Six ways to generate more leads from your ophthalmology website

Content is king  P.6
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This issue of Ophthalmology Business explores a variety of topics, including the value of a website for your practice, a new laser procedure that could permanently turn brown eyes into blue eyes, and new mobile health applications for physicians and patients.

A practice website can help bring potential new patients through your office door, but many practices are not using their online presence to its fullest potential. In “Six ways to generate more leads from your ophthalmology website” (page 6), search engine optimization specialist Tammy Smith offers valuable tips for building a strong online brand and ultimately bringing in more qualified leads.

Developed by Ströma Medical Corporation, a new laser procedure in pilot development could turn brown eyes into blue eyes, permanently. Senior staff writer Erin L. Boyle spoke to members of Ströma Medical’s Medical Advisory Board for more information on the idea behind the procedure, how it works, and its potential for the future (see “Brown to blue: Procedure change eye color,” page 9).

“Mobile health is revolutionary because, by definition, it transforms the provider-patient relationship. While patients are able to use these growing technologies to further improve quality, efficiency, and access to their care, we as providers can simultaneously use these technologies to enhance our delivery of care to patients and optimize treatment results,” said Richard M. Awdeh, MD, editor of the “Technology in ophthalmology” column. In “Diagnostic apps helpful to ophthalmologists, patients,” on page 18, senior staff writer Erin L. Boyle looks at mobile health applications, some that aid physicians with making a diagnosis and others that are geared toward patients.

In “Second look’ financing” (page 24), Bill Rabourn explains how the economic downturn has impacted patients’ options for financing procedures such as LASIK. According to Mr. Rabourn, “You need a ‘second look’ credit source that can maximize approvals, not only for those with challenged credit, but also for those with good credit who cannot be approved by traditional lenders.”

These are just some of the informative articles you will find in this issue. Thank you for reading!
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Six ways to generate
more leads from your ophthalmology website

by Tammy Smith

If you have a website promoting your practice, then most likely you are seeing some success with people finding you online. Perhaps you are getting phone calls from people who see your website in a search or find your business listed in a local directory. Ask yourself this: Can I do more? Are you using your online presence to its fullest potential? Is your ophthalmology website more of an online brochure, or is it a mechanism that helps drive leads and potential new patients through your office door? Here are six tips to focus on if you want more leads out of your website.

Utilize strong content
Information is power. Nothing counts more toward a strong foundation for your online marketing campaign than really good content. Content is what the search engines base your ranking and authority on, and it is what your potential patients will use to formulate a judgment about your professional abilities and expertise. Do not skimp when it comes to quality content. You need substantive content with a strong emotional appeal.

At the Quarterly Digital Intelligence Briefing: Digital Trends for 2013, held in March and conducted by eConsultancy in association with Adobe, 700 digital professionals were surveyed about upcoming trends in digital marketing. 2013 was dubbed “The Year of Content,” and content marketing was ranked as the single most significant trend for the coming year.

What is content marketing?
What is content marketing? Simply put, content marketing is creating and sharing information in order to acquire customers without necessarily serving a direct sales pitch. This content educates, informs, or provides entertainment. Instead of just pitching your services, you are providing useful information that serves to educate and make your buyer more intelligent. If your website delivers consistent and valuable information, you build trust in your word and your brand, and those who read your content will ultimately reward you with their business. This type of information comes in a variety of formats: blogs, news items, videos, white papers, e-books, infographics, case studies, question and answer sessions, how-to’s, podcasts, and more.

Implement clean website design and site structure
If your website has not had a facelift in the last few years, chances are that the search engines, and your

continued on page 8
end users, notice that it is dated. This means that you may not rank as high as you could because you are being “penalized” for junky coding, broken links, dead-end files, or site structure that is hard to navigate. For ease of use and best practices in both design and optimization of your site, it is important that your website is clean and not cluttered. If things start to look and feel messy, or if you have too many items on your site competing for attention, question what you want your user to do. The answer is usually simple—fill out a form, pick up the phone and call, or buy something. Make sure you keep your pages focused on your end goal.

**Link to relevant information within your website**

Don’t leave anyone guessing. Set up proper funneling within your site to get visitors to the information that they need. For example, people might visit your site to find out why they are having blurred vision. They may not yet be ready to contact you at this point, but from further reading, they are shown links to pages with topics like nearsightedness, vision correction options, corrective lenses, and ultimately LASIK. If they are interested, then they will fill out the form or contact you directly by phone.

Without proper linking and information funneling, potential patients will not find the answers they are looking for. If users cannot find information they need on your website, they will leave and check out your competition. Search engines know when a visitor leaves your site to visit another site, and they will rank your site lower in future search results if they see this trend continue.

**Promote your specials**

Hook visitors with special offers and calls-to-action. Most people are looking for specials, promotions, or coupons when doing online research. If you are running monthly specials, put them in the most prominent spot on your homepage—usually in the header or somewhere in the top third of your page. In my years of analysis, the top three most clicked-on links on most ophthalmology websites are: About Us, Financing or Specials, and Contact. Keep these items easy to find.

