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From the publisher

From EHR and physician-patient communication to physician disability insurance coverage and retirement planning, this issue of Ophthalmology Business offers a little something for everyone.

Though most ophthalmologists generally agree that the greatest benefit of EHR is the potential improvement in the quality of patient care, the feature story in this issue of OB considers an additional benefit of EHR: its usefulness as a powerful marketing tool.

You have disability insurance, but are you confident that you can provide for your family in the event that you can no longer practice? On page 10, writer and financial consultant W. Ben Utley, C.F.P., walks you through how to plan for the possibility of disability. And, in another article that helps you prepare for the future, James Dahle, M.D., provides tips on setting up a backdoor Roth IRA to help you achieve valuable tax diversification in retirement.

Finally, do you ever feel like someone isn’t seeing your perspective or hearing your point? In the article, “Can you see what I’m saying?” (pg. 18), Ophthalmology Business gives you tips on how to better synchronize your communication patterns to build stronger relationships with both your co-workers and your patients.

As always, thanks for reading.

Donald R. Long
Publisher, Ophthalmology Business
From the publisher

Keeping patients compliant with the MaculaTester app
An app that helps patients keep track of their chart with automatic reminders
by Faith A. Hayden

At the pinnacle of peril
Many physicians find themselves insured for disability but not adequately covered
by W. Ben Utley, C.F.P.

Making great hiring decisions
Pearls on strategies and things to look for when recruiting for a position in your practice
by Brad McCorkle

Special feature: EHR as a marketing tool

EHR isn’t just for government compliance
Using EHR to enhance your practice’s marketing tools
by Richard A. Driscoll, O.D.

Can you see what I’m saying?
Improve your relationships with patients and coworkers through synchronizing your communication
by Donna Suter

Using celebrity endorsements
Celebrity endorsements can be useful, but when it comes to marketing services, credibility is more important
by Michelle Dalton

Backdoor Roth IRA
A retirement account you might not have known about can help you achieve valuable tax diversification in retirement
by James M. Dahle, M.D.
ASCRS Symposium on Cataract, IOL and Refractive Surgery
April 20–24, 2012

ASOA Congress on Ophthalmic Practice Management
April 20–24, 2012

Technicians & Nurses Program
April 21–23, 2012

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Cornea Day 2012
www.CorneaDay.org

ASCRS Glaucoma Day 2012
www.ASCRSGlaucomaDay.org

Online Program
Available March 30

CHICAGO 2012
American Society of Cataract and Refractive Surgery
American Society of Ophthalmic Administrators
Getting patients with macular degeneration to keep track of their paper Amsler grid, let alone use it weekly, is a challenge that’s plagued ophthalmologists since its invention. But now, Ernesto L. Collazo, M.D., Collazo Eye Associates, San Juan, Puerto Rico, has invented an app to help curb this problem.

The MaculaTester is an electronic, interactive Amsler grid that patients can download to their mobile phones and test themselves with, which helps patients keep better track of the chart. Furthermore, the app allows patients to program automatic reminders on a daily, weekly, or monthly basis, which helps with compliance. Patients can also email test results directly to their physician, who will be able to compare them to previous results to see if the condition has worsened.

“It brings the Amsler grid to the next level, which is helpful because most patients with maculopathies are only seen once or twice a year,” said Dr. Collazo. “Patients need to be screened between visits. Early diagnosis is key. If you have a patient with macular degeneration who’s starting to develop choroidal neovascularization, if the patient starts having leakage and distortion and you catch it early before there’s bleeding, you can prevent vision loss. There’s a critical window of distortion before loss of vision. That’s when you want to see the patient.”

Currently, the app is only available for the iPhone and iPad, but Dr. Collazo is working on a version for Android platforms. This version should be available later this year. “We’re still working on making the app better,” said Dr. Collazo. “The next stage that we’re going to start working on is to make [the Amsler grid results] part of the EMR in the office. With the iPad we can have the larger Amsler grid for the doctors to use in the office that gets loaded into the patient’s EMR.”

