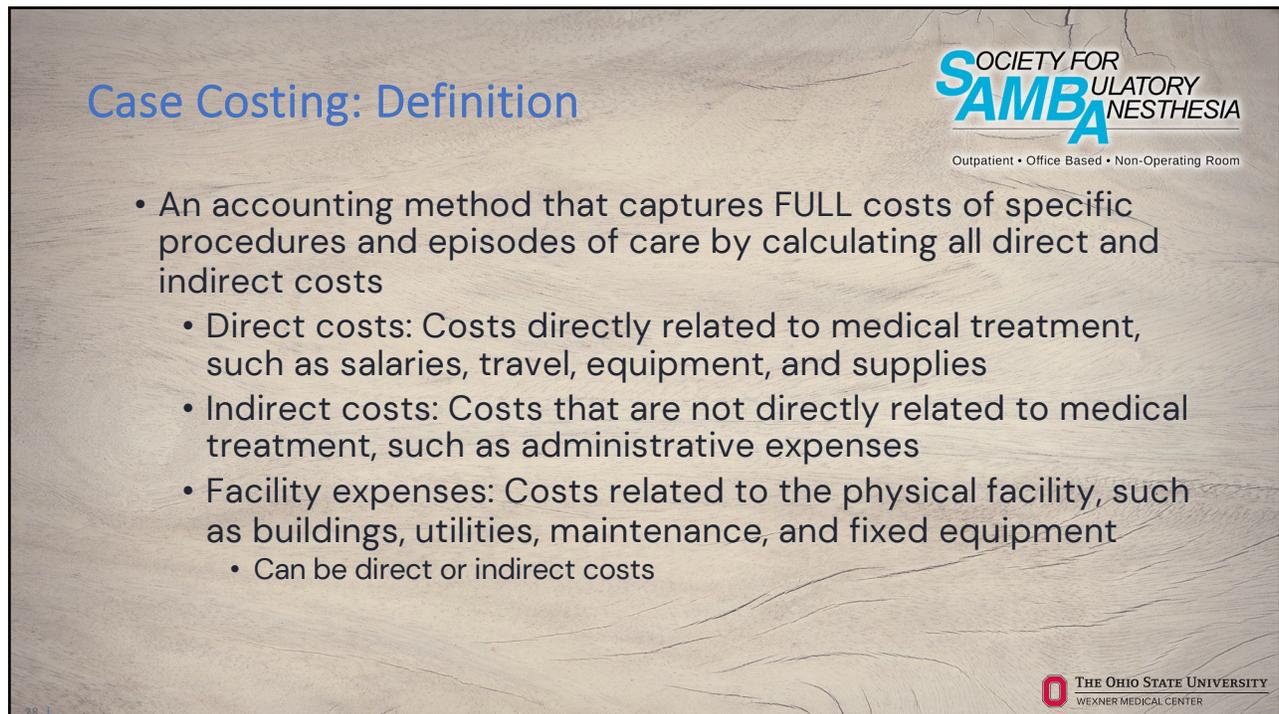
- Understand the reasons behind a denial, as well as the proper steps for appealing the decision.
- An appeal should include any additional information or documentation that should be included with the submission.
- Depending on the payer, there may also be strict deadlines that must be adhered to for successful appeals.
- Appealing a denial is an option, and providers should take advantage of this opportunity whenever possible.



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Case Costing: Why Do It?



Outpatient • Office Based • Non-Operating Room

- Improves budget forecasting
- Better understand expenses and profit margin (the percentage of revenue left after paying expenses)
- Identify areas for cost savings
- Negotiate more effectively with insurers and payers
- Prompt price competition between vendors
- Change physician behavior
- Better understand and evaluate the profitability of different types of procedures to make informed decisions about pricing and resource allocation.



