Office Procedures in Primary Care

Steven Shu, MD, MBA, MS
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Objectives
The participants will learn:
• Why are office procedures important in primary care?
• What kind of office procedures should primary care providers learn?
• How do primary care providers provide the high quality services in office procedures
• Tips for the specific procedures

History: Procedure in Family Medicine
• An integral component of family medicine from its beginning.
• 1960s: ABFP/AAFP developed a core list of procedures (not uniformly endorsed)
• AAFP statement (1993)
  While family practice residents cannot be expected to learn all the procedures within the scope of family practice, they should, at a minimum, teach all residents those procedures done by a substantial number of practicing family physicians or taught in a substantial number of family practice residencies.

Educational Problems and Challenges
Procedure skill training is controversial
• Poorly coordinated
• Often under-emphasized
• Certain procedures are difficult to teach well
• Lack tracking systems
• Few faculty in teaching the limited procedures
• Hard to maintain skills in residency

WHY are office procedures important in primary care?

• Concept of family medicine
• Great value
• Financial reason
**A Scenario of Comprehensive Care**

Traditional family physician will do:
- Chronic disease management
- Yearly Physical
- Refer to GI for colonoscopy
- Refer to colorectal surgeon for hemorrhoid care
- Refer to ENT for nasolaryngoscopy
- Refer to orthopedic for osteoarthritis and tendonitis
- Refer to dermatologist for Skin lesions: AK, moles, genital warts, skin cancer

His family physician Dr. S did:
- Chronic disease management
- Yearly Physical
- Colonoscopy
- IRC/banding for his hemorrhoids
- Skin lesions: AK, Seb cyst, Moles, genital warts, skin cancer
- Nasolaryngoscopy
- Knee and elbow injections

**Great Value of Office Procedures**

- Physician and staff already known to the patient
- Time savings for the patient and hospital
- Financial savings
- Continuity of care and increased patient satisfaction
- Rapid biopsy and histology result
- Greater job satisfaction for the physician
- Greater efficiency in the office practice

*Brown JS. Minor surgery a text and atlas, 1997.*
DISADVANTAGES OF OFFICE PROCEDURES

- Lack of suitable training to perform procedures
- Lack of suitable equipment and premises
- The risk of missing serious pathology
- Allocating sufficient time in a busy practice
- Medicolegal concerns over complications
- Financial disincentives


WHY?

- Concept of family medicine
- Great value
- Financial reason

Financial Issue

- Physician income goes down, the income of primary care physicians is the lowest.
- Fewer medical students are interested in primary care
- Procedure-oriented reimbursement system

REIMBURSEMENT

- Facing much lower reimbursement for services, physicians have to work hard in order to keep up their living condition

Financial Issue

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REIMBURSEMENT


How about fair pay for doctors?

It becomes even clearer that nurses earn more both on an hourly basis and over a lifetime than many primary care physicians …..Primary care physicians are being substantially underpaid.

KARL SINGER, MD, is a general internist and family physician in private practice in Exeter, NH, and the Medical Director of Patient Care.
“I must be working too hard. I can’t remember if I’m on my way home or to my office.”

**What kind of office procedures should primary care providers learn?**

**Office Procedure: Surgery (1)**
- I&D/Foreign body removal/Laceration repair
- Cryotherapy for skin lesions
- Skin tag removal
- Biopsy and benign excision
  - Shaving excision
  - Fusiform excision
  - Punch biopsy (and nailbed biopsy, oral biopsy)
  - Fine needle aspiration biopsy (FNAB)
  - Enlarged lymph node/breast lesion/thyroid nodule

**Office Procedure: Surgery (2)**
- Sebaceous cysts removals
- Ingrown toenail removal
- Removal of lipoma
- No-scalpel vasectomy
- Excisional/incisional biopsy of breast nodules
- Skin cancer removal/flap closure
- Surgery in special locations (lip/ear/nose/eyelid)

**Office Procedure: Joint**
- Injection of tendon sheaths, bursa, and trigger points
- Aspiration and steroid injection of joints
- Hyaluronan injections for osteoarthritis
- Carpal tunnel steroid injection
- Ganglion cyst aspiration/injection/ excision

**Office Procedure: GI**
- Removal of hemorrhoidal skin tag/anal polyp
- Incision/excision of thrombosed external hemorrhoids
- Infra-red coagulation of internal hemorrhoids
- Internal hemorrhoidectomy
- Botox injection/Anal lateral sphincterotomy for chronic anal fissure
- Anoscopy/ flexible sigmoidoscopy
- EGD and colonoscopy
Office Procedure: GYN
• Treatment of genital warts
• Colposcopy with biopsies
• IUD insertion and removal
• Endometrial biopsy
• Marsupialization of Bartholin’s cysts
• LEEP procedure and LEEP conization

