Indecisive patients or Hot Prospects
Lending a hand to patients tangled in the indecision loop
P. 18

The honey bee colony: A model for practice success
P. 24
CULTIVATING GROWTH:
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1. Ophthalmology/Refractive Industry Trends, April 2014, conducted for CareCredit by Chadwick Martin Bailey.
2. Cardholder Engagement Study, December 2013, conducted for CareCredit by Chadwick Martin Bailey.
3. Subject to credit approval.

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From the publisher

Did you know that it typically takes 4 to 8 months for a patient to commit to LASIK and choose his or her surgeon? If you want to know why and what you can do to shorten the path to better vision, read “Lending a hand to patients tangled in the indecision loop” on page 18. This article includes strategies to help make the decision-making process easier for not only LASIK patients, but premium cataract surgery patients as well.

If you missed the ASOA Opening General session at this year’s ASCRS•ASOA Symposium & Congress, you will want to read “A guide to invisible leadership.” In a riveting and inspiring presentation, Paul Deegan explained the philosophy of invisible leadership that he cultivated through a lifetime of participating in mountaineering expeditions to the world’s tallest peaks. Mr. Deegan described to attendees how he applies that philosophy to his everyday life, sharing his thoughts on what it means to truly lead a team. Read more on page 14.

Ophthalmic professionals who are considering starting their own practice will want to check out “The honey bee colony: a model for practice success.” Hugh Johnston, MBA, shares how lessons from the honey bee colony can be applied to decisions faced by the medical practitioner. Turn to page 24 to learn more about the 4 key factors to focus on for practice success.

If you’re looking for ways to improve the patient experience in your practice, you may want to start by looking at your employees. Bruce Maller, president of BSM Consulting, discusses the importance of employee engagement in the modern medical practice in “Employee engagement: The secret to success.” When employees are engaged, they feel connected to the practice’s mission and vision, according to Mr. Maller. Learn how to create an environment of employee engagement in this article on page 26.

We hope you have a chance to relax and enjoy time with family and friends this summer. Thank you for reading Ophthalmology Business, and please contact us if there is a topic you would like to see covered in a future issue.

Donald R. Long, Publisher
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ECG-1227941 Rev. 1/15
A new lightweight, affordable device transforms a smartphone into an ophthalmoscope and fundus camera in one, allowing physicians to perform mobile eye exams anywhere, anytime.

The D-EYE Portable Retinal Imaging System (D-EYE, Padova, Italy) uses a smartphone’s existing camera to take high-definition images and video of a patient’s retina that can be stored and shared from any location.

As a completely portable and low-cost system, the D-EYE imager is an ideal tool for the growing field of telemedicine, with the potential to bring vital retinal screenings to patients who lack access to an ophthalmic specialist.

“It’s a game-changing type of technology,” said Jim White, vice president of marketing and communications for D-EYE. “We feel it is going to open up access to critical eye screenings to a lot of people today who aren’t getting them.”

With the D-EYE imager in their pockets, healthcare professionals can detect a variety of conditions in just a few seconds, from glaucoma to diabetic retinopathy. While the D-EYE will not replace a traditional ophthalmoscope or fundus camera, it is designed to supplement these devices, serving as a vital frontline screening tool for optometrists, general practitioners, and other healthcare providers.

Concept and design
The D-EYE system is the brainchild of Andrea Russo, MD, an ophthalmologist in private practice and a PhD-candidate researcher at the University of Brescia, Italy.

After finishing his residency program, Dr. Russo saw the need for a way to perform quick retinal screenings on the go and to take and share images with other specialists. Dr. Russo quickly realized that the connectivity, computer processing power, and photo and video capabilities he needed already exist in today’s smartphones. With an ophthalmoscope already in his pocket, all he needed to do was to combine them into one device.

Dr. Russo addressed this challenge by designing the D-EYE’s magnifying lens to fit over the smartphone’s camera and LED light and attach to the phone with a lightweight bumper. The D-EYE’s simple, ergonomic design doesn’t affect the functionality of the smartphone and makes it easy to learn and easy to use.

Tech specs
The D-EYE imager is currently available for the iPhone 5, 5s, and 6 and the Samsung Galaxy S4 and S5. The retail price is $450.

The D-EYE lens has a field of view up to 20 degrees, requires no external power or lighting, and eliminates corneal glare. It is ideal for the patient’s pupil to be dilated for the exam, but the D-EYE imager can be used without dilating drops.

The D-EYE system offers:
• Easy viewing of the optic nerve head for detecting glaucoma
• Age-related macular degeneration (AMD) screening
• Screening and grading of diabetic retinopathy and hypertensive retinopathy
• Detection of neurological disorders, hemorrhages, arteriolar constriction, blood vessel abnormalities, maculopathy, cotton wool spots, exudates, neuritis, and more
The D-EYE smartphone app provides step-by-step instructions for taking and recording images and video and archives all exams on a patient information file for convenient data management.

Last month, D-EYE partnered with TreVia Digital Health (Overland Park, Kan.), a leader in healthcare management software, to develop ImageVault, a HIPAA-compliant cloud-based storage service. Powered by TreVia’s industry-best data management platform, ImageVault will enable users to store and share D-EYE images while keeping patients’ protected health information secure. ImageVault will be available later this year.