Other good places to highlight your specials and promotions are on high traffic pages relating to your promotion and community-oriented pages, like blogs or social media sites. For example, on the corrective lenses page, you could list any discounted eyewear or rebate specials on contacts. On the consultation page, you could offer a discount for first time visitors that may entice a new patient to contact your office. On the LASIK page, you could offer a free LASIK consultation or discounted procedures you may have. If you are not currently offering any promotions, you could always ask for interested parties to sign up for a practice newsletter to keep the potential patient in the loop regarding your services and future specials.

**Promote your strengths**

If you are doing something that no one else in the area is doing, promote it! If you have training or skills that are unique to you and your practice, you want to let potential patients see that you are an expert. The “About” pages are a great place to do this, but highlighting special skills or services is always something you want to promote throughout the website in an eye-catching way. Tell potential patients why you stand out from the crowd and why your techniques are unique and sought after.

**Build a loyal community**

It’s no longer enough to just have a website. Your website is one component of a larger network of information about your practice. This network highlights your brand and details your expertise to those in need of your services. This is done on various online platforms—blogging, social network communities like Facebook and Twitter, online ophthalmology directories and medical forums, and more.

Through online community interaction, you have access to people who are looking for the services you provide. Important things to remember about community:

1. Be a good listener. Community members will share their experience and insight if you let them.
2. Be interactive. It is important to share your information on your social platforms.
3. Do not “soap box.” You don’t want to be someone who spews only your message. Be a true provider of information. Share authoritative links and news from other sources. Do this and you will be seen as an authority by both community members and search engines. The more active you are in your online community, the better.
4. React and reward. Reach out and help those who need your information and professional advice. Reward online community members with specials listed on places like Facebook or Twitter.

By focusing on these aspects of your online business profile, you will be building a strong online brand and you will be positioned to bring in even more qualified leads. This, in turn, will help grow your patient base. **OB**

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**Ms. Smith is a search engine optimization specialist at Page 1 Solutions LLC, an internet marketing firm in Golden, Colo. She can be contacted at tammys@page1solutions.com.**
While brown eyes have long been the subject of song and verse, not everyone with the color is satisfied with it. A new laser procedure in pilot development could cosmetically assist those people, turning their brown eyes into blue eyes, permanently.

The popularity of colored contact lenses, which change the eye’s color only temporarily, shows the market for such a procedure, inventor Gregg Homer, JSD (PhD), said. Strōma Medical Corporation (Laguna Beach, Calif.) is developing the permanent laser procedure, as yet unnamed.

“The fundamental principal is that under every brown eye is a blue eye, literally. Therefore, the first and most basic iteration of technology is to change an eye from brown to blue,” said Dr. Homer, chairman and CEO, Homer Labs. “Thereafter, we will explore changes from brown to green and from green to blue.”

Dr. Homer explained that there is actually no blue in the eye. “If you think about it, there’s no blue pigment in your body. What makes an eye blue is the scattering of the light by the fibers in the iris, similar to the Rayleigh scattering of sunlight in the sky.”

When a person looks at a blue eye, what he or she actually sees are grey collagen fibers scattering visible light and reflecting back only the blue light, thereby creating the appearance of a blue iris. People with “blue” eyes have no pigment on their anterior iris, whereas people with brown eyes have a thin layer of pigment on the anterior surface. That thin layer prevents light from getting into or out of the iris stroma, so only the brown opaque pigment is seen.

Iqbal (Ike) K. Ahmed, MD, assistant professor, University of Toronto, clinical assistant professor, University of Utah, Salt Lake City, and a member of Strōma Medical’s Medical Advisory Board (MAB), said a good example of this can be seen in babies who are born with a slate grey eye color, which can change over time.

“Essentially it’s light reflecting off the iris layers, and in the brown eye, you’ve got a layer of brown pigment that’s covering the anterior iris. The idea behind the procedure is simply to reduce or eliminate the brown melanin that’s present in the anterior layers of the iris, the anterior epithelium,” he said.

**Behind the idea**

Dr. Homer did not begin his career in ophthalmology. He left work as a Hollywood entertainment lawyer to work full time as a scientist and inventor, including in the medical space. He became interested in the concept of changing eye color in the late 1990s. At that time, he discovered a paper in the literature on iris pigmentation by RC Eagle Jr.
How it works
Marguerite B. McDonald, MD, professor of ophthalmology, New York University Langone Medical Center, New York; adjunct clinical professor of ophthalmology, Tulane University Health Sciences Center, New Orleans; and Ophthalmic Consultants of Long Island, N.Y., is on the Ströma MAB. She described how the laser works. “This is a Q-switch neodymium YAG laser, which produces a very highly discrimina-

tory photo-absorbed frequency. The laser fires a series of small, computer-guided pulses, right across the iris, to photo-disrupt the stromal melanocytes,” she said.

“Because of the photo-absorption properties of this laser, the energy passes through the clear cornea, and it very selectively hits the brown melanocytes, leaving the cornea and the posterior iris stroma totally undisturbed. The photo-disrupted melanocytes release cytokine protein molecules into the anterior chamber and the cytokine signal recruits macrophages. If you break down ‘macrophage’ into its Greek origins, it means ‘big eaters’ because these are huge cells that eat garbage, they eat debris,” said Dr. McDonald.

“The macrophages arrive after they get the cytokine signal, and they engulf and digest the photo-
disrupted melanocytes as cellular debris. The complete elimination of the melanocytes takes one to four weeks. The final outcome is the removal of the brown stromal pigment and the emergence of the underlying natural blue stroma,” she said.