The app is currently available in both English and Spanish, and Dr. Collazo hopes to expand it to other languages in the future.

For more information on the MaculaTester, as well as an instructional video on how to use it, visit www.maculatester.com. The app is available to download at the Apple App Store. OB

Editors’ note: Dr. Collazo is the inventor of the MaculaTester app.

Contact information
Collazo: ecollazomd@mac.com
Ethics in the Premium Era: Informed Consent, Outcomes and Patient Management

Sunday, April 22, 2012
4:30 - 5:00 PM Registration
5:00 - 6:00 PM Program

Sponsored by the ASCRS Cataract Clinical Committee and Ophthalmology Business.

Moderator
Rosa M. Braga-Mele, MD, FRCSC

Medical Ethicist
John D. Banja, PhD

Panelists
David M. Dillman, MD
Gary Foster, MD
Richard S. Hoffman, MD
Sonia H. Yoo, MD

Join us Sunday immediately following the ASCRS program.
This is a session you won’t want to miss!
You have disability insurance, right? Sure you do. You bought your first (and maybe your only) policy while you were in training. Yet you still have a nagging feeling that something bad might happen to you, and you’re not certain you will be ready to provide for your family if your practice becomes impractical.

Your fear is well-founded. According to the Council for Disability Awareness, a typical professional aged 35 and in good health has a 21% chance of becoming disabled, with a 38% chance that the disability will last more than 5 years.

In the past 15 years of doing financial planning for young doctors, I’ve found that most physician families are poorly prepared for this, the pinnacle of financial peril. Inadequate insurance and insufficient savings leave gaping holes in the safety net many physicians weave for themselves, while the demands of practice push this important-but-not-urgent issue to the bottom of the pile of priorities.

You may have disability insurance, but you’re probably not covered. You have no real plan for the aftermath, and it’s time for you to do something about it.

Insured but not covered

If you haven’t done a thorough review of your coverage, you may find that your insurance contract will pay little or nothing when you make your claim.

Your monthly benefit amount is probably too low. Most physicians are sold a disability policy while they’re still in training. The monthly benefit in policies is based on some fraction of earned income. Given that residents earn about $4,000 per month
and benefits equal about two-thirds of that, you might find that the policy you bought as a resident pays you no more than $2,700 per month. As a practicing ophthalmologist, you may be earning—and spending—significantly more than that to support your family. A resident-sized monthly benefit will leave much to be desired by your practitioner-sized budget.

Your policy’s definition of disability may be needlessly narrow. Most policies cover the catastrophic disability known as “total disability,” but the way that total disability is defined varies greatly from policy to policy. For example, if your policy says, “The insured is totally disabled when both unable to perform the principal duties of the regular occupation and not gainfully employed in any occupation,” then you have what is known as an “any occupation” definition of disability. It means that if you go back to work doing anything at all, you will lose your benefits.

For ophthalmologists, there is no substitute for coverage bearing the “own occupation” definition of disability, which might read like this:

Total disability means that, because of sickness or injury, you are not able to perform the material and substantial duties of your own occupation. You will be totally disabled even if you are at work in some other capacity so long as you are not able to work in your own occupation.

High quality policies will recognize a surgical specialty as your own occupation, so you can keep your options open during disability. For example, if you can’t do surgery any more, you may still be able to practice general ophthalmology. Your earnings plus your benefits may come close to what you were making before you became disabled.

Policy limitations and exclusions might cause your claim to be denied. Have you experienced anxiety, depression, or marital difficulty that caused you to seek counseling or psychiatric treatment? If you disclosed this in your insurance application, there may be a rider excluding claims related to this issue. The language in some policies places a 2-year limit on benefits for mental and nervous claims, regardless of your health at the time you made your application. Before you gloss over this limitation, consider the findings from a 2005 study in the Archives of General Psychiatry: One in five U.S. citizens is bound to suffer from a serious mental disorder in any given 12-month period.

