

JANUARY 30 – FEBRUARY 1, 2026

2026 **ACG'S IBD SCHOOL &
ACG BOARD OF GOVERNORS /
ASGE BEST PRACTICES COURSE**

  **LAS VEGAS**



1

2025 **ACG'S HEPATOLOGY
SCHOOL & SOUTHERN
REGIONAL POSTGRADUATE COURSE**

DECEMBER 5-7, 2025 | RENAISSANCE HOTEL, NASHVILLE, TN

 Register online: meetings.gi.org



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2026 ACG'S ENDOSCOPY SCHOOL
& ACG / LGS REGIONAL
POSTGRADUATE COURSE

MARCH 6-8, 2026 | HILTON NEW ORLEANS RIVERSIDE
NEW ORLEANS, LOUISIANA

ACG LGS LOUISIANA GASTROENTEROLOGY SOCIETY Register online: meetings.gi.org

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Virtual Grand Rounds universe.gi.org

Participating in the Webinar

All attendees will be muted and will remain in "Listen Only Mode"

Type your questions here so that the moderator can see them. Not all questions will be answered but we will get to as many as possible.

A handout with the slides and room to take notes can be downloaded from your control panel.

Moderators:
Andy Tau, MD

Exit

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ACG Virtual Grand Rounds universe.gi.org

ACG Virtual Grand Rounds

Join us for upcoming Virtual Grand Rounds!




Week 50 – Thursday, December 14, 2025
 ACG Guideline: Diagnosis and Management of Gastric Premalignant Conditions
 Faculty: Douglas R. Morgan, MD, MPH, FACG
 Moderator: Juan E. Corral, MD, MPH
 At Noon and 8pm Eastern


In observance of the winter holidays, ACG Virtual Grand Rounds will take a brief holiday break and return on Thursday, January 8th, 2026.




Week 02 – Thursday, January 8, 2026
 GI Nutrition Care Series: Nutrition in Specific Patients- Dysmotility/Disorders of Gut Brain Axis
 Faculty: Kate Scarlata, MPH, RDN, LDN
 Moderator: Iris Wang, MD
 At Noon and 8pm Eastern


Visit gi.org/ACGVGR to Register

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GUIDE TO THE GUIDELINES

Book Series with New Volume



Visit <https://members.gi.org/store/> to purchase your copies!

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Disclosures



Andy Tau, MD:
 3-D Matrix: Consultant; Braintree Pharmaceuticals: Consultant;
 Boston Scientific: Consultant; Cook: Consultant; Neptune Medical:
 Consultant; Steris: Consultant



Kunjali Padhya, MD, FACP:
 No relevant financial relationships with ineligible
 companies.

**All of the relevant financial relationships listed for these individuals have been mitigated*

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ACG's 2025 Practice Management Summit Course Highlights



Andy Tau, MD




**Kunjali Padhya, MD,
FACP**

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AI Masterclass: Optimizing Clinic Workflow

Andy Tau, MD
Austin Gastroenterology




AG Austin Gastroenterology
part of GI Alliance

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8:00 AM

First New Patient Visit of the Day...



10

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#1

Ambient Scribe

Open Evidence (free) 

Doximity (free) 

Freed (\$90/mo.) 

11

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LIVE DEMONSTRATION

12

15

Doximity is very succinct.

15

16

Freed can learn your format.

16

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Copy and Paste

17

The top row shows two screenshots. The left one is the OpenEvidence interface, displaying a patient note with a 'Subjective' section. The right one shows a patient note for 'Ms. Padhya' with a 'Subjective' section. The bottom screenshot shows the Scribe interface, which includes a patient note on the left and a 'Smart Changes' panel on the right with options like 'Update Pronouns', 'More detailed', 'Less detailed', and 'Add billing codes'.

The Clicks Add Up...

18

8:07 AM

Patient asks you a distinct clinical question.
You don't know the answer.

19

#2

Point-of-Care Clinical Information

Open Evidence (Visits)
Doximity GPT 4o

20

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LIVE DEMONSTRATION

21

Find People or Ask GPT Home GPT Dialer Fax Careers Scribe ^{New}

HIPAA Compliant

What brings you in today?

Ask a question Attach

What's new Look up a drug Ask a clinical question Help me write

About DoxGPT

Including free full-PDF access to 2000+ medical journals

nature Annals THE LANCET The NEW ENGLAND PMI

Answers w/o Hallucinations.

22

OpenEvidence Assign to Patient... New Visit

Paragraph B I U Copy Note

Show Codes

and supplementation in patients with chronic diarrhea and unintentional weight loss, pending results of malabsorption workup

Nutritional monitoring and supplementation recommended for chronic diarrhea with weight loss

Problem #3: Inability to Belch (Lifelong)

Assessment: Patient reports lifelong inability to belch with associated gas buildup, chest discomfort, and past compensatory behaviors (self-induced gagging to release gas). Retrograde cricopharyngeal dysfunction (inability to belch) is a rare but recognized condition; recent case series and expert consensus suggest management may include behavioral therapy, botulinum toxin injection, or cricopharyngeal myotomy in refractory cases. Further evaluation and discussion

Retrograde cricopharyngeal dysfunction management options per case series and expert consensus

Plan:

- Clinician to research condition and potential therapeutic options.
- Discuss findings and management strategies at follow-up visit.

03:14 Transcribe

Ask History Send Feedback

Ask a question...

Are there any other questions I should ask the patient?

Check for specific contraindications in my plan.

Augment my plan with evidence.

Learn something new. Write to the

23

OpenEvidence Share New Question

cricopharyngeal dysfunction), and what are the recommended management strategies?

clinical_note_2025-10-23.html

Finished thinking

There is strong evidence supporting botulinum toxin injection into the cricopharyngeus muscle as the first-line management for lifelong inability to belch (retrograde cricopharyngeal dysfunction, R-CPD), though no formal guidelines exist.

