Planning for retirement

Determining when—or if—selling a practice makes more sense than adding partners is an individual decision. Just don’t wait too long to decide P. 16
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From the publisher

Unless you plan to work until your last breath, retirement will be the exciting end of your career trajectory. With a little advanced planning, it doesn’t have to be stressful, complicated, or emotionally draining.

One aspect of that planning includes determining whether or not to sell your practice or add partners who can take over. Ophthalmology Business talks to experts about how to navigate this process in “Planning for retirement” on page 16.

Speaking of careers, some physicians have decided that full-time work isn’t part of their plan. OB shows how that pans out in “Part-time physician work on the rise” on page 20.

On the opposite end of the work life cycle is the “birthing” process you will endure when implementing an electronic health record system. We delve into the details in “What to expect when you’re expecting (an EHR system)” on page 14.

OB is happy to bring you more news you can use about an app that helps patients keep track of their drops (“Dropping in,” page 6), information exchange (“Informed consent and the ophthalmologic marketplace,” page 8), finances (“The unplanned partnership buy-out,” page 12), and “Liquidity management in the new era of ophthalmic economics,” page 24.

Donald R. Long
Publisher, Ophthalmology Business
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Dropping in
by John DiConsiglio Contributing Writer

The EyeDROPS app keeps meds on track and patients on course

It’s among the most vexing dilemmas for eyecare professionals: how to help your patients remember to take their medications correctly. As many as half of all people suffering from serious eye conditions fail to use their drops properly—or forget to take them at all. So it’s no wonder that ophthalmologists and optometrists are often confounded in their efforts to raise patient compliance rates.

A new smartphone application hopes to ease that frustration by helping patients with chronic conditions like glaucoma efficiently manage their meds. The free EyeDROPS download from HarPas International reminds users to take their drops at scheduled times, guides them through proper dosing techniques, and even alerts them when their bottles are running low.

“This is a huge problem,” said Tom Harbin, M.D., glaucoma specialist, Eye Consultants of Atlanta, and co-developer of the EyeDROPS app. “About 50% of people do not take their drops regularly or correctly. It’s just amazing. These are intelligent people who know that the consequence of not taking glaucoma medication regularly is losing sight. But they just don’t do it.”

The app’s pull-down menu accesses a database that lists all available eye drops. Users select the right medication, and then enter the proper dosage and schedule. The app alerts them when it’s time to take their drops. The program stores a record that the medication was taken correctly and automatically reminds patients...
patients about their next scheduled dose.

The app is designed to simplify confusing medication regimens for patients with conditions that require multiple drops per day. Glaucoma patients, for example, may take as many as seven drops each day from a handful of bottles. The app lets users snap a smartphone picture of their medication, helping them keep track of different bottles. That’s particularly useful among generic brands whose labels may be hard to read, Dr. Harbin noted. By recording each dose, the app informs users if their bottle is almost empty. When it’s time for a refill, EyeDROPS reminds them to call their pharmacy and leads them to their contact list. Dr. Harbin is planning a future version that immediately pulls up a pharmacy phone number.

Other features include videos that demonstrate proper drop-taking techniques, like closing eyelids for a minute after inserting a drop and waiting proper intervals between doses. The app will caution users if they are taking their medications too close together. “It enforces good behavior,” Dr. Harbin said.

The EyeDROPS app is free for iPhone users and Android phones. Dr. Harbin and co-developer Scott Pastor, M.D., are working on versions for Windows phones and Blackberries. The app is currently only available in English, but Dr. Harbin noted new programs will include translations into Spanish, German, and French.

### Heading off problems

With 60 million glaucoma patients worldwide, Dr. Harbin said the app can help head off the serious consequences of poor medication use. “With a chronic disease like glaucoma, where there are no symptoms and where the treatment can sometimes irritate the eye, people don’t always grasp the importance of taking drops regularly and correctly,” he said.

While Dr. Harbin anticipated that patients with glaucoma will be the most common users, the app designers are also targeting the 30 million dry eye sufferers who often take multiple drops to moisten their eyes and reduce discomfort. Dr. Harbin envisions uveitis and some allergy patients also employing the app to keep track of multiple drops.

The free app is supplemented by a premium version that includes enhanced functions. Available at a small cost ($1 a month for iPhone users, $1.30 for Androids), the premium app allows users to record a complete eye history on their phone, including past medications, allergies, prior laser treatments, and surgical
Informed consent and the ophthalmologic marketplace

by John Banja, Ph.D.

On a Sunday morning a few years ago I was sitting in a terminal at the Orlando airport waiting for a flight back to Atlanta. A Sunday newspaper was lying nearby, and I picked it up and began glancing through the pages. They say that Florida is an ophthalmologist’s and urologist’s paradise, and I recall being struck by the numerous, occasionally “brassy,” ophthalmology ads.