No plan for the aftermath
You may be surprised by how long it takes to get a benefit check. Income disability insurance policies include a co-insurance-like “elimination period” that may run from 30-365 days, with the majority of policies bearing a 90-180 day elimination period. During the elimination period, you will be disabled but you won’t be paid. In fact, once the elimination period ends and the benefit period begins, you won’t get a check until the end of the month. That means 4-7 months could pass before you can cash the first check.

You probably don’t have an emergency fund. Even though it’s a fundamental part of financial planning, physicians often overlook the emergency fund in their rush to buy a home, fill the 401(k), and pay off student loans. I find that physician families spend $10,000 per month on average, while medical specialists who are married with children may spend $15,000 or more. By parking $40,000-$120,000 somewhere safe and easy to reach, you’ll be ready to bridge the gap during the elimination period.

Ophthalmologists in private practice have one more thing to worry about: business continuity. Payroll, rent, office expense, and interest on business loans continue to run while you’re disabled. Business overhead expense (BOE) insurance can pay all of these expenses and may even cover part of what you pay a locum tenens physician to see your patients while you recover. Having BOE coverage means you won’t need to spend personal assets to keep the doors open, and it also prevents your partners from bearing the burden of your portion of the unallocated overhead. These policies have elimination periods that run 30-90 days, so it makes sense to maintain an emergency fund for your practice as well as your family.

Not urgent, but important
Preparing for a disability is not difficult but it can be time consuming. Once you’ve made it a priority, you can follow these steps to get ready.

1. Gather complete copies of all your insurance paperwork, including correspondence. Call the insurance company and request fresh copies if necessary. Correspondence is crucial since it gives you clues about changes in your policy over the years. If you become disabled, the contract is the first thing your attorney will ask you to produce.

2. Review your policies. Read through and circle key elements in each contract: monthly benefit, definition of total (and partial) disability, elimination period, premium schedule, limitations, exclusions, and clauses that may let you get more coverage without more underwriting. Review the letters and the riders, too. If you don’t understand what you’re

continued on page 12
reading, find an attorney or insurance consultant for help.

3. **Think about how your situation has changed since your policy was placed.** Has your back injury healed? Has it been 2 years or more since you saw a counselor or took an antidepressant? Has your income increased by more than 10%? Use the answers to these questions to improve or increase your coverage.

4. **Re-shop your insurance.** Approach this as if you have no coverage at all. This way, you can learn whether or not you are insurable, what the limit may be on your total monthly benefit, and which features are available in new policies. Don’t buy any insurance (yet).

5. **Compare new insurance to old.** Weigh the benefits of your old policies with those from new coverage options, and consider the cost-per-thousand of benefit from both. Think about adding or replacing coverage based on your findings.

6. **Max it out.** Insurers base their offerings on the size of your earned income, subject to a maximum limit. Even if your cost of living is less than the maximum benefit, get all the coverage you can.

7. **Build an emergency fund.** Most benefits end at age 65, and you need to be prepared for disability beyond that point. Plan to use the excess benefits you receive to cover your expenses during retirement.

**It’s time to do something about it**

You spent decades getting an education and years building your practice. As the months roll by, a disabling accident or illness becomes more likely. And although no one wants to think about it, a split second can mark the end of your days as a profitable physician and the beginning of your life as a disabled doctor—be certain that life is a good one.
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- Growing the overall size of the premium IOL lens market
- Considerations in the selection of a premium IOL
- New developments in laser vision correction
- Advanced IOL technology
- Discussion of technological advances and breakthroughs in cataract surgery
Making great hiring decisions

by Brad McCorkle
The tables have been turned recently at Local Eye Site (LES). Typically, we’re facilitating online recruiting for our eyecare customers, but now we’re the hiring party. Over the last few months, we have been interviewing quite a few candidates for a marketing and sales support position we plan to fill in 2012. We’ve seen a lot, good and bad. Here are our thoughts on strategies and things to look for while recruiting for a position in your practice. Paying attention to these details will help you make better hiring decisions.