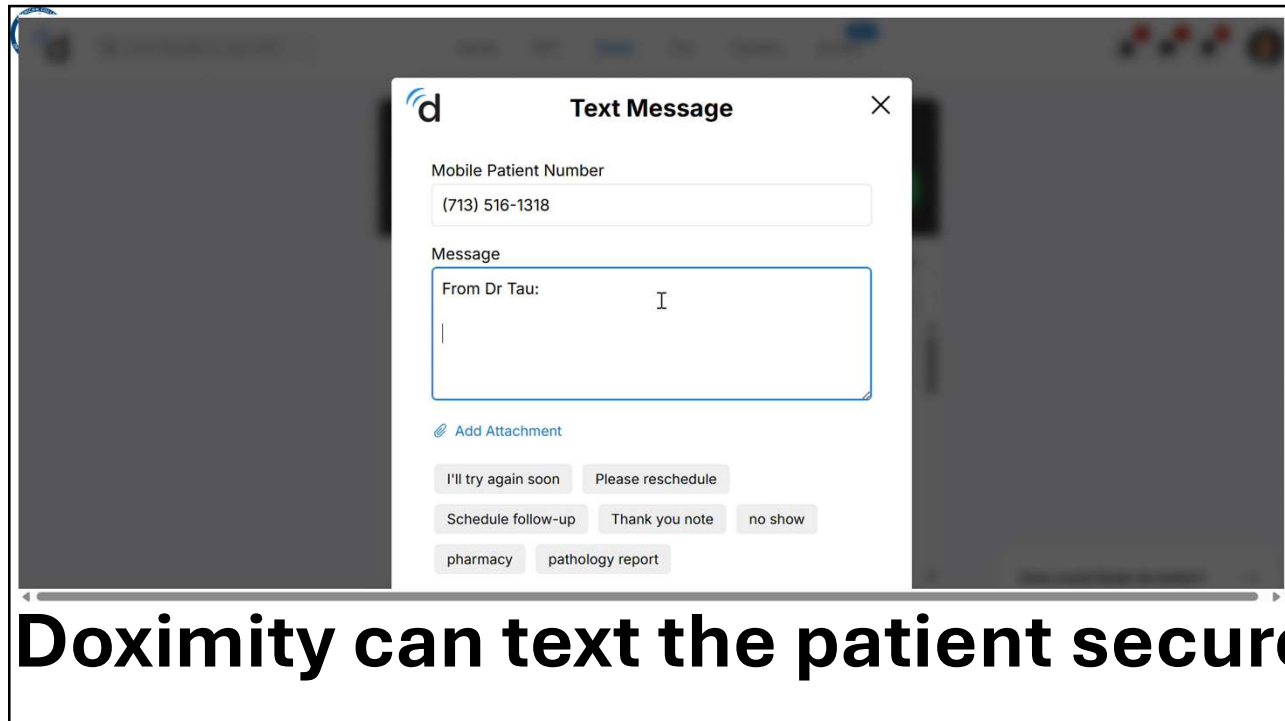
R-CPD is defined as a lifelong inability to belch, often accompanied by gurgling noises, chest/abdominal discomfort, bloating, and excessive flatulence.^[1-3] Symptoms typically begin in adolescence or earlier and can significantly impair quality of life.^[3-4]

Pathophysiologically, R-CPD results from failure of the cricopharyngeal (upper esophageal) sphincter to relax during esophageal gas distention.^[5-7] Diagnosis is primarily clinical, but high-

Ask a follow-up question...

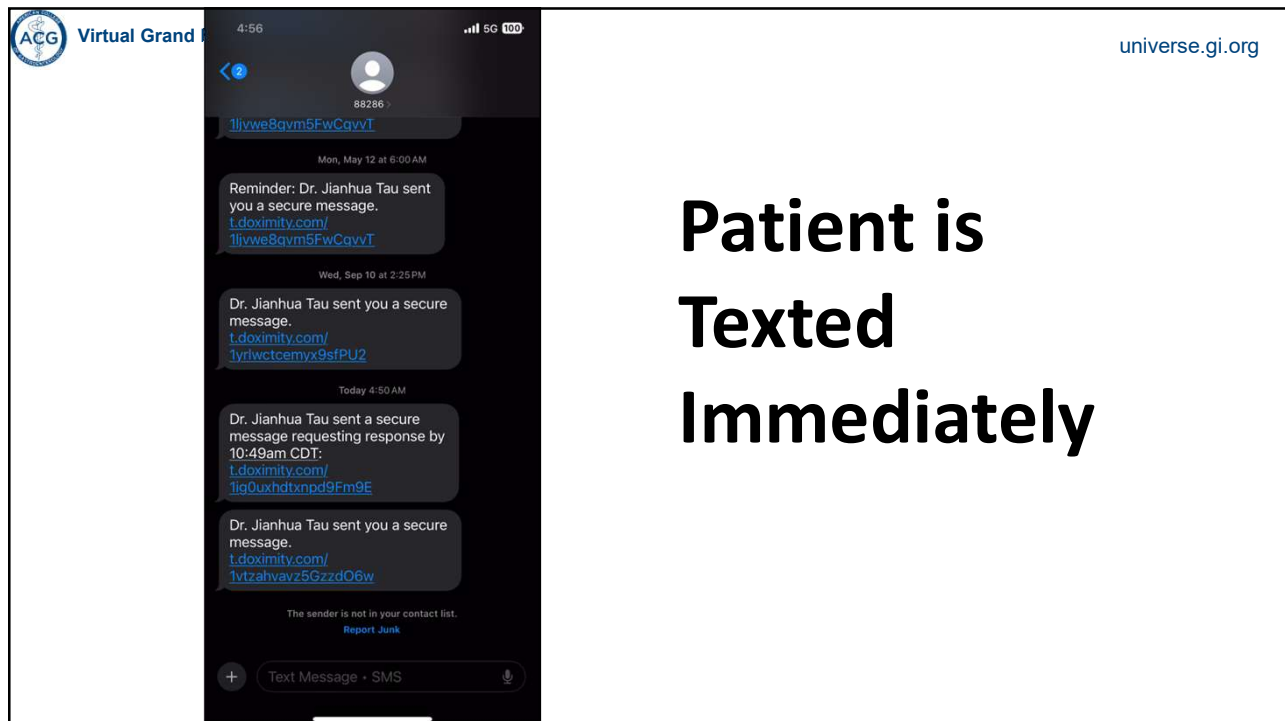
Write to patient what you learned

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Doximity can text the patient securely

25



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OpenEvidence has signed content agreements with JAMA and The New England Journal of Medicine.

OpenEvidence Log In Sign Up

CME has arrived on OpenEvidence

April 2, 2025

CAMBRIDGE, MA, April 2, 2025 - We are thrilled to announce that CME is now available for free on OpenEvidence!

Verified NPI users can now earn AMA PRA Category 1 Credits™. Access the learning experience at <https://www.openevidence.com/profile/cme>, or click on CME in your user menu.

How it works:

- Review and reflect upon your OpenEvidence search results
- Take short learning assessments
- Get your official transcripts

If you have any questions, please do not hesitate to reach out to contact@openevidence.com. You can also use the "Send us feedback" link on the CME page. Tell us what you would like to see next.

We hope this makes your life a little easier. Thank you for making us a part of your professional experience.

[-- See all announcements](#)

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8:10 AM

Patient starts to frantically take notes because she cannot remember all your recommendations.

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#3

Email Bespoke After-Care Summary

Freed

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LIVE DEMONSTRATION

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Freed | Invite team | ? | Profile

+ Start a visit

Search patient name...

All Notes

- Sample Patient 5
10/24/25 6:59am (1 min)
Sample patient example
- Sample Patient 4
10/23/25 6:08am (1 min)
Chronic diarrhea after meals
- Ms. Padhya**
10/23/25 5:31am (4 min)
chronic diarrhea after meals
- Sample Patient 2
10/22/25 2:55pm (6 min)
Difficulty eating and fullness
- Sample Patient 1

Template Library New

Ms. Padhya | Pronouns

Saved about 11 hours ago | Resume

Adult female with post-infectious diarrhea, bloating, and weight loss following India travel, exacerbated by specific foods and stress.

