TRANSITIONS INTO CLINICAL PRACTICE FOR RETINA SPECIALISTS

Beyond the Medical Aspects of Clinical Practice

A CME-certified supplement based on the proceedings from a meeting held in Santa Monica, CA, March 29, 2015

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TARGET AUDIENCE

Retina specialists in their first 5 years of practice

LEARNING OBJECTIVES

Upon completion of this educational activity, learners should be able to:

- Evaluate faculty advice and strategies that can be used to help build their practices and enhance their professional development as retina specialists
- Assess faculty recommendations regarding practice management, including patient scheduling, equipment and medication costs, and recent regulatory changes
- Appraise faculty suggestions to help them prevent malpractice lawsuits

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INTRODUCTION

A panel of leading experts in retinal disease, practice management, and malpractice law recently convened to share their advice and expertise on transitioning into clinical practice with retina fellows and retina specialists in their first 5 years of practice. In addition to covering the medical aspects of retina specialty practices, this unique educational program addressed the nonclinical aspects, including building and managing practices and avoiding malpractice lawsuits. Because increased guidance about the nonclinical aspects of retina specialty practices remains a critical educational need for retina specialists,[1,2] this supplement focuses on these topics. Continue reading for the insight provided by our program faculty, which has proven to be valuable for retina specialists at all stages of clinical practice, not only those who are beginning their careers.

BUILDING AND MANAGING A PRACTICE

Retina practices have changed dramatically over the last 5 to 10 years. The use of intravitreal injections has become more commonplace, affecting patient care in addition to the time management and financial aspects of the practice. The regulatory environment has also changed and continues to evolve with the implementation of programs focusing on improving the quality of patient care while reducing health care costs. Find out how the program faculty are currently handling this changing landscape in their practice groups.

PATIENT SCHEDULING

Patient scheduling is affected by many factors. It is often physician-specific where retina specialists need to balance their personal and professional expectations in terms of the number of patients they want to see each day. It is also dependent on the clinic location, as visit frequency may be less consistent in rural areas. Most of the program faculty have a mix of full and half days in the office. They may often see patients in the morning and perform surgeries in the afternoon or vice versa.

Ancillary and support staff are critical in maintaining patient flow. It is important that they are trained to triage patients, isolate specific diagnoses, and schedule visit types within specific time frames to allow enough time for testing, injections, or procedures if needed. They need to help plan for emergencies and surgery add-ons and can triage patients to get them in sooner to avoid the emergencies that always seem to occur at 5:00 PM on Fridays.

The use of intravitreal injections has greatly influenced patient scheduling and practice flow and accounts for a significant proportion of the retina practice's time. The following options were discussed to help manage the time needed to administer these treatments. However, all faculty agreed that the method used is ultimately driven by each patient's preference.

Injection-only Visits/Injection Clinics/Separate-day Injections[3]

- Definition: intravitreal injections are administered on a separate day from the exam
- Found to be more efficient and allows more patients to be examined when compared with same-day injections, according to one small study
- Patients may be able to drive themselves to their injection visit because they are not dilated
- Not recommended for patients who need to travel long distances for their visits

Same-day Injections[3]

- Definition: patients receive an intravitreal injection on the same day following examination
- The eye is dilated during the exam prior to injection, which allows the retina specialist to check for peripheral tears or hemorrhages following injection
- May be preferred by patients who do not want to take time for two separate visits
- May be preferred by family members who need to drive patients to their visits

Bilateral Injections

- Definition: both injections are administered at the same visit instead of returning every other week for the other eye
- Use drugs with different lot numbers, especially if using compounded agents
- Some patients cannot tolerate the pain in both eyes at the same time
- May be preferred by patients who need to travel long distances for their visits

MANAGING EQUIPMENT AND MEDICATION COSTS IN A PRACTICE

In terms of equipment and deciding whether to buy or lease, your practice needs to identify its requirements and how often commonly used equipment, such as fundus cameras, optical coherence tomography (OCT), and computers, need to be upgraded. The practice size, culture, and preferences also need to be considered. Some advantages to take into account: buying has no monthly payments to worry about, whereas leases can always be modified and there may be some flexibility with upgrading. Overall, the practice should do its homework to determine which options will work best.