A contributing factor in differentiating between the mediocre and good candidates is to consider whether or not people really want to work for your company, or are they just looking for a job? Great opening questions are “What can you tell me about our company?” or “Why do you want to work for our practice?” Sit back and listen. I’ve interviewed MBA students with no clue why our company exists or what services we provide. The silence can be very awkward, but telling. Conversely, I’ve interviewed candidates who have personally used our site in the past to find work, and later to realize their desire to work for our company. I believe those kinds of connections, although not always possible, can create a foundation that increases the odds of a long-term fit.

Another great question is “What have you done to prepare for this interview?” Interview preparedness is also very important to me because I believe it’s a marker of the types of candidates willing to go the extra mile and sometimes points to those passionate about what you do. A very prepared candidate can represent a great recruiting opportunity. Most experts agree that the cost of turnover represents at least 100% of annual salary. That’s an expense we’d all like to avoid, and one way to decrease the likelihood of turnover is to hire people who are passionate about ophthalmology and more specifically want to work for your practice. If your candidates can’t tell you much about how they’ve prepared or at least a well thought-out reason why they want to work for you, perhaps it’s a sign they are not the right fit, so I would encourage you to proceed with caution.

A great sign of preparedness is when candidates ask insightful questions. Good questions from interviewees can be markers of several things:

A. They spent time researching the position. It’s likely that if they prepared, a question or two has come to mind.

B. They have an active mind. Active minds often have good ideas that can help your business down the road.

C. They have options. You would expect the best candidates to be sought by more than one practice, and if they have options, they will probably come with questions geared to help them make the right choice.

Cover letters are an old staple to recruit, more experience with the candidate, and when possible, recruit proactively. It’s difficult to find a great fit for your job and your company’s culture. It’s not likely that you can consistently make great hiring decisions when recruiting in a rush. How many times have you met with your candidate, and have you met with him/her in different environments? Have you solicited help from others in your organization with regard to making a decision about this candidate? Do you have a pipeline of candidates for the future? Perhaps you could even have a few candidates complete a project for you prior to making the employment decision so that you get a feel for their style. The more robust your experience with the candidates, the more likely you’ll make the right hiring decision. OB
EHR isn’t just for government compliance

by Richard A. Driscoll, O.D.

An EHR system allows focused marketing to the group of patients that would most benefit from a specific service or product.
Electronic health records (EHR) have received a lot of press lately, and the government incentive to convert from paper records has finally come into effect. We’ve seen a large number of articles on how EHR can benefit a practice in terms of better record keeping, more accurate billing, and fewer staff needed to maintain records. We all agree that the greatest benefit of EHR is the potential improvement in the quality of patient care.

However, we tend to not notice that all of this digitized information can also be an amazing marketing tool for growing our practices. An EHR system allows focused marketing to the group of patients that would most benefit from a specific service or product, saving time and money compared to mass marketing practices. In our office we have used our EHR software to enhance a number of our marketing tools. Here’s how we do it.

1. Newsletters. A newsletter is a great foundation on which to build your office marketing program. We try to keep ours interesting and light by including an article on a product or service we want to promote, a summary of services, and then something comical. I use a company that formats and creates the newsletter with the content I provide, and my EHR provider is creating a tie-in to my patient database so that sending out the newsletter will be even easier and faster. This is an excellent way to maintain your relationship with your patients between visits as well as let them know about additional services you provide that might interest them.

2. Targeted campaigns. Whether we communicate with patients via email or snail mail, one of the most valuable aspects of our EHR system is the ability to target specific groups of patients. For example, we might select all parents of children on myopia control and target those who have had greater than 1 diopter of change over a 1-year period. We can then send specific literature regarding our orthokeratology program. We have targeted several groups of patients successfully this way.