Note | Transcript | New Letter

New Patient | Learn format

ICD-10 Codes

- F41.9 | Anxiety disorder, unspecified
- F32.9 | Major depressive disorder, single episode, unspecified

Patient Instructions

Dear Patient,

Thank you for visiting us today. Here is a summary of the key instructions from our consultation:

- Diagnostic Tests:
- Fecal calprotectin test to check for inflammation
- Comprehensive stool testing to look for infections and parasites

Secure Send

Freed Emails Bespoke After-Visit Summary

31

Freed | Invite team | ? | Profile

+ Start a visit

Search patient name...

All Notes

- Sample Patient 5
10/24/25 6:59am (1 min)
Sample patient example
- Sample Patient 4
10/23/25 6:08am (1 min)
Chronic diarrhea after meals
- Ms. Padhya**
10/23/25 5:31am (4 min)
chronic diarrhea after meals
- Sample Patient 2
10/22/25 2:55pm (6 min)
Difficulty eating and fullness
- Sample Patient 1

Template Library New

Ms. Padhya | Pronouns

Saved a couple minutes ago | Resume

Adult female with post-infectious diarrhea, bloating, and weight loss following India travel, exacerbated by specific foods and stress.

Note | Transcript | New Letter

New Patient | Learn format

Patient Instructions

Dr J Andy Tau

PS. Regarding my homework, I did find answers regarding Indian's and celiac disease, as well as a likely diagnosis for your inability to burp:

- #1 Indians and Celiac Disease:
- # 2 Inability to Burp

Add Additional Research/Info

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universe.gi.org

Instructions from your medical provider

no-reply@getfreed.ai
To: You
Fri 10/24/2025 11:57 AM

Dear Patient,

Thank you for visiting us today. Here is a summary of the key instructions from our consultation:

- Diagnostic Tests:
 - Fecal calprotectin test to check for inflammation
 - Comprehensive stool testing to look for infections and parasites
 - Upper endoscopy to check for H. pylori bacteria and celiac disease
 - Colonoscopy due to weight loss, blood in stool, and family history
- Medications:
 - Take dicyclomine before meals to help with gut spasms and urgency
 - Take dicyclomine before stressful events to calm the gut
 - Continue taking sertraline as prescribed for anxiety and depression
- Dietary Modifications:
 - Avoid spicy foods and foods that trigger your symptoms for now
 - Avoid garlic, onions, cauliflower, and lentils until further notice
- Follow-up:
 - Return after test results are available to discuss next steps

Please feel free to reach out if you have any questions or concerns. We are here to support you every step of the way.

Patient is Emailed Immediately

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12:00 PM Lunch

PHARMACY COMMENTS:
 ALTERNATIVE REQUESTED :THE PRESCRIBED MEDICATION IS NOT COVERED BY INSURANCE. ➔
 PLEASE CONSIDER CHANGING TO ONE OF THE SUGGESTED COVERED ALTERNATIVES.

Inbox Task: Insurance has denied medication coverage for your patient.

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#4

Insurance Denial Appeal Letters

(Or Pre-Authorization)

Open Evidence
Doximity GPT 4o

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LIVE DEMONSTRATION

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The screenshot shows the OpenEvidence interface. On the left, a medical note is displayed with the following content:

MRN:
 Author / Clinician: Jianhua Tau, Physician

Subjective
Chief Complaint: Diarrhea worse after meals
History of Present Illness:
 The patient reports approximately one year of chronic, watery diarrhea that begins within about an hour after eating and is accompanied by marked abdominal bloating/distention, urgency, and a sensation of incomplete evacuation. Symptoms began after an episode of acute gastroenteritis while visiting India—characterized by nausea, vomiting, and severe diarrhea for several days—and have persisted since. The patient experiences several loose stools per day and has unintentionally lost about 10 lb (from 160 lb to 150 lb). They occasionally notice small amounts of bright red blood on toilet paper or a few drops in the bowl, believed to be from hemorrhoidal irritation due to frequent wiping. Identified triggers include traditional Indian foods and the patient floats the Guadalupe River every summer with occasional water. Past history notable for anxiety/depression; currently taking sertraline, but in Texas; parents immigrated from India.

On the right, a chat window is open with the following message:

Insurance denied Rifaximin. Write a rebuttal using guidelines/evidence. Mention the pt is already on SSRI and thus cannot take TCA given risk for serotonin syndrome. Mention the Texas law (? 0546) that allows for exception to step therapy if an alternative medication is not medically appropriate. If denied again, include request for denier's name and NPI.

Below the chat window are two input fields:

- Are there any other questions I should ask the patient?
- Check for specific contraindications in my plan.

Appeal Letter via Open Evidence

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The screenshot shows a virtual grand rounds interface. At the top left is the ACG logo and the text "Virtual Grand Rounds". At the top right is the URL "universe.gi.org". The main content area displays a text block with the following information:

Dr. Richard Sperling
 Dr. Jianhua Andy Tau
 Dr. Henry Thomas

Phone (512) 454-4588 Fax (512) 459-9869
 Mikel Zamora, PA-C

Date: 10/24/2025 7:34 AM
 Provider: Jianhua Andy Tau, MD
 Patient Name: Jianhua Andy Tau
 DOB (age): 10/3/1984 (41)

To Whom It May Concern:

I


Sincerely,

Jianhua Andy Tau, MD

Jianhua Andy Tau, MRN 1420485, DOB 10/3/1984
 General Letter, Friday, October 24, 2025

Copy and Paste

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6:00 PM

Marketing Department Requests Social Media
Content

39

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#5

**Education/Marketing Content
Creation**

HeyGen (AI Avatar) 

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LIVE DEMONSTRATION

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HeyGen


New video

Projects

Transform any idea into a compelling video
Generate professional videos from simple prompts. Browse community creations for inspiration, or start fresh with your own vision.

Create a 30 second video for social media/public education campaign educating the public about how certain Indian people are at high risk for celiac disease and the misconception that its a disease of only white people. Use an Indian avatar

+ ⌵ Auto ▾ 📱 📺



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Take Home Points

- **AI scribes** write HPI and A&P, adapt to your style, and even cite sources—though (Copy & Paste) EMR integration remains bottleneck.
- **Live clinical queries** pull evidence on the spot from journals like NEJM and JAMA. You may even spontaneously learn things from the AI-scribe itself (Open Evidence)
- **After-visit summaries:** provide bespoke recommendations for patients, boosting recall and compliance
- **Prior-auth & denial letters** can be auto-generated, weaving patient details with literature citations.
- **AI avatars** create marketing and training content—just disclose use.

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Practice Management Summit 2025: The Hits!