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Case Costing: Direct Costs



Outpatient • Office Based • Non-Operating Room

- Staffing
- Specialized staffing
- Implants
- Supplies
- Equipment and instruments
- Pharmaceuticals
- Shipping fees
- Medical waste management
- Scrubs and laundry
- Janitorial Services
- Maintenance contracts



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Case Costing: Indirect Costs



Outpatient • Office Based • Non-Operating Room

- Billing costs
- Licenses/Fees/Taxes/Membership/Insurance Services
- Web site
- Fax/phone/Internet
- Fixed costs
 - Utilities, credit card fees
 - Office supplies
 - EMR, EHR, Computer OS
 - Transcription services
 - Service fees (Security, Parking, Landscaping)
- Prevention of data breaches, cybercrime, hacking and ransomware



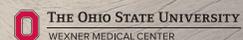
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Case Costing: Measure and Report



Outpatient • Office Based • Non-Operating Room

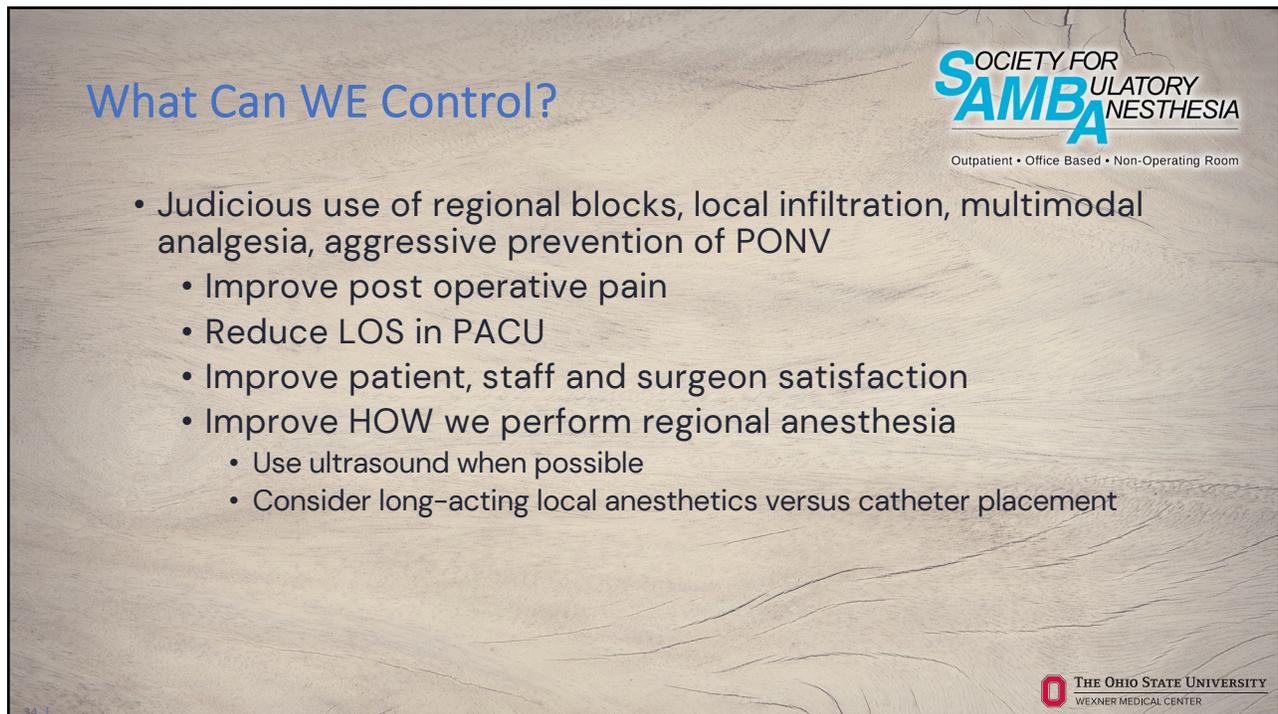
- Track your pre- and post-change improvements
 - Spreadsheet, video, PowerPoint presentation, reports, newsletters
 - Report to physicians, management and STAFF how effective changes were
- Allow staff to generate and implement ideas
- Sustainability plan:
 - No one time events!
 - Review and report regularly
 - Assign staff members to be responsible for maintaining work and improvement and give them TIME to do the work



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What Can WE Control?



Outpatient • Office Based • Non-Operating Room

- Consider long-acting local anesthetics versus catheter placement
 - **Interscalene Brachial Plexus Block**
 - April 6, 2018: FDA approves new use of bupivacaine Liposome for nerve block pain relief following shoulder surgeries
 - EXPAREL is reimbursed for procedures performed in ASCs using the code C9290
 - **BE COST AND TIME EFFECTIVE:**

	Pain Pump	Single-shot Bupivacaine Liposome
Kit/needle/tray	\$113.95	\$13.65
Pump	\$200-450	
Meds	\$78-235	\$234*
Total	\$626-800	\$247

All prices taken from my personal Henry Schein pricing information last accessed 10/1/2024.

