

Retina Comes of Age in the ASC Setting

The time has come to integrate retinal procedures and surgical efficiencies.

BY PRAVIN U. DUGEL, MD



Beginning with this issue, Retina Today will feature a new column in every issue that focuses on issues pertinent to retina and its migration and place within the ambulatory surgery center (ASC) setting. This column will present articles by dedicated individuals who have shaped the ASC industry through decades of relentless legislative campaigning; surgeons, administrators, and nurses who are dedicated to efficiency; and industry leaders who recognize the new paradigm shift in manufacturing equipment. The common thread will be a passion and a devotion to providing the best patient care in a specialized ASC.

—Pravin U. Dugel, MD

Over the past 5 years, retina has undergone an unprecedented transformation. The change in medical retina is easy to see and comprehend; however, equally important is the change in surgical retina. The marriage of vastly improved surgical technology with increased reimbursement has raised the interest of retina surgery in ambulatory surgery centers (ASCs). I am convinced that there will be a major shift in vitreoretinal surgery to ASCs. The implication of this shift is a new focus on efficiency.

Efficiency can be defined as the best use of time to provide the best possible patient outcomes. Speed is an undeniable component of efficiency, though not the primary one. I am often asked “How fast do I have to be to succeed in an ASC?” or “How many cases a day must I perform?” There is no correct answer — the answer may be “just do what’s right.”

SPEED IN PROCEDURES, NOT PATIENT CARE

So where does one gain speed? One thing is certain—speed is not gained by taking shortcuts in the eye while performing surgery. Rather, speed can be gained by making events and tasks around the surgery move more quickly. For example, our average turnover time at the Spectra Eye Institute in 2006 was 14 minutes between vitreoretinal surgeries. In 2007, we reduced it to 12 minutes; in 2008, our goal is to reduce it further to 7 minutes. If we achieve this, we will save 1.5 hours a day on turnover times alone. I have often told my colleagues who visit me in Spectra that at the end of a successful visit, they should be underwhelmed by my surgical skills and overwhelmed by my surgical staff.

Efficiency requires a surgeon to be devoted to improving himself and his staff. The direction and goals must come

from the surgeon, who must reinforce and vertically integrate the idea that efficiency in an ASC cannot be achieved by compromising patient care. This concept must be engrained and vertically integrated, and the required duties must be understood, accepted, and executed by everyone, from the director to the janitor of the ASC.

CAN PATIENT CARE = PROFITABILITY?

When surgeon and staff learn how to achieve efficiency without compromising patient care, another marriage occurs: patient care and profitability. Yes, both can and should go hand in hand in a properly run ASC. In fact, one should not happen without the other. Recent technological and reimbursement changes encourage this. Table 1 and 2 show a comparison of reimbursement changes among ophthalmic subspecialties for 2007 and 2008 in Arizona.

Table 1 shows the percentage change in reimbursement between ophthalmic subspecialties. Note that the pars

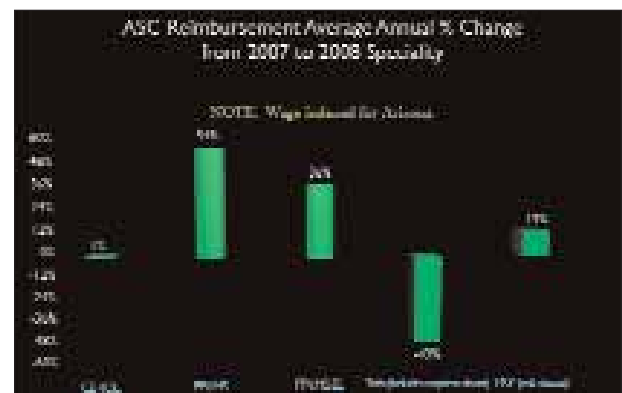


Table 1

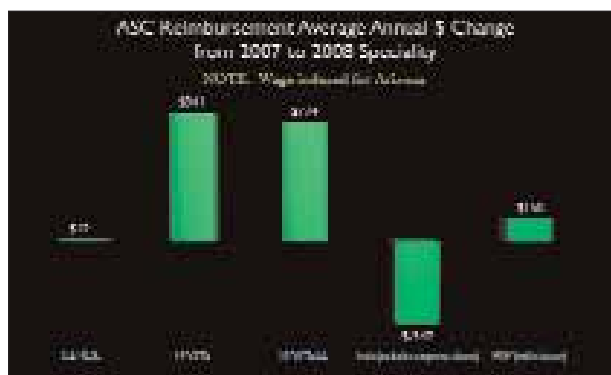


Table 2

plana vitrectomy (PPV), membrane stripping (MS) and PPV, MS, EL codes are newly implemented starting January 1, 2008 and, therefore, not subject to a phase-in period.

So what does that mean in real dollars? Table 2 demonstrates the actual interspecialty dollar difference.

IS RETINA READY FOR THE ASC?

Historically ASCs were the domain of anterior segment surgeons. With the recent changes discussed above, I have looked at various scenarios in my own ASC. I asked myself which ophthalmic subspecialty is most profitable per unit of time in an ASC. In other words, if my ASC, Spectra Eye Institute, had 1 free hour, which subspecialty surgeon would be profitable for us in that hour? At Spectra, the median number of surgical cases per subspecialty per hour is: three cataract surgeries, two retina surgeries, one glaucoma shunt surgery, one corneal transplant. I studied this scenario for the Spectra Eye Institute adjusted for our local reimbursement. The calculations reflect the net profitability for the ASC after all the disposable and overhead costs have been considered.

Table 3 shows that in our scenario of the number of median cases per hour at the Spectra Eye Institute, PPV, MS and PPV, MS, EL are more profitable than standard cataract surgery. This must be carefully qualified: this is only a hypothetical comparison and does not address other, albeit



Table 3



Table 4



Table 5

more rare, longer and more complicated retina surgeries. Only the more common retina surgeries were considered.

I am often asked how many surgeries an hour are needed to be profitable in an ASC. To try to give a local answer to that question, I kept the other subspecialties constant and varied the retina surgeries from one surgery an hour to one surgery every 2 hours, as seen in Tables 4 and 5.

My calculations suggest that with the current reimbursement system and with the current technology, retina surgery at the Spectra Eye Institute becomes unprofitable only when the average case takes 2 hours or longer. I must again stress that it is not the speed of the surgeon that determines the number of surgeries per hour, but rather the efficiency of the entire surgical team (surgeon, scrub, nurses, staff).

RETINA + ASC = NEW CHALLENGES

Has retina come of age in the ASC? Indeed, it has. This shift to ASCs brings new challenges, however, and will have a profound effect on a wide range of issues: staffing, legislative concerns, inventory management, billing and coding, and instrumentation. This shift will force not only surgeons, but also the support industries to adapt to a new paradigm that focuses on efficiency, not bells and whistles. ■

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