ACG Practice Management Summit Faculty
Presented by Kunjali Padhya, MD

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Innovation in the ASC and Clinic



John Fang MD
Professor of Medicine and Clinical Director,
Division of Gastroenterology
University of Utah Health



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Core Metrics: Can't improve what we don't measure

- **Case Volume-** # procedures performed in a specific timeframe
- **True Completion Time (TCT):** Scheduled procedure start time to the time the patient exits the room post-procedure ("wheels out)
- **Throughput Time:** Time from patient arrival to discharge
- **Procedure Duration**
- **Turnover Time:** Time between endo procedures
- **First Case On-Time Start (FCOTS):** % procedures starting on schedule
- **Cancellation Rate:** % scheduled procedures that do not proceed
- **No-Show Rate:** % patients who fail to arrive for their procedure



Gastrointest Endosc. 2014;79:637-645

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Structural Innovations

AI AI AI

- Automation
 - Pre + post- procedure
 - Reminders
 - Education
 - ChatBot
- EMR templates
- Efficient scheduling
 - Predictive models
- 3rd Party vendors
 - HIVE, NAVGI 360 (Braintree), Memora, Twistle

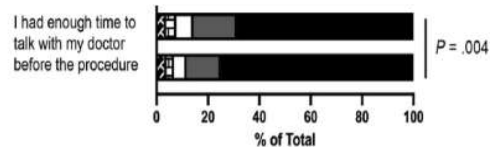
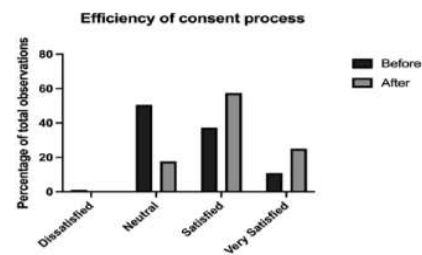


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Solutions to Bottlenecks: Video Consent

- **Problem: Consent process**
 - Not standardized
 - Rushed
 - Dual consents needed
- **Solution: Consent Video**
 - Standardized
 - Multiple languages
 - Included anesthesia/GI
 - Allows more time talk to patient



Gastro Hep Advances 2023;2:1082-1087

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Plan-Do-Study-Act

• PDSA

- Time Motion studies in manufacturing
- Used in OR surgery/anesthesia
- Framework systematically implement QI changes stepwise process

- Enables iterative, data-driven changes with stakeholder buy-in

- **Plan:** development of a proposed intervention

- **Do:** implementation of this intervention

- **Study:** analysis of how the intervention affects outcomes

- **Act:** adaptation of the findings into practice

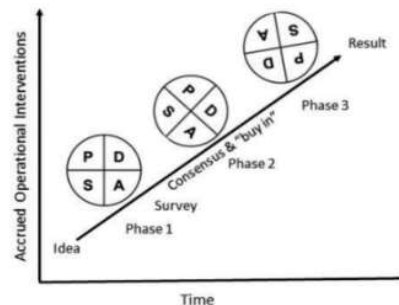
49



Plan-Do-Study-Act

• Repeat

- Start small to prevent disruptions in opinion and workflow
- "Ramped up" over time as support is gathered through proof of concept.
- Initial results encourage organizational consensus and stakeholder buy-in to Q) initiative and
- Supports larger changes and operational improvements downstream




Endosc Int Open 2024;12:E642–E648

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ACG 2025



Withdrawal Time: Is It Time to Get Out of the Hospital?

Dr. Lanre Jimoh, MD, MBA
Partner
Carolina Digestive Health Associates

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Affiliations with multiple hospitals

- **Negotiation Leverage:** Essentially, the GI group becomes a free agent that both systems want on their team, rather than a captive that can be taken for granted.
- **Patient Access and Referrals:** Being in multiple systems also broadens your referral base. You can see patients from both hospital networks, and your referring primary care doctors have more options to send you cases regardless of which system the patient's insurance or PCP is aligned with.
- **Workload Balance:** Of course, multi-hospital affiliation can increase the complexity of scheduling and call (covering two ERs). It requires sufficient physician manpower to split coverage. But many groups manage this by designating certain docs to certain hospitals on certain days, etc. The key point is flexibility: you can choose how much to engage with each hospital. If one relationship deteriorates, you haven't "pulled out" of hospital work entirely – you can shift focus to the other or to your ASC. It's like diversifying a stock portfolio: don't invest all your effort in one hospital.

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Stay or Go? – Evaluating “Pulling Out”

- **The Big Question:** Is it time to pull out of the hospital? In other words, should private GI groups consider severing (or reducing) their hospital roles and focusing on outpatient practice? The answer likely isn't a simple yes/no universally – it depends on local conditions and the feasibility of alternative models. Here we break down considerations.

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Pros

- **Avoiding the Hassle:** No more 2 AM emergency cases
- **Financial Control:** out-patient procedures only, optimize efficiency
- **Lifestyle Improvement:** No more nights and weekends

Cons

- **Patient Care Continuity:** Hospitals might hire their own GI which could fragment care.
- **Loss of Complex Cases:** Hospital work includes complex GI bleeding, advanced endoscopy in ICU patients, etc.
- **Relationship Damage:** A full “pull-out” could strain relations with hospital systems and even referring physicians

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Take Home Points

- **A Balanced Approach:** A middle ground – **reduce** hospital commitments without eliminating them. For instance, **negotiate protected time (or pay) for call**, scale back to covering one hospital instead of three, or rotate hospital duties among a larger pool to lighten individual load. Meanwhile, **grow the outpatient side** such that the hospital is one component of your practice, not the tail that wags the dog. In essence, **assert your boundaries** with hospitals (don't be exploited), but **maintain a presence for the critical acute care** that patients need and that keeps your skills sharp.

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Anorectal Ancillaries



Eric D. Shah, MD, MBA, FACG

University of Michigan
Associate Professor of Medicine

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Anorectal manometry

Think: endoscopy

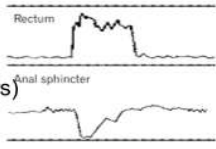
MONEY:

1. Capital expenditure for a "tower"
2. Disposables (high resolution catheters)
3. Space to house the equipment (newer equipment, not so)

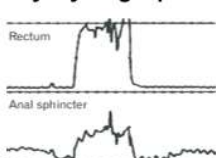
TIME: to train your staff

THE GOAL: to identify dyssynergia

No dyssynergia present



Dyssynergia present



IAPWG PROTOCOL

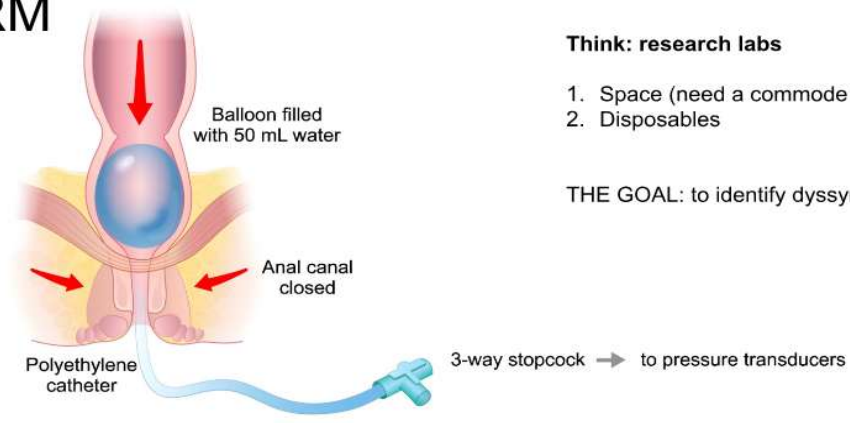
Time (mins)	Activity	Recovery Interval
0	Stabilization – 3 min	
3	Rest – 60 s	
4	Short squeeze – 5 s	30-s recovery interval between short squeezes
5	Short squeeze – 5 s	
6	Short squeeze – 5 s	
6	Long squeeze – 30 s	60-s recovery interval after long squeeze
7	Cough	
8	Cough	30-s recovery interval between each cough and push
8	Push – 15 s	
9	Push – 15 s	
9	Push – 15 s	
10	Rectal sensory testing	
11		
12	RAIR	

