Back to basics

Measuring key drivers for patient satisfaction P.12
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From the Publisher

Physicians might have the latest, state-of-the-art equipment and the best surgical technique, but if patients walk away dissatisfied, they are selling their practices short. As John Pinto says, “patient satisfaction is the core ‘product’ of your practice.” What are some of the steps you can take to improve patient satisfaction?

In this issue of Ophthalmology Business, Mr. Pinto, president of J. Pinto & Associates Inc., discusses the importance of making customer care a priority. Turn to page 12 to read his tips on telephone surveys. And in “Using patient surveys effectively” (pg. 18) learn how to use survey results and get ideas for creating better surveys.

Are you prepared to deal with a dissatisfied customer in the moment? Michelle Dalton, contributing editor, interviews physicians who offer pearls for bettering customer service through improving day-to-day patient interactions.

This spring Ophthalmology Business introduces its new technology spotlight column. This issue features the Eye Pro 2011 (pg. 8). Check out this handy app for biometry on the go.

Inevitably, practices get to the point where they need to renovate the physical space of the clinic or surgical center. In “Surviving office renovations” (pg. 20), Faith Hayden, staff writer, covers all the bases, from tips on how to select the appropriate architect for the job to minimizing practice disruption.

Thanks for reading.
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Help patients navigate eye health information online

by Vanessa Caceres Contributing Editor

The internet offers a mixed blessing to eye doctors. On one hand, it gives clinicians a place to send patients for more information about eye diseases. On the other hand, there are numerous places where patients might obtain inaccurate information.

On the plus side, physicians can tell patients during appointments that they can search online from the comfort of their home for more information about their disease. “For example, I’ll get patients with rosacea with thousands of questions. I’ll suggest that they read up online and then we’ll talk more during their next visit. It helps when they come in with a basic understanding,” said Robert Latkany, M.D., founder and director, Dry Eye Clinic, New York Eye and Ear Infirmary, New York.

Encouraging patients to read more information about eye health or eye diseases online puts patients in a proactive role, which is beneficial, believes Kelly W. Muir, M.D., Duke Eye Center, Duke University, Durham, N.C. “Seeking out information is the sign of an engaged patient,” she said.

For certain conditions such as dry eye, patients may be stuck in an information lurch without the internet, Dr. Latkany said. Not all eye doctors give dry eye much chair time, so the internet provides an avenue to obtain some basic facts. The internet also enables patients to change font size, look at imagery, translate information that is in English to other languages, or listen to audio instead of reading a large amount of text, said Dr. Muir. These functions can help patients with low vision, low health literacy, or who speak English as a second language.

“With a multimedia base, we can make materials available to more people,” Dr. Muir said.

Although not all information on the internet is reliable, some aspects of eyecare, such as cataracts and cataract surgery, are usually presented online in a straightforward manner, said John D. Sheppard, M.D., professor of ophthalmology, microbiology, and immunology, Eastern Virginia Medical School, Norfolk. “In that realm, the internet can be a helpful resource,” he said. If a patient is older and not internet savvy, Dr. Sheppard often observes that a younger family member will help him or her access information.

Another advantage of the internet is that it often leads patients to your practice in the first place via searches for local specialists, Dr. Latkany said.

And the downsides ...

Of course, the internet as a resource for eye health information has downsides. First, if you think that patients find it overwhelming to navigate the healthcare system, see how they react to navigating the pages and pages of sites that appear when they search for information on glaucoma, macular degeneration, or dry eye. For example, if you type in “what is glaucoma” on Google, the site provides more than 3 million results.

“I think the problem is navigating that material without overwhelming patients. There’s so much out there,” said Dr. Muir, who regularly publishes studies on glaucoma medication compliance and its connection to patient literacy level.

When patients do obtain information from certain sources, there’s no guarantee that the site is reliable or unbiased. Dr. Latkany once partic-
ipated in a dry eye forum online where someone wrote that a certain eye drop remarkably changed his dry eye after trying many other drops. Dr. Latkany later found out the person who posted the message was a pharmaceutical representative.

Dr. Sheppard also finds bad health advice online. For instance, dry eye patients will find recommendations online about using vasoconstrictor eye drops to treat their condition. Some who have dry eye never see a doctor for treatment, so they continue to use inappropriate treatment, Dr. Sheppard added. “They will self-diagnose,” he said.

For topics such as LASIK surgery, patients may get led to negative information posted by a vocal minority, Dr. Sheppard said.

The internet also turns some people into mini-physicians, Dr. Latkany said. “Patients will say, ‘You are telling me to use a certain treatment, but I read in this study with 10 patients [a different recommendation]. They will quote a research article from a random place that is not nationally recognized or where much of the information is not published in a peer-review journal. I have to tell them to be careful what they read and to consider who wrote it and what are the writer’s connections to the marketplace,” he said.

**Finding better resources**

So how can physicians help lead patients to reliable information on the internet?