Because intravitreal injections have become the standard of care for many retinal diseases, a fair amount of a practice's revenue is often tied up in medication costs. The majority of practices follow the Buy and Bill Model, where the practice purchases the drug upfront and seeks reimbursement after it is used. The steps for this model are outlined below.

1) Acquisition

- Can be purchased directly from the company, the supplier, or through a compounding pharmacy

2) Inventory Management

- Needs to be connected to the acquisition process
- Can be tracked in a variety of ways including paper-based logs, spreadsheets, or electronic systems

3) Reconciliation

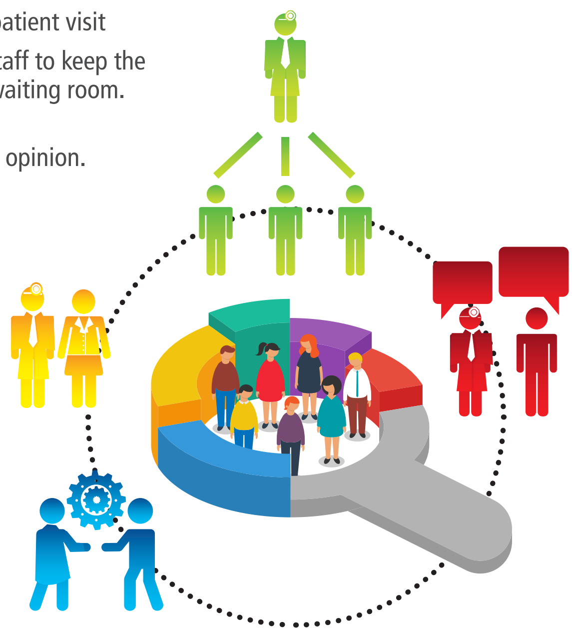
- Need to ensure the practice is reimbursed for the drugs purchased and used
- File claims within a few days
- Keep an eye on patient balances and insurance deductible and copay costs
- Ask your staff to educate you about how the different patient-assistance programs work

Some faculty members described experiencing the Specialty Pharmacy Purchase Model recently in their practices. In this model, the payer has an agreement with the pharmacy and they purchase the drug from the pharmacy and then send it to the practice to use for that patient. The patient will pay an upfront deposit for the drug and the retina specialist bills for the injection.

BUILDING A PATIENT BASE AND KEEPING THEM HAPPY

The faculty described several ways that retina specialists just starting out can help increase the number of patient referrals as well as strategies to help manage your patients' expectations and keep them coming back to your practice.

- Go out and meet people face-to-face, including optometrists and diabetologists. Do not drop in unannounced, but instead call the office and say you would like to stop by to say hello and meet them
- If a new patient comes in, call their referring health care provider, introduce yourself, and describe the patient findings
- Send a report or call the referring health care provider after every patient visit
- If you are running behind for a patient's scheduled visit, ask your staff to keep the patient informed and to isolate any disgruntled patients from the waiting room. Apologize to the patient for being late when you do get to the visit
- Do not be offended or threatened if your patients request a second opinion. Offer them recommendations within or outside the practice
- Be realistic with patients regarding their expectations and explain what they can expect following treatment or surgery and which complications may occur
- Educate patients about why specific procedures may be needed and give them time to think about it. Surgery videos can also be helpful educational tools
- Call post-op patients early that evening to check in and mention what will happen at their follow-up visit the next day
- Patients appreciate having your cell phone number in case they need to reach you post-surgery. However, let them know this number is for urgent matters, not for prescriptions, directions, instructions, or appointments



> "There are some patients who, for whatever reason, may not hit it off with you and you may not hit it off with them. It's okay to offer a second opinion either within the practice or outside the practice. Sometimes, when a retina specialist new to the practice is asked by a patient to see someone else for a second opinion, the retina specialist will think 'What am I doing wrong?' I don't think it's an issue of right or wrong. Patients want a second opinion. I think the worst thing you can do for patients is not to send them for a second opinion to wherever they want to go. Keep the patient engaged. Don't be threatened. It's not anything against you."
>
> -Gaurav K. Shah, MD

BUYING INTO A PRACTICE

One change the faculty noted was that fewer retina specialists are interested in buying into a practice and are choosing to become employees of the practice. They predicted that retina practices consisting of both partners and employees will continue to grow. For those who wish to buy into a practice, the faculty offered the following advice:

- Consider whether or not you want to buy into a medicine-only practice. You may want to think about how to make your practice entrepreneurial, such as becoming more involved in clinical trials or investing in ambulatory surgery centers (ASCs) or real estate for the practice
- Consider the effects of insurance contracts. Having several or losing one can have a significant impact on the number of patients who can come to your practice depending on the insurance carriers included in their networks
- Look at the buy-in contract and how the drug costs are handled for buy-outs. You may need to pay money back to cover acquisition costs

> "There are some people who want a job and there are some people who want an opportunity, and that's fine. But it's important to understand that they pay differently. If you want a job, you get a salary, you come, you work, you leave. If you want an opportunity, you're working not only *in* the business, but you're working *on* the business. You're getting into clinical trials, you're working on surgery centers. All of these things are really time consuming. It isn't like it just happens."
>
> -Paul E. Tornambe, MD

> "The way I look at a practice is I think of it as a house in a neighborhood. You thought you were getting a house in a certain neighborhood that keeps changing but you're paying what the neighborhood was worth 10 years ago. The house valuation goes up and down, but you're paying for Beverly Hills and maybe now the neighborhood has changed."
>
> -Gaurav K. Shah, MD

CHANGES TO THE REGULATORY ENVIRONMENT THAT YOU NEED TO KNOW ABOUT

Several regulatory changes have already occurred or are on the horizon, which will impact reimbursement for retina practices. A brief overview of these recent changes is provided below, but retina specialists are encouraged to further educate themselves about these changes. The American Society of Retina Specialists (ASRS), American Society of Cataract and Refractive Surgery (ASCRS), and American Society of Ophthalmic Administrators (ASOA) have already done most of the homework for you. Utilize their resources and tools to help guide your practice into this new regulatory environment.

Meaningful Use[4,5]

Definition: using certified electronic health record (EHR) technology to improve quality, safety, and efficiency; reduce health disparities; engage patients and family; improve care coordination; improve population and public health; and maintain privacy and security of patient health information.

How it affects retina specialists:

- Payment adjustments will begin in 2015 for providers who are eligible, but decide not to participate in the Medicare EHR Incentive Program
- If you were not an eligible professional in 2013 and did not file, you may be looking at a payment adjustment for 2015

Physician Quality Reporting System (PQRS)[6,7]

Definition: a quality reporting program that encourages individual eligible professionals (EPs) and group practices to report information on the quality of care to Medicare.

How it affects retina specialists:

- The use of incentives for successfully reporting PQRS ends in 2015
- If measures are not successfully reported for the 2015 reporting period, EPs will be assessed a 2% reduction in all Medicare fee-for-service payments in 2017, but may also be subject to a separate value-based payment modifier (VBPM) penalty between 2% and 4% depending on their practice size
- EPs need to select and report on 9 of the available measures to avoid a penalty
  - Measures include the following domains: patient and family engagement, patient safety, care coordination, population and public health, efficient use of health care resources and clinical processes, and effectiveness
  - Some measures are reported via claims and others are reported via EHR
  - One measure selected must be a cost-cutting measure
  - 6 available measures are related to retinal disease or surgery

Value-based Payment Modifier (VBPM)[7,8]

Definition: is tied to the PQRS and provides incentives and payment adjustments based on the quality of care and cost of care that EPs provide under the Medicare Physician Fee Schedule.

How it affects retina specialists:

- Currently, only groups with 100 or more EPs are subject to the VBPM payment adjustments in 2015
- Payments will be affected in 2017 for all providers based on their performance in the 2015 reporting period. This translates to a 2% to 4% VBPM reduction (depending on the size of the practice) for all Medicare fee-for-service payments for those who did not successfully report PQRS measures in 2015. Therefore, all solo practitioners and smaller groups are urged to start participating in PQRS now

International Classification of Diseases-10 (ICD-10)[9,10]

Definition: it will replace the ICD-9 code sets that are used to report medical diagnoses and inpatient procedures and affect the diagnosis and inpatient procedural coding for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA).