To get started, users simply need to download the D-EYE app, attach the mounting bumper and D-EYE lens to the phone, set up a patient file, focus the camera, and begin recording images.

**Mobile technology for mobile healthcare**

With the interest in telemedicine on the rise, there is a large unmet need in the medical world for portable, affordable technologies such as the D-EYE imager.

While ophthalmologists have sophisticated eye exam equipment in their offices, other medical professionals often don’t have access to those large, expensive technologies. Optometrists, neurologists, family and general practitioners, nurses, emergency medical technicians, and even veterinarians can take advantage of this technology.

The D-EYE imager is an excellent tool for hospital rounds or out-of-office visits; the simple design makes it perfect for bedridden and elderly patients. Physicians have found it particularly useful for examining children who may not be able to sit still long enough for traditional slit lamp exams and fundus photography.

The D-EYE system is ideal for practicing medicine in rural regions or remote parts of the world where sophisticated eye equipment—or even basic health services—are not available. Healthcare providers in these areas can use the D-EYE system to perform basic screenings and send images to a specialist who can review them remotely.

Physicians also enjoy using the D-EYE to share retinal images with patients or caregivers.

“It helps take some of the mystery out of what’s being done and puts patients and their family right up front with the doctor to see what has to be done,” Mr. White said.

**Find out more**

The D-EYE imager is available for direct purchase on the D-EYE website and through Wilson Ophthalmic (Mustang, Okla.), its U.S. distributor.

The D-EYE imager will be showcased at the upcoming meetings of the European Society of Cataract & Refractive Surgeons (ESCRS) in Barcelona from September 5–9 and the American Academy of Ophthalmology (AAO) in Las Vegas from November 14–17. For more information, visit www.d-eyecare.com.

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Source: D-EYE
Five key functionalities to look for in an ophthalmology EHR

by Scott Heintzeman and Dan Montzka, MD

It’s well known that satisfaction levels with electronic health records (EHRs) vary widely among medical practices. When a practice suspects that its EHR is less than ideal, it may be because the selection process didn’t account for functionality that could make a tremendous difference in whether the chosen solution proved to further productivity or hinder it. That can be especially true of ophthalmology, where productivity can depend largely on whether the EHR was designed to meet the specific needs of the specialty.

Ophthalmology practices that have decided to seek a new EHR will want to focus on features and functions that are of value to any type of practice, including strong customer support, certification for meaningful use and readiness for ICD-10. But beyond those general requirements, practices should look for the following characteristics and functions that are ophthalmology-specific and can contribute greatly to EHR satisfaction.

1. Development driven by clinical ophthalmology expertise. Ophthalmology is a complex and unique specialty, and there are many subtleties in its workflows. Having at least one practicing ophthalmologist working closely with the EHR’s development team can help the developers understand far more precisely why a doctor needs certain things in certain places and how screens can best be set up. There’s a big advantage, too, if contributing specialists are rigorous beta testers of the EHR to assist in guiding prerelease refinements needed for optimization.

2. A knowledge-based system based on an ocular problem list. This function can generate values that make it easier for the doctor to record findings, which helps to speed up documentation, ensures that charts are more complete, and contributes to a well-run practice. That’s because the knowledge base is the backbone of the charting process, and everything falls out of the problem list. When this function is implemented properly in the EHR, it’s easy for a technician to enter a patient’s diagnosis from a referring physician before the patient arrives for the appointment. During the actual exam, clinical content from the knowledge base can flow through the EHR—for example, with guidance on which part of the eye to focus on and the most common findings. This kind of functionality is especially valuable to ophthalmology, which often treats elderly patients with multiple diagnoses; if the system can generate the right combination of templates, charting will be greatly simplified. In the best systems, the knowledge base is collaborative, with shared knowledge continuously strengthening the system with deeper relationships between clinical diagnoses, clinical findings, and treatment recommendations, including those related to subspecialties.

continued on page 10
3. **Customizable discussion items.** EHRs present discussion items that doctors can select to create letters, and the ability to customize the discussion items can make it easier, faster, and more efficient to generate letters while promoting a uniform style of writing. As with the ocular problem list, a knowledge-based system can take this to a higher level of specificity and assistance so that when the doctor is finishing an exam and ready to create a letter, the EHR will present the most useful default discussion items along with the most useful alternatives. The more the EHR is able to eliminate irrelevant choices and limit discussion items to what's truly relevant, the less time it takes to generate the letter and move on to the next patient.

4. **Exceptional support for customization.** Most EHRs offer some degree of end-user customization, and it’s important to see a demo of the customization process to understand what you can handle on your own. Equally important is having a vendor that will provide a customization service rather than leaving it all in the practice’s hands; most clinicians don’t have a lot of spare time for it, and some customization goes well beyond adjusting user interface mechanisms.

Beyond customization support, you should seek a vendor who offers exceptional training and technical assistance—whether its onboarding new employees, implementing a new system, or responding to ideas for enhancements and integrations. Having a strong vendor/provider relationship is as important as the technology itself, and having a reputation of responsiveness and strong customer support can be the distinct difference between EHR vendors with similar offerings.