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What Can WE Control?



Outpatient • Office Based • Non-Operating Room

- Consider long-acting local anesthetics versus catheter placement
 - EXPAREL is reimbursed for procedures performed in ASCs using the code C9290
 - As of October 1, 2024, EXPAREL is reimbursed at \$1.45/mg (CMS)
 - Allowed amount for reimbursement:
 - \$385.70 266 mg (20 mL) dose
 - \$192.85 133 mg (10 mL) doce
 - The NOPAIN Act will provide separate ASP+6% Medicare reimbursement in HOPDs
 - Effective January 1, 2025, this new federal policy will provide separate reimbursement for proven non-opioid pain management options such as EXPAREL.
 - This will expand Medicare reimbursement beyond the ambulatory surgery center, where separate payment is already available via code C9290 for EXPAREL.

<https://www.exparelpro.com/reimbursement>

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What Can WE Control?



Outpatient • Office Based • Non-Operating Room

- Consider other reimbursable medications to reduce LOS
 - Aponvie (aprepitant)
 - substance P/neurokinin-1 (NK1) receptor antagonist, indicated for the prevention of postoperative nausea and vomiting (PONV) in adults.
 - Administered as a single, 30-second IV injection prior to induction of anesthesia.
 - No need for IV fluid bag or oral administration 3 hours prior to surgery (Emend)
 - APONVIE is separately reimbursed by Medicare at ASP + 6% in HOPDs and ASCs under 3-year transitional pass-through status effective April 1, 2023
 - Average Sales Price + 6% in HOPDs and ASCs
 - Effective April 1, 2023, use C9145 when billing for APONVIE
 - Wholesale acquisition cost: \$58.00/32mg vial
 - C9145: Inj, aponvie, 1 mg \$1.86 (\$59.52/vial)

APONVIE [package insert]. San Diego, CA: Heron Therapeutics Inc; 2022.
<https://aponvie.com/pdf/PONV-Reimbursement-Guide.pdf>

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What Can WE Control?



Outpatient • Office Based • Non-Operating Room

- Consider other reimbursable medications to reduce LOS
 - Barhemsys (amisulpride)
 - selective dopamine-2 (D2) and dopamine-3 (D3) receptor antagonist indicated in adults for:
 - prevention of postoperative nausea and vomiting (PONV), either alone or in combination with an antiemetic of a different class
 - treatment of PONV in patients who have received antiemetic prophylaxis with an agent of a different class or have not received prophylaxis
 - The recommended dosage is 5 mg (PONV prevention) or 10 mg (PONV Rescue treatment) as a single intravenous (IV) dose infused over 1 to 2 minutes. (No need for IV fluid bag)

1. Centers for Medicare & Medicaid Services. Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Application Summaries and Coding Recommendations. Third Quarter, 2023 HCPCS Coding Cycle. CMS website. Accessed May 3, 2024. <https://www.cms.gov/files/document/2023-hcpcs-application-summary-quarter-3-2023-drugs-and-biologics-posted-10/17/2023-updated-12/28.pdf> 2. Centers for Medicare & Medicaid Services. Addendum B Updates. CMS website. Released October 2023. Accessed May 3, 2024. <https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/addendum-b-updates/october-2023-0>
Barhemsys [package insert]. Indianapolis, IN: Acacia Pharma Inc; 2022.

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What Can WE Control?



Outpatient • Office Based • Non-Operating Room

- Consider other reimbursable medications to reduce LOS
 - Barhemsys (amisulpride)
 - The CMS has established the HCPCS Level II code J0184, "Injection, amisulpride, 1 mg," for Barhemsys, effective January 1, 2024.
 - Effective October 1, 2023, Barhemsys has been granted a transitional 3-year pass-through payment status by the CMS. Pass-through status provides additional payment for Barhemsys (ASP + 6%) for ASCs and HOPDs when billed to Medicare for a period of three years.
 - J0184: Inj, amisulpride, 1 mg \$9.06
 - Wholesale acquisition cost:
 - 10mg \$90.00; 5mg: \$45.00