Rao, et al. J Neurogastroenterol Motil 2016; 22(3):423-435.
Carrington EV, et al. Neurogastroenterol Motil. 2020 Jan;32(1):e13679.

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Balloon expulsion testing accompanies ARM



Balloon filled with 50 mL water

Anal canal closed

Polyethylene catheter

3-way stopcock → to pressure transducers

Think: research labs

1. Space (need a commode or restroom)
2. Disposables

THE GOAL: to identify dyssynergia

Lee, et al. J Neurogastroenterol Motil 2014; 20(3):407-409.

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Patient selection is key

Good fit

- History of vaginal delivery
- Weight lifters
- Hemorrhoids are associated with constipation
- Poor prep due to pelvic floor
- Tried psyllium or PEG and referred to a gastroenterologist

Poor fit

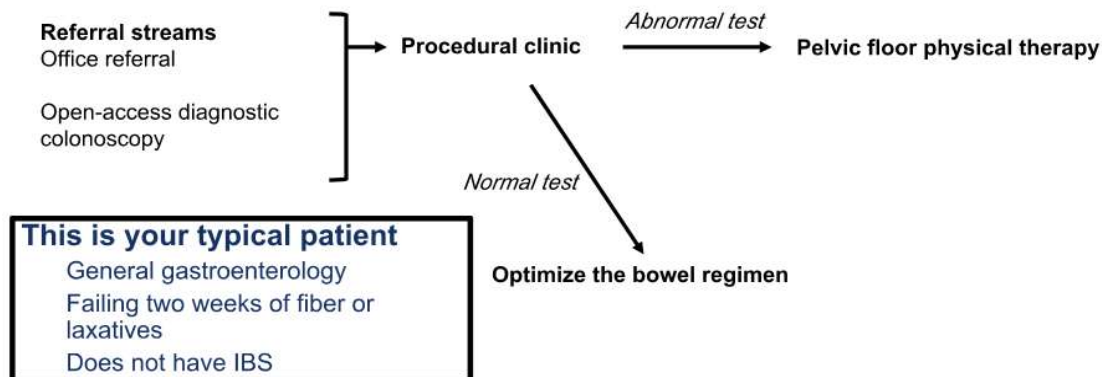
- Patient declines PT or testing
Offer something else
- Anal fissure
Treat that appropriately
- Anal stenosis
Refer to surgery
- Significant psych comorbidities
Refer to psych, not PT

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How to set up your clinic

The big picture



60



How to set up your clinic

Procedural clinic option 1

- One half-day per week for your staff
- Staff with one MA or nurse
 - Performs the test in a clinic room
 - 30 minute appointments
 - 8 patients total
 - Need lube, blue pad, wipes
- You interpret off-site and send results to referring MD
- FOR HIGH RESOLUTION REUABLE ARM:
 - You need enough catheters: You will need central cleaning
 - Consider disposable catheters and cost differential

Template	Schedule
30 minutes	Procedure
30 minutes	Procedure
30 minutes	Procedure
30 minutes	Procedure
30 minutes	Procedure
30 minutes	Procedure
30 minutes	Procedure
30 minutes	Procedure
30 minutes	Procedure

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How to set up your clinic

Template	Room 1	Room 2
15 minutes	Procedure	
15 minutes	Room turnover (MA)	Procedure
15 minutes	Procedure	Room turnover (MA)
15 minutes	Room turnover (MA)	Procedure
15 minutes	Procedure	Room turnover (MA)
15 minutes	Room turnover (MA)	Procedure
15 minutes	Procedure	Room turnover (MA)
15 minutes	Room turnover (MA)	Procedure
15 minutes	Procedure	Room turnover (MA)
15 minutes	Room turnover (MA)	Procedure
15 minutes	Procedure	Room turnover

Procedural clinic option 2

- One half-day per week to offset your clinic days
- Staff with one MD/NP/PA + one MA
- Run two clinic rooms simultaneously
- Stagger 15 minute appointments
- 16 patients total
- You interpret on-site and use the brief visit to discuss results: 90% adherence to PT visits
- This model is similar to hemorrhoid banding

Shah ED, et al. Clin Gastroenterol Hepatol. 2023 Apr;21(4):1082-1090.
Shah ED, et al. Clin Gastroenterol Hepatol. 2023 Apr;21(4):1070-1081.

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There is a pelvic floor PT near you pelvicrehab.com

HOME ABOUT JOIN BLOG CONTACT

Search Again 48109 Find!

TruWell Physical Therapy
L 248-76-1839
2653 Oakley Park Road Suite 202 Commerce...

Kathryn Hanson, PT, DPT, PRPC
L 215-733-4374
193 East Sherman Blvd Muskegon, Michigan 49448

Connie M Strey PT, WCS, BCB-PMD, CM...
L 920-729-0962
375 W. Prospect Ave Appleton, Wisconsin 54914

Katie Tredo, PT, DPT, PRPC
L 364-877-0141
107 W. Glen Oaks Ln Suite 170 Mequon, WI...

Lauryn Beecher, PT, DPT, PRPC, RYT
L 414-241-5041
316 E Silver Spring Dr Waukesha, Wisconsin 53127

Karan Munger, MSPT, cert...
L 616-354-1299
8299 Jupiter Ave, NE Suite C Baymont, MI 48...

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How to Establish a Chronic Care Management (CCM) Ancillary Service

Rathi Narayan, MD, MBA, FACC
Managing Partner
Gastroenterology Associates
Kingsport, TN

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What is CCM? - CMS definition

Non face-to-face services for Medicare patients with multiple chronic conditions, requiring structured care planning and coordination between healthcare visits.