In another campaign, we promoted our new ocular coherence tomography (OCT) equipment. We created an attractive, four-color mailing piece with graphics and 3-D images of the OCT scan and explained the types of exams that could be done with it. We then targeted any patients with a glaucoma or retina diagnosis that would benefit from an OCT exam and mailed the piece to that group. The cost of the campaign was very minimal, and we had several patients make appointments to be examined with the OCT scan. For some of the patients, additional testing and multiple office visits were required, making the return on investment excellent with this activity.

3. Marketing affiliates. Forming affiliate relationships with vendors might seem unusual at first, but it can be an excellent way to generate additional revenue for your clinic while providing your patients with a valuable service. I discovered that I was spending an inordinate amount of time explaining to patients how to determine if they were buying a good quality omega-3 supplement, when they much preferred that I just tell them something they could remember: which brand to buy. Thus I contacted a vendor of a brand that I liked and trusted and set up an affiliate program. We wrote several newsletter and blog articles discussing dry eyes, the benefits of omega-3 supplements, and how to determine which kind of omega-3 supplements to buy. Then in the newsletter we included direct links to the recommended product.

Through my EHR system I was able to select patients who had the word “dry” in their diagnosis. That sort of patient culling would have been impossible with paper charts. Through the affiliate link, our office generates revenue for every purchase made from our link. This service is widely available, directly through many vendors.

4. Eliminating SPAM. We did a similar targeted campaign involving Latisse (bimatoprost, Allergan, Irvine, Calif.), the FDA-approved treatment for growing eyelashes. When the drug was released, we sent out information on the drug and how it worked. However, rather than targeting only women, we targeted both men and women within a certain age range. My thought was that men would forward the information to their wives.

This campaign didn’t work out as planned. So many recipients reported the information as SPAM that it created problems with my newsletter company. However, this experience made me realize the importance of targeting my marketing campaigns to the appropriate audience. Sending all information to every patient isn’t effective and actually decreases the potential response rate.

Keep in mind

Word of mouth still remains the most important tool for increasing the number of patients we serve. Yet there are several ways we can improve our relationship and grow our practice with our current patients. A little creative thinking combined with the ability to target efforts to the specific patients who would most benefit can go a long way in growing practice revenues. Furthermore, by promoting stronger relationships with our existing patients we increase the likelihood of future recommendations from current patients.

Dr. Driscoll is an optometrist with Total Eye Care, Colleyville, Texas. He can be contacted at 817-416-0333 or rdriscoll@totaleyecare.net.
Can you see what I’m saying?

by Donna Suter

“If there is one secret to success, it lies in the ability to get the other person’s point of view and see things from his angle as well as your own.”

Henry Ford

Henry Ford saw that flexibility in understanding others is perhaps the most important stepping stone to success. While you may be an expert at analyzing the data collected during an eye health exam and identifying disease, how adept are you at recognizing the four basic personality styles?

And yet, experience has taught you that people, both patients and employees, are more receptive to messages that are synchronous with their own orientation to speed, detail, risk, task, or relationships with people. Synchronizing communication involves a lot more than these concepts. Another area of interesting work is Neuro Linguistic Programming (NLP).

The idea behind NLP is that we process information in a combination of visual, auditory, and physical modes. The current theory is that you can determine which mode is primary for people by the words they choose. By using terminology that is similar to what is preferred by other people, you can synchronize or connect more easily with them.

People tend to understand and learn more easily with information that is related in visual, auditory, or physical terminology, depending on their natural preference.

“I see what you mean” is a visual reference. An example of a visual-auditory crossover reference is “I see what you’re saying.”

“In other words” is an auditory reference. You may hear this kind of phrase when an auditory-dominate person is trying to get a visual or physical person to “hear” what he or she is saying. Other auditory references include “it sounds like” and “you can tell that.”

“I get the sense that…” is a physical reference. Other physical (also referred to as kinesthetic) references are “get a feel for this,” “go through the motions,” and “gut feeling.”