For cataract or refractive surgery, members of ASCRS created the Eye Surgery Education Council to provide patient information online. Dr. Muir, who treats glaucoma, sometimes refers patients to the American Academy of Ophthalmology or American Glaucoma Society websites (see sidebar for a list of website resources). “I’m comfortable with the information that they provide,” she said.

The National Eye Institute also has easy-to-read information online, Dr. Muir said. “The government information is often written at a lower literacy level,” so it is more accessible to a wider group of patients, she said.

In fall 2011, Bausch + Lomb (Rochester, N.Y.) partnered with the well-known websites WebMD and Medscape to create a variety of online resources related to eye health. Included in these resources are slide-shows, videos, and articles, said Calvin W. Roberts, M.D., chief medical officer, Bausch + Lomb. The WebMD information is geared toward the general public, and the eye health information on Medscape targets doctors.

Although doctors can choose how they will use the WebMD resources with patients, one idea is suggesting patients peruse the information after their appointment, Dr. Roberts said.

“Patients can go to the site and learn more about their condition,” Dr. Roberts said. “If patients have that basic information, I have found it can elevate my discussion with them.”

Both the consumer-geared and patient-geared sites will have further expansion this spring, Dr. Roberts said.

Dr. Latkany generally does not recommend websites to patients, but he said that a wealth of information on dry eye is available on the Dry Eye Zone website.

Dr. Sheppard has successfully used information from Eyemaginations (Baltimore), which provides video tutorials about a number of eye diseases and conditions. The video tutorials are available in English and Spanish.

Finally, Dr. Sheppard said to remain cognizant of when patients want to obtain more information on eye health—and when they don’t. “In the waiting room, we were broadcasting educational material for awhile, but we found out all patients wanted to see was the Food Channel,” he said.

**Editors’ note:** Dr. Latkany has financial interests with Alcon (Fort Worth, Texas). Dr. Roberts is chief medical officer for Bausch + Lomb. Dr. Sheppard has financial interests with Alcon, Allergan (Irvine, Calif.), Bausch + Lomb, and Vistakon (Jacksonville, Fla.).

**Contact information**

**Latkany:** 212-689-2020, relief@dryeyedoctor.com

**Muir:** kelly.muir@duke.edu

**Roberts (via Elizabeth Murphy):** elizabeth.murphy@bausch.com

**Sheppard:** 757-622-2200, docshep@hotmail.com
The Eye Pro 2011: Biometry on the go

by Faith A. Hayden Staff Writer

Edmondo Borasio, M.D., cornea, cataract, and refractive surgery specialist, Moorfields Eye Hospital Dubai, United Arab Emirates, knows ophthalmology is a mobile profession. To address physicians’ ever-growing ambulatory needs, Dr. Borasio has developed a suite of ophthalmic calculators for the anterior segment surgeon called the Eye Pro.

“My job is mainly cataract, refractive, and cornea, so I chose to include things that were useful for my practice,” said Dr. Borasio. “I’d say the app is mostly useful for a cataract and refractive surgeon or a cornea surgeon.”

Dr. Borasio doesn’t recommend the app for glaucoma surgeons or pediatric ophthalmologists, for example. There are, however, certain features that can be useful for all specialties, such as the visual acuity (VA) converter, which converts VA between LogMAR, Snellen, and decimal notation.

Other features of the Eye Pro include a corneal/spectacle plane converter, which converts refractions between the corneal and spectacle...
plane; the AstigMaster, which calculates the surgically induced astigmatism vector for single patients, either using K values or refractions; biometry post-laser refractive surgery, including BESSt 2 Myopia, BESSt 2 Hyperopia, BESSt 1 formula; an astigmatism-correction reduction calculator, which predicts the final astigmatism following incision or toric IOL misalignment; custom keratometric index-based calculations; and thick and thin lens equations.

“Another use is in theatre,” Dr. Borasio said. “Should you have a complication or want to check last minute the power of the lens that you’re about to implant, you can do it in theatre and wrap the iPhone in a sterilized bag.”

The Eye Pro also includes a graph called the Astig Plot, which allows users to create astigmatism plots for congress presentations or scientific paper submissions. Plots aggregate astigmatism data on an autoscaling doubled-angle polar plot, illustrating each individual astigmatism and the mean. Users can send the plot via email, and files can be read from URL or through iTunes.

Dr. Borasio is currently working on a 2012 update for the Eye Pro. This update will include a toric calculator, which will allow users to calculate the power of a toric IOL directly. Eye Pro has about 1,000 users so far, and Dr. Borasio said feedback has been positive. The app costs $26.99 and is available for purchase on iTunes. Eye Pro is compatible with the iPhone, iPod Touch, and iPad.

For more information on the app, visit http://edmondoborasio.com/Dr_Edomondo_Borasio/Eye_Pro_2011.html. OB

Editors’ note: Dr. Borasio is the inventor of Eye Pro app.

Send us your favorite APP!

Have a favorite app that helps you with business or personal activities? Email smajewicz@eyeworld.org with the app name and how it helped you.