65

Patient eligibility

- **2 plus chronic conditions**
- **Expected to last 12 plus months**
- **Places patient at significant risk**
- **Medicare beneficiary**



66

Eligible GI conditions

- **Inflammatory conditions**
- **Functional disorders**
- **Organ specific disorders**



67

What to Know

- **Clinical staff can furnish services under direction of the billing practitioner on an incident basis**
- **Clinical staff to be licensed in the state in which services are being furnished**
- **TCM can be billed together with CCM**

68



CMS and federal compliance requirements

Technology requirements

- **Certified EHR system \$15,000**
- **CCM billing software \$6000**
- **24/7 access platform \$12,000**

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Operational Requirements


- **Patient consent process \$3000**
- **Staff training program \$8000**
- **Care plan development \$5000**
- **Quality reporting set up \$4000**

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ROI analysis

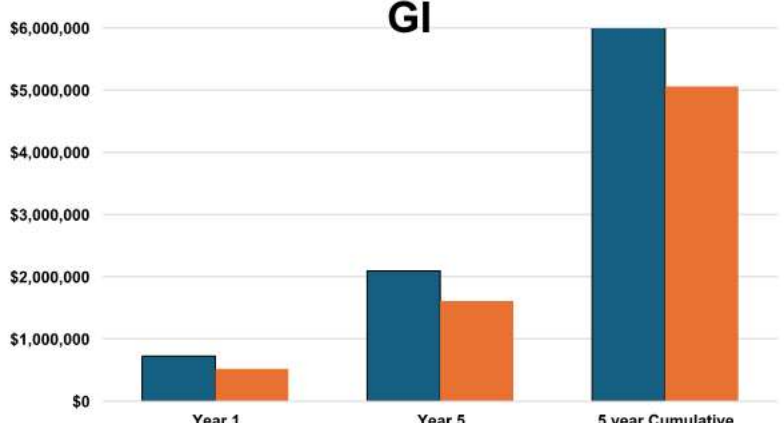
- Initial investment \$53,000
- Monthly revenue \$60,000
- Break even point 4.2 months



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CCM Growth Projection – Medium GI



Year 1 (2025)	Year 5 (2029)	5-Year Totals Cumulative
Revenue: \$720,527	Revenue: \$2,093,962	Revenue: \$6,719,536
Profit: \$516,527	Profit: \$1,609,948	Cumulative Profit: \$5,059,517
Patients: 675	Patients: 1,778	Average Annual Growth: 24.3%

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Conflict Resolution: Difficult Patients and the Impact of Customer Satisfaction



Sunanda V. Kane MD, MSPH, MACG
Professor of Medicine
Chief Patient Experience Officer
Mayo Clinic

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Common causes of anger for patients

- Wait Times
- Miscommunication
- Service Failure or Perceived Service Failure
- Complex Medical Situations



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How we respond matters



Instead of This...	Try Saying This...
Calm down.	I can see this is really upsetting. Let's talk through it together.
That's not true.	I hear that's how it felt to you; let's walk through what happened.
I already told you...	Let me go over that again to make sure it's clear.
It's our policy.	Let me explain why we do it this way and what options are available.
You're being rude.	Let's keep this respectful so I can best support you.
You're overreacting.	This seems really important to you; I want to understand more.
It's not my decision.	Let me explain why we recommend this.
You have to wait.	I know it's frustrating. We're working hard to get to everyone as quickly as we can.
You're wrong.	Let's take a moment to look at this together.
That's not my problem.	I can't solve that directly, but I will help you take the next step.
I have already explained this to you.	Let me go over this again, just to be sure we're on the same page.
This isn't up for debate.	I want to be transparent about what options are and aren't available.
You're not listening.	Can we pause for a moment. I want to be sure we're hearing each other.

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Warmth Perceptions	Competence Perceptions	Resulting Emotions	Resulting Behaviors
Warm + Competent	Admiration, Pride	Attraction, Loyalty	
Cold + Competent	Envy, Jealousy	Begrudging Cooperation, Obligatory Association	
Warm + Incompetent	Sympathy, Pity	Indifference, Neglect	
Cold + Incompetent	Contempt, Disgust	Rejection, Disassociation	

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Summary

“You can’t not have an experience”

Understanding Anger

Recognizing triggers and emotions behind patient anger helps healthcare providers respond more effectively and empathetically.

De-escalation Strategies

Utilizing specific de-escalation strategies can help diffuse anger and create a more positive healthcare environment for everyone.

Setting Boundaries

Employing clear and compassionate communication techniques is essential for diffusing tension and improving patient interactions.

Prioritizing Self-Care

Healthcare providers must prioritize their own well-being to manage stress effectively and provide better patient care.

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Bumps, Detours, and Off Ramps: Navigating Career Pauses and Transitions



Lauren Feld, MD
Assistant Professor
University of Massachusetts

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Individual Considerations for Family Planning

Family planning

- Pregnancy and fertility complications
 - Infertility: 1 in 5 women gastroenterologists
 - Pregnancy complications:
 - 68% of women gastroenterologists
 - 35% of hepatologists reported job-related stressors contributed to an adverse pregnancy outcome
 - 6+ overnight calls per month in the third trimester was associated with health issues during pregnancy and in delivery
- Oocyte cryopreservation
 - Most effective at ≤ 32 yo
 - Financial cost: oocyte cryopreservation at 33yo, attempt pregnancy at 40: \$30,333-\$79,057
 - Scheduling flexibility considerations

Ali et al, AJG, 2023

Feld et al, HepComm, 2023

Bakkensen et al, Fertil 2022

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Practical Model for Family Friendly Work Environments

Pregnancy accommodations
Reduced overnight call burden during third trimester of pregnancy
Anti-bias protection
Endoscopy ergonomic accommodations
Bereavement leave for pregnancy loss
Reimbursement for fertility treatments and adoption
Protected time for all pregnancy- and fertility-related appointments and tests

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Practical Model for Family Friendly Work Environments

Parental leave policy

Transparent and publicly available

Accessible to all physicians for birth, adoption or fostering

Consistent across genders with attention to equity for the LGBTQ+ community

Adequate duration: recommendation for 12 weeks minimum

Transparent policy on compensation and leave

Adjusted RVU targets to account for leave

Opt-out leave policies to encourage leave is taken and minimize bias

Avoidance of “pay back” policies or increased workload before leave

Adequate coverage solutions for colleagues, including team-based care models and locums

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Practical Model for Family Friendly Work Environments

Family friendly return-to-work

Modified overnight call post-partum

Transition plan for return to work that does not include making up call from leave

Time blocked into clinical schedule for lactation

Accessible lactation rooms

Allowing part-time and flexible work schedule upon return

Transparent compensation implications of modified return to work schedule

Autonomy over schedule

On-site quality childcare

Coverage solutions for sick childcare

Leadership should recognize and mitigate bias, discrimination, or penalties against those who take leave or request reduced work hours

Equitable promotion policies that do not penalize for parental leave or reduce work hours

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Legal considerations

- Pregnancy Discrimination Act (PDA; 1978)
 - Can't fire or refuse to hire due to pregnancy
 - Must get reasonable accommodations and/or leave (also under ADA)
- Family and Medical Leave Act (FMLA; 1993)
 - 12 weeks of (unpaid) job protection
- Providing Urgent Maternal Protections for Nursing Mothers Act (PUMP; 2022)
 - Reasonable break time and a private, non-bathroom space for employees to express breast milk for up to 1 year after the child's birth
- Pregnant Workers Fairness Act (PWFA, 2023)
 - Must provide reasonable accommodations (modified duties, flexible scheduling, extra breaks) for limitations related to pregnancy, childbirth or related medical conditions