Potential
Many people are excited by the prospect of permanently changing their eye color, Dr. Homer said. The procedure would likely cost about $5,000 for both eyes, although physicians would set the price, not the company itself, and it would vary depending upon territorial demand curves.

Dr. Homer, whose doctorate is in evolutionary neurology, said from a biological standpoint, there are many reasons that people might want lighter eyes: the clearness of the eye possibly revealing more genetic defects and disease, and the fact that people often show their attraction to another with an enlarged pupil, which is easier to see in a lighter eye. He was quick to point out, however, that eye color is purely a matter of personal preference. “We are not proposing that some qualitative difference exists between dark and light eyes. Our goal is simply to provide consumers with a choice.”

Dr. McDonald said blue eyes are exotic in many places, which could be part of the procedure’s appeal.

“It is unique, it is a first of its kind, and they’ve done a lot of studies indicating that the potential mar-

tet is huge: I am behind them all the way because I appreciate the deliber-

ate approach,” Dr. McDonald said. “They’ve got the best people on their team, the best scientists, the best pathologists, and they’re going to make sure that people are not harmed by this. Each step moves forward hinged on the last one, the top concern being safety.”

For more information, visit the company’s website, www.stromamedical.com.
Learn from the experts.
Hear tips and pearls from the experts on EyeWorld’s Video Reporter from the 2013 Asia-Pacific Association of Cataract and Refractive Surgeons Annual Meeting

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Read it, Watch it, Share it!
Eye on your money: Insightful answers in your interest

by W. Ben Utley, CFP

Question
I’m a 45-year-old eye surgeon and I own my practice. This year I got nailed with a huge tax bill despite the fact that I maxed out my 401k and bought new equipment last year. I took home about $500,000 last year pre-tax. I have 10 employees who earn about $40,000 on average, and I’m carrying all of them in my profit sharing plan too.

In your last column, you said that a defined benefit pension plan might save me taxes. I know there’s no free lunch out there, and I’ve heard these plans are kind of risky. Is it true? If so, what are the risks? Or are they actually a decent deal?

Answer
Looking at the headlines these days, you might begin to believe that “pension” is actually a four-letter word. Recent data from the Pew Center on the States showed that the country’s 100 largest pension plans are facing a combined shortfall of almost $1 trillion. That means employees in these plans are going to get a nasty surprise when they hit retirement age: way less money than promised.

But when I spoke with a few of the nation’s top “pension geeks” (that’s what they call themselves), I got an entirely different impression, especially about pension plans for small business owners.

“It’s kind of a shame,” said Michael D. Hughes, an employee retirement benefits attorney and pension guru based in St. Petersburg, Fla. “I think a lot of people are missing the boat by overlooking these plans,” he said. Defined benefit plans, particularly the new breed of plans known as “cash balance plans,” are often a slam dunk for high earning professionals, particularly those who already max out their 401(k) and profit sharing plan contributions like you do.

The Employee Retirement Income Security Act (ERISA) calls these “hybrid” plans, said Dan Kravitz, author of Beyond the 401k, and president of his own cash balance plan design firm in...
Los Angeles. They combine the features found in both defined contribution plans (e.g., 401k) and traditional defined benefit pension plans. As the business owner, you get a tax deduction for making contributions to the plan. As a taxpayer and a physician, your portion of the plan gains asset protection from bankruptcy creditors and can grow tax-deferred since this is a qualified plan under ERISA.

One more feature of cash balance plans makes them a win for your employees, too. Mr. Kravitz, who worked as a teacher before he began doing pension stuff back in 1989, still has an “old school” pension plan from his days as an educator. He said the school district’s plan is so complicated that, “I still have no idea how much money I’m going to get at retirement.” Since this is a benefit for your employees (not just a fat tax shelter for you), it’s nice for them to be able to look at their annual statement, see the cash balance, and know what it’s worth to them. It’s a nice feature if you’re aiming for higher rates of staff retention.

Unlike 401k plans, you as a business owner bear responsibility for the performance of the investments in your plan, and that’s where the risk comes in. By design, the plan assumes a rate of return or “interest crediting rate” that may be pegged to a benchmark (like the yield on the 30-year U.S. Treasury bond) or it may be set arbitrarily, usually at a rate near 4%. If your investments earn less than the interest crediting rate, you as the plan’s sponsor are responsible for making up the difference. That’s the bad news.

The good news is that eye surgeons can contribute way more money to a cash balance plan than they could contribute to a stand-alone 401k/profit sharing plan. According to Norman Levinrad, a pension actuary with Summit Benefit & Actuarial Services, Eugene, Ore., you might contribute as much as $120,000 more to a cash balance plan than if you had only a 401k plus profit sharing plan alone.

That extra contribution could save you about $48,000 in state and federal taxes, depending on where you practice and pay taxes.

There is one more catch but it’s manageable. The feds wants to make sure that everyone in the plan is treated fairly, so you will be required to include your employees in the plan and make a contribution for them as well. In this case, you’re contributing to their profit sharing plan accounts, so you may have satisfied the contribution requirements already.

So yes, there are some risks but the benefits far outweigh the costs. This is indeed a good deal for someone in a situation like yours.