Apps selected will be published in Ophthalmology Business and their submitters will receive a $50 iTunes card. You may be selected for a brief interview.

What app do you find most useful?

“I really like the HopStop app for traveling. It automatically gives you mass transit (subway or bus) or walking directions for all major U.S. and some European cities. It can be really helpful for traveling or meetings.

Just punch in your location (or let it use the location service on your phone) and then where you want to go. It will tell you where the nearest subway stop is and what subways or busses to take to get to your destination.”

Richard Tipperman, M.D., attending surgeon, Wills Eye Institute, Philadelphia
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Back to basics
by John B. Pinto

“He profits most who serves best.”
Arthur F. Sheldon

“Always do more than is required of you.”
General George S. Patton

“Alone we can do so little. Together we can do so much.”
Helen Keller
Measuring key drivers for patient satisfaction

What do you and your practice sell, really? Aside from objective clinical and surgical outcomes—greater comfort, blindness averted, optimal sight—patient satisfaction is the core “product” of your practice.

A high level of patient satisfaction pays numerous dividends:
- Complaints are lower, reducing staff stress and freeing up their time for other duties.
- Established patients stay with the practice, reducing the high cost of recruiting new patients.
- It costs about $500 to recruit a new patient with direct-to-consumer advertising; satisfied patients tell their friends about your practice for free.
- Happy patients create a positive feedback loop, spurring the referral behavior of optometrists and physicians.
- Satisfied patients invest more trust in your care, giving their consent for needed services more readily, reducing patient education time, and making it easier to broaden your scope of care.
- Satisfied clinical patients stay in the practice and purchase optical goods and elective services; they don’t have any excuse to shop around for alternatives.
- When your patients are truly satisfied with your care as a physician, including the mechanics of their transit through your office, your professional life is more personally rewarding.

What elevates patient satisfaction?

The list is enormous and limited only by your resources, empathy, and imagination. One client has a glass-fronted refrigerator with free drinks. In another office they have a rule: “Never say ‘No’ to patients, no matter what they ask.” A third ophthalmologist calls every new patient the next day to see if there were any overlooked questions from the first visit.

Most practices are aware that excess waiting time is the number one complaint of patients about their doctor visits. In ophthalmology, the primary waiting time (the time from on-time arrival to rooming of the patient) should not exceed 20 minutes. The total transit time for a routine visit should not exceed 70 minutes. If your patient flow timelines materially exceed these upper limits, conduct a time study and engage your entire practice team to compress the visit to patient-expect ed bounds.

How do we know if we’re getting things right, if everything we’re doing is enough?

The world’s largest businesses take customer care seriously, hiring academic research specialists to dissect the nuances of their service-value proposition. Every customer service action and public word uttered by the Fortune 500 is parsed for its contribution to a happy client. Staff are scripted to say and do the right thing at every interaction.

Of course, no private medical practice has the resources to evaluate customer satisfaction to this depth or level of statistical formality. You must take a guerilla approach to marketing research, just as you have learned to be a guerilla fighter when

continued on page 14
it comes to your overall marketing tactics.

Most practices stop short at brief written surveys and call the job done. They hand out survey cards at checkout or mail follow-up questionnaires to a cross-section of patients.

Written surveys like this have a limited place in customer satisfaction studies. They can objectify just how many patients feel about one issue or another—for example, to identify what portion of your patients feel that waiting time is appropriate versus excessive. But written surveys are notoriously less useful at identifying actionable problem areas in the first place. What are the service gaps? As the typical small practice owner or manager, this is the most important information to gather.

Written surveys suffer a variety of shortcomings, the largest of which is an adverse selection of respondents: Only your raving fans and your biggest detractors will tend to respond. In addition, written surveys don’t allow patients to elaborate much on their feelings and can’t draw out very creative suggestions for your operational problems.

For a deeper understanding of your practice’s ability to satisfy patients, phone surveys are vastly superior. A so-called “laddering” survey (think: “I’m climbing down a ladder into this patient-customer’s mind”) will allow you to explore in depth how you’re doing. Here’s the simple protocol.

Before starting, make sure that you have provider understanding and approval of the process. The results of this survey protocol will almost always include negative comments from some patients about their doctor. If you spring any negative survey results on unsuspecting doctors, without providing them in advance with the courtesy of reviewing the protocol, it’s understandable that they will reject the findings. Depending on how serious you are about the study, select between 5 and 20 patients at random per provider per month seen in the past month. Select a surveyor to place the calls—this can be the practice administrator, the marketing director, or an outside party; it shouldn’t be someone who is likely to be overly attached to the outcome of the study or have his/her feelings hurt, for example, a physician’s spouse, a receptionist, or a technician. Call each selected patient and use the following introduction:

“Hello, this is Mary from Dr. Susan Smith’s office, your eye doctor. Each month we select a few patients at random who we’ve recently served to find out what kind of a job we’re doing here at Smith Eye. I’ll only need a few minutes of your time, if you can help us out.”