5. **Native drawing system.** Much more so than doctors in other specialties, ophthalmologists need the ability to draw during clinical documentation. It’s important that the drawing capability be well designed and easy to use during an exam; a drawing capability built directly into the EHR will often prove especially convenient. Drawing systems that include the ability to overlay new images to contrast pre- and postop transformations as well as the ability to annotate directly on new images can greatly improve productivity and enhance clinical documentation.

Beyond these key ophthalmology functions, look for additional EHR advantages that may benefit your practice—such as an e-prescription tool with favorites lists that can be customized for each provider, or bidirectional lab integrations that streamline the lab order process and present results in the patient’s health record. If you haven’t looked into EHRs in some time, you’ll be pleasantly surprised at features and functions such as these among the most advanced systems. But above all, be sure that the EHRs you consider include the 5 key ophthalmology functionalities covered here, and you’ll be well on your way to making sure that your new EHR proves to be vastly more satisfying than the one it replaces. OB

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A dispensary’s key to improved profits

When it comes to discerning the efficiency and effectiveness of optical dispensaries, it can be challenging to know where to begin. Often, ophthalmology practices find that their dispensary is turning a modest profit seemingly on autopilot; as a result, a “don’t fix what isn’t broken” mindset settles in amidst the daily duties of accomplishing priority #1: patient care. Since the dispensary is performing “OK”—and because the most pressing items and formulas for proper dispensary benchmarking aren’t readily known—many practices are content to leave well enough alone.

However, not taking stock of a dispensary’s performance on a regular basis is akin to leaving money on the table. Equipped with the following list of important steps and simple benchmarking arithmetic, ophthalmology practices can realize an elevated revenue stream that has been waiting for them, fittingly enough, right next to their own waiting rooms.

Dispensary size
Finding a dispensary’s “Goldilocks zone”—not too big but not too small—is crucial to eliminating unnecessary overhead costs. A functional formula is as follows: Take the total number of annual refractions and multiply that figure by 0.65 to represent a goal capture rate of 65%. Take the result and divide it by 3, which represents the minimum acceptable unit turnover rate.

For the sake of easy math, let’s use 3,000 annual refractions for this example. Sixty-five percent of 3,000 is 1,950, divided by 3 is 650. So the ideal number of frames on display for a practice doing 3,000 refractions per year is 650. No matter what your calculations, the minimum needed is generally 1,000. The benchmark for inventory turnover is 3–5 times...
per year, so a 650-piece inventory can easily support 3,250 unit sales, which generally would mean your practice would be performing more than 5,000 refractions per year.

There are pitfalls involved with being both too high above and too far below this ideal figure, though the former—too many frames on display—is by far the most common. Maintaining too large an inventory takes dollars away from the bottom line in wasted time, makes vendor negotiations more difficult, and increases costly returns.

Maintaining a tiny inventory, as low as 250 pieces, can work in more of a “boutique,” minimalistic setting, but doesn’t function as well if you have standard frame displays. If all of your inventory fits on 1 or 2 frame displays, patients feel like there is a limited selection. If the frames are displayed on glass shelves or in jewelry cases, you can carry a small selection that gives the look and feel of a larger inventory.

**Average selling price**

It may seem elementary, but taking the time to determine a dispensary’s average selling price can help inform broader inventory decisions.

The math itself, of course, is easy. Take the dispensary’s total annual frame revenue and divide it by total units sold. For example, a dispensary generating $365,000 of frame revenue while selling 1,950 units has an average selling price of $187 per set of frames.

That $187 figure now becomes a measuring stick by which to gauge current inventory. The majority’s retail price should fall just slightly above that figure, with balanced percentages priced at levels above and below it. Here’s an example of what a dispensary with a $187 average retail selling price would look like:

- Under $100 = 5%
- $101–150 = 15%
- $151–200 = 35%
- $201–250 = 25%
- $250–300 = 15%
- More than $300 = 5%

This often-neglected benchmark is very important in determining your future purchases. If your average retail is $187 but you have purchased too many frames in the $275 price point, you may be alienating patients; conversely, if you purchase too many frames in the $125 price point, you may be undermining your dispensary’s potential.

**Cost of goods: The importance of proper vendor selection**

Vendors have great salespeople; it’s part of their jobs to be amiable “people persons.” We all love our vendor representatives. When choosing the right dispensary vendors, however, feelings are far less important than facts. Use your own sales data history to make clear determinations based on business rather than bias. Vendor reports, though nice, should be used to support your internal data, not relied upon for purchasing decisions.

Again, it’s just a matter of mathematics. Track a vendor by its annual sales, both volume and average selling price. Divide annual unit sales by 3 inventory turnovers. For example, if Frame Vendor A has an annual sales history of 300 frames in your dispensary, you should be carrying 100 frames from that vendor at any given time. If that same vendor has multiple sales reps carrying different lines, analyze that vendor by designer and apply the same formula, always keeping in mind your overall goal of balanced price points. In some cases, very high end or specialty or even children’s products may not meet the minimum turnover desired but are still essential to keep in order to fit the desired selection.