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To PE or Not To PE: Lessons Learned and the Road Ahead

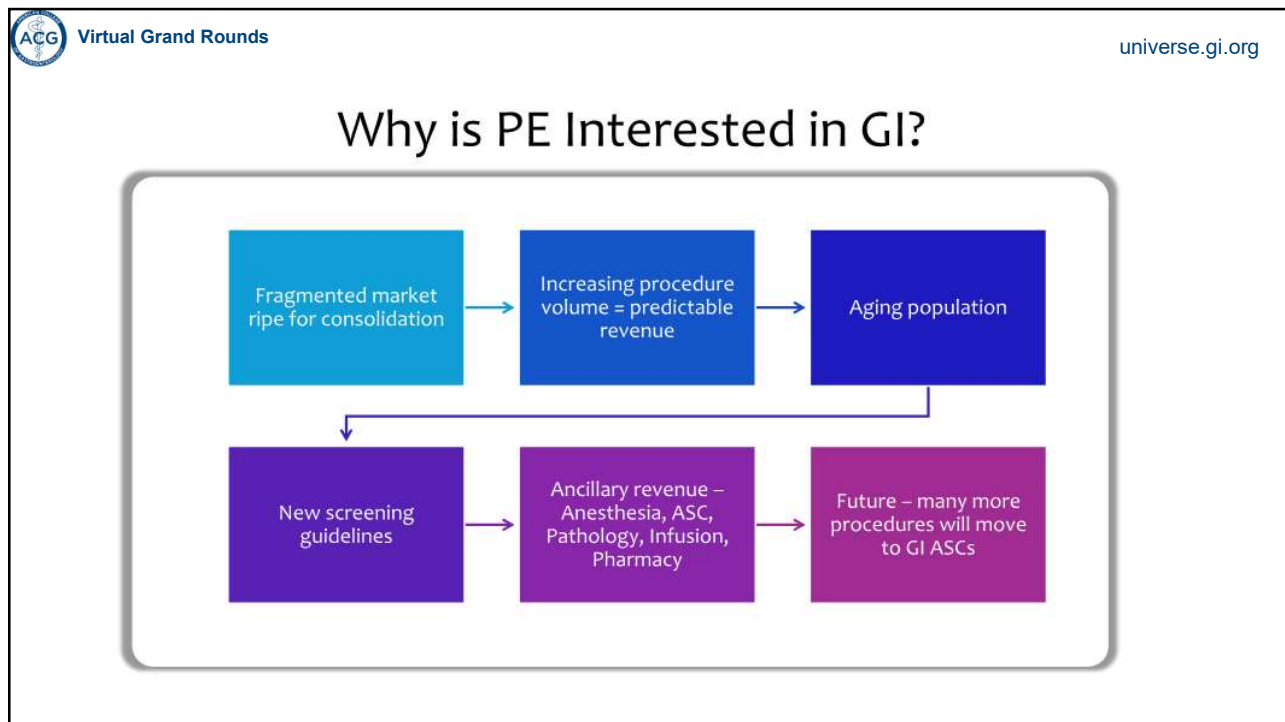


Harish K. Gagneja, MD, MACG, FASGE

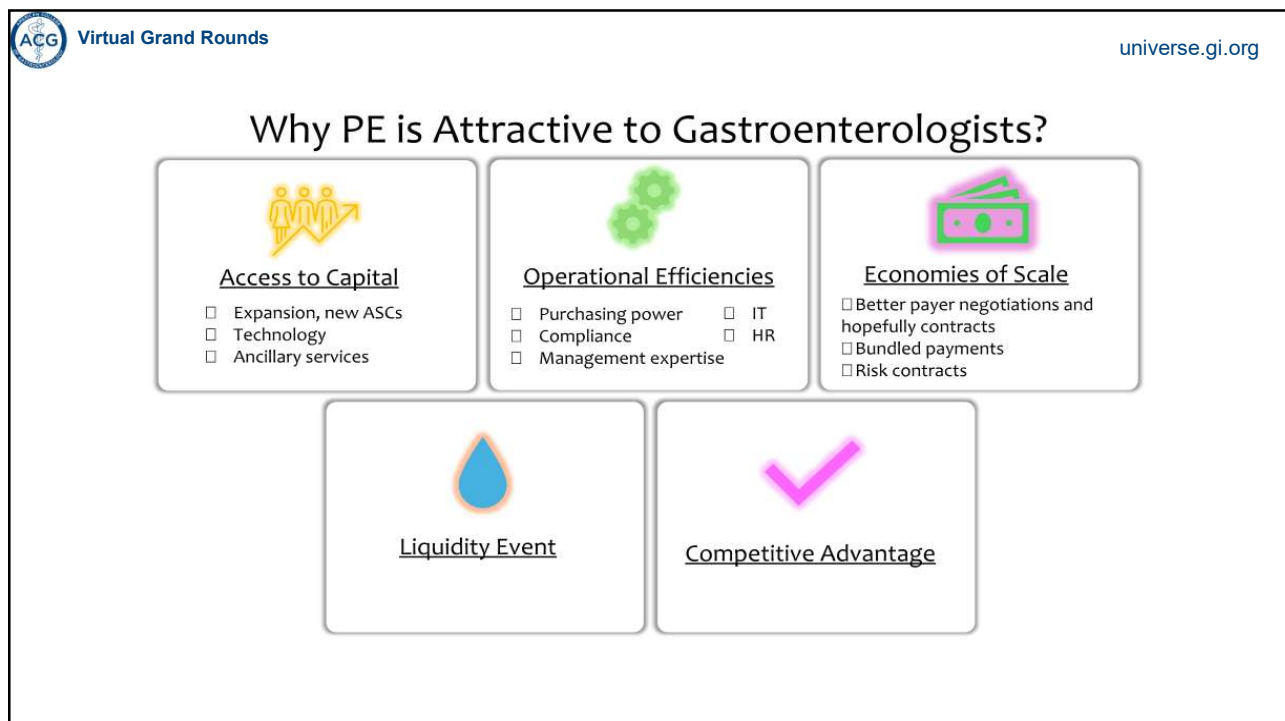
*Vice-Chair, American College of Gastroenterology Board of Governors
 Chair, South Texas Division Clinical Governance Board, GI Alliance
 Member, Physician Executive Board, GI Alliance
 President, Texas Society of Gastroenterology and Endoscopy (TSGE) (2014-16)
 President, American Association of Physicians of Indian Origin (AAGIO) (2022-2024)*