With the patients’ approval, you can then pursue a line of questioning that takes them through their global experience with the clinic:

- How easy was it making an appointment?
- Did we provide you with a reminder call?
- Was it easy finding the office and getting a place to park?
- Describe your experience checking in with the front desk.
- Were you seen on time, or did you feel like your wait was excessive?
- Tell me what kind of a job the technician, the staff member who first worked you up, did.
- How did your time with the doctor go? Did she answer all your questions? Address your chief concerns?
- At check-out time, were you clear about when you should next come back for an appointment? Did the fees seem fair and reasonable?
- Is there anything else we could have done more of, less of, or differently to make your total experience better?

With a cooperative interview subject and an adroit interviewer, these sessions can last 15-20 minutes or longer. Write down each patient’s responses and collate the results monthly.

Implement any obvious improvements. Discuss material failings, privately in many cases, with the relevant parties (e.g., take a technician aside and tell him how patients are mentioning how he’s too abrupt sometimes). Repeat the survey monthly or quarterly for each provider.

The frequency and depth of such interviews should be proportional to the quality of patient care and caring you’re providing. If your practice has a lot of problems, increase the survey frequency; if you have few problems, you might only need to repeat this survey protocol a couple of times a year.

Do you think this is going overboard—that your staff would never have time to call a few patients a month? Consider this. We’ve had a Toyota 4-Runner in the driveway for the past 5 years. If you can overlook a couple of recent recalls, Toyota is famous for the satisfaction level of its customers.

When I take our SUV into the local dealership for routine service it sets me back about $75. Invariably I’m called within 24 hours by a customer service rep who asks, “How did we do?” If a zillion-dollar company can call every customer it serves about an oil change, can’t you do the same for at least a cross-section of your clinical and surgical patients? OB

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John Pinto is president of J. Pinto & Associates Inc., an ophthalmic practice management consulting firm established in 1979, in San Diego, Calif. He can be contacted at 619-223-2233 or pintoinc@aol.com.
Join us Sunday immediately following the ASCRS program. This is a session you won’t want to miss!

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

by Michelle Dalton Contributing Editor

Why improving customer service should remain a constant goal

Good communication makes for good relationships, and that may be no truer than in the doctor-patient pairing.

“Customer service is a top priority for us and a challenge for any large institution,” said Sonia H. Yoo, M.D., professor of ophthalmology, Bascom Palmer Eye Institute, Miami.

“We’ve made a concerted effort to identify those weaknesses and develop concrete ways to improve our interactions with patients, not just at Bascom Palmer but throughout the entire medical school.”

Ultimately, however, the responsibility for customer service lies with the physician, said Uday Devgan, M.D., in private practice in Los Angeles, and chief of ophthalmology, Olive View-UCLA Medical Center, and Eric D. Donnenfeld, M.D., a partner in Ophthalmic Consultants of Long Island (OCLI), Rockville Centre, N.Y., and clinical professor of ophthalmology, NYU Medical School, New York.

“Everyone in the office is an extension of you and represents you in every interaction with the patient,” Dr. Devgan said. “The office staff reflects you 100% ... Little things like addressing patients with ‘Yes, Ma’am’ or ‘Yes, Sir’ go a long way. Ultimately, anything that’s displeasing is the surgeon’s fault.”

“Customer service has to begin and end with the physician,” Dr. Donnenfeld added. “We are the heart of customer service. If patients come in and they are unhappy with their vision, but the technicians or optometrist or even another ophthalmologist tells them they should be happy with their outcomes, that’s a red flag.”

The key to dissipating a potentially volatile situation is not to go on the defensive, said Elizabeth A. Davis, M.D., a partner at Minnesota Eye Consultants, Bloomington, and adjunct assistant professor of ophthalmology, University of Minnesota, Twin Cities.

“You need to acknowledge the complaint, be receptive, be empathetic, and let patients know you understand the frustration,” she said. “Apologize for them being upset, without letting fault be assigned.”

The weakest link

Within the office setting, every interaction is an opportunity to make an impression on the patient. At OCLI, the front office staff is given “extensive training,” Dr. Donnenfeld said. “We make sure each patient is greeted with a smile. Certain words will trigger the staff to make a patient a priority. You’re only as good as your...
weakest link, and every aspect of the interaction in our offices has to be superlative.”

Dr. Devgan tells patients who will need more chair time to book their appointments right before lunch or late in the day.

“I don’t mind going into my lunch or evening hours if it means the patient leaves feeling more confident about the diagnosis or treatment regimen,” he said. “I give patients my real cell number and personal email and tell them not to hesitate if they have any questions. Usually, patients are very respectful and rarely contact me on my cell, but many choose to send me a follow-up email with additional questions, which I am happy to answer.”

Whatever the perceived issue is, addressing the issue quickly and (when possible) resolving it to the patient’s liking is crucial.

“When you do resolve whatever the problem may be for the customer-patient, he or she is even more indebted to you because it reiterates that you care,” Dr. Davis said.

Physicians are trained in their craft and in patient care, but not in customer service, Dr. Yoo said.