Ideally you will want to purchase from only 8–10 vendors and buy in deeper volumes to get the best possible pricing. By calculating inventory turnover for each vendor, you may find some smaller vendors with non-exclusive products that can be eliminated.

**Selection**

Let’s continue our inventory math with, “How many frames in each category do I need?” Women not only need more selection than men, there are many more frame styles and shapes available for women. As we take another look at our ideal 650-piece dispensary, the breakdown would generally look like this:

- Women 45% = 293 frames
- Unisex 20% = 130 frames
- Men 25% = 162 frames
- Children/Teens 10% = 65 frames

Standard inventory split would be 85% ophthalmic/15% sun wear. While these are general guidelines for a “typical” dispensary, the exact demographic mix of your practice will ultimately determine the final percentages. For example, a pair of pediatric specialists would have a much larger portion of their dispensary dedicated to children’s eyewear.

Frame inventory is one of the largest dispensary expenses. Managing it well, buying carefully, and reevaluating every inventory benchmark at least annually will ensure maximum profitability from your inventory.

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**Ms. Walker is director of operations for Vision Associates Inc., which offers turnkey, customizable optical dispensary management and consulting services that allow eyecare practices to maintain ownership and control of their dispensaries while relieving them of the time and effort involved in their everyday operation, all while increasing profitability. Visit www.visionassociatesinc.com for more information.**

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July 2015 • Ophthalmology Business
A guide to invisible leadership
by Lauren Lipuma Staff Writer

Humble beginnings
Mr. Deegan first found himself in a leadership role as a teenager, when he discovered that mountaineers climbing Mount Everest had been leaving trash on the mountain since the first ascent in 1953.

“I thought this was wrong, I thought something should be done about it, but nobody else seemed to be stepping up to the plate,” he said. “So I figured that person may as well be me.”

Mr. Deegan shared his idea with an experienced expedition leader, and the 2 men decided to lead a trip to clean up the trash at Everest base camp. But several weeks before they were to depart, Mr. Deegan’s co-leader told him he would have to meet the team on the mountain a few weeks into the trip, leaving Mr. Deegan and the expedition doctor in charge of 42 volunteers.

“Back then I thought leading a team was all about standing in the front and telling people what to do,” he said. “That attitude lasted for less than 3 minutes.”

Mr. Deegan chronicled the mistakes he made as a novice leader on that trip and then recalled a climb he took soon after—an expedition to the top of Mont Blanc, the highest peak in the European Alps. This trip consisted only of Mr. Deegan and 2 other climbers, and none of them thought that they needed a formal leader with such a small team, he said.

The 3 men realized soon into their trip, however, that they had made a mistake. Weather conditions on the mountain deteriorated, they did not know the route to the summit, and Mr. Deegan was experiencing altitude sickness.

“At this point, we needed someone on our team to stand up and seize the leadership reins and to...
make an informed decision,” he said. “But none of us did this. Instead of regrouping and tightening our team, our team literally fell apart.”

The 3 men made it to the summit and back, but the grueling expedition left Mr. Deegan searching for a way to learn how to lead.

“Leading from the front on the Everest cleanup had been a nonstarter for me, and now this leaderless experiment had descended into leaderless chaos,” he said. “I realized I had so much to learn about leading a team.”

Empowerment and courage

Mr. Deegan began attending lectures, reading books, and watching documentaries about leadership in a wide range of specialties. At one point, he came across a quote from the ancient Chinese philosopher Lao-Tse: “When the best leader’s job is done, the people say, ‘We did it ourselves.'” These words struck a chord with Mr. Deegan, and he adopted them as his personal mantra.

In addition to continuing to organize and lead his own expeditions, Mr. Deegan also began to seek out opportunities to learn from experienced expedition leaders. Two years after his Mont Blanc trip, he joined an expedition to Mount McKinley led by John Barry, a former commander of a British Special Forces Unit specializing in mountain and arctic warfare. Mount McKinley turned out to be significantly more unpredictable than Mont Blanc.

“The summit was static, but everything else was in a state of flux,” Mr. Deegan recalled. Weather conditions were severe, crevasses opened up, and the team members’ health was occasionally in jeopardy, but Mr. Barry’s leadership got the team through the ordeal.

“The way that John dealt with all these variables wasn’t by pushing on in the blind hope that things might get better,” Mr. Deegan said. “John had the courage to periodically press the pause button. This gave him time to evaluate our situation and to modify our plan based on what was happening to us and what was happening around us.”

Every day, Mr. Barry brought the entire team together to discuss what was going on and to solicit their thoughts before making key decisions, Mr. Deegan said. Mr. Barry asked less experienced team members to speak first so that their opinions would not be swayed by those of more experienced climbers.

“John instinctively knew that sometimes a less experienced person or a new person is actually in a better position to propose a novel solution to an existing problem than an experienced person who’s been accustomed to doing the same thing day in and day out,” he said. “I should know because I was the least experienced member on John’s team.”

In any organization, a profitable exercise can be to sit down with new staff members and ask them what anomalies they’ve seen in the organization, what can be improved, and how they could be improved, Mr. Deegan said.