Mr. Hughes believes now is a good time for physicians to consider setting up a cash balance plan, and he should know. He has been at this game a long time, having started his law practice just one year after ERISA became law, almost 40 years ago.

“When you look at the tax and compliance issues surrounding these plans, it’s just about as good as it’s been since the 1980s in terms of what you can do and how you can design these plans.”

Speaking of design, I want you to know you will need a small team to make a cash balance plan a reality in your practice. First, you will need an actuary to calculate how much you can contribute to the plan. Next you will need an attorney to draft the plan documents. Once the plan is in place, you will need a bank, brokerage or mutual fund company to hold or “custody” the plan’s assets. If you’re crazy, you will manage the plan’s investments yourself, but if you’re smart, you’ll hire a registered investment advisor to do it for you. You will need a third party administrator or “record keeper” to keep track of the value of each participant’s balance in the plan. And you will need an accountant to file the plan’s Form 5500 each year, which is a report to the Department of Labor.

Sound overwhelming? Don’t fret. You can acquire each one of these team members independently (like you might if you called Mr. Hughes), or you can get them all in one place (like you might with Mr. Kravitz or Mr. Levinrad), though none of them offer investment management or custody services.

The all-in administrative cost for a cash balance plan might run you as much as $7,000 per year or maybe just a couple thousand more than you already pay for your 401k and profit sharing plan. All three of the pension gurus I interviewed for this column said that they would generate a free proposal to help you determine the costs and benefits of a plan for your practice, as is the custom in their line of work. At the very least, you or your office manager should make an effort to get further details.

**Keep an eye on your money**

The key to financial security is vigilance. Get curious. Ask questions! Dig for answers ... or email your questions to eyeonyourmoney@physicianfamily.com so I can do the digging for you. If I use your question in “Eye on your money,” I will send you one of my favorite personal finance books to feed your head and a cool “Eye on your money” coffee mug to satisfy your thirst for answers. **OB**
EHR conversion:

by Larry R. Brooks, AIA

Have you ever felt like a data entry clerk with your new electronic health record (EHR) system? If so, your conversion may not have been as successful as you had wished.

As many of you are finding out, converting your practice to an EHR is not an easy task. It seems the focus is on the business of the EHR such as where data is entered within the record, coding, how the data is stored, what happens with power or computer failure, meaningful use, etc. Less attention is paid to how and by whom the data is captured in the exam lane, how the doctor reviews data before the visit, or how many and where computers should be in the clinic.

Not addressing these aspects results in many doctors losing face-
to-face time with patients due to data entry, having their back to the patient while reviewing/working the EHR, or hunting for a computer to review information.

To keep these from happening in your practice, add space, staff, and flow to the list of items to evaluate when choosing an EHR system. Start with the exam lane since the doctor seeing a patient is the basis for having a health record in the first place. Assess your current exam lane and determine if there are things in there that do not need to be, and if there are things that need to be in the lane that are not.

Correct these issues first, and then begin to develop a plan as to how the data will be gathered, by whom, and how that data will get entered into the EHR. Here are things to consider.

**Question**

Will the doctor have a scribe or not? Will the scribe also be the same staff that worked the patient up?

- The location and orientation of the computer will need to be different depending on who is entering the data. The configuration of the cabinetry in the lane may be different as well.

**Solutions**

1. Strongly consider a scribe if you don’t have one already. All too often we see doctors spending more time facing the computer chart than they do the patient and spending much more time in the lane now with the EHR than they did with the paper chart. This leads to less favorable satisfaction
surveys and less patients seen. With scribe staffing services these days, most often the use of a scribe is a net gain in patient volume and profit.

2 If a scribe is going to be in the lane, try to place the scribe at the end of the counter nearer the door. This allows them to enter slightly after the doctor and get to their spot without crossing the paths of the doctor and patient. Having the computer screen on an arm that extends out is still a good idea because there will be times the doctor wants to see the record or show images to the patient in the chair, and you want to be able to do this without leaving the patient’s side or the patient leaving the chair. See the diagrams of the exam lane. Some practices have two computer screens, one for the scribe and one for the doctor. This second screen could be mounted on the ophthalmic stand.

3. If you are not going to use a scribe, consider a moveable cart that has the computer on it or the screen on a long arm mounted above the counter. Some practices incorporate the EHR screen and the computer acuity so images can be shown on the screen. The objective is to get the screen in a location that allows you to face the patient and family during the data entry portion of the exam.

If the staff that works the patient up is different than the staff scribbling (or no scribe) then there needs to be some system to get pre-exam work-up information to the doctor and follow-up work instructions to the staff.

**Solutions**

1. We feel the best solution is to have multiple staff working with you that work up and scribe/assist in the lane on the patient they worked up. That staff stays behind to perform any follow-up work. This helps with the continuity of the visit by having the support staff the same. In this case the tech/scribe would present the patient to you at the door before entering so you know who, why, and what. And when done you do not have to find someone to give instructions to.

2. If the scribe is different than the work-up staff, there will need to be a computer station that the doctor can go to review the chart and pre-exam work before entering the lane. This station needs to be centrally located to all the lanes in the doctor’s pod, or you can use portable tablets. Due to privacy issues, having these on the wall in the hall is not the best solution. Some practices not using portable tablets will print a summary sheet on the last visit, test results, etc., and place it in the chart rack outside of the lane.