“It’s foreign to most doctors. Some are really good and pick it up as soon as they start interacting with patients, but others don’t get it as easily.” A job in retail during high school taught Dr. Yoo valuable customer service lessons.

There are some very straightforward things we can do that make impressions on our customers,” she said. “It could be something as simple as helping patients find the right department or physician when they walk into your office by mistake.”

**Successful customer service**

Without taking blame, “make sure you fix the problem as best you can,” Dr. Davis said. “It starts with having a friendly, receptive staff who can help address any issue before it mushroomed.”

Dr. Donnenfeld agreed—if or when “something is perceived by the patient as important, you need to acknowledge the complaint and resolve it. You have to communicate to patients exactly how you’re going to resolve their issue. The worst thing we can do is let our patients feel as though they’ve been abandoned.”

For Dr. Davis, one of the easiest things the staff can do is to alert patients about wait times. “If a surgeon is running more than 5-10 minutes behind, let patients know and offer to reschedule if necessary. Most of the time, patients just want to know if there is a delay and how long it’s anticipated to be.”

The University of Miami takes customer service seriously enough that it hired Press Ganey (South Bend, Ind.) to develop a patient questionnaire to provide feedback.

“We ask them everything from how satisfied they were with registration to whether or not they liked the coffee in the waiting room or the temperature in the office,” Dr. Yoo said. “You can’t improve your interactions unless you know where you’re perceived to be.”

Each physician is given reports identifying areas of needed improvement—and concrete goals for the next month, she said.

“For instance, if one physician is typically 40-45 minutes behind schedule, the goal for the following month would be to cut that to 30 minutes, and then continually improve upon that,” she said.

Dr. Devgan said his customer service philosophy sounds simple—deliver the same service he wants to receive in his own life—but it works.

“All patients are greeted by name when they come in and asked how they’re doing,” he said. “I have a 10-minute rule. I don’t ever want patients waiting for more than 10 minutes before a tech sees them. If the techs are running behind, I’ll grab the patient chart myself and bring patients back.”

Improving customer service improves patient satisfaction, Dr. Yoo said. “Part of that is also addressing pain when the patient has surgery and in the immediate post-op. We follow-up with a phone call that night to ensure the patient is comfortable.” If patients are experiencing any kind of discomfort post-op, the issue needs to be addressed immediately, she said.

“It’s not just about the medical care and surgical outcome; patients will not have a good experience if they are not comfortable afterward,” she said.

If surgeons and staff deliver the kind of care they expect to receive in their own lives, patients will have a better experience and word of mouth referrals will remain high, Dr. Devgan said. **OB**

**Contact information**

Davis: 952-567-6068, eadavis@mneye.com
Devgan: 800-337-1969, devgan@gmail.com
Donnenfeld: 516-766-2519, eddoph@aol.com
Yoo: 305-326-6322, syoo@med.miami.edu
Using patient surveys effectively

by Vanessa Caceres Contributing Editor

What you don’t know can hurt your practice

Just what do your patient want from your practice? “The ophthalmology business is a lot like a fine restaurant. There are a lot of moving parts, and people expect an excellent experience every time,” said practice consultant John Pinto, San Diego. The quest to consistently deliver top-notch patient care is a challenge that can be made easier with the use of patient satisfaction surveys. However, surveys don’t mean much if practice leaders don’t make changes based on patient comments.

To that end, Cynthia Matossian, M.D., Matossian Eye Associates, with three locations, 10 providers, and 49 employees in Pennsylvania and New Jersey, believes her practice has made great strides in improving patient satisfaction with the help of satisfaction surveys. With a response rate of 34%, Dr. Matossian said 99.8% of the comments they receive on the survey are positive—and it’s a percentage that has grown as she and staff members continue to implement changes based on survey comments.

Previously, the practice surveyed patients once a year on rotating quarters, so they could get a different cross section of patient responses. However, those surveys were done by an outside company, and results weren’t tabulated until 2 or 3 months after the survey was filled out. “If the patient had said some-
thing negative, it became a moot point. We could not address the issue in real time,” Dr. Matossian said. For that reason, she, Clayton Grinage, C.O.E., practice administrator, and Cheryl Price, front desk supervisor, decided a little over a year ago to try an online survey. Staff members collect email addresses from patients who have had appointments on a given day. Ms. Price emails the survey to those patients at the end of each day.

The survey has 10 questions, nine of which patients choose an answer for and a tenth one that is open-ended for comments. It is conducted via the online tool Survey Monkey. Ms. Price sends the survey with an introduction to let patients know what the survey is about and why it would be helpful to provide feedback. The survey also includes a picture of the doctor who saw the patient, Dr. Matossian said.

**Using the results**

Mr. Grinage tabulates responses and shares the results with the practice as part of a regular agenda item during monthly staff meetings.

The survey has led to a number of changes in the way the practice does business. For example, Dr. Matossian now has staff from different areas—front desk, billing, and ophthalmic technicians—wear different colored scrubs, based on a patient comment. Someone who responded to the survey suggested that would be a way to help see who works in which area, she said.