By ensuring there was a free flow of information among all members of the team, Mr. Barry empowered them to make their own decisions. With that empowerment, they were able to squash small problems before they became bigger issues, Mr. Deegan said. “John led us by empowering us to lead ourselves.”

No room for passengers

In 1995, 3 years after the McKinley expedition, Mr. Deegan got the opportunity to return to Everest—this time to climb it instead of clean it.

On this trip, led by mountain-eer Henry Todd, Mr. Deegan did not reach the summit, but with Mr. Todd’s guidance, set a personal altitude record.

“Henry’s style of leadership was very different than John Barry’s,” he recalled. “Henry’s was more like a soccer team player-manager, issuing instructions from the touchlines and occasionally coming onto the field of play.”

This “soccer team” style of leadership gave each climber a considerable amount of autonomy. While climbing under an overall framework, each team member was free to make all of his or her own minute-to-minute decisions—an aspect of climbing Mr. Deegan enjoyed.

But in the 1990s, a new style of “fully guided” expeditions to Everest...
of those expeditions, 3 of whom were guides.

"It doesn’t matter whether you represent 50% of your team, or 10% of your team, or 1% of your team," he said. "There will come that day when your observation, your suggestion, your decision, or your action influences the outcome of a situation by 100%. And it’s for that reason I believe there’s no room for passengers on any type of team."

**Embodying Lao-Tse’s words**

Several years later, Mr. Deegan led an expedition to summit several peaks in central Asia that had never been climbed before, allowing him to test the leadership skills he had learned from those past expeditions. He worked hard to adhere to Lao-Tse’s philosophy of invisible leadership during the trip, giving his team members the kind of autonomy that Henry Todd had given him on Everest and periodically pressing the pause button, as John Barry had done on McKinley.

He described the incredible experience of ascending a mountain that no human had ever set foot on before. "While I remained a student of leadership, at that moment, surrounded by my team, I realized I had at least come a little way in my quest to learn about leadership since those first faltering steps picking up rubbish at Everest base camp," he said.

As his team made their ascent, Mr. Deegan reflected on what he had learned—and knew what he needed to do. For the first time on this expedition, he led from the front—but a few feet short of the top, he stopped and waited for the rest of his team. Then, together, they stepped onto the summit as one.

Editors’ note: Mr. Deegan has no financial interests related to his comments.

**Contact information**

Deegan: www.pauldeegan.com
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Lending a hand to patients tangled in the indecision loop

by William B. Rabourn Jr.
A person who persists in investing this much time and energy in researching a refractive procedure and providers has a genuine interest ... ... Consider them “hot” prospects.

How long does it take for a person inquiring about LASIK to become an actual LASIK patient? You don’t have to run the numbers for your practice to know that it takes too long—typically 4 to 8 months—for patients to commit to LASIK and to choose their LASIK surgeon. It’s not only LASIK patients who have commitment issues; the expansion of cataract surgery options to include premium lens products, laser cataract technology, and adjunctive refractive procedures often complicates and lengthens the decision-making process of those patients as well.

Why does it take so long?
The shortest path from one point to another may be a straight line, but since fear and money are involved, the rules of geometry don’t operate here. Many patients take the scenic route that involves several levels of “let’s see” research of treatment, provider, financial, and payment options. More often than not, this research path doubles back on itself in rather exhaustive fashion several times before arriving at a decision. No one wants patients to make an impulsive decision about something as important as their vision, so is it such a bad thing for patients to take their time?

Of course not, but we often view these consumers as indecisive or unmotivated, and that is a mistake. A person who persists in investing this much time and energy in researching a refractive procedure and providers has a genuine interest. Consider them “hot” prospects on an anxious quest to rule out perceived negatives and find a way to get—and pay for—the vision they want. Stress may be the culprit that turns their proactive research into a protracted process. The size of the investment and the perception of risk add anxiety to a situation already fraught with it. Plagued with fear of making a mistake, many fail to make a decision either way.

If you asked, you would very likely find that a significant number of patients have negative feelings about the time involved in decision making; remaining “on the fence” can be like sitting on the hot seat—less comfortable and more stressful than standing on either side of it. Not surprisingly, they typically feel more positive as they make their way closer to achieving their goal. Once clear of the angst of decision making, they are quite often really ready—even impatient—to have their procedure as soon as possible.

What can be done to shorten the path to better vision?
The decision path will never be the ideal geometric straight line, but there are things that can be done to work out some of the hairpin turns.

Begin by considering that LASIK consumers—and, increasingly, cataract patients—are very often tasked with making decisions related to the procedure itself and who will perform it, and how to pay for the results they want. Each decision you help them get out of the way at the beginning of the process makes it easier and less stressful to focus on the remaining issues.

Call in someone with influence. When it comes to making a decision to have LASIK, eyecare professionals may have more influence than primary care physicians, but many patients typically rely more heavily on family—very often a spouse—or a friend for advice. When scheduling a consultation, it’s a good idea to encourage patients to bring someone they trust to participate in the discussion with the surgical

Q: “Patients”? “Consumers”?
Who are they?
A: We use “patients” and “consumers” interchangeably here because today’s patients are encouraged to become informed consumers of medical care, and technology makes it easier for them to do so. The prospective patient who visits your website to explore their options, to learn about a technology, or to research your qualifications exhibits appropriate and responsible consumer behavior. With elective procedures (in this case, cataract surgery options and LASIK), they are called upon to make a decision that will impact their health and a consumer decision that will affect their finances.