Now, I not only have nothing against physicians’ advertising, but I believe physicians did themselves a disservice for decades by discouraging advertising. After all, advertising is a form of consumer education, and someone’s knowing about the existence of a particular physician practice can make an enormous difference in the quality of his or her life. The fundamental ethical concern regarding physician advertising is that such ads must be reasonably truthful and professional so as not to compromise the integrity of medicine and its practitioners. But what I took away from those ads was the extent to which certain kinds of ophthalmology services, especially anterior eye procedures like premium lens implants and LASIK, seemed to lend themselves almost naturally to the “marketplace.”

Perhaps this is not only because the cost of these services can be projected much more accurately than other kinds of surgeries, but that payers understand LASIK and premium lenses as cosmetic interventions whose costs should be borne by buyers. Spectacles are the least costly remedy for correcting vision, so that if patients want something else for largely aesthetic reasons, they should pay out of pocket. Possibly then, the fundamental intuition that consigns certain anterior eye services to the marketplace is that one can argue that they are in the same category as rhinoplasties, Botox, and face lifts. If that’s right, however, then informed consent becomes a strategic, and not just an ethical, feature in these marketplace arrangements.

continued on page 10
Ever since Adam Smith described the modern marketplace in *The Wealth of Nations*, we’ve acknowledged that buyers need to be as reasonably well informed as possible for markets to run well. That’s because buyers’ informed purchasing decisions will force (competing) sellers to deliver the best quality services and products at the best prices. Alternatively, chronically unsophisticated, comprehending buyers might find themselves at the mercy of sellers and be manipulated into wanting what they get rather than getting what they want.

Interestingly, studies suggest that most ophthalmology patients receive a very detailed informed consent process, even though an article by Kimberly Wynkoop in the Summer 2011 *Ophthalmic Risk Management Digest* stated that “an inadequate informed consent process was the single most important driver of PIOL malpractice claims” that the Ophthalmic Mutual Insurance Company received. So, despite the elaborate informed consent process that ophthalmologists provide patients, it seems that many patients don’t think of it as ending with the delivery of services, but rather see it as extending into an indefinite, post-purchase future. But patients who complain after surgery about the quality of their informed consent might be confusing it with their physician’s post-treatment communications or communicational style, which might strike the patient as distant, uncaring, incomprehensible, or evasive. This latter speculation is quite likely because we know that physicians sometimes fail to handle disgruntled patients artfully, and as the insurance company’s claim experience showed, these patients sometimes initiate a lawsuit. For them, poor “informed consent” is simply a proxy for what they experience as poor customer relations.

procedures. Patients can also keep track of their compliance rates and chart their intraocular pressure information on a continuous graph.

The extra features allow for a more interactive experience between patient and physician, Dr. Harbin said. Patients can send their compliance information directly to their doctor or a family member. The app responds with email updates, congratulating good compliance rates and encouraging lagging patients to improve their usage. Premium users can also sync their medication schedule between their phones and the EyeDROPS website. Future versions may include “gamification” or rewards features that allow users to compete for a high compliance record.

With more than 500 EyeDROPS app users worldwide—from India and Asia to across the U.S.—Dr. Harbin said feedback has been positive among both eyecare professionals and patients. “Eye drop takers have a lot to think about—confusing regimens, taking multiple drops at different times, keeping track of their pressures, their prescriptions,” he explained. “They appreciate when you can give them a helping hand. If we can keep them taking their drops regularly and correctly, we can make a big difference in their treatment.”

The EyeDROPS app is available for Android phones through Google Play and for iPhone through the App Store. At both sites, search for “EyeDROPS.”

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In any event, those ophthalmology ads I read in Orlando are only the beginning of the informed consent process in the ophthalmologic marketplace. Rightly or wrongly, many patients might understand informed consent as an ongoing affair that extends after their surgery occurs. Maybe they understand informed consent as a mechanism for enabling marketplace trust—a trust that becomes especially fragile when their outcomes are less than what they expected. Consequently, I would urge ophthalmologic practices to think hard about the quality of their providing information. Do they check their communication practices for their comprehensibility, especially with patients who have trouble understanding and processing information? Have they adequately discussed and prepared the patient for the possibility of complications and a less than perfect outcome, even when the ophthalmologist has scrupulously followed the standard of care? Is the patient adequately prepared to accept some degree of responsibility in such cases, i.e., that an important ethical as well as legal consequence of a good informed consent is that patients realize they are assuming some degree of risk by consenting to purchase a procedure about which they have been duly informed?

Fulfilling these informed consent obligations helps in realizing the best in customer relations. And while not all ophthalmologic consumers will be satisfied all the time, skillful information exchange can help realize the best that a marketplace in ophthalmology can provide.

**OB**

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The unplanned partnership buy-out

by Brad Ruden, M.B.A.

The two areas most obviously affected by an unplanned buy-out are the practice’s reputation and/or the practice’s financial situation.
There are two ways for a physician partner to exit a medical practice: the planned transition and the unplanned transition. The great majority of partnership documents I have seen address, in some form, the planned buy-out of a partner. However, many partnership documents I have reviewed have failed to address when an unplanned event triggers the buy-out of a partner.

Planned buy-out

A planned buy-out is addressed in most partnership/partner agreements. It typically specifies—just like a buy-in—how the partnership share is to be valued and paid out. A planned buy-out is an orderly process where the departing partner has provided proper notice and the practice can prepare accordingly. Under a planned buy-out there should be little to no disruption in patient care, practice productivity, or financial performance.