**Question**

Will there be a need to print information for the patient to take home? If so, how will this be handled?

- Often times the doctor wants to give patient education material, a copy of the visit summary, paper script, etc., to the patient. Where will the printer go and who will give the printed material to the patient?

**Solutions**

1. Space for a printer can be incorporated into lower cabinetry most often to allow papers to be printed there in the exam lane. This keeps the printer close to the scribe and the counter clear.

2. A printer can also be placed at an alcove or tech station if this is central to all lanes in the pod. If it’s a paper script, the doctor will need to walk to this location to sign the scripts so it should not be remote from the lanes.

3. If it is a glasses script, we often recommend you to print in the optical dispensary, if you have one, so the patient goes there to get it. This has proven to increase sales.

**Conclusion**

EHR systems are great storage tools that don’t often improve the patient/doctor interaction. Do not let your EHR turn you into a data entry clerk, reduce patient volume, or reduce the time you spend with patients. As you evaluate and implement your EHR, look at how it will be used during the exam process, not just how the business of coding, storage, and meaningful use is addressed. There are systems out there that handle the patient visit better than others and accomplish all the other items as well. **OB**

Larry R. Brooks is an architect, president of Practice Flow Solutions, Norcross, Ga., and widely known as an expert in improving the flow patterns of medical practices. He can be contacted at brooks@PracticeFlowSolutions.com.
digital.EyeWorld.org

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Diagnostic apps helpful to ophthalmologists, patients

Health mobile apps can assist in the diagnosis and maintenance of patient care

From diagnostic mobile phone applications (apps) that measure basic body functions to specific apps for ophthalmology, new ways of accessing technology are offering opportunities for both physicians and patients.

Diagnostic apps outside of ophthalmology include SpotCheck, a free dermatology app. For a small fee, it allows users to submit a photograph of their moles to board-certified, experienced dermatologists. According to information about the app, within 24 hours, users receive notification of whether their mole looks atypical or not. The app also allows users to find dermatologists nearby who can assist more directly.

Another such app is PulseCheck, an inexpensive pulse-measuring app. It measures a person’s pulse through the light on the phone’s camera lens, which screens through the finger and measures the contrast of blood flow. The app then informs the user if his or her pulse is normal. Other similar apps—Heart Rate, Stress Check by Azumio—also measure heart rate.

Physicians as well as patients have expanded ways of accessing diagnostic information, both in the office and at home. These apps offer a broader audience the ability to be more involved in their diagnosis and care.

Physician diagnostic app

Diagnostic apps for ophthalmologists include Eye Chart Pro, which offers a variety of visual acuity charts that can track a patient’s visual acuity. Physicians can use this app to measure visual acuity with Snellen, Landolt, HOTV, and Sloan letter charts, with lines randomized, an important aspect to the app, according to developer Manu Lakkur, Boston.

“I designed Eye Chart Pro after my experiences as a chronic eye patient,” he said. “I noticed that after a few trips to the eye doctor, I
had memorized the visual acuity chart, so at first I just set out to build a chart where each line could be randomized. Professionals began using it and I realized that having a visual acuity exam in a format they were familiar with in a mobile device was useful. I worked with doctors who used the product to add additional features, one at a time.”

In addition, an iPhone or iPod can be used as a remote to control the iPad app with the Eye Chart Pro Remote Control app. The iPad can be placed on the examination room wall and used instead of a projector, with features including a shutter to isolate individual lines on the chart.

Physicians outside of ophthalmology can find the app useful in diagnosing visual acuity issues that could require a referral to an ophthalmologist.

“It’s not designed for patients. We purposefully stayed away from diagnosing acuity. We’d rather provide medical professionals with a tool to help them in their jobs,” Mr. Lakkur said.

**Patient diagnostic app**

Diagnostic apps for patients include the SightBook app from DigiSight Technologies (Portola Valley, Calif.), the first web-based system for the mobile monitoring of vision for retinal patients. Mark S. Blumenkranz, MD, member of the DigiSight Board of Directors (BOD), and professor and chairman, Stanford University, Stanford, Calif., co-developed the app with fellow DigiSight BOD member David Palanker, PhD, three and a half years ago.

“The diagnostic apps that I think are most useful to ophthalmology are those that allow patients to be able to monitor their vision outside of the office and to provide more data with regard to how they’re doing. [These include patients who] have diseases that place them at risk for vision loss, as well as patients who are on active therapy and who are on some of the more recent drugs that have come out, like Lucentis [ranibizumab, Genentech, San Francisco], Avastin [bevacizumab, Genentech], and EYLEA [Regeneron Pharmaceuticals, Tarrytown, N.Y.], in which we tend to tailor the treatment according to how the patient’s doing,” said Dr. Blumenkranz.

**Patient adherence**

Another platform technology that includes an app is CheckedUp. This app is in its clinical beta-testing mode now and enrolling key practices across the country. Richard Awdeh, MD, professor of ophthalmology, Bascom Palmer Eye Institute, Miami, and a member of the CheckedUp team, started development of this app in late 2011.