Good stress/bad stress
In and of itself, stress is not necessarily “bad,” as it can motivate one to act or to adapt to a situation.

Ongoing, unrelieved stress, however, often leads to negative thinking and may interfere with concentration and the ability to take action. The more stressed-out the prospective patient, the more likely he or she will become caught up in an endless loop of uncertainty that may exacerbate the problem.
counselor and the surgeon and get the information they need directly from the experts. Exposing both to a compelling value story increases the likelihood that the patient has support and encouragement from someone who can share responsibility for the decision, making it easier to commit to the procedure without undue delay.

With the advent of new technology, cataract surgery has gone from a single decision (do it now versus wait a little longer) procedure to an impressive but somewhat daunting assortment of “package” options, all with price tags. It’s not at all unusual to have someone—a spouse, significant other, or another trusted advisor—drive a patient to and from a cataract evaluation. If included in any discussion of the patient’s options, this person may provide reassurance, reduce stress, and help the patient navigate available alternatives.

Pre-qualify sooner rather than later. The “fear” issue has its roots not only in anxiety about the procedure itself; for many patients, paying for the procedure can also be a fairly scary prospect. When the discussion of payment options is relegated to the end of the conversation, after candidacy has been confirmed, the issue looms like the elephant in the room that no one wants to acknowledge until it can no longer be avoided. Getting this issue out of the way can reduce the patient’s anxiety level and introduce a shortcut to the decision-making process.

Typically, at least half of LASIK procedures are paid for with cash, and many patients use a bank card or a healthcare credit card, such as CareCredit, to pay. Studies have shown that patients who have a healthcare credit card are more likely to use it than to use their bank card to access care. When the provider does not accept healthcare credit cards, a significant number of these patients are likely to defect to another provider that will honor it. If it appears that the patient may elect to pay with a credit card, take a page out of the real estate agent’s play book by getting your prospects qualified for a healthcare line of credit upfront, sooner rather than later. Encourage them to apply early in the process by emphasizing the wisdom and convenience of having this particular type of credit line at hand to use when an urgent health or wellness need arises. Once they know for certain that your fee can be worked into their budget, they can keep their goal in sight without having to peer around that elephant.

Appeal to reason and to emotion. We think it prudent to base important decisions on logic and reason, and consequently equate emotion with irrationality. Brain imaging studies, however, have demonstrated that emotion happens to be an essential component of the ability to make decisions, including the buy/don’t-buy/wait-to-buy question these patients face.

We conscientiously provide them with appropriate data on risk and results, and thinking it “unprofessional,” we may even go out of our way to avoid any appeal to emotion. We tend to see fear as a problem caused by lack of information and address the issue by appealing to reason (providing more information). It would, indeed, be unprofessional to skimp on the information patients need to make an informed decision, but keep in mind that neglecting emotional factors may not be in their best interest because stress and fear may interfere with committing to the solution to their problem.

Well-informed consumers may also be caught up in a prolonged quest for more or different information because what they think they want is not in sync with what they feel they need and can afford, and no one has addressed those feelings. A successful real estate professional sells home ownership, not houses. Similarly, the most effective surgical counselors realize the importance of focusing attention on the emotional aspects of affordability and bad vision vs. great vision. They do not sell a procedure or a technology; they offer the patient an affordable opportunity to break free from the lifestyle limitations imposed by their vision problem.

**Reflection and reassurance**

These patients already know that the technology and expertise you offer make it possible to have the better vision they need. Encourage them to reflect upon why and how much they want it. Ease their minds by helping them to plan for the unexpected. Show them how that very same dedicated line of credit that they can have “on call” in their pocket when an urgent need for treatment arises the week before payday can also make their vision correction procedure feasible now. Their decision path may never—and probably shouldn’t—follow the straight line geometric ideal, but the journey to the vision they want doesn’t have to be protracted to be productive. OB

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Resurge app: new tool for cataract surgery patients

by Ellen Stodola Staff Writer

The Resurge app, available for use on smartphones, is a tool for patients undergoing cataract surgery to keep track of their appointments, keep track of their eye drops, monitor cataract development, and keep track of visual function. The app was developed by Lee Mielcarek, MD, FACS, and his daughter, Lacey Morgan Mielcarek, MS, ABOC, who both work at Mielcarek Eye Lifetime Vision Center, Media, Pa.

“It started with trying to get some kind of a modern recordkeeping device to help patients with their postop drops,” Dr. Mielcarek said. Patients used to receive written notices of drop plans and regimens, but as changes to the plan occur or if additional or different drops are needed, it becomes complicated for the patient, he said. With the app, postop drop schedules are set up with reminders for patients; that way the information is all right there in front of them.

Resurge also offers a way to measure preoperative vision so that it can be compared to postoperative vision. This allows patients to actually see how much they have improved.

