

TIPS FOR GOING SOLO DURING A PANDEMIC



Even the worst timing can't stop motivated clinicians from successfully starting their own practices.

BY COURTNEY CRAWFORD, MD, AND SHAWN KAVOUSSI, MD

Between all of the chatter about private equity acquisitions and practice management struggles due to COVID-19, it's been a hard 2 years for retina specialists harboring a dream of being their own boss. But the pandemic didn't stop a few brave clinicians from setting out on their own, and two of them shared their stories with Retina Today. In this article, Courtney Crawford, MD, and Shawn Kavoussi, MD, discuss what it was like for them when opening their solo practices amid a global pandemic—and the steps they took to ensure the business was a success.

A DREAM COME TRUE



BY COURTNEY CRAWFORD, MD

During training, I thought the coups de grâce for a retina specialist was to join a large retina-only group, and I did everything that I could to make that happen.

But once I got there and became a partner, I realized I wanted something else out of my career.

Nearly 2 years ago, I decided it was time to try something new: venturing out on my own. I thought that some of these smaller, nimble practices were onto something, and I wanted to be a part of it. I had come to realize that I couldn't depend on someone else to make my dreams come true; the onus was on me to make it happen. Here's how I did it.

BEGINNINGS

I had decided to start my own practice a full year before I finally opened the doors. In that time, my wife and I talked through much of the strategy together, and I worked out the logistics, including applying for a PLLC, setting up the finances (loans, bank accounts, credit cards, etc.), finding the right location outside of my non-compete area, finalizing my

TIPS FOR STARTING YOUR OWN PRACTICE

- Remember, you can do it.
- Start the planning process early.
- Talk to others who have done it—none of us are on an island, and you can learn a lot just by talking to others who have opened their own practices.
- If you are departing from a group, expect a little turbulence.

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business plan, and purchasing equipment.

All of this was in motion right before COVID-19 really started. When the pandemic hit, the patient volume at the large practice in which I was working dipped by about 20% to 30%, so I knew that it wasn't an ideal time to open a practice, but I also knew patients needed to be seen, especially in the world of retina where they depend on their intravitreal injections. I knew we would survive. Not only that, when it's time to pull the trigger, you can't hit pause; I was opening the practice, one way or another.

One of the most important steps my wife and I took was to seek help from a practice building consultant. Doctors do very well with checklists, and he provided us with a detailed rundown with the timeframe of when each item needed to be completed. This was critical to our success.

LOCATION, LOCATION, LOCATION

I was fortunate to find a community at least 30 miles from the large practice I was leaving (to adhere to my non-compete clause) that needed a retina specialist. A general ophthalmology clinic in the area shared the building with a dentist that, as luck would have it, was moving out of the space. I had already comanaged several patients with that ophthalmologist, so it was a fortunate opportunity to retrofit the dentist's office space for my new practice.

The build-out process is one of the most challenging aspects of opening a practice, and I created my own scheme for how I wanted the clinic to flow. I am happy with the flow, but when I do another build-out, I will do it differently—you can't avoid some learning experiences.

THE RIGHT TOOLS

When equipping the new space, I decided to acquire an equipment loan and purchase new tools. Retina medicine is intrinsically linked with advanced technology, and I wanted to provide my patients with a technologically savvy clinic. We believe in patients sharing not only in their diagnosis, but in their experience, and to do that, patients need to see everything that I'm seeing, whether that's with fundus imaging or OCT. The equipment is an expensive investment, but it's also a crucial part of the treatment process.

MARKETING STRATEGY

One of the most important aspects of starting my own practice was patient acquisition. I have been fortunate with new patients due to the limited competition and the fact that about 50% of my patients followed me. No matter how many patients follow you, you can't ignore marketing, even

in the retina world. To this day, the best marketing is still face-to-face with a handshake. Referring doctors want to know you before they send their patients to you.

I have also invested time into our social media presence, which is a bit uncharacteristic for retina clinics, but even older people are on Facebook and Instagram. I also advertise in the local magazine.