Office Procedure: OTHERS
• Chalazion removal
• Nasolaryngoscopy
• Cosmetic care (Botox, filler, and laser)
• Fracture management
• Sclerotherapy/phlebectomy/endovenous laser ablation for varicose veins
• Cystoscopy/hysteroscopy/arthroscopy

How do primary care providers provide the high quality services in office procedures

How?
• Understand WHY
• Passion
• Skills: technical & management
• System
• Complete knowledge

Understand WHY
• Concept of Family Practice
• Great value
• Financial reason

Passion
ELEMENTS FOR SUCCESS

- Familiarity with procedural technique
  - Proper instruments for the procedure
  - Careful planning (self training, budgeting, marketing, staff, scheduling…)
  - Training and Instruction of nurses

- Patient counseling/education
  (brochure, handouts, websites, …)

- Pre- & postoperative Instructions
- Proper measures to prevent complications
- Proper patient follow-up
- Know the procedure coding

- Patient counseling/education

- Postoperative Instructions

- Proper measures to prevent complications
- Proper patient follow-up

- Know the procedure coding

- Familiarity with procedural technique

- Review procedure books
- Watch DVD

- Residency training
- CMEs on procedures
  - AAFP annual assembly
  - National Procedural Institute
- Procedure preceptor
- Accumulate the cases

- Proper instruments for the procedure

- Smaller surgical instruments
- Multiple choices of sutures/punch instrument
- Extra instrument: nail splitter, Ives anoscope, sets of instrument for vasectomy and chalazion
- Variety of instrument packs
- Radiofrequency electrosurgical unit
- Large instrument: all endoscopes, laser equipment
- Cardiac monitoring device if do IV sedation

- Careful planning: learning time

  Minor procedures: 3-6 months
  Average procedures: 6-12 months
  Large procedures: 12-24 months
ELEMENTS FOR SUCCESS
- Careful planning: budgeting

Major procedures:
- Equipment
- Staff: RN, LPN, or MA
- Marketing
- Consumables
- Rental space

ELEMENTS FOR SUCCESS
- Careful planning: Marketing

Internal market
External market

ELEMENTS FOR SUCCESS
- Careful planning scheduling

- Patient’s arriving time
- Procedure time
  - Prep time
  - Operating time
- Recovery time
- Turnover
  - Room availability
  - Instrument: endoscope

ELEMENTS FOR SUCCESS
- Training and instruction of nurses

OFFICE PROCEDURE FORMS

- Preoperative information sheet
- Postoperative instruction sheet
- Informed consent permit form
- Procedure recording sheet
- Nursing instruction sheet
- Counseling sheet for counseling session

OFFICE PROCEDURE FORMS

ELEMENTS FOR SUCCESS
- Proper measures to prevent complications
  • Familiarity with contraindications
  • Standardization of every procedure and process
  • Procedural skills
  • Training and Instruction of nurses
  • Patient counseling/education (pre- & postoperative Instructions)
  • Proper patient follow-up

ELEMENTS FOR SUCCESS
- Proper patient follow-up
  • Don’t forget to give the detailed written post-procedural instruction.
  • Emphasize the main points in the instruction and how to monitor the complications
  • Remind when patients should have wound check or follow up
  • Call patient next day after a major procedure
  • May consider a follow-up visit in 1-2 days

Complications
- No panic, most complications are manageable in the office
- Use common sense
- Proper measures
- Indication for ER or refer to a specialist

How?
• Understand WHY
• Passion
• Skills: technical & management
• System
• Complete knowledge

Standardization and System
• Scheduling
• Patient counseling
• Instruments
• Patient flow
• Nurse training
• Skill
• Follow-up policy
Complete Knowledge

- Procedure
  - Indication
  - Contraindication
  - Anesthesia
  - Options and Alternatives
  - Potential complications

- Diseases related to the procedure

- Coding and billing

Coding and Billing

- Accurate coding can increase your revenue and decrease your “fraud”
- You work hard and deserve every penny you made
- You (physician) are the only one who can code your services properly
- It is important to become familiar with procedure codes (especially new changes)

Tips for the specific procedures

Anesthesia

- 2% Lidocaine with epinephrine
- Epinephrine prolongs duration of action of anesthetic and reduces bleeding
- 2% Lidocaine without epinephrine for certain areas such as finger, toe, and penis
- Topical anesthesia
- Infiltration anesthesia (direct or Field block)
- Nerve block
- Conscious sedation

BEING A PAINLESS DOCTOR

- Use small-caliber needles (30 gauge)
- Stretch the skin prior to the injection
- Initially administer subdermally
- Pause after the needle is inserted
- Administer sol. Slowly, under low pressure
- Talk to the patients (verbal anesthesia)
- Add Sodium bicarbonate?