Nowadays, a lot of people have a smartphone with them most of the time, Ms. Mielcarek said. Patients may get distracted and not remember if they’ve taken their drops, so it makes sense to have an app right on their phone, she said.

This is especially helpful when prescriptions change and one drop...
may be discontinued while another is increased. It’s a good way to transmit information and have a record to rely on. This is also helpful when patients have surgery on the second eye, Ms. Mielcarek said, because changes can be made quickly on the app so patients can keep everything straight.

Dr. Mielcarek said about 5 of his patients are using Resurge currently, and they seem to be enjoying it. “We’ll have to expand it to everyone soon because I think it’s important that everybody can partake in it,” he said.

The app is valuable not only to patients but also to relatives of patients, Ms. Mielcarek said. For those patients who are older and are coming to their appointments with a daughter or son, it might be helpful for the children to be able to monitor the parent’s progress through Resurge.

Resurge is currently available on the iPhone and will soon expand to Android devices as well. In the future, even more features will be added to the app. For example, a feature will be added where the percentage of doses taken is shown so that both the doctor and the patient can see the compliancy rate with the drops.

Ms. Mielcarek joined her father in practice 7 years ago, and her mother, Eileen, also works at the practice as an operating room nurse. “We see what patients in all parts of the practice experience, including during preop, surgery, postop, and in the optical shop. There are tests on the app that show how the cataract affects a person’s vision but the doctor doesn’t necessarily have the time or ability to monitor,” she said.

The app tries to evaluate visual function and not just the Snellen chart, Dr. Mielcarek said. While he can ask patients about their history and use the Snellen chart, it’s nice to have a realistic picture of patients’ daily lives to see how the vision issues translate there. Resurge can help to dissect the quality of the vision and determine how to approach certain issues. It can subjectively measure common vision complaints such as contrast, night driving, and fading color contrast.

In addition, with the app, the patient can take a picture of his or her eye if there are questions about an issue that may be hard to diagnose over the telephone. The patient cannot directly send the photo to the doctor, but he or she can take a photo to show the doctor during the next appointment.

A lot of patients are anxious before going into surgery, Ms. Mielcarek said, so the app has some positive affirmations that patients can repeat to help calm them down before surgery.

The Resurge app can be used across ophthalmology subspecialties, not just for cataract surgery. It can be applied to LASIK surgery, and it can be used to keep track of different glaucoma medication regimens.

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The honey bee colony: A model for practice success

by Hugh Johnston, MBA

What can we learn from biomimicry that can help build successful ophthalmology practices?

Biomimicry is a developing field that looks to nature and natural systems for inspiration. It is helping companies realize new design technologies and achieve competitive advantages. Well before the new interest in biomimicry, the honey bee has provided inspiration for design and process. The economic philosopher Adam Smith drew inspiration from the workings of a honey bee hive when he wrote *The Wealth of Nations*, a seminal tract on capitalism and the cohesive societal benefits of specialization—all from the harmony observed in the honey bee colony.

As ophthalmic professionals, our needs are more practical, but still the lessons from the honey bee colony can be applied to decisions faced by the medical practitioner.

You might be concluding a residency with ambitious thoughts of starting your own practice. Or perhaps you and a few other colleagues want more control over your destiny and are contemplating splitting off from the larger group to form your own. Perhaps you are considering buying into a practice where the senior MD has an active interest in turning the reins over to someone at an earlier stage of his or her career.

Observation of the behavioral processes of the honey bee colony has value in guiding our decisions related to the prospect of beginning a new practice.

The honey bee colony controls its own reproduction through the issuance of swarms. A swarm departs an existing colony to establish itself in a new location where, hopefully, it will survive. The colony's behavior in preparation of the issuance and the behavior of the swarm once issued are instructive.
As ophthalmic professionals, our needs are more practical, but still the lessons from the honey bee colony can be applied to decisions faced by the medical practitioner.

When a swarm occurs, the departing queen, who has been put on a diet in preparation for flight, will be joined by the majority of the most experienced bees in the colony. In preparing to abandon their existing hive and establish a new one, the worker bees gorge on the hive’s honey stores. The consumed honey provides sustenance as the swarm investigates locations for the new hive and is also converted into the production of wax, which is used to build combs that structure their new home once discovered. Out of its previous home, the colony, having found temporary shelter, disperses a minority of “scouts” to locate the optimal place to relocate the colony. By consensus these scouts select a new location and the swarm flies off to make their new home.

What is instructive is the process the colony goes through to ensure its survival: the preparation of the queen, the selection of the most capable for gathering pollen and nectar (stores needed to feed the young and surplus that the colony will depend on to overwinter), the selection of a new location near sources of pollen and nectar, and shelter (the right sizing of the cavity allowing for growth but confined enough to allow efficient protection from predation and elements).

The first requirement for anyone considering starting a new practice is the presence of established patients. Without the revenue stream of established patients, the new practice is at risk, and building a patient following is a long-term process. Nothing is more frustrating to a trained provider who is paid by services rendered than a shortage of patients in the front office.

When buying into a practice, carefully evaluate the viability of an established patient panel. An MD who has reduced his/her practice over the past several years may have fewer active patients than the volume of patient records may suggest.

