

Practice Growth, Relocation Bring Economies

A new facility located above an ASC improves efficiency.

BY CARL C. AWH, MD

How would you like to have your main office—a brand-new state-of-the-art facility—located one floor above the ambulatory surgery center (ASC) where you do most of your surgery? That is now the situation for Tennessee Retina, the seven-surgeon, retina-only practice in which I am a partner.

In April we moved into a new 18,000 sq ft office that we designed with the help of an architectural firm with ophthalmology office expertise. Moving three practices into a new facility was a herculean task, but well worth it. We take pride in the facility, which we think is optimally designed for a busy clinical private practice involved in clinical research.

We would not be in this brand-new facility if we had not recently expanded our original four-surgeon practice. In July 2008, two surgeons from another local practice joined our group, and in January 2009 an additional solo practitioner came on board. We consider this a merger of equals, although for practical reasons we maintained the corporation of the largest group, but with a new name – Tennessee Retina. The addition of our new partners was done in stages, determined by the expiration of their leases. For the first few months, we were a single legal entity but were still practicing in our original offices. Now we are all under one roof, so to speak, and are enjoying the interaction and cooperation of our new partnership.

Our newly expanded physician contingent allowed us to become the first ophthalmologists to use the multispecialty ASC above which we are located. This ASC was previously

not doing any ophthalmic surgery; now it has opened up an operating room just for vitreoretinal surgery. That provision was made economically feasible through our ability to offer the ASC a sufficient volume of cases. With seven of us, we were easily able to provide the surgical volume necessary to establish this new service.

EFFICIENCIES

Our larger practice has led to new efficiencies in a number of areas. As separate entities, the three groups practiced in 20 locations. Now that we are together, we have eliminated geographic overlap and competition, and we now have 16 offices. We have hired a sea-



The partners of Tennessee Retina (left to right): Carl Awh, MD; Gary Gutow, MD; Brandon Busbee, MD; Kenneth Moffat, MD; Trent Wallace, MD; Peter Sonkin, MD; and Everton Arrindell.



Figure 1. Patient check-in.



Figure 2. The exam room hallway.



Figure 3. Technician station.

soned ophthalmology practice manager as our chief executive officer with the objective of freeing the physicians' time to do what they do best – practice medicine. Of course, we remain actively engaged in the management of the practice, but the benefit of having an experienced administrator in place is already obvious.

In addition, we have gained efficiency through proximity to the ASC. Before the practices combined, all of our surgery was hospital-based. Now we perform a substantial number of our cases in an ASC one flight of stairs below our main office. We do not yet have an ownership stake in the ASC, although we have plans to acquire a small share. But even without an ownership interest, the efficiency that we have gained by operating in the ASC environment is tremendously valuable. Time is money, and we have more time in our schedules with this arrangement.

The increase in the number of surgeons brings its own efficiencies of scale for the practice, as well as better coverage for weekends, meetings, and so on. It also leads, we believe, to a higher quality of patient care. Whenever physicians are in a better position to learn from one other, the quality of the group is elevated.

REACHING CONSENSUS

Working with a group of seven surgeons entails compromise. The core practice had been in business for over 30 years and the others a minimum of 15 years. After that amount of time, there is a tendency to get set in one's ways; things work well, and there is no real motivation to scrutinize practice patterns. The merger has given us a reason to evaluate the major and even minor elements of our practice, and our goal is eventually to optimize and standardize each one.

With every change we make in the ways each of us has been practicing, our goal is to agree on the method that will work the best — whether it is a long-standing habit of one doctor or a novel method for all of us.

It is possible, believe it or not, to get seven surgeons to agree. We have a colle-

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gial group, and thus far everyone has been willing to compromise, with the understanding that it is better to come to an agreement, to institute change, and to refine a process than to seek the perfect solution before instituting change. For example, although we expect one day to make the transition to electronic medical records, we decided to stick with paper charts for now. This forced us to assess and rework the charts and forms that we had each been accustomed to. There are new abbreviations, different colors, and revised layouts for all, but the compromise has been a huge benefit to our staff, who had struggled for the first few months with three completely different sets of forms and charts.

We have not run into an issue that we have not been able to resolve collectively. By no means has every decision been unanimous, but every decision has been accepted by discussion and vote.

PLENTY OF ROOM

We designed our new facility with a goal of providing high-quality, efficient care in an elegant but practical space. This includes, of course, the requirement of handling the increased patient volume that most retina practices have seen with the introduction of intravitreal injections for exudative age-related macular degeneration (AMD). We have taken into account that our patients are mostly older, often in wheelchairs, and often accompanied by family members.

The office is spacious, with halls much wider than the typical office and comfortable waiting areas with large flat-screen televisions for patients and family members. It is also set up to facilitate the efficient movement of doctors and technicians (Figures 1-3). I often describe the clinical area as a “retina hospital,” as opposed to a retina office. There are no dedicated injection rooms—the equipment needed to do an injection is not specialized, so we can do them in the exam lanes—but we have enough lanes that we can run a busy “injection clinic” with ease.

Seven physicians never practice in the office at the same time. On any given day no more than three doctors see patients in the main office, although the office

is designed to handle up to six working doctors in a pinch. Most of our 15 other locations are satellite offices that we serve anywhere from a half day to 3 days a week. At least one surgeon is in the operating room each day.

Our practice has a commitment to clinical research; we participated in all the pivotal clinical trials for AMD in recent years, for example. Therefore, we have a large number of patients coming in for clinical trial visits, which are typically time- and space-consuming. Dedicated interview areas and exam lanes for study patients allow us to treat these patients as VIPs while not impeding the function of the regular clinic.

We look forward to further growth, whether that comes from adding more doctors or locations or simply working more effectively with the team that we have. These are issues that we will continually evaluate.

THE TIMING

Our decision to merge was years in the making and was independent of current social and economic events. With the economy suffering and recent uncertainty about the future of national health care policies, however, the fact that we now have a larger group is reassuring. The efficiencies brought about by our new arrangement can only help us to deal with these issues.

Medical practices face constant challenges. We have competition locally with other groups, we face the economic pressures common to all medical practices, and we never know when an upheaval in our practice pattern will be brought about by some revolutionary change in treatments, as with the advent of antiangiogenic injections.

We can never be complacent. One of the pitfalls of larger groups is the tendency to assume that “someone else” is watching the details. To date, we have done a good job of keeping focused on our mission: providing world-class care to our patients and to our referring doctors. We look forward to many years of continued growth here too—but no more office moves! ■

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