Unplanned buy-out

An unplanned buy-out is usually triggered by an unforeseen event. Some—but not all—of the reasons for an unplanned buy-out could be:

- A partner’s death from accident or sudden illness;
- A partner’s disability from accident or sudden illness; or
- A partner’s withdrawal from, or the termination of, his/her employment with the practice without proper notice.

Additionally, there are unforeseen legal issues that can cause an unplanned buy-out:

- A partner being named as an individual in any lawsuit or legal proceeding that may damage the reputation of the practice;
- The partner’s disqualification from the practice of medicine; or
- The adjudication of a partner’s bankruptcy, an assignment for the benefit of the partner's creditors, or the administration of the partner’s assets in any type of creditor’s proceeding.

In addition to all the above, the partners themselves may instigate an unplanned buy-out for administrative reasons, such as:

- A partner being “voted out” of a practice for a reason outlined in the Partner’s Agreement; or
- A severe reduction in a partner’s contribution to the practice, drastically altering the practice’s financial performance.

Ramifications of an unplanned buy-out

The two areas most obviously affected by an unplanned buy-out are the practice’s reputation and/or the practice’s financial situation.

If the unplanned buy-out was triggered for legal or disciplinary reasons (i.e., the arrest or conviction of a partner, disqualification to practice medicine, etc.) then the practice’s reputation may be affected, and the loss of the partner’s productivity also likely means the practice’s ability to treat patients and financial performance is affected, particularly if the departing partner had a unique skill set within the practice.

A practice may engage the services of a PR firm to address those issues that may affect its reputation, but what about the financial aspect? If one doesn’t have provisions in place addressing the unplanned exit of a partner, a practice could be hit with a double whammy of losing the exiting partner’s productivity while also having to find the funds to pay for that partner’s whole buy-out.

Key-man insurance may cover some of the circumstances (and buy-out) surrounding the unplanned exit of a partner, but it would be very unusual for such insurance to cover all of the possible scenarios. What then?

An absolute worse case scenario is where a practice may be legally liable for payment of a full buy-out but financially can’t afford to make the payments because of the unplanned loss of the departing doctor’s productivity. The result could be the messy dissolution of the practice—an unpleasant outcome for the departing partner who was hoping to receive buy-out funds as well as the partners who wish to continue practicing.

With that in mind, I take the position that if proper notice isn’t given for the buy-out, some or all of the departing doctor’s goodwill may be forfeited and excluded from the buy-out. Since the departing physician isn’t available to transfer the goodwill in a timely manner, it simply follows that not all (if any) of the goodwill should be paid out. In this way, the practice—whose financial performance may be hit by the unplanned loss of the departing doctor’s productivity—isn’t put into a bigger financial bind by having to fund a full buy-out. In an unplanned transition, a practice may be able to pay for the departing doctor’s share of tangible assets and A/R but, under some circumstances, greatly reduce or eliminate what they may pay for goodwill.

Summary

The departure of an established physician partner from a practice can be unsettling, even more so when the departure was unplanned. While the planned buy-out can be addressed, it is the unplanned buy-out that looms as potentially dangerous. Failing to consider the ramifications of an unplanned buy-out can be severe for all involved.

Editors’ note: Mr. Ruden is an Accredited Valuation Analyst, MedPro Consulting & Marketing Services, Scottsdale, Ariz.

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What to expect when you’re expecting (an EHR system)

by Robert Lamont, Scott Peterson, and Leslie Mackner

h, a baby on the way! Who doesn’t love the excitement of a new baby? Who doesn’t cringe at the thought of all the work that having a baby entails?

Expecting a baby is much like implementing a new electronic health records (EHR) system. There’s a lot of worry involved, a lot of planning to help things go smoothly, some panic if there are complications, and the after-the-fact realization that some of your initial worries weren’t necessary.

Human conception to childbirth averages 9 months; ironically, the average timeframe from planning to implementation of an EHR system also takes about 9 months. In fact, bringing an EHR system into your practice is not unlike giving birth to your first child in more ways than just length of time.

We have successfully used an EHR system in our offices since 2010. We decided in 2009 to take the EHR plunge. We truly believe in the value of EHR for our 15 locations. However, we often hear about ophthalmic practices that prefer to stick with a paper-based system, even as the threat of government penalties for not using EHR gets closer.

For any parent out there who’s read the classic What to Expect When You’re Expecting, we think you’ll find the same similarities we did with implementing our EHR system. Birthing a baby—and birthing an EHR system—may not be easy, but it’s done all the time. And you can do it, too.

Attitudes, aka, the dirty diaper

Just as no one likes a dirty diaper, no one likes a bad attitude. The smell of a bad attitude can waft through your practice and affect everyone on your staff, from the front office to the back office. Even those who had positive expectations for an EHR can change their opinion if the ophthalmologists and administrators on staff are griping about it. That can undermine the EHR success.

We like to think of bad attitude not only as a “dirty diaper,” but also a reminder to keep your bad attitude in check even before conception.