“Mobile technology lends itself very nicely to us as ophthalmologists. The ability to monitor our patients’ adherence to treatment plans and monitor their disease progression while they are out of the clinic revolutionizes our ability to care for our patients,” Dr. Awdeh said. “Imagine having data points that are taken on a daily or hourly basis, rather than intermittent data points that are taken every three or six months during a clinic visit.” CheckedUp is focused on engaging patients in their treatment care plan.

**FDA regulation**

Because these medical mobile apps are diagnosing and monitoring health issues, the U.S. Food and Drug Administration has taken notice, with draft guidance on the matter in 2011. It defined a “small subset” of medical apps as those that “impact or may impact the performance or functionality of currently regulated medical devices” and as a result would be more closely regulated than other medical apps, according to a release from the FDA. The subset is considered to be apps used as accessories to medical devices already FDA-regulated and those that change a mobile device into a regulated medical device.

According to news reports, final guidance is expected from the FDA by the end of fiscal year 2013.

“The draft guidance suggests that things that measure refractive error, like refractometers or vision charts for instance, are thought to be considered Class I because they essentially replicate,” Dr. Blumenkranz explained. “There’s no potential for harm, and they represent another way of measuring vision, analogous to putting up a cardboard light panel with letters of different sizes on the wall.”

He said the FDA’s draft guidance seems to have the right idea about regulating more impactful diagnostic apps.

“I think when devices are used to make a specific diagnosis or when they directly indicate that you should use more or less of this drug at home, insulin for instance, based on your glucose reading, then that’s a different thing. I think those kinds of devices need to be more strictly regulated. It depends on the nature of the app,” he said. OB

Editors’ note: Dr. Awdeh has financial interests with CheckedUp. Dr. Blumenkranz has financial interests with the SightBook app. Mr. Lakkur has financial interests with the Eye Chart Pro app.

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The ethics of speaking up

by John D. Banja, PhD

Studies of preventable disasters and catastrophes have frequently noted that they have long “incubation” periods wherein personnel knew about serious problems leading up to and causing the disaster but either 1) failed to speak up about them or 2) did speak up but supervision or leadership was nonresponsive. To take some dramatic examples, for at least six years before the Challenger disaster of 1986, NASA knew about problems with the O-rings of the shuttle’s external fuel tanks. On the morning of the launch, engineers who worked with the O-rings were calling their supervisors and urging postponing the mission because they knew the O-rings were particularly fragile in cold temperatures, and it was near freezing at the launch site. Seventeen years later, the falling debris that damaged and doomed the space shuttle Columbia was a recognized problem for more than 20 years, but because nothing bad had happened during that time, the problem had been downgraded to a low-risk hazard. In medicine, perhaps the most recent example of recognizing but not responding to a disaster-in-the-making is the case of Dr. Nidal Hasan. Dr. Hasan was the army psychiatrist who, in 2009, opened fire in Fort Hood, Texas, killing 13 people and seriously wounding 29 others. In the months preceding his unspeakable act, Dr. Hasan’s superiors had been noting his behavior growing increasingly erratic and bizarre but failed to take any action that might have prevented the tragedy.

Although less dramatic, we know that failing to speak up or take decisive action despite knowledge of an employee’s problematic conduct is frequently discovered in root cause analyses of harm-causing medical errors. Sometimes personnel directly involved in the error will be known to have been acting strangely or carelessly prior to the error occurrence. Or a subsequent risk management investigation will discover a prolonged period wherein people knew about equipment failures, poor documentation or communication practices, poor attention to details, or personnel failing to follow standards, rules, or regulations.

I point all this out not only to call attention to the very common failure to speak up about on-the-job problems, but to acknowledge the difficulty in doing so. We hate to confront a colleague or speak to a supervisor about a colleague’s job performance because we fear retaliation; or we believe that even if we do call attention to a problem, administration will do nothing about it; or we experience a failure of nerve because we don’t have the skill set to approach and manage the problem (or the person) in an effective way.

As I have studied the problem of taking constructive action over the problematic practices of employees—and this is very common—I have come across a number of suggestions from the literature that I’d like to share.

The first is that if you want to have staff members who are willing to speak up about policies not being followed or other employees’ problematic behaviors, personnel must feel safe enough to do so. Administration or leadership must protect individuals who have the courage to call attention to the problematic behaviors of others and must convince staff that they can always feel safe in doing so—which can be challenging if the individual alleging fault occupies a lower rung on the organizational ladder than the individual whom he or she is complaining about, e.g., a nurse calling attention to a physician’s behavior. Nevertheless, if an employee fears that he or she will be harmed by speaking up, the odds are that it won’t happen and performance misbehaviors will continue.

A second reason why personnel don’t speak up is that they might believe nothing will result from their doing so. If employees are confident that leadership will be unresponsive to their efforts, they will probably not risk their personal welfare.

A third reason for not speaking out is that personnel might feel they simply don’t know how. Beginning such conversations can be especially difficult, and I’ve supplied a list of suggestions as to how one might...
Advisable, empathic responses to employees acting problematically*

- “Perhaps you don’t realize this but…”
- “I could be wrong here” or “Tell me if I’m getting this right”
- “Can I tell you what I’m seeing and get your perspective?”
- “It seems to me that the way you do X is different from what is expected. My understanding is … . Is that yours?”
- “What do you think can be done about this?”

