How clinics help the preop process

The preoperative process is critical to safe care and a smooth OR process. Missing paperwork, incomplete assessments, and the need for last-minute consults can disrupt any surgical day.

Is a preoperative clinic the answer? Each organization needs to weigh the cost against the potential benefits, such as fewer delays and cancellations and improved reimbursement through more accurate coding of patients’ comorbidities. Clinics also help to ensure regulatory requirements and payer guidelines are met.

*OR Manager* spoke with leaders of 3 preoperative clinics, each with a different format, who say the clinics have made the presurgical assessment process more efficient and consistent.

**Standardizing the assessment**

The preop clinic at Brigham & Women’s Hospital in Boston is a “one-stop shop” that streamlines the process and eliminates redundancy because clinical protocols can be standardized and uniformly applied.

“Having a dedicated preoperative clinic centralizes and standardizes the work,” says Angela Bader, MD, MPH, associate professor of anesthesia, Harvard Medical School, and director of the Weiner Center for Preoperative Evaluation.

Brigham has more than 40 ORs and other procedural sites that provide anesthesia services.

The clinic has a central waiting room and space for performing all assessments and laboratory work, including 16 examination rooms and a room for chart organization.

Nurse practitioners employed by the hospital and supervised by on-site anesthesiologists perform the histories and physicals as well as the anesthesiology and nursing assessments for 80 to 90 patients per day.

Many patients have complex medical conditions that warrant an intensive preop evaluation. Though Dr Bader says administrators of other hospitals have told her they don’t need a preoperative clinic because of their size, she notes that even small community hospitals need a preoperative assessment program that includes all of the necessary elements.

“It’s just a question of what’s the most efficient, centralized way to get those elements done.”

**Know billing, payment systems**

Understanding regulations and reimbursement policies for preop assessment is necessary to plan for the preop clinic’s operational structure, Dr Bader says.

Organizing the clinic for efficient assessments is essential to the financial performance of the hospital’s procedural areas. Standardizing documentation also ensures coding will be accurate. Histories and physicals (H&Ps) performed in surgeons’ offices gener-
ally are not standardized, she says. They may not include all of the patients’ comorbidities and may not sufficiently address medical conditions not related to the reason for the surgery.

Although reimbursement for the preop evaluation may not go directly to the clinic, she points out that the anesthesiologist, surgeon, and hospital all receive portions of the payment for the procedure.

**Screening for high-risk patients**

The University of Miami Health System in Florida has a preoperative clinic that covers 2 hospitals and is staffed with an anesthesiologist and internist who assess high-risk patients and supervise phone screening for all surgical patients.

“By designing the process this way, the internist is able to bill for a preoperative medical consultation, and the sicker patients benefit from seeing both an internist and an anesthesiologist,” says Seema Chandra, MD, medical director of the University of Miami Health System Preoperative Assessment Center and assistant professor of clinical medicine and pediatrics. The clinic, open since February 2010, sees about 15 patients a day, with a plan to scale up to 25 to 30 a day. The hospital has 14 ORs and a related facility with 4 ORs; the combined annual surgical volume is about 13,000 cases.

**Documenting comorbidities**

High-risk patients benefit from seeing a physician preoperatively, and their comorbidities can be documented so treatments can be coded correctly for proper reimbursement, she notes. The internists and anesthesiologists have developed algorithms for the assessment, minimizing same-day testing and delays. Some of the clinic’s operational expenses are supported by providing the preop medical consults in addition to the preanesthesia assessments.

Presently, the surgeons perform the H&Ps, but the clinic is working with the 2 surgical sites to see if the medical consults can also be used as a surgical H&P.

The clinic’s anesthesiologist already had been working at a preoperative center at the smaller of the University of Miami’s hospitals and was willing to continue in that role in the combined hospital clinic. Internists who cover the center vary.

Together, the internist and anesthesiologist generate a consult that goes to the surgeon and is placed in the patient’s chart. Any further testing is coordinated by the clinic.

**Which patients are at high risk?**

For a consult to be billable, medically necessary reasons for the consult must be documented.

A 14-point questionnaire completed in the surgeons’ offices determines whether the patient needs a medical consult in the clinic (illustration). Examples of questions are: “Do you have diabetes? Have you had any cardiac procedures like a stent or pacemaker implanted?” If patients answer yes, they’re eligible for a medical consultation by the preop clinic.

If the screening shows patients are at a lower risk, and the surgeon has no medical reason for referring them to the clinic, a nurse performs a telephone screening.

The same anesthesiologist who sees patients in the clinic reviews the telephone screening results. If the anesthesiologist determines that a patient needs further testing, the nurse informs the surgical coordinator, who communicates with the patient’s primary care physician to order the tests. The only tests that are billable are those that are reasonable and necessary for diagnosis or treatment.