9 months of eating well

Just as it’s normal to have fears about having a child—some of which will never be realized—it’s normal to have fears about how an EHR system will change your practice. We feared that after spending a significant amount of money, the EHR system would be nothing more than a failed project. We feared that the practice management system attached to the EHR would not work. We feared our billing module would not sync correctly with the EHR system and that we would go out of business. We feared we would see patients, track their information in the EHR, and then the system would be down a week later.

In short, we were afraid of breaking the baby, and we were afraid of failure.

What we learned from this is our attitude and preparation made all the difference. We found that implementation came with a learning curve, but there were no true disasters. In fact, our behind-the-scenes advance preparation helped things run more smoothly. We had our A-team of physician leaders, technicians, and IT folks to help us set things up, and we devoted internal resources and time needed to make implementation successful.

Some assembly required

Just as some new parents might buy baby furniture and assume it’s assembled only to bring it home and realize they need to put it together, the same holds true with an EHR. We’ve heard of practices that assume they can hire an IT company to install everything with their EHR system and that it will magically work seamlessly with every other software system in the office. Sorry to say, it’s just not true. It’s an ongoing commitment to keep your EHR system healthy and keep your staff trained on how to use it. And some staff members (think of your typing “hunters and peckers”) will require more training than others.

Healthy weight gain

Pregnancy naturally entails some weight gain, and so does implementing an EHR system. You will likely add overtime to your practice due to the amount of work involved when you implement the system. You may also add staff—additional employees who, ideally, will be skilled in helping you navigate the technical challenges of your new EHR.

Choosing to view the weight gain as a positive instead of a negative will go a long way toward avoiding the “dirty diaper” we mentioned before.
Finding support, aka, going to Lamaze class

The transformative experience of having a child often requires support from peers, and the same can be said with the transformative experience of implementing an EHR system. If you work in a small ophthalmic office, it’s even more crucial that you find support from others in a similar situation—whether it’s the ophthalmic practice down the street or one across the country. Talk with colleagues at meetings—particularly those who are further ahead in the “giving birth to an EHR” process—to see what you can learn. We were surprised at how candid some of our fellow practices were about their own hurdles, but it helped us avoid the same mistakes.

The complicated pregnancy

Sometimes a new mom might plan to have a natural childbirth, and she ends up needing a Caesarian section. The same last-minute change can happen with your EHR system. You may think everything will run smoothly, and you end up having to change the practice management system you’re going to use. Change happens. Be ready for it.

Another common complication (or challenge) is learning the new language involved with EHR. Before we got our EHR system, we weren’t familiar with technical terms like radio button. Just in the way that pregnancy and childbirth is made easier when you learn some of the related lingo, it made life easier when we started using the same language the EHR folks used so we could better communicate and overcome our learning curve.

Staying committed

Once the mother’s in labor, there’s absolutely no turning back. That baby is coming and all of your fears have to be cast aside. The same can be said about starting to use an EHR system. You have to have an unwafering commitment and remind yourself of its greater good. At the end of the day (or should we say, at the end of your delivery?), your EHR is about taking care of your patients. Your patients come to your office to see the doctors and the technicians they trust. They don’t care what kind of server you have or what kind of EHR system you use. If you keep the focus on better patient care, you can get closer to using an EHR system that will work effectively for your practice. Much like the stories of painful and long labor, every mother knows it was worth it in the end. We feel the same about our EHR baby.

OB

Editors’ note: The authors work for the Eye Care Center of Central Pennsylvania, which has 15 locations in central Pennsylvania. Robert Lamont is the CEO, Scott Peterson is the CIO, and Leslie Mackner is the clinical IT coordinator.

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Planning for retirement

by Michelle Dalton Contributing Writer
Ophthalmologists in private practice will eventually have to face the question of what they want to do with their practice once they’re ready to retire—but there are realistically only two viable options to keep a practice open. One, sell the practice outright, or two, bring other partners on board by selling the retiring partner’s share. The third option, of course, is to close the practice and sell the equipment, but that also means putting a staff out of work and potentially leaving the community without vision care. If the decision is to bring on partners so that the practice can continue to serve its community, when becomes the operative question.

For Richard L. Lindstrom, M.D., founding partner, Minnesota Eye Consultants, the day he went into private practice on his own was the day he started planning for retirement.

“The first thing anyone has to do is decide on solo practice, a small practice, or being a part of a large group,” Dr. Lindstrom said. “In my golden years, I wanted to have the freedom to do what I wanted to do, and without partners I knew that was going to be difficult.” So he decided to build a group practice where each partner-owner has an equal equity share. The practice currently has seven partners, but will soon grow to eight.

“Everyone is an equal partner; I started off owning 100% of the practice, now I own 1/7,” he said.

At Price Vision Group in Indianapolis, founder Francis W. Price Jr., M.D., is planning to hire two or three surgeons to take over “when I leave in 10-12 years,” he said. Because his practice employs more than 40 people, he has no plans to shut the doors, but doesn’t yet have a formal succession plan in place.