When the other acts defensively or angrily, you might say:
- “I’m sorry this is upsetting. Can we work this out more calmly together?”
- “I’m disappointed that this discussion didn’t go as well as I had hoped. I will have to think more about it. Please contact me soon if you would like to continue talking about this.”
- “I hear you.”
- “This must be difficult for you to hear.”

*These strategies are taken from the work of Kent Neff, MD, and from the Vital Smarts essays on “Dialogue Heals” and “Silence Kills.” Readers are strongly encouraged to study these materials, as they can be useful in managing difficult conversations.

begin these kinds of conversations in the sidebar.

Also, consider this: Leadership is utterly crucial in developing and modeling the kinds of attitudes and behaviors that create a safe environment for employees to speak up. Importantly, everyone in leadership must be committed to a safe and nonretaliatory policy for personnel who, with good intentions, call attention to system weaknesses or problem behaviors. Remember that systems never run optimally and that personnel will always be deviating from rules and standards. The administrative response to these occasional frustrations should always be a constructive and respectful one, not necessarily a punitive one, as penalizing responses should be reserved for repeated or reckless violations of rules, policies, or standards.

Consider rewarding employees who speak up and devoting resources to training employees about the need for rule following; the consequences of overlooking substandard performance; and how to manage situations wherein an employee observes another’s questionable behavior or practices.

Leadership should always provide feedback to an employee who has called attention to problematic events or behaviors and tell him or her what has been done. Oftentimes, leadership is responsive to complaints or incident reports, but the employee making the report is never informed of any subsequent constructive actions and comes to believe that nothing came out of his or her effort.

All employees, unless they work in solitude, should have some ability to approach another employee and offer constructive criticism, yet there is often very little organizational training to that effect. Unfortunately, many personnel wait too long to say anything so that when they finally do, they are so upset by the severity of the situation that they can come across as shrill or even hysterical. The best advice to employees—actually in conducting any kind of emotionally challenging conversation—is to remain calm, be well rehearsed and respectful, let the other person rant and rave if he or she must, and try hard not to get angry back but, instead, try to get the other’s point of view. Of course, any employee confronting another or reporting another’s problematic behavior should be reasonably certain of his or her observations. Oftentimes, the employee whose work is being criticized will become defensive, so good evidence for any kind of report that negatively implicates another’s behavior is a must. Notice how the conversation suggestions in the sidebar are respectful and seek the other’s point of view, making it more difficult for him or her to get angry or hostile.

Leadership must understand how difficult it is for (up to 85% of) personnel to confront other employees who are behaving poorly. The challenge for leadership—and there is no substitute for it—is to understand that these problems will always be present, to protect employees who do speak up (assuming their motivations are just and their observations are credible), to respond to allegations, and to insist on a work atmosphere of dignity and respect for everyone. Accomplishing and sustaining this isn’t always easy, but it’s always worth doing. OB

Dr. Banja is a medical ethicist at Emory University and the public member of the ASCRS Governing Board. Readers are invited to send comments or cases to him at jbanja@emory.edu.

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Tips for marketing an optical dispensary

by Ellen Stodola Staff Writer
In ophthalmology, some may only think about the doctors and procedures that go into the practice. However, it is also important to consider the marketing of a practice, and this includes the optical dispensary side as well. Vision Associates Inc. is a consulting company that specializes in marketing optical dispensaries. Two principals of the company, Joseph A. Casorio and Kurt Behrle, both licensed opticians, along with Mary Walker, COE, director of operations, shared tips for marketing an optical dispensary. There are many factors for a practice to consider when marketing the optical dispensary, from layout to ways to gain awareness from patients and potential customers.

The look of the optical dispensary
One of the first aspects to consider is the layout and look of the optical dispensary. “I think that every practice administrator, manager, [and staff member] should walk into the practice from the patients’ side,” Ms. Walker said. It’s important to see what the patients see when they enter. In addition, each staff member should wear a nametag so that patients can identify those who work there as soon as they walk in.

Oftentimes there is a lot of clutter in the dispensary. Although it may seem that signs and materials are helpful, Ms. Walker said that if there is too much signage, it may be difficult to read and end up having little to no impact. The atmosphere has to be one in which people will want to purchase, and this includes a clean, tidy dispensary.

Mr. Behrle said that it’s important to ask the doctors to look at their dispensary and see if it is a place where they would want to buy.

Cross promotions
Mr. Casorio mentioned cross promotions of products as a way to market a practice. He said offering patients who are there for a specific product or service a discount on another product could attract more business. For example, he said practices could offer contact lens wearers or LASIK patients savings on non-prescription sunglasses. This would help facilitate crossover between the clinic and the optical dispensary side of the practice.

Utilizing website and email marketing
Mr. Behrle said it’s also important for an optical dispensary to have a good website, which helps to attract outside patients and keep current patients informed. Make sure that the optical section of the website is kept up. Oftentimes, practices focus on highlighting services like LASIK, cataract surgery, and other subspecialties and might have a weaker optical page.

Collecting patient emails is a simple and valuable way to market a practice. Email marketing can be used for a variety of purposes, including informing patients about new technologies, including letting them know of events that are going on, or sharing human interest stories about the doctors or other staff members.

Updating patients monthly with email newsletters can help them stay informed and keep the name of the practice in front of them.