1. Centers for Medicare & Medicaid Services. Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Application Summaries and Coding Recommendations. Third Quarter, 2023 HCPCS Coding Cycle. CMS website. Accessed May 3, 2024. <https://www.cms.gov/files/document/2023-hcpcs-application-summary-quarter-3-2023-drugs-and-biologics-posted-10-17-2023-updated-12-28.pdf>. 2. Centers for Medicare & Medicaid Services. Addendum B Updates. CMS website. Released October 2023. Accessed May 3, 2024. <https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/addendum-b-updates/october-2023-0> Barhemsys [package insert]. Indianapolis, IN: Acacia Pharma Inc; 2022.

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What Can WE Control?



Outpatient • Office Based • Non-Operating Room

- Judicious use of regional blocks, local infiltration, multimodal analgesia, aggressive prevention of PONV
 - Improve post operative pain
 - Reduce LOS in PACU
 - Improve patient, staff and surgeon satisfaction
 - Improve HOW we perform regional anesthesia
 - Use ultrasound when possible
 - Consider long-acting local anesthetics versus catheter placement
- MAC anesthesia may be more time and cost effective than GA/LMA/ETT
- TIVA versus inhalational agents for GA
- Multimodal analgesia

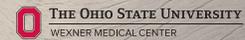
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What Can WE Control?



Outpatient • Office Based • Non-Operating Room

- The RIGHT patient
- With the RIGHT insurance
- Into the RIGHT OR/procedure room
- In the RIGHT pavilion/building/facility/site
- At the RIGHT time
- In the RIGHT order



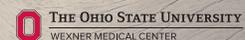
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What Can WE Control?



Outpatient • Office Based • Non-Operating Room

- The RIGHT patient
 - Pre-op assessment: is the patient appropriate for an ASC?
- With the RIGHT insurance
 - Is that procedure covered at your ASC?
- Into the RIGHT OR/procedure room
 - Previous surgeon case length accuracy? Equipment needed elsewhere?
- In the RIGHT pavilion/building/facility/site
 - More profitable at an HOPD or inpatient?
- At the RIGHT time
 - Dialysis, elderly, NPO requirements, implant/equipment/staffing needs
- In the RIGHT order
 - Extended PACU needs for urination, irrigation, bleeding assessment



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Billing Essentials at Your ASC

Thomas Durick, MD

Assistant Professor - Clinical

Anesthesia Clinical Operations Director – Outpatient
Care New Albany Ambulatory Surgery Center

Associate Director, Ambulatory Anesthesia Division



THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

HANDOUT



The Benefits of Advanced Business Degree

Jarrett A. Heard, MD, MBA

SOCIETY FOR
SAMBA ULATORY
NESTHESIA
Outpatient • Office Based • Non-Operating Room

ASC and OBA Medical Directors' Meeting Friday, October 18th, 2024 • Philadelphia, PA



Benefits of an Advanced Business Degree

Jarrett A. Heard, MD, MBA
The Ohio State University Wexner Medical Center
Associate Professor – Clinical Anesthesiology
Medical Director Ambulatory Perioperative Services
Director Executive Leadership and Business in Anesthesiology
Fellowship

1

Objectives

- Explore the role of a business degree in healthcare
- Review dual MD/MBA training programs
- Differentiate the MD vs. MD/MBA physician

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www.SAMBAhq.org

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Business Degree in Healthcare



- Balance expenses
- Accounting/Finance
- Operations
- Data gathering

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3

Business Degree in Healthcare



- Organizational Behavior
- Strategy
- Marketing
- Negotiations

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4

Business in Healthcare

- Improve access/logistics/efficiencies
- Innovation
- Change Management
- Emotional Intelligence
- Leadership

5

MD/MBA

- MD/MBA
 - 33 out of 125 US Medical Schools - 2002
 - 26.4%
 - 92 out of 151 US Medical Schools – 2022
 - 60.9% (60 programs not identified in 2002)

6



Earn an executive MBA, participate in executive-level meetings and gain expertise in OR utilization, capital expense requests, operation gains/losses and procedural reimbursement.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER



Executive Leadership and Business in Anesthesiology Fellowship

We've been nationally ranked as a *U.S. News & World Report* "Best Hospital" for **31 consecutive years**.