D. Brian Kim, M.D., is at the opposite end of the spectrum, having recently bought into a practice in Dalton, Ga., when the senior partner wanted to retire. The practice had three M.D.s and three O.D.s, and when the initial founder retired, “that’s when they started to look for someone. We learned a lot of lessons from that,” Dr. Kim said, including bringing someone on board before a partner retires better serves the community. Now the succession plans allow for the senior-most partner to cut back on hours while bringing the junior partner up to speed.

Carol Boerner, M.D., knows all about retirement—she sold her practice outside of Boston to retire to Vermont, but soon found herself
drawn back into another practice, Vermont Facial Aesthetics (Norwich, Vt.).

“The hardest thing for me was selling the practice; I sold it five different times before the paperwork was actually signed,” she said. “I felt I had a responsibility to my patients to leave them in good hands (all puns intended).” Overall, it took her 2 full years to sell the practice, all the while commuting back and forth from Vermont and practicing in both places.

“I needed to keep working in Massachusetts while living in Vermont or I’d have had nothing to sell,” she said. “As a solo practitioner, all you’re really selling is your good will, reputation for great care, and some used equipment when you sell your practice. And then you worry about the staff who made you so successful—will they stay when someone new comes on board? Or will the new person want cheaper staff or his own crew?”

**Different options**

At Minnesota Eye Consultants, all the physician owners partake in a “major retreat every year, and we meet for 3-4 hours every month” to discuss practice business, Dr. Lindstrom said. By the time he’s prepared to fully retire in about 10 years, his personal share of the practice will be 10%, which the remaining nine owners can buy out, or have a tenth physician-owner buy in ... and so on, and so on to continue ensuring a high quality practice remains in the area, he said.

His business model offers “the best of the best,” Dr. Lindstrom said. “It was the wisest decision I ever made—I actively recruit people who are better than I am. My patients know they’re being left in good hands, and I’m not worried because the quality of care is so great.”

Surgeons need time to grow into ownership roles, he said, and in his practice’s case, it’s 10 years, but at that point the surgeon is a full owner.

Dr. Kim’s practice had a much smaller evaluation/assessment period of only a year.

“If everyone agrees at the end of that year, the doctor buys into an equal share immediately. We took the value of the practice and I bought into it for one-third,” Dr. Kim said. “The benefit of a quick buy-in period is that as soon as I bought in, I had equal access to profits and to our optical ambulatory surgical center. I think that’s key with buy-ins. A lot of M.D.-owned practices have much longer wait times—physicians will set down roots after 2 or 3 years but have nothing to show for it, and for me, that wasn’t advantageous.”

Plus, if a physician decides the fit isn’t right or the practice decides for the physician the fit isn’t right, the physician has to “start from scratch someplace new,” he added.

Solo practitioners need to decide if they want to relinquish some of the control, Dr. Price said. Dr. Boerner agreed—going from being solely responsible for every decision to sharing that responsibility means swallowing some ego, and that may not be easy for some surgeons.

**Preparing for ... ?**

Dr. Lindstrom’s advice to those who are not yet nearing retirement? “Plan at least 10 years ahead. If you have a valuable practice, you have to recruit really talented people and give them a better deal than you might want,” he said. “Take at least a decade to fully implement your plan and talk with your mentors, your consultants, anyone else whose business acumen you value.”

Dr. Boerner concurs, noting in retrospect she should have planned for her first retirement sooner.

“Einstein’s Theory of Relativity needs another corollary—some explanation for the elasticity of time you’ll notice the moment you wake up with nowhere to go,” she said. “Things seem to take longer during ‘retirement’ ... maybe because you’ve slowed and no longer have to rush from place to place. It was both scary and intoxicating.”

For surgeons who did not ease into retirement, she recommended scheduling one thing every day.

“At 61 years old, I ended up going back to school and opening a new practice because I couldn’t stand not having somewhere to go every day,” she said. “This time around, I’m actively thinking about who I’d like to take over the practice.”

Dr. Price predicts he’ll be able to transition out of active practice by increasing the amount of time he can devote to his research before completely retiring.

“When you’re in solo practice, you have the freedom to decide on what products you want in your office, what the surgical schedule is, who to hire,” he said. “There are no conflicts, but there’s the issue of cash flow when you’re the only one supporting everyone’s salaries.”

Dr. Lindstrom agreed, noting each practice needs to determine what its dynamic will be in the upcoming years as owners gear up for retirement.

“You have to know what you want to do and what you want to be as you head into retirement,” he said. **OB**

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Part-time physician work on the rise

by Vanessa Caceres Contributing Writer

Why part-time work is increasing and how some ophthalmologists swing it

A desire for better work/life balance is leading a number of physicians, including ophthalmologists, to consider part-time work. Could it be a good option for you or another physician on your staff?

Some physicians who are choosing the part-time route are fresh out of medical school and just starting a family. Others are closer to retirement age but not quite ready to play golf or tennis all day.

Although it is difficult to track down statistics regarding the number of part-time ophthalmologists in practice right now, there is a definite trend toward part-time physician work.