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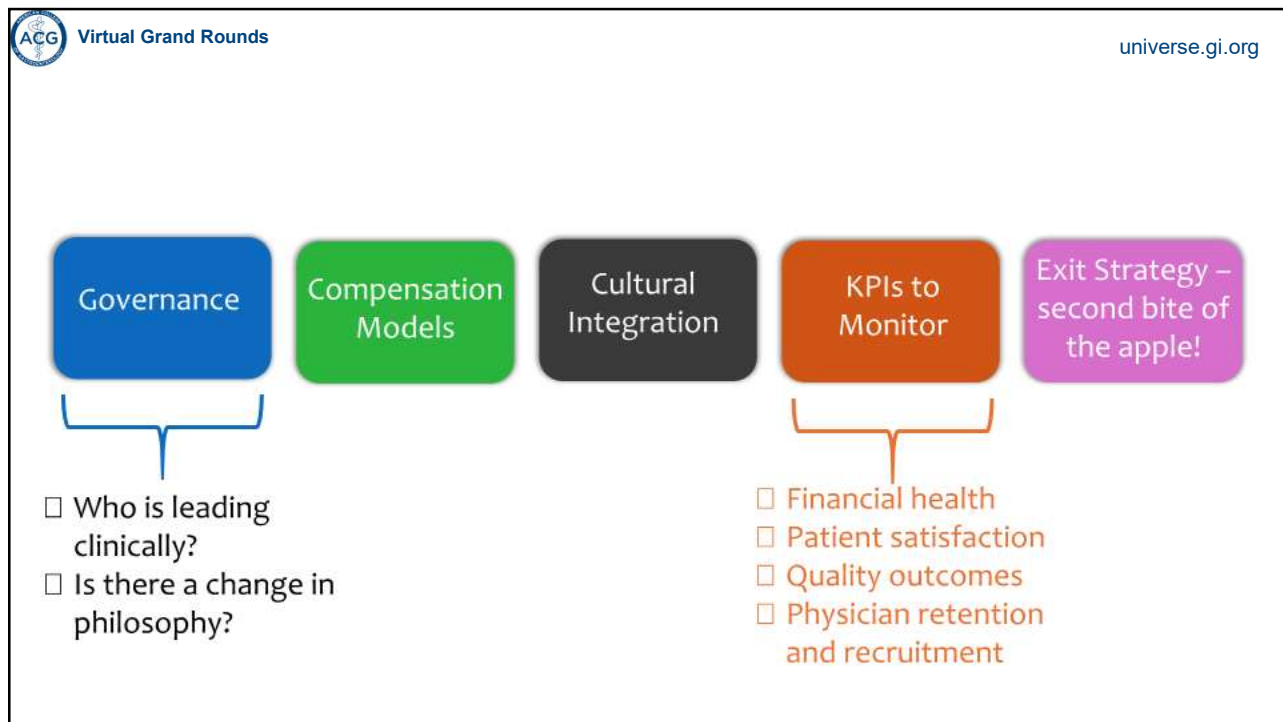
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<h3>Cultural Fit</h3> <ul style="list-style-type: none"> <input type="checkbox"/> PE partners' track-record in healthcare 	<h3>Alignment of Incentives</h3> <ul style="list-style-type: none"> <input type="checkbox"/> Shares long-term vision <input type="checkbox"/> Physician retention and recruitment <input type="checkbox"/> Growth strategies aka income repair 	<h3>Tax Planning</h3> <ul style="list-style-type: none"> <input type="checkbox"/> Capital gains versus income treatment

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<h3>Practice Prep</h3> <ul style="list-style-type: none"> <input type="checkbox"/> Clean up financials <input type="checkbox"/> Optimize operations - improve EBITDA <input type="checkbox"/> Resolve internal disputes 	<h3>Legal</h3> <ul style="list-style-type: none"> <input type="checkbox"/> Governance structure <input type="checkbox"/> Contracts <input type="checkbox"/> Leases <input type="checkbox"/> Compliance 	<h3>Physician Alignment</h3> <ul style="list-style-type: none"> <input type="checkbox"/> Agree internally on goals
<h3>Professional Advisors</h3> <ul style="list-style-type: none"> <input type="checkbox"/> Healthcare/M&A attorneys <input type="checkbox"/> Investment bankers 	<h3>Know Your Worth</h3> <ul style="list-style-type: none"> <input type="checkbox"/> Benchmark against recent GI deal <input type="checkbox"/> Deal multiples 	

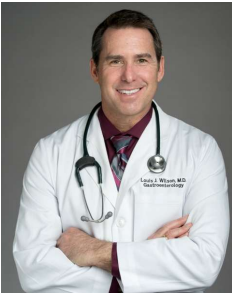
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Succession Planning Strategies



Louis J. Wilson, MD, FACG
 Managing Partner
 Wichita Falls Gastroenterology Associates

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It gets complicated fast

Five Questions:

- A. What is your employment model?
- B. What is our time horizon?
- C. What do the members of your group want?
- D. What is your compensation model?
- E. What is your leadership structure?

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Succession Planning by Practice Model

Category	Physician Owned Private Practice	PE Backed MSO	Hospital System Employed
Ownership	100% Physician owned	Physicians are minority stakeholders	No physician ownership (under contract)
Primary goal of Succession	Transfer ownership and leadership while preserving value	Maintain workforce and profitability	Continuity of staffing coverage
Timeline	2-5 years	6 to 18 months	3 to 6 months

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Succession Planning by Practice Model

Category	Physician Owned Private Practice	PE Backed MSO	Hospital System Employed
Identifying a successor	Internal associate	MSO recruitment team	System recruitment department
Transition process	Mentorship, gradual transfer	Mentorship may be from board or leadership team	Minimal mentorship, overlap duties for a time.
Legal considerations	Buy-sell agreement, ownership transfer	Employment contract, no direct exchange of ownership, partnership tract	No ownership issues, new agreements, incentives

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Succession Planning by Practice Model

Category	Physician Owned Private Practice	PE Backed MSO	Hospital System Employed
Compensation	Successors buy into the practice, compensation directly tied to ownership	MSO compensation model, buy in opportunities	Salary and bonus structure
Key Risks	Failure to identify successor, loss of practice value	Difficulty recruiting, pressure on profit margins	Disruption of care, staff coverage, little financial risk
Factors for success	Early planning, buy-in and buy out terms, strong transition	Strong recruitment pipeline, integration into MSO operations	Efficient recruiting, onboarding, schedule continuity

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Identifying Your Successor

1. Integrity
2. Optimism
3. Strategic thinker
4. Servant leadership
5. Effective communication
6. Accepted by partners

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What is your off ramp?

- Buy out agreement.
- Ancillary participation.
- An agreement on your exit strategy.
- Call responsibilities.
- Timeline for clinical exit.
- Add predictability and allow transfer of clinical duties.
- Allows for continued mentorship.



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Facilitate Transition with a Culture of Responsibility Sharing:

1. Share responsibility.
2. Spread leadership opportunities.
3. Assign a clinical project or two.
4. Assign an ancillary service line.
5. Include in negotiations and strategic discussions.
6. Involve practice administration early.

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Questions



Andy Tau, MD



Kunjali Padhya, MD, FCG

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