INVEST IN RESEARCH

I've always been involved in clinical research, especially considering Jeffrey S. Heier, MD, a wonderful researcher, is one of my mentors. When I began planning my practice, I made sure to include clinical research. To do that, I had to negotiate for a research area in the building that could handle rooms with 20-ft lanes and extra equipment. The research aspect of my business is also its own PLLC, so from day one, it was like operating two different businesses.

It takes a long time to get clinical research up and running, and it took about 6 months to finalize the facility necessary for our clinical research. Now, we are involved in six different trials and doing great.

BUMPS ALONG THE WAY

Another important part of this process is assembling your team. They're an extension of you, so you need to find people who are like-minded, buy into what you want, and agree with how you want to operate the practice. That, perhaps, has been the biggest challenge for me. I'm a people person, and I cut my teeth in the army in terms of leadership and developing a team.

I have learned that I don't have to hire people who are already a part of the eye care community. I can teach them the skills they need to be technical in eyes; what I can't teach is the right mindset, the human touch.

WHEN YOU ARE READY, GROW

I started Star Retina because I wanted to take exceptional care of patients. Our patients are extremely complimentary, and I know that we are providing a superior level of care. I have focused on creating an efficient process; I don't believe that there should ever be a time when a patient spends more than 45 minutes in my clinic. Their time is valuable.

If I had the opportunity to do it all over again, I wouldn't do anything different. But I have learned a lot along the way. I may have started as a solo practice, but I have always had an eye on growth. I hope to add another retina specialist to the practice this year, and maybe more after that. If you find something that works for you and your patients, don't be afraid to grow.

TIPS FOR EQUIPPING A NEW RETINA PRACTICE



BY SHAWN KAVOUSSI, MD

In June of 2020, I opened a solo retina practice in Houston. At the time, we were still learning about COVID-19, and even when regulations allowed it, many patients were hesitant to come into clinics. It was a challenging time, but the slow pace gave me a chance to take care of administrative tasks and ramp-up. I bought equipment, hired staff, and made sure I had a strong network for referrals. I had been working at a multispecialty group for almost 4 years, and I continued to work there while making the transition, an overlap that allowed for an amicable departure and mitigated the pressure to have a full schedule immediately.

EQUIPMENT DECISIONS

One of the most urgent tasks was equipping the office. My device decisions were driven by the desire to start with top-of-the-line models to optimize patient care and reduce the need to refer out for imaging or certain procedures. Below is a list of my top five equipment selections.

OCT: Spectralis (Heidelberg). I chose this model for two reasons. First, I wanted all imaging modalities in one unit— anterior and posterior OCT, glaucoma module, multicolor fundus photography, fundus autofluorescence, fluorescein angiography, ICGA, and OCT angiography. This device delivered, making quality image capture an efficient and smooth process. Second, top-quality images are a requirement for most clinical trials, and I wanted to have the tools necessary to participate in clinical trials.

I use the 30° lens for fluid assessment in macular diseases. The 55° lens excels at imaging the posterior hyaloid to help me demonstrate posterior vitreous detachment status to patients who are referred for flashes and floaters. The 55° lens also captures the optic nerve, the macula, and nasal peripapillary area all in one slice and highlights any residual posterior hyaloid adhesions in the vitreoretinal interface.

Ultra-widefield angiography with a 105° lens was integral for diagnosing multiple evanescent white dot syndrome in a young patient whose wreath-like hyperfluorescence extended anteriorly just beyond the borders of the 55° lens.

Indirect Ophthalmoscope: Omega 500 (Heine). This tool is lightweight, portable, and provides optics that are

EXTRA PRACTICE-BUILDING PEARLS

The ever-evolving pandemic has required modifications to our practices, especially to better accommodate elderly patients. For my new office, this meant paying extra attention to clinic flow to ensure the waiting room remained unclogged.

My office space was intended for only three examination rooms, but by equipping the laser room with a fully functional diagnostic slit lamp and converting an administrative space into an imaging room with the OCT, B-scan, and a motorized reclining chair, three functional rooms grew to five. Procedures can be prepped and performed in all five rooms, and patients are continuously moving forward in a safe and socially distanced manner.