PUNCH BIOPSY

- Stretch perpendicular to the skin lines
- Hold the punch perpendicular to the skin
- Choose the punch site at the edge of the lesion

Zuber TJ, Punch Biopsy of the skin, Am Fam Physician 65(6): 1155
ELECTROSURGICAL SHAVE EXCISION
- Intradermal infiltration underneath the lesion
- Horizontal slicing with the right depth (No.15 blade/PERSONNA/electrosurgical loop)
- Control bleeding with Drysol
- Perform the electrosurgical feathering
- Suited for raised lesions; not used for pigmented moles (Punch Bx or fusiform excision)

FUSIFORM EXCISION
- Typical excision has 3:1 length-to-width ratio with an angle of <30 degree at ends of the wound (avoid dog-ear formation at ends)

FUSIFORM EXCISION
- Aligned with lines of least skin tension
- Extensive undermining of skin edges
- Placement of deep, buried SQ sutures
- The halving principle to avoid dog-ears
- Skin edge eversion by proper suture placement
INGROWN TOENAIL REMOVAL

- Simple wedge exc. can leave behind spicule
- Lateral nail avulsion & matricectomy has achieved greatest success
- Electrosurgical matricectomy produces less drainage than phenol matricectomy
- Digital ring block with 2% Lidocaine without Epi
- Adequate time for the effect of digital block
- Oral antibiotics are needed to prevent the infection if the infection (paronychia) exists

MINIMAL EXCISION TECHNIQUE FOR SEBACEOUS CYSTS

- Avoid administrating the anesthetic into cyst
- Vertical 11 blade stab incision
- Vigorous squeezing removes contents, frees cyst wall from surrounding tissues
- Cyst wall grasped with hemostat and gently delivered (intact) through the small incision

LIPOMA REMOVAL

- SubQ lipoma is easy to be removed
  Watch for the nutritional vessels
  Difficult lipoma: deep lipoma, lipoma in the face, neck and back
  Lipomatosis (Madelung’s disease)
  Adiposis dolorosa (Dercum’s disease)

Gohar A. Salam, Lipoma excision, Am Fam Physician 2002; 65:901
NO-SCALPEL VASECTOMY
- A major improvement in surgical sterilization
- Originally developed in China
- Less invasive and fewer complications
- Pre-procedure counseling is very important
  - Watch vasectomy videotape
  - Counseling checklist
  - A week rule

NO-SCALPEL VASECTOMY
- Three finger technique (Dr. Shu developed)
- Two-finger technique

ASPIRATION AND INJECTION
- Need a good knowledge of surface anatomy
- The most common complication: pain, bleeding and infection (<0.01%). The postinjection flare: 2%
- Steroid: no more frequently than every 3 months, <3 times/year
- Adding 1% Lidocaine without epinephrine
- Potent steroid: 1 ml large joint, 0.5 ml for med. joint, 0.25 ml for small joint
- Hyaluronan injections: 3 injections, 1 week apart

GANGLION CYST
- Asymptomatic small cyst: observation
- Symptomatic or large cyst: try aspiration and steroid injection
  - High recurrent rate
- Surgical excision in the most cases
- Refer if ganglion cyst in the volar side
FNA
• Quick, easy, cost-effective technique for evaluating palpable breast/thyroid/LN lesions
• Evaluate cystic vs solid, benign vs malignant

VARICOSE VEIN MANAGEMENT
• First office visit:
  • history and physical exam
  • mapping of varicose veins and take pictures
  • Duplex ultrasound mapping
  • Discuss the treatment of options and risks/benefits, and give patient information sheets
  • pre-auth from insurance company

VARICOSE VEIN MANAGEMENT
• history and physical exam
• mapping of varicose veins and take pictures
• Duplex ultrasound mapping
• Discuss the treatment of options and risks/benefits
• pre-auth from insurance company
• Sclerotherapy: Sotradecol
• Micro-phlebectomy
• Endovenous Laser Ablation or VNUS

VARICOSE VEIN MANAGEMENT

ANORECTAL DISEASES
• Very common in family practice
• Various conditions:
  • Hemorrhoids, fissure, polyps, perianal abscess
  • Anal tag, warts, any lesion needs biopsy
• Many treatment options:
  • Conservative treatment with anal care
  • I&D
  • Infra-red coagulation and electric desicication
  • Banding
  • Hemorrhoidectomy
  • Partial anal sphincterotomy
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