When leaving a group practice to start out on your own it is advisable to communicate to patients to whom you have provided care rather than risking the defection of patients who are suddenly being examined by someone with whom they have had no relationship. After all, patients choose who they see for their care. The services of a good attorney can help you gain more influence over how your departure is communicated.

The second requirement for anyone starting an independent practice is referral sources. A cultivated network of primary care physicians, pediatricians, and optometrists creates the opportunity for practices to experience organic growth. This is particularly relevant as behaviors of provider organizations, encouraged by ACOs, form soft-wired connections to specialists who share financially and politically in patient outcomes.

The third requirement is the desirability of experienced, flexible staff that can perform a variety of tasks needed to contribute to the productivity of the MD and the sustainability of the practice. While low cost/less experienced staff may, in the short term, appear more attractive given the cost pressures associated with start-ups, in the long run, the productivity of experienced staff will pay greater dividends in efficiency and patient satisfaction.

Finally, the requirement of selecting the right location for your practice—far enough away from the office you are departing, but not so far away as to deter your established patients from following you to the new location or become an impediment for you to maintain the immediacy of your referral network. The workspace needs to be large enough to accommodate growth, but not so large as to be inefficient or unnecessarily costly. Amenities to facilitate the use of public transportation and accessible parking will make a difference to patients and the viability of your practice.

By focusing on these 4 key factors—established patients, referral sources, experienced staff, and office locations—you can avoid many of the pitfalls of those who forge ahead letting circumstance guide decisions rather than pursuing a strategy and taking the time to prepare for the successful establishment of a thriving practice.

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Mr. Johnston is practice administrator at Massachusetts Eye Associates in Chelmsford, Mass. He can be contacted at HughRJohnston@gmail.com.
Employee engagement: The secret to success
by Lauren Lipuma Staff Writer

Business expert discusses the importance of employee engagement in the modern medical practice

A successful practice is built on delivering a great patient experience—and that experience begins and ends with your practice’s employees and the degree to which they are engaged. That was the message that Bruce Maller, president of BSM Consulting, Incline Village, Nev., delivered to attendees at the 2015 ASCRS•ASOA Side X Side meeting in Aventura, Fla.

“We’re in a service business,” Mr. Maller said to attendees at the meeting. “At the core, that is what our primary mission is—to deliver a great patient experience.” The goal of a practice should be to make sure that patients leave the office, they have nothing but positive things to say about their experience, Mr. Maller said. This is especially critical in the modern medical environment because patients now have a huge ability to influence others online.

What does “engagement” really mean? When employees are engaged, they feel connected to the practice’s mission and vision. At its core, however, Mr. Maller believes that engagement equals ownership. “It means that employees are willing to be held personally responsible for their actions,” he said.

Fostering employee engagement provides a better patient experience and directly translates to a practice’s financial success, Mr. Maller said. In addition to reducing staff turnover, employee engagement enhances productivity and efficiency—engaged employees are 2–3 times as productive as those who are not. Disengagement of personnel, on the other hand, leads to a toxic work environment, and that toxicity is easily inflamed by drama, he added.

Creating an environment of employee engagement requires 2 things—behavior and process. The behavioral aspect requires that physicians and administrators embrace their role as leaders, while the process side requires that they make employee engagement a strategic imperative within the practice.

“The best of the best performing practices have as their secret sauce good physician leadership and good administrative leadership,” Mr. Maller said.

Practice leaders need to have a high level of emotional intelligence to be successful—they should be self-aware, empathetic, good listeners, and likeable.

On the process side, practice leaders need to be thoughtful, disciplined, and focused on the goal of making employees feel connected to the practice.

An effective employee engagement program should start at the beginning—with recruiting and training incoming staff members. After the initial training period, it is important to identify staff members who could become future leaders in the practice, Mr. Maller said, and help them develop critical leadership skills.

In addition to developing leaders, it’s important to create a career path for employees, to show that the practice cares about them and is interested in their professional development, Mr. Maller said.

Next, physicians and administrators must effectively communicate employee performance. “Evaluations are not meant to be critical,” Mr. Maller said. “They’re meant to be a conversation. They should be positive, uplifting, honest, and direct, but not harsh.”

The final piece of an employee engagement program is effectively using incentive compensation plans. Incentive plans are incredible management tools that Mr. Maller believes are often underutilized. Incentives enhance job satisfaction, improve customer service and patient satisfaction levels, foster teamwork, and facilitate employee recruitment and retention.

Incentives also give employees a sense of ownership, he added—employees know that when the practice does better, they will do better as well.

Incentive plans can be based on the individual employee’s success or the success of the entire team. Mr. Maller recommends tailoring incentive programs to fit the needs of each individual practice. He also recommends incorporating incentives into the practice’s budget at the beginning of each fiscal year.

Creating a culture of engagement by investing in employees is really an investment into the entire practice. These strategies create a more positive and pleasant work environment, drive increased productivity and efficiency, and improve patient care and word of mouth referrals. In Mr. Maller’s words, at the end of the day, a great culture will always trump a great strategy.

Editors’ note: Mr. Maller has no financial interests related to this article.

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