Even more important than the office layout is the office location, and the most important aspect of location is the strength of the surrounding network and potential referral sources.

Starting my career in a group practice not only helped me to develop clinically and professionally but also helped me grow my community network in such a way that the best future solo office location was immediately obvious. Of course, it's possible to start solo right out of fellowship, but the build would be slower as the network develops.

ideal for small pupil settings. It also requires fewer intra- and inter-patient beam adjustments compared with other indirect ophthalmoscope options.

Tonometer: Tono-Pen Avia (Reichert). This device has an excellent battery life and can go years without calibration, which reduces disruptions to patient flow. During the COVID-19 pandemic, I have turned to the Tono-Pen in lieu of applanation for its reduced face-to-face contact and the ease of replacing a sterile tonometer cover after each patient.

B-Scan Ultrasound: Compact Touch (Quantel). Like a B-scan in tablet form, the Compact Touch was the most portable ultrasound I could find. The 15 MHz probe produces high-resolution images, and although it lives in my OCT room, it easily moves to any examination room for patients with limited mobility.

Laser: IQ 577 with MicroPulse (Iridex). When I was deciding what kind of laser to purchase, the need to treat central serous retinopathy (CSR) led me to look for a unit that included a subthreshold option. My previous practice did not have a subthreshold laser, and I could only offer observation for 3 to 6 months or off-label eplerenone, which comes with a long list of possible side effects. Furthermore, if the fluid didn't resolve, I had to refer out to another practice.

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START WITH TOP-OF-THE-LINE MODELS.

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When I opened my practice, I was weighing the pros and cons of the IQ 577 with micropulse and the PASCAL with Endpoint Management (Iridex). While the preset grids and patterns on the PASCAL were appealing, the IQ 577 had the option to mount on an ergonomic motorized table with the slit lamp I had chosen, the CSO 115V SL990. Needing to maximize my 2,000 square foot office, I chose the IQ 577 and the Iridex laser indirect ophthalmoscope, so that my laser room could double as an extra examination space.

Because micropulse is noninvasive, it's a painless, low-risk, versatile treatment option for many conditions. For example, it is now my first-line treatment for CSR. The laser divides power into microsecond bursts interspersed with longer resting intervals to allow complete relaxation of energy, preventing thermal buildup and tissue necrosis. Micropulse has been shown to produce acute visual rehabilitation and reduce the incidence of chronic CSR.¹ Studies have also demonstrated that micropulse laser therapy can reduce fluid in patients with chronic CSR.^{2,3}

The laser is also useful as an adjunct therapy for center-involving diabetic macular edema after anti-VEGF therapy. Traditional continuous wave focal laser is a useful supplement for eccentric leaking microaneurysms after the fluid is reduced. For milder cases, especially those with shallow eccentric fluid or central fluid but VA of 20/20, micropulse has a favorable risk-benefit profile and patients much prefer it to observation. I remind patients that it may take 6 to 12 weeks before they appreciate any quantifiable effect.

Most retinal tears can be treated with 360° continuous wave laser through the slit lamp adaptor and a Volk quadraspheric contact lens. Any remaining far peripheral tears are treated with the laser indirect headset and scleral depression.

FINAL THOUGHTS

The key to success when building your own practice, particularly as treatment approaches change, is having the equipment necessary to adapt. ■

1. Arora S, Sridharan P, Arora T, Chhabra M, Ghosh B. Subthreshold diode micropulse laser versus observation in acute central serous chorioretinopathy. *Clin Exp Optom*. 2019;102(1):79-85.

2. Scholz P, Ersoy L, Boon CH, Fauser S. Subthreshold micropulse laser (577 nm) treatment in chronic central serous chorioretinopathy. *Ophthalmologica*. 2015;234(4):189-194.

3. Scholz P, Altay L, Fauser S. Comparison of subthreshold micropulse laser (577 nm) treatment and half-dose photodynamic therapy in patients with chronic central serous chorioretinopathy. *Eye (London)*. 2016;30(10):1371-1377.

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