When you are communicating with other people, a way you can synchronize or “connect” (a physical reference) with them is to listen carefully to their word choices. Identify...
with people’s feelings by using reflective statements that allow you to adapt to their state of mind without agreeing with or joining them.

Adapting and being flexible can be tough. If this isn’t so, what are the reasons we keep repeating?

Research shows us that approximately 40% of the country places a high priority on consistency (which will make using NLP to communicate difficult). The research also shows that 54% of the population will resist change.

Making the choice to be more flexible when listening and speaking to others means that you are opening yourself up to learning more about others and yourself. Some people see things only one way, their way. They make a quick judgment based on their first impression and refuse to consider alternatives.

While you may be thinking this is a closed-minded approach, it is what most of us naturally do. As trained eyecare practitioners, you discipline yourself to never make a diagnosis until all the data from the eye health exam and patient history form has been reviewed. Yet you might label (a visual reference) an employee or a patient as difficult based on something that happened years ago.

It is human nature to defend our first impressions. The research clearly shows that first impressions are formed quickly and based on a small amount of information, and are long-lasting and resistant to change. The research also shows us that the most communicatively competent people are more open to new information than average people are.

Assumptions, judgments, and opinions are all based on limited information. If you stick to your first impressions and defend them vigorously, you’re continuing to operate on a limited information base. Flexibility in listening includes being open to the possibility that someone else may have something to teach you.

Recognize the things that get in the way of your ability to listen with an open mind. When you feel yourself getting defensive or hear yourself automatically objecting to someone else, ask yourself a few questions:

- What can I learn by listening to this person with an open mind?
- Everyone knows something I don’t. What does this person know?
- What are the real issues behind what this person is saying?
- How does this compare to what I already know?
- What is the main point here?

To get more comfortable with change, make an effort to try something new—just to get out of your long-established habits. Listen to a different radio station on the way to work, move your trash can; if you’re talkative, listen more, if you’re quiet, speak up in meetings; or read an article about a subject you know nothing about. These are all ways to practice flexibility.

Of course there are times to remain firm in your beliefs, but being stubborn in business and life can hurt you and others in the long run. When adapting to others, instead of abruptly changing the way you communicate, start small and work your way up. You might be surprised at what you can gain. OB

Ms. Suter is a practice management and business coach. She is best known for her work with dispensing ophthalmologists. She can be contacted at 423-545-4562 or suter4pr@donnasuterconsulting.com.

**Tips for improving physician-patient communication**

- Help patients ask the right questions
- Adopt an EHR (electronic health record)
- Encourage feedback about your patients’ experience
- Use email
- Make it all about the patient
- Accommodate foreign language speakers

Source: “6 ways to enhance physician-patient communication,” In Practice blog, Medical Group Management Association
Using **celebrity** endorsements

by Michelle Dalton Contributing Editor

When it comes to marketing services, celebrities can be useful, but credibility remains more important.
Tiger Woods, Florence Henderson, Brooke Shields, Claire Danes, Kirby Pucket, and Janine Turner are among the celebrities who have endorsed either an ophthalmic procedure (LASIK, Crystalens [Bausch + Lomb, Rochester, N.Y.]) or pharmaceutical (Latisse, Restasis [Allergan, Irvine, Calif.]). Endorsements—celebrity or otherwise—“can help compress the decision-making process because of perceived credibility of the endorser. The most pure form of that is someone you know and trust on a personal level,” said Shareef Mahdavi, president, SM2 Strategic, Pleasanton, Calif., noting friends and family carry more credibility than a celebrity.

“People believe their friends and family. If someone you know personally ‘likes’ something on Facebook, it’s been shown to be 88% believable. When a company tells people on Facebook to try something, it’s about 14% believable,” he said.

Nowadays, celebrities charge fees to tweet, said Matt Jensen, executive director, Vance Thompson Vision, Sioux Falls, S.D. “That can be a liability for your brand if Celebrity A is reported to be paid to recommend your brand.”