“Since 2005, the part-time workforce has grown by 62%,” said Mary Barber, vice president at the healthcare recruitment firm Cejka Search, St. Louis. “This trend tracks with the change in profile of today’s medical workforce, in which the two fastest growing segments are female physicians entering the practice and male physicians approaching retirement.”

A 2010 survey conducted by Cejka Search and the American Medical Group Association found that 13% of male physicians and 36% of females practiced part time. That’s an increase over 7% and 29%, respectively, in 2005.

“Some physicians are drawn to practices where they know part-time work is an option,” Ms. Barber said.

“Physicians entering practice are usually interested in a full-time schedule, but knowing that the culture of the practice permits flexibility later in their careers can give the practice a competitive edge. Additionally, physicians who are not ready to fully retire can continue to practice on a part-time basis, which is critical during this time of physician shortage,” she said.

Of course, part-time work as a physician usually involves more than the standard 20 hours it might in other professions. Instead, part

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Save The Date!

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April 17-21, 2015

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time can mean a 4-day workweek, reduced hours one or two days a week, or job sharing.

Ophthalmal practice management consultant John Pinto, Pinto & Associates, San Diego, notices a definite trend among ophthalmologists toward part-time work. He estimates about two out of 10 ophthalmologists who are in their 50s and 60s are working a 4-day workweek, although those physicians may see as many patients as the full-timers. For ophthalmologists who are in their 60s and 70s, about half are exiting completely, and the other half are continuing part-time non-surgical work, Mr. Pinto observes.

Mr. Pinto also estimates that about a third of ophthalmologists right out of medical school are expressing an interest in reduced hours. “Two-thirds appear to be nearly as 100% work-focused as the previous generations, while a third seek a less time-demanding, less risk-taking, less all-consuming career,” Mr. Pinto said. “Gender issues also arise. Half of all new grads are now women, many of whom have delayed starting a family to complete their training.”

Ophthalmologists are lucky to be in a specialty that allows for some scheduling flexibility. “Ophthalmology is a great specialty to pursue part time at the outset and then to ramp up commitments as parental demands taper,” Mr. Pinto said.

In this article, two part-time ophthalmologists provide a snapshot of why they made that choice and how it plays out at their respective workplaces.

**Family priorities, reduced hours**

Working in a flexible department has allowed Nathalie M. Guibord, M.D., cornea, refractive and cataract surgery, Department of Ophthalmology, Geisinger Medical Center, Danville, Pa., to work 2½ to 3 days a week seeing patients. Including chair time and other administrative work, she puts in a total of 35-40 hours a week. Dr. Guibord has three young children and opted for part-time work because of her family obligations.

“As long as I see a certain number of patients and I’m not seeing them at midnight, my department is flexible,” she said.

In addition to a flexible department, Dr. Guibord said that being married to a supportive spouse—a fellow ophthalmologist who works full time and understands the business—helps with this kind of arrangement.

In addition to her time seeing patients, Dr. Guibord has a reduced number of on-call hours and regularly takes administrative work home.

She said she enjoys her half-time arrangement. “I can practice ophthalmology and still have a family,” she said.

However, Dr. Guibord said she is a realist about the limitations of part-time work. “I can’t achieve the same career goals. I’d like to say the arrangement does not affect my career, but I think it does,” she said.

She also still has to respond to emergencies, even if they occur on her so-called days off. There have been times when a babysitter has not been available and an office assistant has had to help watch her children. “I can’t say, ‘Sorry, I can’t operate on your open globe.’ Things happen,” she said.

**Job sharing**

Amir Arbisser, M.D., and Lisa Arbisser, M.D., whose practice in Iowa has various locations and 21 doctors, wanted to take off more time from their practice to spend time with their grandchildren and enjoy their house in Florida. However, when they would take a few weeks off, their office assistants did not have enough work to sustain...
them. Additionally, the Arbissers still had to pay an equal share of overhead as other doctors.

After some discussion, they approached Paul Arnold, M.D., and Priscilla Arnold, M.D., about job sharing. The Arnolds were quickly on board.

Although it may be an unusual arrangement, the Arbissers and the Arnolds alternate the months they work at the practice, with each couple working in 4- to 5-week blocks.

This arrangement makes use of otherwise unused capacity at the practice. It also requires a fine-tuned schedule. “The administrative staff members work out the [scheduling] choreography,” Dr. Amir Arbisser said. “You need to have a rhythm.”

The months that they are working, Dr. Arbisser said he and his wife will work more intensely than they had before. When scheduling surgeries on two eyes, they will schedule them a week or two apart when possible instead of a few weeks apart. However, if there are any post-op medical issues or emergencies usually treated by the ophthalmologists who are off, then the other couple will handle it.

“Most patients understand that this helps with our longevity,” Dr. Arbisser said.

The job sharing done by the Arbissers and the Arnolds may have not been possible 30 years ago, Dr. Arbisser observed. However, with physician shortages and a greater general interest in work/life balance, he believes now is the time to take advantage of arrangements like this.

“It’s very evident that there will be a shortage of doctors, so the ability to retain doctors as an ongoing resource and keep their career fresh is an important alternative,” he said.