“We didn’t see the value of seeing low-risk patients in the clinic because the main
UPAC Preoperative Screening Form

1. Do you become short of breath or develop chest pain when climbing a flight of stairs? NO YES

2. Do you have high blood pressure that requires 2 or more medications to control it? NO YES

3. Have you ever had heart disease, pacemaker/defibrillator, heart surgery, angioplasty or a stent placed? NO YES

4. Have you ever had blood clots, stroke, carotid artery blockage, or TIA (“mini-strokes”)? NO YES

5. Are you currently taking blood thinners such as Coumadin (warfarin), Plavix (clopidogrel), Effient (prasugrel), etc.? NO YES

6. Do you have a history of excessive bleeding following medical or dental procedures, or have you had to see a doctor due to problems with bleeding or clotting? NO YES

7. Are you morbidly obese (more than 100lbs overweight)? NO YES

8. Do you have asthma, chronic bronchitis, emphysema, or sleep apnea? NO YES

9. In the last two years have you been on steroids like prednisone for a condition such as lupus, severe rheumatoid arthritis, chronic lung conditions, or hypopituitary condition? NO YES

10. Do you have diabetes? NO YES

11. Do you have kidney problems and regularly see a nephrologist (kidney specialist) or receive dialysis? NO YES

12. Do you have a history of cirrhosis or chronic liver disease? NO YES

13. Are you currently being treated for cancer, excluding basal cell? NO YES

14. Have you or anyone in your family ever had significant complications with anesthesia other than nausea or vomiting? NO YES

Based on your medical history, your surgeon will determine if further medical evaluation is needed to prepare for surgery. You may be required to see a physician for evaluation and optimization of your medical condition prior to surgery, or you may be asked to complete a short phone screen with a registered nurse prior to surgery.

_____________________________ _______________________________ _____ / _____ / _____    _____________
Patient Name (PRINT)   Signature    Date      Time

TO BE COMPLETED BY SURGEON AND/OR DESIGNEE – PLEASE FAX COMPLETED FORM TO UPAC AT 305-243-7292

SURGERY LOCATION: □ UMH □ UMHC-SYLVESTOR

□ If responding YES to any questions, a preoperative consultation with a physician is recommended (select one):
□ UPAC Physician □ Primary Care Physician (PCP) □ Specialist: ______________________________

□ If responding NO to all questions, patient will complete a phone screen with a registered nurse prior to surgery.

If requesting a consultation:
Based on a review of the patient’s medical history and specific medical conditions outlined, a consultation with a qualified internist or specialist (as directed) is requested. This consultation is requested to minimize risks of developing complications as a result of surgery and/or anesthesia.

_____________________________ _______________________________ _____ / _____ / _____    _____________
Surgeon Name (PRINT)   Signature    Date      Time
goal is to reduce preoperative medical risks and minimize first-case delays and same-day cancellations,” says Dr Chandra. The high-risk patients, not the low-risk patients, are the ones whose cases are cancelled or delayed.

**Three-tiered assessment**

A three-tiered program in the preoperative assessment service at Kettering Medical Center in Kettering, Ohio, enables surgeons to refer complex, high-risk surgical patients to a nurse practitioner for a preop H&P or to a hospitalist who will perform an H&P as well as follow the patient postoperatively. Low-risk patients have a nursing assessment.

Patients’ risk is assessed using the Metabolic Equivalent Task (METs) scoring tool, a measure of a patient’s physical activity level. (A METs table is available at www.americanheart.org/presenter.jhtml?identifier=3046878).

Patients are screened when they are contacted to make their appointments. Depending on their METs score, they are scheduled for a phone or a face-to-face assessment. Surgeons can also request a fact-to-face assessment for patients.

Patients are assessed in the preoperative clinic, open 5 days a week from 9 am to 7:30 pm. Kettering has 21 ORs and 2 endoscopy suites and a volume of 16,000 surgical cases a year.

The hospitalists are not employed by the hospital. They bill for their professional services, and the hospital bills for a facility component.

When the nurse practitioner performs the assessment, the hospital bills for both the nurse practitioner’s services and facility services. No fee is associated with the nursing assessment, which is considered part of the preoperative evaluation.

“We have to have a minimum of 6 cases a day done by nurse practitioners to break even,” says Trisha Osborn, Kettering’s business manager for perioperative services.

Preoperative assessments by the nurse practitioner or physicians must be scheduled, but patients can come to the clinic any time for a nursing assessment.

Hospitalist assessments have been available for a few years. The nurse practitioner service was started about a year ago, and the “drop-in” nursing assessments began about 6 months ago. Nursing assessments also can be performed by telephone.

Day of surgery cancellations have decreased 2% since all 3 tiers of the program were initiated, says Lynn Filiatrault, RN, CNOR, clinical nurse manager.

Previously, 75% of testing and assessments were performed within 48 hours of surgery. Now most are performed 2 to 3 weeks in advance, with only 15% performed 48 hours before surgery.

**Surgeons encourage program**

The surgeons encouraged the creation of the preoperative assessment program, says Filiatrault. The program relieves surgeons of the assessment and ensures assessments meet regulatory requirements. The surgeons and anesthesiologists have developed a

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**Updated guidelines on preop fasting, aspiration**

The American Society of Anesthesiologists (ASA) has updated its *Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration*. The guidelines apply to healthy patients having elective procedures.

Preop fasting guidelines are essentially the same as the previous guidelines:

- 2 hours for clear liquids
- 4 hours for breast milk
- 6 hours for infant formula, nonhuman milk, or light meal.

The guidelines are based on an evaluation of the literature, surveys of experts, and a survey of active ASA members. The update includes data published since the guidelines were adopted in 1998.

preoperative testing protocol linked to specific diagnoses and comorbidities.

Though additional reimbursement is not available for the preop screening clinic, the hospital hopes the service will pay for itself by reducing cancellations and delays, says Osborn.

The hospital found that when patients’ cases had to be cancelled on the day of surgery because of incomplete testing or charts, a high percentage of those patients went somewhere else to have their surgery performed.

“For us, it became a matter of how can we get the patients through the system successfully the first time? The preoperative clinic has done that for us.”

—Judith M. Mathias, MA, RN

Nurse practitioner competencies used at the Brigham and Women’s preoperative clinic are available from the Society for Perioperative Assessment and Quality Improvement (SPAQI) at www.spaqi.org (membership required).

References