Another change made is letting patients know how long they should expect to be at the practice for their appointment, Mr. Grinage said. Previously, if a new patient scheduled his first appointment during the lunch hour, he might be frustrated to find the appointment taking 2 hours. For this reason, front desk staff are now knowledgeable of how long certain appointment types will take and let patients know those average times when they set appointments, Dr. Matossian said.

Other times, the changes that patients suggest are more subtle. For example, comments such as “It would have been nice to have known …” have led to changes in the way that staff members explain certain practice policies, Ms. Price said.

“The survey lets us implement changes on a real-time basis,” Mr. Grinage said.

**Pearls for your patient surveys**

Here are a few suggestions to effectively use patient survey results:

1. Send out the survey on the same day as the appointment. This keeps the patient experience fresh and avoids having patients add a layer to their comments as time passes, Dr. Matossian said.

2. Include a photo of the doctor that the patient saw, Dr. Matossian recommended. This will help patients remember their experience and lets them tailor their comments to specific doctors if they saw more than one provider on the same day.

3. Use easy questions and easy choices, Dr. Matossian said. Don’t bog down your survey with 20 questions. Stick to a few and use mostly set answer choices (but one open-ended question can help patients give specific comments, she added).

4. Consider an oral survey. Mr. Pinto is actually in favor of oral surveys for subjective but useful feedback. (For telephone survey pearls, read Mr. Pinto’s story on pg. 13.) He has advised clients to have someone at the practice not directly involved in patient care call five patients a month per doctor to ask them straightforward questions about their experience during their appointment. Although you can use such surveys to focus on certain issues—say, patient education for those newly diagnosed with glaucoma or post-op care—it’s usually best to get a 360-degree view, he said. Oral interviews can also help pick up on subtle issues, such as a doctor who may be giving more attention to family members than the patient himself during a visit, Mr. Pinto said.

Mr. Pinto believes written surveys tend to capture opinions only from those who are particularly satisfied or unsatisfied with service. However, he said if a practice finds that written surveys provide them with the feedback they need—and, importantly, that they make changes based on the results—then they can still be helpful.

5. Make multiple uses of your data. The positive feedback Dr. Matossian’s practice obtains is also used for anonymous testimonials on their social media sites. Additionally, the feedback gives specific comments to share with staff members to positively reinforce what they are doing right, Mr. Grinage said. Plus, practice staff members have used the email addresses they have collected for marketing purposes and to send out announcements, such as inclement weather notices, Dr. Matossian said.

**Contact information**

Grinage: 215-230-9200, cgrinage@matossianeye.com

Matossian: 215-230-9200, cmatossian@matossianeye.com

Pinto: 619-223-2233, pintoinc@aol.com

Price: 215-230-9200, cprice@matossianeye.com
Anyone who's undergone an office renovation will tell you it can be a many months-long nightmare governed by Murphy's Law. But it doesn’t have to be. With the right architect at the helm, an office construction project can rejuvenate an office space with added efficiency, enhanced workflow, and improved patient experiences.

Picking an architect
But how do you pick the ideal firm to develop your practice renovation? For administrators Carol Wittmer and Orval Gilmore, choosing an architect comes down to two factors: experience and communication.

Ms. Wittmer has weathered five office construction projects in her 15 years as an administrator at Eye Center of Northern Colorado, Fort Collins, Colo., the last between 2007 and 2008 when the practice had more volume than its single operating room could handle.

Expanding out to a second surgery center “adds a whole different level of state regulations, so you’ve got to have someone who is very experienced and knowledgeable in the field,” she said.

“If you have someone who knows your specialty then [he/she] knows patient flow,” said Mr. Gilmore, Eye Care Physicians & Surgeons, Salem, Ore., whose latest construction project included an interior remodel in 2009. “[The architect] builds designs around what’s going to be best for your patient flow and how an exam room should be laid out for an ophthalmologist. It’s different from a primary care doctor because we use different equipment.”

Although you want your architect to have insider knowledge, he/she also needs to listen and learn the specific office needs.

“Practices are not cookie cutter,” Ms. Wittmer explained. “You can’t have someone who is taking a cookie-cutter approach and not listening to your providers and how they function.”

Weighing the options
Both Ms. Wittmer and Mr. Gilmore's practices went with veteran healthcare architect John A. Marasco, owner of Marasco & Associates, Denver. One of Mr. Marasco’s main philosophies is properly managing clients’ expectations and educating them on all possible construction options.

“We try to make [clients] understand the timing needed, what kinds of disruptions and difficulties to expect, and all the different prob-
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lems that can creep in,” Mr. Marasco said. “It’s important to lay out all the different [construction] options for clients to consider the costs and the benefits, as well as the interruption perspective. But in the end it’s the client’s decision, not ours.”

That choice can cause hand wringing among physicians and administrators because a practice runs the risk of expanding out too much for its volume. In Ms. Wittmer’s case, her practice hired a consultant to assess volume in addition to running its own numbers. But even with various experts weighing in, a practice can still end up under- or overestimating space needs.