Collaboration occurs across **110+** medical center departments, divisions, institutes and centers, as well as **18** colleges and schools at The Ohio State University.

Our eighth and newest hospital, the **1.9-million-square-foot Inpatient Tower**, opens in 2026.



You'll love living in Columbus, **America's 14th largest city** and among the **Top 10** for concentration of young professionals.

Executive Leadership and Business in Anesthesiology Fellowship

- A unique, innovative Anesthesiology fellowship that provides leadership and administrative training.
- 50% of the fellow's time is spent as an attending in ORs.
- The other 50% is spent in non-clinical work, including research, administrative meetings and completion of a 17-month Executive MBA from The Ohio State University Fisher College of Business.
- Two-year commitment
- Clinical work as an attending fully funds the MBA tuition.

7

Mini-MBA Graduate Healthcare Certificate

Creating visionary physician leaders




Outpatient • Office Based • Non-Operating Room

100%
online

15
credit hours

The role of physicians is evolving. The business of healthcare has changed significantly in the last decade and requires all physician leaders to develop managerial and interpersonal skills to deliver value to their patients. Business acumen will improve the leadership and decision-making skills of anesthesiologists, vital skills to improve the efficacy of healthcare delivered around the world.

The Society for Ambulatory Anesthesia, SAMBA, and The Ohio State University Fisher College of Business have partnered to create a Mini-MBA Graduate Healthcare Certificate Program for SAMBA members to meet the expanded needs of leaders in anesthesiology.



PROGRAM COMPONENTS

15 CREDIT HOUR CORE CURRICULUM

Six graduate-level courses:
 Strategy Formulation and Implementation MBA 6293
 Operations MBA 6233
 Organizational Behavior MBA 6201
 Leadership MBA 6202
 Data Analysis for Managers MBA 6273
 Finance MBA 6223

All courses are part of Fisher College of Business's Working Professional MBA program. All courses will be online.

PROGRAM OBJECTIVES

By the end of this program participants will:

- Understand the fundamentals of strategy
- Gain insight into the operations function and how it contributes to ensuring effective and efficient flow of materials and information
- Study employee interactions and organizational processes that seek to create more efficient and cohesive organizations
- Learn the factors that influence individual and team performance and techniques to improve it
- Achieve an application-oriented understanding of data-driven decision-making



"Physician leaders must be visionaries; creating collaborative culture, innovative ideas, and empowering people. Having a business acumen not only allows physicians to see things from a different perspective, but it also allows them to find creative solutions and lends them credibility in their respective organizations."

Jarrett Heard, MD, MBA
 Physician, Associate Professor of Anesthesiology, The Ohio State University Wexner Medical Center

Learn more:




Outpatient • Office Based • Non-Operating Room



8

Differentiation

- What is really does...?
- Allows you to think differently
- **Gives you CREDIBILITY!!!**

Differentiation

- “Hammer and Nail”
- Increases your toolkit
- Promotes a greater sense of curiosity and innovation

Differentiation



- Leadership
- Emotional Intelligence
- Access and Timeline Trajectory - Career
 - Executive Meetings
 - Development/Upward Mobility

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Differentiation



- Hospital Administration
 - Medical Director
 - C-Suite: CMO, COO, CFO, CEO
- Health Care Policy/Research
- Entrepreneurship
 - Insurance Companies/Pharmaceuticals
 - BioTechs
 - Data Analytics
 - Consulting

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Differentiation

- Administrative Roles
- Executive Roles
- Promotion
 - Academics
 - Private Practice - Partner

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Should I pursue it?

- Only if you have a vision...
- 49.3% of physician-MBAs remain clinically active in some capacity
- 27.7% of physician-MBAs report clinical medicine as primary role

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Objectives

- Explore the role of a business degree in healthcare
- Review dual MD/MBA training programs
- Differentiate the MD vs. MD/MBA physician

Questions?

References



- 1.) Folawiyo, L, Wilton, S., Forman H. Characterization of the Landscape of Joint MD/MBA Programs in the US, 2002 to 2022. JAMA Network. June 2023
- 2.) Considering a combined degree. AAMC. 2024
- 3.) Ljuboja, D, Powers, B. When Doctors Go to Business School: Career Choices of Physician-MBAs. American Journal of Managed Care. June 2016