For ophthalmic practices considering using celebrity endorsements as a marketing strategy, if the celebrity falls out of favor with the public there is an inherent risk the practice could be negatively impacted as well. With today’s society focused on the pulse of celebrity, “if the celebrity does something ‘bad,’ it can do more to harm the brand than promote it,” Mr. Mahdavi said. Mr. Jensen and Mr. Mahdavi cited Tiger Woods as the prime example of a celebrity falling out of favor.

Conversely, both men noted Florence Henderson’s Crystalens promotion as a perfect match.

“She’s still America’s most loved mom,” Mr. Mahdavi said. “She did a lot to help people understand getting their eyes checked for cataract. She did as much to help people understand cataract and that it’s curable as she did to help promote the Crystalens. She is the ideal celebrity endorsement.”

“Florence Henderson speaks to stability and long-term confidence,” Mr. Jensen said.

Outside ophthalmology, celebrities have been used successfully to promote various disease states (Mary Tyler Moore and the Juvenile Diabetes Foundation, Sally Field and bone density drug Boniva), “and then there’s self-help/self-improvement, where Latisse, LASIK, and premium IOLs fall,” Mr. Mahdavi said.

An advantage to celebrity endorsement is “it suggests what you’re doing is mainstream. It’s a psychological cue,” he added.

**Successfully using endorsements**

Within the ophthalmic community, Maloney Vision Institute (Los Angeles) has leveraged the use of celebrities to its advantage—at press time, the Institute featured an Olympic gold medalist and two reality TV personalities, as well as a mention of TV shows on which Dr. Maloney had been featured (requests for interviews for this article were not returned).

The question for others, however, is how to leverage a celebrity if the surgery was done elsewhere.

“It depends on how good a communicator you can be,” Mr. Jensen said. “So while you may not have implanted Florence Henderson, you can tell your patients that she’s someone who had all options available to her and she chose the same lens you’re recommending.” Noting Ms. Henderson paid for the lens adds to her credibility in endorsing it, too, he said.

That said, it’s difficult to measure how effective a celebrity endorsement can be.

“The more relevant a celebrity is to the target audience, the more effective that endorsement is going to be,” Mr. Mahdavi said.

In a world cluttered with ad messages, celebrity endorsements can help a particular technique or drug stand out.

“Everyone wants to treat the local celebrity, the mayor, chief of police, etc., for self-help procedures,” Mr. Mahdavi said.

When Allergan began its latest ad campaign for dry eye drug Restasis, it opted to use a practicing ophthalmologist, Mr. Jensen said.

Alison Tendler, M.D., “writes a lot of scripts for Restasis but she uses it herself. That lends authenticity to the campaign,” he said.

**Leveraging popularity**

For practices considering using celebrity endorsements, leveraging the manufacturer’s investment in the celebrity is just logical, Mr. Mahdavi said. “It makes all the sense in the world to have the same ad in your office your patients are seeing in magazines or on TV.”

Celebrity endorsement will drive interest and awareness on the front end, but on the back end (consideration and finally action), celebrity endorsements don’t really work, Mr. Mahdavi said.

“What you really want is patient endorsements—having them post/like/tweet about their experiences,” he said. “The mouse is powerful.”

Mr. Jensen agreed—testimonials and authenticity mean more in promoting a practice’s offerings than a celebrity will. “If your mom endorses your surgery it’s not as effective as if your competitor’s mom endorses your surgery,” he said. OB

**Editors’ note:** Mr. Mahdavi and Mr. Jensen have no financial interests related to this article.

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The backdoor **Roth IRA**

by James M. Dahle, M.D.

A retirement account you might not have known about can help you achieve valuable tax diversification in retirement

Tax diversification is a worthy goal to lower your tax bill in retirement. Tax diversification means that some of your assets are in tax-deferred accounts (like a 401(k)), some are in tax-free accounts (like a Roth IRA or health savings account [HSA]), and some are in taxable accounts (like a standard brokerage account). Each of these types of accounts is treated differently by the IRS, and careful retirement planning of withdrawals can minimize your tax bill dramatically, allowing you more money to enjoy retirement, leave to heirs, and donate to charity.