“I think we erred on the side of not expanding our facilities enough,” she said. “We tried to run too much capacity through one space. We are limited in parking. There’s only so much capacity your front desk and waiting room can handle. And the compromise is the patient experience. That’s something all of us in medicine are trying to balance.”

Get your staff involved

Many people, including staff, are resistant to change. Involving employees in the process may help ease any negativity.

“We really tried to involve our office in this because you’re making big changes,” said Mr. Gilmore. “In our last remodel, we changed every single wall in our clinic.

You’ve got to bring [staff] along with the process so there are no surprises.”

Collecting staff opinions will make employees feel valued and important. They also might develop a quality idea that your architect hasn’t thought of.

“We always explore staff recommendations,” said Mr. Marasco. “It makes the whole process smoother because marrying the staff to the project is really important for them to physically execute the concepts involved. And if they’re not involved in that designing process, then they don’t really understand how they’re going to use the new space, how it differs from their old space, and how it’s going to improve their life.

“I tell my clients we learn as much as we teach every time we do a project because people bring new ideas and concepts to fruition,” Mr. Marasco continued. “And if [those ideas] look like they’ll work, we do them.”

Just because staff have suggestions, though, doesn’t mean those thoughts are relevant or productive. It’s critical to remember who the expert in the room is during dis-
agreements, and place the architect’s professional opinion a bit higher than staff without disrespectfully shutting employees down.

“There are some [staff] suggestions that are just not going to fly,” Mr. Marasco said. “Sometimes simply by discussing why that is and where the problems are and allowing our professional experience to come out is enough.”

Occasionally a practice will have a staff member extremely adamant about an idea and unwilling to take the designer’s word for it. In those cases, Mr. Marasco has that staff member speak with another facility who has been through the same process.

“If it’s an office manager, we have [him/her] talk to another office manager,” he said. “They’ll discuss why [the idea] didn’t work in that particular facility. Generally, that does the trick.”

Minimizing practice disruption

In a perfect world, all ophthalmology offices could afford to shut down during a remodel or limit construction to nonbusiness hours. But since these options are prohibitively expensive, the majority of practices have to work around renovations and patient appointments.

“There were times we were working off concrete floors and had plastic screens shutting areas off,” said Mr. Gilmore. “You have to step up your customer service.”

In Ms. Wittmer’s case, the waiting room and front desk were temporarily moved during the renovation.

“At the time, we were seeing about 300 patients a day,” she said. “It was very hectic for our patients and our front desk staff. We hired two high school kids as greeters, and they helped our patients find the right place to go.”

Practices should consider providing drinks and cookies to keep a good rapport. Ms. Wittmer’s office hosted a coloring contest for the pediatric patients.

“Most of them drew pictures of construction workers,” she said. “We had a lot of fun with that. I think it made for a better experience for our patients because they put up with a lot.”

Don’t forget that staff endures stress and annoyances during remodeling as well. Mr. Gilmore suggested treating them to pizza or coffee and donuts to say thank you.

“You’ve got to keep your employees happy,” Mr. Gilmore said. “A lot of it is attitude and bringing your staff along and understanding people don’t like change. You have to tell them, ‘It will be OK. We’ll get through this, and it will be great when we finish.’”

Editors’ note: Mr. Gilmore and Ms. Wittmer have no financial interests related to their comments. Mr. Marasco is the owner of Marasco & Associates.

Contact information
Gilmore: ogilmore@salemeyedoctor.com
Marasco: John@mahca.com
Wittmer: cwittmer@eyecentemoco.com

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by Michelle Dalton Contributing Editor

Three physicians take separate paths to start companies that may change the face of ophthalmology

A n AREDS supplement in beverage form. A topical neovascular age-related macular degeneration (AMD) eye drop. Compounds to treat dry AMD. The fact that physicians would be involved in developing these products is not surprising. The fact that they would be the founders of the companies developing the products might be.

Ophthalmology Business spoke to three innovators who believe their efforts may change ophthalmology for the better.

Imagen
Imagen Biotech (New York) is a “venture-backed biopharmaceutical company focused on identifying and developing therapeutics for blinding diseases with high unmet medical needs, including dry AMD.” Co-founded by Matthew Feinsod, M.D., and David Guyer, M.D., both of whom were instrumental in the development of pegaptanib, Imagen has been funded to develop approximately three compounds through phase II and uses in-licensing as its way to achieve those goals, particularly for dry AMD. Dr. Guyer said ophthalmology in particular lends itself to in-licensing because of its highly-specialized nature.

“Dry AMD is a multi-billion dollar untapped market,” Dr. Guyer said. “Imagen in-licenses compounds; it’s too expensive to build our own research lab.” Once the company decided what targets it wanted to focus on, “we hunted around the world to find what we thought would be the right compound.”

Dr. Guyer attributes the success of the companies with which he’s been involved to “quality management.”

“Imagen is comprised of serial entrepreneurs,” he said. “I know if—or when—the company runs into a stumbling block, it’s something we’ve all seen before.”

