Managing the New Logistics of AMD Therapy

In an ongoing series, a practitioner explains how his multi-office practice manages the increased patient volume brought on by intravitreal injections.

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Retina Group of Florida: Practice Profile

Number of surgeons: 8

Number of FTE non-physician staff: about 45

Number of offices: 5

Number of intravitreal injections in the past 12 months: anti-VEGF: 12,000
other: 500

Q: RANIBIZUMAB (LUCENTIS, GENENTECH) IS A COSTLY DRUG. HOW DOES YOUR PRACTICE HANDLE INVENTORIES TO AVOID LOSS?

A: We set an inventory level for each of our five locations, and do a daily inventory. When an office drops below a certain level, we place an order. We order once a week to maintain inventory.

Whether seeing a patient for the first time or in follow-up, we typically make the decision to inject and do the injection on the same day, virtually 100% of the time. We do not want the patient to have to come back for another visit because of the inconvenience, the need to arrange transportation and so on. As it is, they're going to be coming in frequently for injections and follow-ups, so we try not to make it more than needed. So we want to have the inventory such that we don't run out. On the other hand, we don't want to have too many vials of a $2,000 drug sitting around.

At one point, we were overstocked, but by checking inventory daily and ordering weekly to restock we have reached a steady state.

Ordering is centralized in one office. The order is logged, and when it's received, the shipping box is opened and each vial is numbered and then divided for the five offices so that we know where each numbered box is going. Then when each box is used, that number is assigned to the patient it was used on and internally attached to the bill. That way the paper trail is solid.

Q: HOW DO YOU HANDLE INSURANCE PRECERTIFICATION?

A: It depends on the insurance plan. If the patient is in a managed care program, we must get approval. Frequently those patients will have to come back for injection. Some managed care companies can take a week or more to approve.

In many cases managed care companies supply us with the drug. We do not buy the drug for the patient. The payer purchases it and sends it to us. That creates delay, so we have different ways of working around that, depending on the situation. We do whatever we can to treat the patient promptly; 99% of the time the patient is treated that day, and we figure a work-around for not having the dose there at that moment.

For non-managed care patients and Medicare patients with secondary insurance, if it is a secondary we have experience with, we give the injection that day and assume we are going to get paid. The patient signs an advance beneficiary notice in that case, so that if for some reason there is no payment we have recourse with the patient.

Q: HOW DO YOU HANDLE COLLECTIONS?

A: Like everybody, we have had every sort of problem with insurance companies. If a Medicare patient with no secondary insurance would have to pay the 20% out of pocket, we will often use bevacizumab (Avastin, Genentech) in that situation, so that the patient's payment burden is reduced.

Q: HAVE YOU ADJUSTED YOUR PHYSICAL PLANT TO ACCOMMODATE THE INCREASED DEMAND FOR INJECTIONS?

Yes, we have. We pretty much use every room available. Sometimes when there are no patients in workup we use workup rooms for injections. Anywhere that is private, that looks like an exam room and has a chair and a tray stand can be used.

If we were to open a new satellite, we would now plan for a somewhat larger space and definitely a larger number of rooms. For a while we considered doing injections clinic style, all in one space in a big injection room. That never happened because we thought it would be uncomfortable for the patient.

As an aside, I have been treating patients with cytomegalovirus (CMV) retinitis since I started practice. I gave many injections in the 1990s for CMV infection in the retina. In recent years the number of cases of CMV retinitis has declined, but I was somewhat used to high-volume injections from that past experience. Now suddenly the use of injections for patients with age-related macular degeneration and other retinal conditions has exploded. I think that the transition to high-volume injections was easier for those retina specialists who had prior experience with CMV retinitis.

Q: WITH EIGHT PHYSICIANS, HOW DOES YOUR PRACTICE MANAGE DIFFERENT APPROACHES TO GIVING INJECTIONS?

A: At our last office meeting, one of the physicians said, "We've got to standardize our technique of giving injections." I immediately said, "There is zero chance that this conversation is going to end with agreement." Twenty minutes later, everybody admitted, "OK, Halperin was right. We can't do it."

Within this eight-physician practice there are eight different ways of doing injections. Some surgeons use antibiotics, some use only povidone-iodine; some use a lid speculum, and others do not. There is no consistency. But our staff is great. Everybody on the staff knows off the top of their heads how to prep for each of us. It may be written down somewhere, but we don't need to know that. For each us the routine is flawless.

I have recently changed my patient flow to help with office efficiency. For patients who are returning for follow-up, the technician that does the work-up decides if the patient is likely to require an injection at that visit. If so, they prepare the patient with pre-injection drops, and set up the room for the injection. Then, when I see the patient and evaluate the OCT, if I decide to proceed with the injection, I can do it without leaving the room. I have found that this saves a lot of time, and it also provides a better patient experience, because my time with the patient is continuous.

Q: DO YOU HAVE ROUTINE CALL-BACKS OR FOLLOW-UP VISITS AFTER INJECTIONS?

A: We did for a while, but we found that it really did not add any benefit. The call is one random moment in time. If something happened 5 hours before, or happens 15 minutes after the call, what is gained by the call?

Instead, we stress to the patient the importance of calling if there is any change in the visual acuity, the comfort of the eye, the number of floaters, anything like that. Because infections are rare, this seems to work. Every patient gets printed instructions and a discussion of what to look for.

Q: DO YOU HAVE A POLICY ON WHEN OFF-LABEL INJECTIONS ARE USED?

A: I think our practice is a microcosm of the world of retina practice. We have physicians who use ranibizumab almost exclusively, people who use bevacizumab almost exclusively, and people in between. The decision-making is a bit of a moving target. I have gone through multiple iterations of my own thought process — at times more of one drug, at times more of the other. I am currently comfortable with the mix I am using.

Q: ARE THERE SPECIAL CONSIDERATIONS IN YOUR PRACTICE DUE TO YOUR GEOGRAPHICAL AREA, WITH THE HIGH POPULATION OF SENIORS IN FLORIDA AND THEIR SEASONAL MOBILITY?

A: Usually the "snowbird" patient knows what drug his physician up north is using. Often they bring a letter to advise us of the situation. We are familiar with many of the practices in the north that our patients come from, and we have a standard way of handling that, not just for AMD injections but for any issue.

Change causes anxiety. Patients do not want to come to Florida for a vacation and have all their medications changed because the doctor down here does things differently. If the patient is used to receiving one drug, we want to respect that and not make the experience any more difficult than it already is for the patient. ■

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