Consider the following two examples of retired, married physicians.

Physician A has a portfolio that is entirely in a 401(k).

Physician B has one-third of his portfolio in a Roth IRA, one-third in a 401(k), and the last third divided between a taxable account and an HSA.

Now in their first year of retirement, they both need to spend $100,000, let’s say $80,000 on living expenses, $10,000 on health care, and $10,000 on charitable donations.

Physician A pulls $100,000 out of his 401(k). There are no penalties, since he’s over 59 1/2, but he still...
has to pay tax. His adjusted gross income is $100,000. He gets to deduct the married standard deduction of $11,600 and personal exemptions of $7,300, leaving a taxable income of $81,100. The first $17,000 of that is taxed at 10%, the next $52,000 is taxed at 15%, and the final $12,100 is taxed at 25%, for a total tax bill of $1,700+ $7,800 + $3,025= $12,525.

Physician B has a lot more options. The stock market actually had a bad year, and he was able to tax loss harvest some of his taxable account assets and thus will deduct $3,000 of losses from his taxes. He uses some of his appreciated taxable account assets to make his $10,000 charitable contribution, all tax free. He then uses his HSA to pay his $10,000 in healthcare costs. This leaves him $80,000 in expenses, which he needs to pull out of his traditional and Roth IRA. He pulls $40,000 out of the 401(k) and $40,000 out of the Roth IRA. The $40,000 out of the Roth comes with no tax bill, just like the taxable account and the HSA money. He is able to deduct his $3,000 in investment losses from the $40,000 in income he generated by pulling it out of the 401(k). What is his overall tax bill on the same income as Physician A? He has $37,000 in adjusted gross income. He then deducts his standard deduction and personal exemptions, leaving him a total of $18,100. The first $17,000 of this is taxed at 10% and the last $1,100 is taxed at 15%, for a total tax bill of $1,700 + $165 = $1,865.

One doctor pays an overall tax rate of 12.5%, the other pays 1.9%. It’s easy to see why tax diversification is beneficial.

A wise physician investor should be careful in how he achieves tax diversification. He doesn’t want to forgo the huge tax breaks offered for tax-deferred investing that he would get by maximizing his traditional retirement plan contributions. But there are ways to get money into tax-free accounts at both ends of the career path. A resident doctor is in a low bracket and should be using Roth IRAs. A semi-retired or retired physician can do Roth conversions at a reasonable rate. But what about the mid-career physician at the peak of his earnings? The best bet for him is what I call the backdoor Roth IRA.

Up until recently, there was an income limit that prevented most doctors from contributing to Roth IRAs AND converting traditional IRAs to Roth IRAs. That limit has now been eliminated for conversions. A mid-career doctor doesn’t necessarily want to do a Roth conversion, but he would love to contribute to personal and spousal Roth IRAs, which would allow him to squirrel away $10-12,000 a year into a tax-advantaged retirement account above and beyond his 401(k). So how can he do this?

Step 1: Contribute money into a non-deductible traditional IRA. (The income limit is for the deduction, not the contribution.)

Step 2: Immediately convert the traditional IRA to a Roth IRA.

Step 3: Repeat next year.

There’s a catch, naturally. Roth conversions are done “pro-rata” and have to take into consideration ALL of your traditional IRAs, including SEP-IRAs. So before you do this, you need to get rid of your traditional IRAs. You can do this by rolling the money into your employer’s 401(k), opening a solo 401(k) and rolling the money in, or by converting your entire traditional IRA to a Roth IRA over one or several years.

Making backdoor Roth IRA contributions each year can provide the wise physician investor with tax diversification when he arrives at retirement. Your financial advisor or mutual fund company can help you get started. OB

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