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Editors’ note: The physicians have no financial interests related to this article.

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“It’s only when the tide goes out that you learn who’s been swimming naked.”
Warren Buffet

What a funny term, “liquidity management.” What does it mean?

Does it refer to keeping saline on an intraoperative eye? Staying hydrated during your next 10K run? Stocking up adequately for this Friday night’s party so the punchbowl doesn’t run dry?

None of the above, at least if you own or manage a practice-business.

Liquidity management is a core business discipline, and perhaps one of the most important skills you’ll want to improve in the years ahead, as fees almost certainly decline, expenses continue to rise, and the typical practice board member becomes inclined to take every last dollar of free cash flow out of the practice to sustain doctor lifestyles.

“Liquidity” is simply your access to capital, cash—right now. If you are a highly liquid practice-business, you have a lot of cash or cash-equivalents at the ready. These equivalents include:

- One or more lines of credit at your commercial bank
- The doctor’s access to available personal funds
- Home equity credit lines that haven’t been tapped
- The practice’s accounts receivable, to the extent they might be used as collateral by a receivables factoring company in a pinch

Liquidity is not the value of your optical frames on the wall or your drug inventory. It’s not the value of your office building (unless you could rapidly sell it and lease it back). And it’s not future earnings, which are not available if you need access to a near-term infusion of cash.

Liquidity was once no big deal in the business of eyecare.

Younger readers won’t remember, but there was a time in this profession when cataract surgery paid nearly $5,000 in terms of today’s devalued currency, and profit margins were commonly above 50%. In this long-ago environment, even the most ragamuffin ophthalmologist with the most profligate lifestyle could live in the nicest house in town, drive off in the nicest car on the lot, and still sock away half of his salary to loan back to his practice on a rainy day.

It was also an era of lower risks: lower competition, fewer slip-and-fall lawsuits, along with cheaper risk management. It was once a snap to get a disability policy that could almost immediately replace all of your income.

No so much anymore. Liquidity is something that must now be closely managed. And you’ll have to watch it like a hawk a decade from now, when the economic ecology of eyecare could be vastly different.

Here are some basic pointers to get you started:

1. Keep your eye on three key domains, all of which drive the need for your ready access to capital:
   - Cash flow fluctuations: As described above, most practices have a soft first quarter. An

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DEAR FRIENDS & COLLEAGUES

We are pleased to invite you to join us at the 26th APACRS annual meeting which will be held from 11 to 14 July 2013 at the brand new Suntec Singapore Convention Centre after a multimillion-dollar redevelopment.

The theme of the meeting Pearls from the Orient will be a global focus on the anterior segment bringing together world leaders and innovators in the field of Cataract, Refractive and Corneal Surgery & External Eye Disease and Glaucoma.

On behalf of the APACRS, the Asia Cornea Society, the Cornea Society and the Organizing Committee, we look forward to welcoming you to Singapore!

Prof Graham BARRETT
President
APACRS

Prof Donald TAN
President
Asia Cornea Society & the Cornea Society

Dr Ronald YEOH
Organizing Chairman

IMPORTANT DATES

18 July 2012
Online abstract submission

28 August 2012
Registration and Housing Open

18 February 2013
Deadline for abstract submission

18 March 2013
Deadline for 1st tier early bird registration

18 May 2013
Deadline for 2nd tier registration

10 July 2013
On-site registration

ABOUT SINGAPORE

Expect many surprises in scintillating Singapore, from our newly renovated convention venue to the many easily accessible attractions, including the iconic Marina Bay Sands Hotel and Shopping Centre, Resorts World Sentosa with Universal Studios, the revamped Night Safari, and the brand new Gardens by the Bay, a spectacular new Botanical Garden where nature and gourmet dining come together!

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PROGRAM HIGHLIGHTS

The 26th APACRS annual meeting promises to be the anterior segment event of 2013 anywhere in the world!

Collaborations between the Asia Cornea Society, the Cornea Society and the Asian Angle Closure Glaucoma Club mean that for the first time there will be a Cornea Day and Glaucoma symposiums on Thursday 11 July 2013.

The highlights of this meeting include:

MASTERCLASSES

Advanced courses covering Mastering FemtoPhaco, Glued IOLs, Femto Flap Creation, Biometry, FLEX to SMILE and IOL Fixation.

CORE INSTRUCTIONAL COURSES

Covering Phaco Fundamentals, Retinal updates, Ocular Trauma, Optimizing Outcomes in Toric IOLs, Pterygium and what the refractive surgeon needs to know about glaucoma.

QUALITY SYMPOSIUMS

The most topical issues in cataract and refractive surgery tackled in ‘standard’ as well as more adversarial and entertaining debate-style symposiums.

LIVE SURGERY

Featuring femtosecond and standard phaco surgery with the latest implants.

KITARO ARTIFICIAL EYE WETLABS

For the first time at any APACRS meeting, we will be offering wetlabs under the supervision of experienced phaco teachers and Prof. Junuske Akura, the award-winning inventor of the KITARO wetlab system.