How it affects retina specialists:

- Will expand from 14,000 to 68,000 codes and codes will now consist of 3 to 7 digits instead of 3 to 5 digits
- More specificity will be built into codes and there is no laterality in codes
- Combination codes will be available. For example, under ICD-9, when billing for an anti-VEGF injection in a patient with DME, three codes (a diabetic code, ophthalmic diabetic code, and DME code) were needed. These codes will be combined under ICD-10
- At time of publication, the planned implementation date is October 1, 2015

> "Our environment has changed dramatically. I've been at this for the better part of 30 years and I've seen more changes in the last 5 to 10 years than I've seen in the last 30 years, not just in ophthalmology, but specifically in retina. Make sure you know where your resources are, who you can go to for information, and that you structure your practice to accommodate inevitable changes in our regulatory and reimbursement landscape. No longer can we just sit back and say the practice will take care of itself. We need to make sure we adjust for these changes as a practice."
>
> -William T. Koch, COA, COE, CPC

> "I just cannot stress enough to the young doctors of our future, the importance of getting involved with advocacy. We need to get involved with the state and national societies as well as our subspecialty societies. We need to financially support political action committees (PAC) such as OPHTHPAC and Surgical Scope Fund because we need to put our money where our mouth is. Without our involvement both with time and money to these organizations, we have no voice. If we have no voice, others will make the decisions for us and things are just going to get uglier and more onerous. We have to speak for our patients, our profession, and our specialty by getting involved."
>
> -Judy E. Kim, MD

OPHTHALMIC PRACTICE RISK MANAGEMENT

Malpractice lawsuits start in the following way: a problem occurs, the patient is unhappy, the patient seeks the advice of an attorney. The attorney then acquires your records, which are reviewed by a specialist in the same specialty to determine if your recommendations and care followed the accepted standard of care. If it is concluded that a deviation from the standard of care occurred and caused injury or damage, then a malpractice lawsuit follows. Advice to help you avoid this situation is outlined below.

PROPHYLAXIS OF MALPRACTICE: SUGGESTIONS TO HELP AVOID LAWSUITS

The Importance of Accurate and Thorough Medical Record Keeping

- Start documentation with the patient's first phone call to the office
    - Even though a doctor/patient relationship has not yet been established, you can be sued if a person calls in with complaints of retinal detachment symptoms and an appointment is scheduled for 2 weeks later
    - Inform your staff which phone calls and situations require immediate attention. Tape a card on each phone so the receptionist knows which situations constitute an ophthalmic emergency. The receptionist should interrupt you if there is any doubt
- Other elements of good record keeping
    - The more information you can put in a medical record, the better. It is important to document because it conveys to the jury that you are thoughtful, did something the patient needed to know, and put it in his/her records
    - Document when patients fail to come in for an appointment. A system should be in place, such as a phone call, to remind these patients about the importance of follow-up care
    - Protect patient records because you do not want confidential information getting into the wrong hands
    - Make sure that you see all lab results and consultant reports
    - Document any complications that occur during your surgeries in the operative report
    - Document all medication refills
- Alterations of medical records
    - When people get sued, they may realize they forgot something and alter the medical records. This is very troublesome in any form and suggests a conscious feeling of guilt. If you need to alter the records because you forgot something, do not do it in a clandestine way. Date the new entry and document why you are doing it. It is still problematic, but shows you realized that you forgot something and noted it when you looked at the records later
- Coordination of care
    - When working with other physicians, identify who will be managing which aspects of the patient's care and adhere to those divisions of responsibilities
- Dealing with managed care organizations (MCOs) or capitation groups
    - If you recommend a certain treatment or management strategy and it is rejected, you need to serve as the patient's advocate. Make copious notes about refusal of treatment or suggested medication so if something happens later on, it has been demonstrated that you were the patient's advocate and were turned down

Documentation

Informed Consent – Why It Is Necessary

- Required by every state
- The patient must be given information about the diagnosis, proposed treatment, associated risks, hazards, complications, and alternatives, and they must be disclosed in understandable terms. The patient needs to have the opportunity to ask questions and accept or reject the proposed treatment. It is very important that the patient know what is planned and what can happen
- Inform patients if you recommend off-label uses as part of their treatment plan
- Using videos to explain risks and complications to patients can be very helpful and assist in the informed consent process
- Have patients consent in writing with someone from your office witnessing their signature
- For non-English speaking patients:
  - Need to obtain a translator or make sure a family member is accurately translating the information
  - Document who the translator is in the patient's medical records
- What to do if a patient refuses your recommendation
  - Informed refusal: if a patient refuses proposed treatment or surgery, you need to warn the patient about the risks and consequences of that refusal. You need to make sure the patient also accepts and understands the risks and consequences
  - For example, if you recommend a wait-and-watch approach and the patient wants to have surgery, you need to document this in the medical records

