

Handling Increased Patient Flow in a Retina Subspecialty Practice

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BY ALEX STOCKDALE

In the past 7 years, with the introduction of pharmaceutical treatments for age-related macular degeneration (AMD), retina practices across the United States have been faced with the challenge of handling increased patient volume. As the chief executive officer of Southeastern Retina Associates, I have encountered this challenge in the largely rural area that is served by our 21 offices in Eastern Tennessee, Virginia, North Carolina, and Georgia.

Not long ago, retina subspecialists could offer little in the way of treatment for patients with exudative AMD. The role of the retinal surgeon was often limited to administering laser treatments when appropriate to slow the advance of the disease. With the U.S. Food and Drug Administration's approval in 2000 of verteporfin photodynamic therapy (PDT) (Visudyne, Novartis, Basel, Switzerland), followed by the approvals of pegaptanib sodium (Macugen; OSI/Eyetech, New York, NY) and ranibizumab (Lucentis; Genentech, San Francisco), retina subspecialists first gained the ability to stabilize vision in some AMD patients, then the ability to improve it. With monthly intravitreal injections of ranibizumab, approximately 40% of AMD patients in clinical trials experienced significant improvement in visual acuity.

But along with this improvement in visual outcomes came an increase in utilization and thus in patient volume. More patients with AMD are referred to us for treatment, and they must be seen more frequently. With ranibizumab, many patients are seen monthly for intravitreal injection. With pegaptanib the schedule is every 6 weeks. In addition, there have been increases in the vol-

ume of off-label injections of drugs such as triamcinolone acetate (Kenalog; Bristol Myers Squibb, New York, NY) and bevacizumab (Avastin, Genentech).

This increased patient volume presents new challenges for practice administrators and executives. How do we handle the patient flow so that our physicians can see the maximum number of patients in an efficient fashion? And how do we make sure, when appropriate, that these visits are paid for by the patient or by his or her insurance company?

This article describes some of the steps we have taken at Southeastern Retina Associates to address these questions.

RURAL SETTING

Our association includes 12 retinal surgeons and one low-vision specialist, supported by 150 total staff, in 21 offices serving a region that includes much of Eastern Tennessee and parts of Georgia, Virginia, and North Carolina. This year, our offices will handle approximately 80,000 patient encounters.

Ours is a large, and largely rural, catchment area, and some patients travel long distances to see us, as we are the only provider of retina subspecialty care in many of these regions. For patients who have come a long way, if an injection is needed, we want to try to give it to them that same day so that another visit is not necessary. This means that on any given day we have to be prepared to facilitate intravitreal injections.

Because we started giving injections of dye with the approval of verteporfin PDT in 2000, our staff has a lot of

experience with streamlining the process. Intravitreal injections are different from dye injections, of course, but the staff also accumulated experience with intravitreal injections of pegaptanib and triamcinolone before the approval of ranibizumab. But the sheer volume of treatments rose with the approval of ranibizumab last year, both because of the increase in the numbers of patient referrals and because of the frequency of treatment.

The way injections are scheduled varies according to the physician's preference. Some of our physicians prefer to approach injections in a clinic-type arrangement, with a block of injections booked on one day so the physician can get into a rhythm and work efficiently.

We usually have four to six rooms devoted to the patient flow for one physician. Two or three rooms are devoted to workup, and patients then flow to the other two or three rooms to be seen by the physician. At any given time, patients might also be in the laser room awaiting treatment or in a diagnostic area for a fluorescein angiogram or optical coherence tomography. The physicians get a real workout. It is vital that staff be there to direct them efficiently to their next encounter.

Some of our offices have been remodeled to accommodate the increased patient flow, and we have added staff. We want patients to have a good experience, and we want them to be handled professionally. We believe in giving patients a lot of attention, and our physicians have supported the decision to add staff so that patients have a positive experience. Ultimately, more staff means the clinic runs more efficiently.

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Frankly, even with this greater efficiency, our physicians often work longer hours as well to accommodate the increased workload.

PATIENT ACCESS TO CARE

In addition to changing the physical configuration of our offices to accommodate increased patient volume, we have had to make changes to our billing practices.

We have adopted a modern practice management system and electronic charts and chart storage. This is not a full electronic medical records (EMR) system, but it is an EMR-like system. The patients' charts are accessible securely online, but certain functions are still done on paper and scanned in. Some of our physicians just work better that way. With the electronic system we have a greater ability to manipulate data for billing and other purposes.

The digital records system and the practice manage-

ment system have allowed us to decrease the number of billing and front office personnel we employ, despite the increase in patient volume. This has helped to offset the increases in staff elsewhere in the practice. We have billing offices in our three main locations, and personnel in the satellite offices can call them if they have questions.

We want to ensure that everyone who needs these treatments receives them, and to that end we work with Genentech's Access to Care Foundation, Single Point of Contact (SPOC) and copay assistance programs.

Through its Access to Care Foundation, Genentech provides free medicine to those who cannot afford to pay for it. For on-label uses of ranibizumab, patients with AMD who are uninsured and have no other way to pay for treatment will usually qualify for this program. In a similar way, Pfizer's Helpful Answers program offers assistance for pegaptanib, and Novartis supports the Together Rx Access program for verteporfin PDT.

The SPOC program and similar programs at the other companies help us to verify that patients have adequate insurance coverage to pay for treatment.

We make a concerted effort to collect copays, and we collect on average about 80% of copays on the day of service. A number of copay foundations that receive support from the pharmaceutical companies can help patients with the balance billing, which can be significant with a drug that costs nearly \$2,000 per dose.

We also give away a lot of care for those who cannot afford payment and do not qualify for one of these assistance programs. We are the only provider of retina subspecialty care in many areas that we cover, and we consider it part of our mission to provide care to those who cannot pay. Our physicians are very generous in charitably donating their time for indigent patients.

Regarding the injections themselves, we cannot afford to give away a drug like ranibizumab or pegaptanib. If a patient needs an on-label treatment—generally, any type of AMD—he or she will qualify for one of the assistance programs. For patients who need off-label treatments—for instance, a patient with diabetes or pathologic myopia or another disease where the physician believes the patient may benefit from treatment—we may choose to treat them with bevacizumab, the oncology drug, because that can be done more cost-efficiently with similar effect. But these are the exception. Currently, roughly 80% of the injections in our association are with ranibizumab. ■

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