SHARED CARE CAN BENEFIT RURAL PATIENTS

Bringing state-of-the-art surgery to small local hospitals.

BY PAUL J. HARTON, MD, PHARMD

Everyone involved in eye care knows the benefits of the integrated care of surgical patients. When these patients are treated by optometrists and ophthalmologists, the surgeon gains greater surgical volume, and the optometrist benefits by having a reliable partner who will treat his or her patients well and return them to their local eye doctor's care in a timely fashion.

Less often mentioned are the benefits of integrated care for the patients themselves. In the rural areas where I share surgical care with several local optometrists, the patients benefit by having surgery performed by an experienced high-volume surgeon using state-of-the-art equipment, without having to travel a great distance to a metropolitan center for surgery. Unless there is a complication, patients are returned the following day to their optometrist for postoperative care in their local setting. This model saves patients travel time and money, spares them the anxiety of navigating a distant city to find an unfamiliar medical facility, and entails minimal interruption of the local doctor-patient relationship.

MY PRACTICE

I practice at the Harbin Clinic, a large multispecialty medical group in Rome, Georgia. We perform about 2,000 cataract surgeries per year, and many of these surgeries are for patients who are comanaged with approximately 30 local optometrists in northwestern Georgia and northeastern Alabama.

For the patients of those optometrists who are close to Rome, within a 30-minute drive or so, I operate at our center in Rome. For several optometric practices that are farther away from Rome, however, I perform surgery at their local community hospitals, using the services of Sightpath Medical to deliver the equipment I need when I need it.

Sightpath is the country's largest provider of mobile ophthalmic solutions, supplying more than 1,300 surgeons in 49 states. The company has been providing roll-on–roll-off equipment and services for me since I joined the Harbin Clinic more than 15 years ago.

This arrangement makes it possible for me to walk into hospitals in Bremen, Georgia, and Centre, Alabama, and perform phacoemulsification with exactly the same equipment I use at home in Rome. As a result, I can care for patients in these distant locations with local optometrists to the benefit of all involved.

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HOW IT WORKS

For rural hospitals, ophthalmology is not a lucrative specialty. A high volume of procedures yields a relatively small amount of payment to the hospital. Therefore, these facilities are not inclined to spend $100,000 on a phaco machine and microscope that will be used only once a month. My comanagement arrangements help to overcome this problem.

Sightpath negotiates with the hospital for a portion of the facility fees for the cataract surgeries I perform there. I receive the physician fee I would normally get at home, and Sightpath invoices the hospital for its share of the facility fee. The payments are kept totally separate. The hospitals realize that they are not going to make a lot of money on any one procedure, but they are not going to lose money. Meanwhile they are providing a valuable service to the community. In addition, patients are not driving to another city and getting pulled away from local services. So, the hospitals like this arrangement.

For me, the roll-on–roll-off services make operating remotely an easy task. Sightpath provides the same type of phaco machine I use in Rome—we will soon be getting a brand new Centurion unit (Alcon)—as well as the microscope, the phaco packs, a YAG laser if I need it, and all related equipment. Depending on the contract, the company can

also supply the surgical instruments and a scrub technician if needed.

Because I am a regular customer, the company knows I will be in Bremen these days of the year, Centre these days, and so on. A technician shows up with a van full of all the equipment, and the crew rolls it all in and sets it up, similar to roadies for a rock band. The scrub technician and I walk in and basically just have to scrub for surgery and get started. The hospital provides the labor for pre- and postoperative care.

MODELS OF INTEGRATED CARE

Of course, surgery is only half of the shared care model for the surgeon. In my practice, we also perform preoperative examinations on every patient in advance of surgery. We use a number of care models, depending on the site.

For example, we spend 2 days each month in the Carrollton/Bremen, Georgia area. We generally see 25 to 30 patients in one day, then come back the next month to perform surgery for roughly 75% of those patients. A week after that surgery day, we begin the process again.

However, in Centre, Alabama, the volume of patients is lower, so we do everything in one day: surgery in the morning for patients we have seen the previous month, then preoperative examinations in the afternoon for patients who will undergo surgery the following month.

We use a third model at some centers that are closer to Rome. We travel to the optometrist's office for preoperative exams, but the surgery is performed in Rome because these patients are only about a 30-minute drive away.