FILM FESTIVAL

The Film Festival fuses ophthalmic surgical acumen with cinematic vision and we expect a bigger and better Film Festival this year!

NURSING PROGRAM

Our nurses play a critical support role in our practice and are integral to enhancing the overall patient experience. This is a wonderful opportunity for them to network and share experiences and to take home pearls of wisdom which are practical and applicable to your practice.
With a bit of planning, you can painlessly sequester capital—and capital access—that will help you sleep more soundly and manage your organization from a position of strength.

increasing number even have a month or two each year (as is common for retailers and restaurateurs) where, as the old saw goes, “Your outgo exceeds your income, so your upkeep becomes your downfall.” They run in the red.

- Unplanned events: Some things like fire, flood, and doctor disability can be insured against. Other things can’t. What if you’re in a two-doctor practice and your partner leaves? You’ll have to buy him out. You will lose his revenue production (while covering the fixed costs he left behind). And you’ll have the considerable cost and time delays of finding a new doctor to take his place. You can calmly get through a crisis as if you have an extra half-million dollars at the ready.

- Opportunities: What if a neighboring competitor retires abruptly and you can only win a bidding war for his practice if you can come up with cash? Or if you come across a terrific potential partner-track associate, but when she’s hired, you’re going to have a lean year personally covering her salary and costs until her practice develops. Think back. Every year there has probably been at least one great opportunity that you had to pass up because you didn’t have enough of a cushion to be bold.

2. You need to know where you want to head. Look at the three domains above, estimate what kind of cushion you need, add it up, and then throw in a little extra that will help you sleep at night. Here’s an example, imagining a fairly prosperous two-doctor practice, Smith Eye:

- Fluctuations: Smith Eye is in the Snowbelt. Both doctors like to take a month off in winter, which makes sense since many of their patients also fly south. They have two months, January and February, when core expenses are barely covered, and doctor draws are lean. They review the numbers and see that the difference between a crummy month and an average month is $50,000 in net cash flow. So they need a revolving $100,000 or so in the kitty to cover cash flow fluxes and the occasional blizzard.

- Unplanned events: The two doctors who own Smith Eye enjoy practicing together so much that neither is going to leave voluntarily. And all of the usual contingencies, death and disability, fire and flood and the like, are more than adequately covered by insurance. All except for one biggie: a Medicare fee cut. The doctors figure that based on their current overhead structure, if there is a 10% fee cut (the most they imagine happening in any one year) they will have a net 15% pay cut. They think it will take the better part of a year to sort things out, reduce personal and practice costs, and boost patient volumes. They each make $350,000 a year now. A 15% pay cut on a $700,000 combined owner distribution comes to $105,000.

- Opportunities: The owners of Smith Eye are pretty conservative and both in their late 50s. They are not interested in buying up practices or getting new equipment, but they ARE going to be hiring a new partner-track doctor in about a year. They figure the new doctor will start covering their costs after the first year, but could end up being a net drain of $150,000 in the first year, a bit more if things don’t work out well.

- So all up, Smith Eye probably wants to have not less than $355,000 in liquid, readily accessible funds. $400,000 would be better. They set this higher figure as their target.

3. Bridge the gap. If you own Smith Eye, need $400,000 in liquid funds on hand, and only have $200,000, you’re $200,000 short. The doctors of Smith Eye could catch up in several ways. They could catch up slowly by withholding an affordable portion of their draws for a couple of years. They could swiftly catch up by taking out a new line of credit or pledging a portion of their personal funds to the practice in the event of an emergency. They could even nibble away at the gap a bit by taking less vacation and improving their first-quarter operating performance. Or they could catch up by delaying the admission of a new associate until the practice is so busy that the new provider is immediately productive as soon as he/she arrives.

There has never been a more critical time than now to start actively managing the liquidity of your practice. With a bit of planning, you can painlessly sequester capital—and capital access—that will help you sleep more soundly and manage your organization from a position of strength. Meet with your accountant and administrator soon.

Editors’ note: Mr. Pinto is president of J. Pinto & Associates Inc., an ophthalmic practice management consulting firm established in 1979, with offices in San Diego.

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Make Plans Now to Attend
2013 ASCRS•ASOA Symposium & Congress
Specialty Meetings

Make the most of your time in San Francisco next April by attending either of our specialty programs. Each offers focused information on key subspecialties that affect nearly all ophthalmic practices.

Sponsored by the Cornea Society and ASCRS. Cornea Day 2013 is geared toward practicing ophthalmologists with an interest in comprehensive ophthalmology, anterior segment surgery, and corneal disease.

Pressure is important, but don’t lose sight of the vision! Presenting glaucoma treatment in a cataract and refractive context.

Join us for glaucoma pearls and updates to enhance your practice.

For registration, housing and program updates go to...
www.CorneaDay.org

www.ASCRSGlaucomaDay.org

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OMIC has declared a 20% dividend for all active physician insureds to be applied as a credit to 2013 renewal premiums. The 2013 credit also applies for any ophthalmologist who joins OMIC with a policy effective date prior to December 31, 2012. Request a Quick Quote and begin saving with the nation’s largest ophthalmic insurer.

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