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SAMBA 2024 Annual Meeting
May 2-4, 2024

Patient Selection at the ASCs Panel: What are the Adult Redlines for ASCs?

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Goals:

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- Match patient needs to facility resources
- Concerns: medical issues, risk of admission
- Resources: staffing, surgical equipment, lab requirements, imaging

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Staffing is a resource

Acuity

Volume

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Not all ASCs are resourced equally…

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Screening

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Case is booked & Dropped in CPM queue

Initial screening via phone call or MyChart

If flagged for any concerns then triaged to APP/MD team

APP calls for more information, gathers information, brings patient in for evaluation or potentially a short telemedicine video chat to view airway

Anesthesiologist makes decision on appropriateness of facility

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How to decide?

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Pregnancy…Never say Never

What actually is needed?	• Depends on gestational age…
Ability to do DOP tones/FHR assessments for viability before & after	• RN with capability to assess & coordination with OB if not adequate
Ability to perform C/S if needed (after age of viability)	• OB & team in house with all supplies (including ability to give blood)

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Pregnancy: Better for the Hospital

- Late-term pregnancy
- High-risk pregnancy
- Symptomatic pregnant patients (GERD, cardiopulm)
- Bleeding risk (accreta)

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End-Stage Renal Disease patients

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- Coordination of Care plan to optimize dialysis care plan
- POC testing on DOS for potassium
- Ability to do patients early in the day

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ESRD – Better for the Hospital

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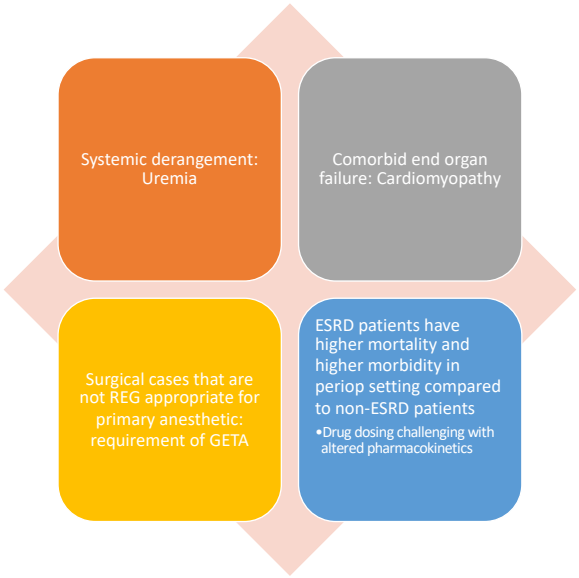

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Implantable Cardiac Devices: Pacer/AICD

Depends on the reason for having it!

- Compensated
- Not compensated

Heart failure optimization- YES!

Sick sinus syndrome

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Implantable Cardiac Devices: Pacer/AICD: Better for the Hospital

Electrophysiology not available on site, or for interrogation prior to DOS

Pacer dependent, with EP not available

AICD placed for decompensated cardiomyopathy with low EF

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Severe Pulmonary HTN

Depends on the surgery

Something we can do with a block only?

Risk of GA

Local only?

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Pulmonary HTN: Better for the Hospital

- Moderate or Severe PAH (PAP > 50 mm Hg)
- Symptomatic: Class 3 or 4 PAH
- Untreated Class 1 or 2 PAH
- Right Heart Strain
- PHtn a/w excess morbidity and death in patients undergoing noncardiac surgery
  - Increased risk of HF, arrhythmia, hemodynamic instability, respiratory failure, prolonged ventilator support and intensive care needs.

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CHF

- Compensated vs Decompensated
- Compensated:
  - Symptoms stable, well managed
  - Pulmonary edema/fluid retention minimal or does not impact function

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Decompensated CHF: Better for the Hospital

Decompensated CHF:

- Deterioration in patient status
- Pulmonary edema, lethargy/malaise, reduction in exercise tolerance, increasing DOE,

Better for hospital b/c:

- Due to recurrent ischemia, infection, arrhythmia, electrolyte disturbances
- Mortality after noncardiac surgery higher in patients with heart failure compared to other cardiac comorbidities

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End stage liver disease

Nonstarter for us as our transplant group isn't on board

Ability for blood (thrombocytopenia)

POC (dialysis)

Would need documentation of varices

Liver enzymes

Ability to give albumin/electrolytes

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ESLD: Better for the Hospital

Decompensated cirrhosis: MELD score	
Active bleeding varices	
Ascites requiring frequent paracentesis	
Encephalopathy	
Mortality rates very high (16.3% for patients with cirrhosis, compared to 3.5% in control group) 30 days after undergoing nonhepatic general surgery	
Decompensated:	Acute hepatic failure risk, sepsis, bleeding, renal dysfunction

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Time to Wait Guidelines:

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- Wait 60 days after a MI
- Wait 90 days after a drug-eluting stent
- Wait 30 days after acute stroke or TIA
- Wait at least a week after stopping GLP-1 inhibitors
- Wait at least a week after stopping Phentermine

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Thank you!

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