Soon, we will be trying a new model with the help of another rural hospital in Cedartown, Georgia. We will set up an office in the hospital's medical office building. This will serve as a neutral site for four local optometrists to send their patients to for cataract evaluations. Those patients may then have surgery at the local hospital, thus maximizing their travel time.

In the first three models, on the days we do preoperative examinations, we essentially take over the optometrist's office for half a day when he or she is not seeing patients, or if the office is big enough, we use separate rooms so that we do not interfere with the daily operations. We pay rent for the space for that time (more on this in the next section), and we bring our own team of two technicians, a front-end person to check patients in and handle paperwork, and a surgical counselor to schedule surgeries and ensure that patients know what to expect from their surgery. Patients are billed through our office, so the billing is totally separate from the optometrist's business.

LEGAL CONSIDERATIONS

It is important to pay attention to legal issues in making shared care arrangements. All parties must be compliant with the relevant regulations.

The first rule with integrated management is that it is not done on a routine basis. Every case must be considered on its individual merit. To comply with this, we have each patient sign a consent-to-comanage agreement. We explain that, most likely, if everything goes well and there are no complications, we will release the patient to the care of his or her optometrist the next day so as not to burden any patient with undue travel; however, if anything goes wrong, I will want to see the patient myself in Rome the next day.

Postoperatively, if there were no complications and I feel the patient can be released to the optometrist, I send a transfer agreement to the optometrist, indicating that everything went fine and the patient is now returned to his or her care.

Those two components are essential: the consent on the front end and the transfer on the back end.

If there is any type of complication, I talk to the family. I tell them this is not a case that went as smoothly as I would like and that I feel that I need to see the patient the next day. Almost always the patients and their families do not mind traveling to Rome for the postoperative visit under these circumstances. Once the patient has stabilized, I then sign the transfer agreement.

I always tell patients, whether I see you postoperatively or not, you can always call me. This is also mentioned in the consent to comanage. I am always available to the patient.

The other issue that must be attended to in shared care arrangements is to avoid any appearance of a kickback or incentive for referral. Because antikickback regulations have become more stringently enforced lately, we now have a chief compliance officer in our clinic, an attorney who works with us to craft the lease agreements we are now required to have with our collaborating optometrists.

As mentioned, when we go to these satellite offices, we take over the optometrist's office for half a day and pay rent for the space. There are two important criteria that must be met with these arrangements in order for them not to be perceived as inducements.

First, there must be a lease that spells out the frequency with which we will use the facility—once a month or whatever the arrangement is. Second, the rent paid for the space must be fair market value. Payment cannot be based on volume or a per-procedure amount. It has to be a flat rate based on what the property rental is worth for the time we use it.

This can be a sticking point because the optometrist, who is giving up a day in the office, may want to be compensated for lost revenue. However, to do that could be construed as an inducement and would be illegal. The lease amount can only be for the fair market value of the space. In consideration of this, we try to be sure we rent the space at a time when the optometrist would not be in the office anyway. For instance, the optometrist in Carrollton is not in the office on Wednesday afternoons, and that is when we use his office.

Of note, the payment cannot be more than fair market value, but it also cannot be less than fair market value, because that could be construed as an inducement to the ophthalmologist.

BETTER FOR PATIENTS

My integrated care partners and I believe that these arrangements are in the best interest of our patients. There are many underserved rural communities, and this is one way to reach these communities with state-of-the-art surgical care. Many of the elderly patients we see in rural Georgia and Alabama have only Medicare for insurance. Gas money is a luxury. Therefore, this service we provide is valuable to them.

It is important, in these rural communities, for optometrists and ophthalmologists to have strong, trusting, positive relationships. Our local optometrists like our arrangements because they know they will get their patients back after having their surgery done locally. They also like having an ophthalmologist coming regularly to their office.

For us, these arrangements provide a way to ensure a good surgical volume without having to see as many patients. If I see 20 patients in Carrollton, I will probably end up operating on 15 of them. If I see 20 patients in Rome, perhaps only three or four will be surgical patients, and the rest will be for refractions, red eyes, and other things.

These cooperative models are important today, not just because of these benefits, but also because of the growing volume of patients that we will see in the future. Ophthalmology is heavily oriented toward the geriatric population, which will continue to grow as the baby boomers age. The integrated health care model is the wave of the future. Primary care physicians now frequently use nurse practitioners. Similarly, ophthalmologists need to work with optometrists, because ophthalmologists alone cannot possibly serve the increasing elderly population coming down the pike. We will need the help of primary care optometry. ■

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