The “classic” venture capital approach, he said, is to receive business plans and fund already established entities; the VC firm Dr. Guyer is affiliated with “likes to start new companies with serial entrepreneurs who we know well.” Imagen has secured up to $40 million in Series A financing from several ven-

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tured capital firms, including SV Life Sciences (Boston); Dr. Guyer is a partner.

“Dry AMD represents the largest untapped ophthalmic market,” Dr. Guyer said. A viable dry AMD treatment may rival statins in terms of revenue, Dr. Guyer has said.

**OJO (Insightful Solutions)**

Insightful Solutions’ (New York) founder and chief executive officer Jodi Luchs, M.D., said the idea to combine the AREDS vitamins into a beverage came to him one morning as he was preparing for cataract surgery. The Age-Related Eye Disease Study (AREDS) found that taking high levels of specific antioxidants and zinc can reduce the risk of severe visual loss in patients with advanced AMD by about 25%. The AREDS vitamins include vitamins C and E, beta-carotene, and zinc; the AREDS 2 studies, currently underway, are evaluating lutein and zeaxanthin with and without the addition of omega-3s.

“The baby boomer generation is always looking for ways to proactively protect their health and vitality and have been a major influence in the success of functional beverages,” Dr. Luchs said. Since many patients have difficulty swallowing pills, the idea was to “combine the formula in a great-tasting drink.” For more than 2 years, Dr. Luchs worked with a flavor house to ensure a palatable taste that would incorporate the vitamin formulations, without tasting like a vitamin. OJO fortified eyecare nectar was launched in December 2011 with three flavors: mango blackcurrant, orange cranberry, and peach blueberry. “The AREDS vitamins require multiple dosing, and in addition to their large size, are associated with frequent stomach upset. These factors often limit the ability of patients who would otherwise benefit from these vitamins from taking them,” Dr. Luchs said. OJO is an all-natural, 50% juice beverage promoted as a “natural beverage alternative to the AREDS vitamins,” Dr. Luchs said.

Dr. Luchs’ co-founder, Aliza Lewis, is a beverage industry consultant, but also a childhood friend. At a recent beverage industry trade show, OJO was named the “hottest new beverage,” and Dr. Luchs said distribution to a national natural foods grocer and a chain pharmacy will be underway in early 2012. He is also considering distribution through vitamin and supplement outlets.

“Our marketing team likes to call OJO the ‘visionary drink,’” Dr. Luchs said. “Right now there is no other beverage out there targeting the baby boomers that also offers an eye health benefit.”

Dr. Luchs said he’s poured his “heart and soul” into ensuring OJO’s success.

**PanOptica**

Led by two veterans in ophthalmology, PanOptica (Bernardsville, N.J.) also uses in-licensing to develop compounds. Its lead compound, PAN-90806, “is a potent and selective inhibitor of vascular endothelial growth factor (VEGF)” that previously completed preclinical proof-of-concept studies and preclinical murine studies. In its former life, the compound was deemed to be unacceptable to pursue as an oncology drug. If ongoing studies prove successful, PAN-90806 will be the first topical anti-VEGF to treat neovascular AMD.

Martin Wax, M.D., co-founder of PanOptica, said, “there is a great opportunity to leverage compounds from other specialties and develop them in ophthalmology.”

From the beginning of PanOptica, Dr. Wax believed some molecules would be more successful as ophthalmic targets and actively went about in-licensing for 4-6 months.

“The venture capital world was unfamiliar with our model,” he said. “Our deals are structured so we can ‘kick the tires’ for a few months and see if the compound works in ophthalmology—does the compound have the ability to be formulated as an eyedrop? Does it show mode of action against a particular disease? If our internal research is positive, we pull the trigger on the licensing agreement that’s been pre-negotiated.”

PanOptica has raised $30 million in Series A financing, also led by SV Life Sciences and others; SV Life Sciences provided early seed money.

“SV Life Sciences believed in our ability to find the right drug candidates,” Dr. Wax said. “[David Guyer] based his decision to invest on the strength of our management team.”

Dr. Wax said there are three main routes when considering in-licensing as the business model: a company approaches the startup, the startup has a therapeutic target in mind and determines where to acquire it, or the startup can “look at properties of the chemical compound to determine if the same properties would successfully treat [the intended disease].”

In PanOptica’s case, “topically applied PAN-90806 decreased lesion size compared with a control group that received no treatment. Similarly, in mice with oxygen-induced ischemic retinopathy, PAN-90806 demonstrated significant reduction of the mean area of pre-retinal neovascularization compared with controls, an experimental model relevant to diabetic retinopathy,” the company said. OB

Editors’ note: All the physicians have a proprietary stake in the companies they founded.

**Contact information**

**Guyer:** 212-359-9491, david.guyer@svlsa.com

**Luchs:** 516-623-0110, drojo@ojonectar.com

**Wax:** 908-766-2202 or 973-663-6470, mwax@panopticapharma.com
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