Ms. Walker said another simple marketing practice to keep patients happy and coming back is to send a thank you note after a purchase. This helps set optical dispensaries apart from larger chain stores, she said. It’s especially easy if the office is already collecting the email addresses of its patients.

Community events
Mr. Casorio, Mr. Behrle, and Ms. Walker stressed the importance of events that practices can participate in to promote their optical dispensaries. Events like trunk shows can help draw excitement and attention from the community and showcase a variety of products. These can be designed to cater to specific products, brands, or even groups of people. Other events, like open houses or information booths, can help display the services that are offered. These can combine information on a practice’s products and services with food and social activities.

The effectiveness of marketing strategies can vary depending on the size of the practice, and it’s important to remember that each practice is unique. Certain ideas can work for one practice and not for another, and everyone is going to react differently to how things are done. Mr. Casorio said there is no magic wand that will help propel a practice forward. “It’s about doing all the little things right,” he said. “That’s where you build your practice because not only do you create patient loyalty, but you create patient referrals.”

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Not all that long ago, people with good jobs and good credit routinely used it to purchase goods and services. More than a few of them used that credit to purchase LASIK and other refractive procedures, then enjoyed the benefits of their new vision while they paid down the balance rather than postponing until they saved enough to pay cash. Your ability to monetize their demand by offering easy-to-apply, fast decision credit supported your procedure numbers.

That was then. Since the economic downturn that began in 2007, far too many applicants are being turned down by the financing services most practices have relied upon to serve the needs of patients with good credit.

People with good jobs and good credit are still using their credit to purchase goods and services, but for several reasons there are simply fewer of them to go around. During the downturn of the business cycle, the unemployment rate that had been stable for the previous 30 months doubled from 5.0% (December 2007) to 10.0% (October 2009). According to the U.S. Bureau of Labor Statistics, the decline in employment during that same period was greater than that of any recession of recent decades, and average consumer expenditures across all sectors of the economy—including healthcare—dropped to 2003-2004 levels. The recession officially ended in June 2009, though many economic indicators, including unemployment, still have not returned to pre-2007 levels.

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In more ways than one, the downturn devastated the income and FICO scores of households that had been considered good credit risks. Many struggled to honor their mortgage and credit card obligations, but the payments were sometimes late. Most will be able to rebuild their credit when they successfully recover economic equilibrium, but it will take time. During the interim, a number of them will still need and want better vision.

In the meantime, even consumers who never lost that equilibrium may be saddled with a FICO score that is no longer an accurate reflection of their creditworthiness. During Q4 of 2008 and through 2009, most banks slashed some credit lines and closed inactive credit lines, with the effect of reducing the amount of credit available to many consumers whose situations may not have been otherwise affected by the downturn. As a result, these individuals saw their available credit ratios shrink, which made them look “maxed out” on their credit lines. When these credit ratios shrink, so do the credit scores of prudent consumers whose always-timely payments had made them excellent credit risks. Previously credit worthy non-working spouses and those with low income but good credit scores have been affected by the Ability to Pay Act, which requires banks to ensure that credit applicants have the ability (defined solely as income) to repay the credit they are requesting.

And some of those consumers still want the benefits of LASIK, but their applications for credit are being declined by lenders still offering “one-size-fits-all” financing tied to the current FICO score and somewhat arbitrary measures of ability to pay, even though they otherwise remain the same good risks they had been in the past. On average, up to 50% of all applicants are being declined, and many more are not even applying because they anticipate they will be declined.

You are already aware of how your patients’ credit acceptance affects your practice’s procedures, acceptance. You may have already realized that the traditional sources of credit you have relied upon are not offering those patients the credit they need. You need a “second look” credit source that can maximize approvals, not only for those with challenged credit, but also for those with good credit who cannot be approved by traditional lenders.

Tough times have challenged the industry to come up with innovative, game-changing economic solutions, and that is what we are seeing now. While the financing partners you have used in the past are still doing business as usual, key industry experts have dared to reinvent healthcare consumer financing. They are making it easy to access the solution you and your patients need—you just may have to look elsewhere for an unprecedented degree of flexibility that results in considerably higher approval rates.

This financial innovation means a consumer’s FICO score determines not whether the application is approved or denied, but instead which bank will provide the applicant credit for vision/LASIK, dental, orthodontic, cosmetic, hearing, and veterinary services.

The patient interface with the lender remains much the same. When applying online or at your office, patients instantly learn if they are approved by one of several lenders.

We can expect to see this innovative multi-bank flexibility give birth to other new credit products that will make it possible to approve many who may have been declined before the economic downturn, with minimal risk of loss.

When you have “second look” financing options in place, many potential LASIK patients who have been declined by business-as-usual financing in the past may want to take a second look at you and what your practice can offer them. You already know who they are; you have their contact information and a golden opportunity to do some very focused marketing to bring them back in to your office. LASIK providers routinely communicate competitive advantages with regard to technology and experience, yet an innovative credit solution may be just as powerful a message; the first providers in their markets to signal that they offer “second look” financing may enjoy a valuable competitive advantage.

Unemployment rates and other economic indicators will continue to fluctuate, even in the best of times. People with less-than-ideal FICO scores will continue to seek solutions for their vision problems. You can’t solve their financial difficulties, but you can offer them better, more flexible financing options than in the past. You will look better when you make it possible for them to see better—any way you look at it, that’s a win/win situation.

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