Communication With Patients' Family Members

- Because of HIPAA laws, you need to get the patient's consent to share any information about them with their family members. Make sure it is documented which family members may ask questions and receive information about the patient
- Document if there is a family member that the patient does not want in the exam room with them
- However, you may discuss a patient's care, diagnosis, and treatment with another one of their physicians without violating HIPAA laws

Reducing Medication Errors

- Corticosteroids and antibiotics are the medications most implicated in claims against ophthalmologists
- Ask patients at every visit if they have any allergies to medications
- If you are not certain if a medication you choose is the best choice for a patient with a medical condition, ask someone who is knowledgeable
- Document all calls from pharmacists
- Document all prescription refills that occur via phone and include the drug, frequency, strength, and directions for use

Communication

Managing Your Patients' Expectations

- Try to prevent patients from having unreasonable expectations and educate them about potential problems that may occur
- Communication with your patients is important
  - Patients want to know that their physician is listening to them
  - Give patients an explanation of what you are doing as you do it
  - Minimize distractions during patient visits
- If vision was not restored to the patient's expectations following treatment, malpractice was not committed if you followed the standard of care

Making Your Practice a Safe Environment

- Adhere to the Americans with Disabilities Act
- Make sure there is adequate access to your building even when construction is taking place outside
- Ensure that there is sufficient seating in your office
- Address equipment malfunctions immediately
- Warn patients about the effects of dilation. If you think they will have difficulty driving after the appointment, counsel them about having someone else drive them

Advice on Giving a Deposition

- Definition: an informal procedure not taking place in court, but has the same effect and force as if you were testifying in court. A court reporter is present, and you are administered the oath and questioned by the lawyer. The process format is question, answer, question, answer
- Know the details of your chart/medical record so you do not have to search to answer any questions
- It is also helpful if your lawyer understands your area of practice so he/she can help you prepare for the types of questions you may encounter. It is also useful to have a rehearsal deposition with your lawyer
- Answer questions as shortly and succinctly as possible
- Read the record from the deposition before you sign it

> "The troublesome thing about being sued is it follows you forever. Every time you apply for renewed or new hospital privileges, every time you apply for new insurance, every time you apply to become a providing member of a health insurer or managed care organization, every time you apply to certain organizations, they'll ask you about your lawsuit and claims history."
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> -Howard A. Slavin

CONCLUSIONS

As emphasized throughout this educational program, the practice environment has changed dramatically for retina specialty practices and continues to evolve. Take away these points to help you successfully make this transition from your fellowship to clinical practice:

- Decide if you prefer to be a practice employee or a partner
- Stay up-to-date with regulatory changes and how they may affect your practice
- Get involved in advocacy efforts to speak for your profession
- Protect yourself and your practice from malpractice lawsuits
- Take steps to run your practice in an efficient manner by finding the management strategies that work best for your practice
- Work to grow your patient base and to keep them happy because, ultimately, patients come first

> "It's always interesting to see people or fellows who have started in practice. As long as they're available and they do a good job, patients will come to them. I think that's the key: being available and doing a good job because at the end of the day, that's what makes a difference. It's not complicated."
>
> -Gaurav K. Shah, MD

> "Making the transition from your retina fellowship to clinical practice represents an exciting and challenging time. Take advantage of your mentors, colleagues, and seniors to learn as much as possible to help you make this transition as seamless as possible. Most importantly, as you make this transition, stay involved with your subspecialty societies and the broader ophthalmic community."
>
> -SriniVas R. Sadda, MD

> "The first few years of practice will be challenging and rewarding. When I was starting practice, my new boss Gary Abrams had one important, succinct piece of advice: 'If you concentrate on taking great care of your patients, everything else will fall into place.' As usual, Gary was right. The burden for new physicians can be overwhelming, given the importance of running an efficient practice, the ever-changing economic landscape, and the unfriendly medicolegal environment. Focus on staying current with the ophthalmic literature and the standard of care, and spend time listening and talking to your patients, and you will have an intellectually stimulating and very rewarding career."
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> -Dean Eliott, MD

COMMENTS?

E-mail us at transitionsretina@spirelearning.com to provide any comments about this article, share your experiences, or give advice to other retina specialists who are starting out in clinical practice.

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