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Every business is at risk

P. 20
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From the publisher

The cover article of this edition of Ophthalmology Business addresses an issue that some physicians may think they don’t have to worry about: business fraud. However, most frauds take place from within the company’s own ranks, and more times than not, by trusted individuals who we would never suspect. “Fraud: Every business is at risk” (pg. 20) lists red flags for fraudulent behavior.

Physicians know that potentially blinding conditions such as glaucoma and macular degeneration are usually asymptomatic until the late and difficult-to-treat stages. Is it possible that technology will be able to help identify these people before they experience significant visual dysfunction? A variety of online and app-based services offer screening and therapeutic opportunities for people with glaucoma, macular degeneration, and diabetic macular edema. Tony Realini, MD, explores this topic in “Want to examine your own eyes? There’s an app (or a website) for that” (pg. 6).

In this issue we delve into fellowship options for residents. Depending on where a resident’s interests lie, a private practice fellowship may be advantageous. Three physicians who offer fellowships in their practices give details in “Private practice fellowships” (pg. 14). On the other hand, a greater number of potential patients and world-class opportunities to collaborate across subspecialties are benefits for residents considering fellowships in academic settings. Find out more in “Fellowships in academic settings” (pg. 16).

The final article of this issue is “Physician shortages and ophthalmology” (pg. 24). Because of both an aging population and a general population growth, a 2012 report from the Annals of Family Medicine predicts the total number of office visits to primary care physicians will increase from 462 million in 2008 to 565 million in 2025. The same study said the U.S. will need almost 52,000 additional primary care physicians by the year 2025. Contributing writer Vanessa Caceres discusses how the dwindling number of primary care physicians will affect eyecare.

We hope you find these articles useful. Thank you for reading!
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Want to examine your own eyes?

by Tony Realini, MD

We all support and promote the concept of screening eye examinations, but in reality, people without any vision symptoms are relatively unlikely to seek out eyecare. Potentially blinding conditions such as glaucoma and macular degeneration are usually asymptomatic until the late and difficult-to-treat stages. Can technology help us identify these people before they experience significant visual dysfunction?

Perhaps. A variety of online and smart device app-based services offer both screening and therapeutic opportunities for people with glaucoma, macular degeneration, and diabetic macular edema.

**Glaucoma**

Screening for glaucoma is complicated by the lack of a standardized diagnostic definition of the disease. Screening for glaucoma using intraocular pressure (IOP) is of limited value given that many people with glaucoma have normal IOP and most people with elevated IOP do not have glaucoma. Screening by optic nerve appearance often requires dilation for an adequate stereoscopic view. The value of perimetry is limited by its lack of both availability and portability in screening settings.

Until now.

Tsontcho Ianchulev, MD, University of California, San Francisco, has launched a foundation (KeepYourSight) and spearheaded the development of a web-based perimetry test to identify patients with moderate and advanced glaucoma. Located at www.keeyoursight.org, the test can be self administered by people on their home computer at no cost and tracks reliability indices such as false positive and negative responses as well as fixation losses. The suprathreshold 24-2 testing strategy takes about 5 minutes for both eyes (tested separately), and the results are reviewed by experts and reported back to subjects by email within one to two days.

“This test is 90% accurate in detecting moderate or severe glaucoma, which represents more than 70% of undiagnosed glaucoma … and should be the main focus for early screening and timely intervention from a public health perspective. While early and preperimetric glaucoma is another important frontier, the urgency and need there is less critical,” Dr. Ianchulev said.

“We recommend periodic rescreening every six to 12 months for people over 50 so that we can monitor the earliest possible changes before there is any threat to central vision.”
The foundation is currently fundraising to expand capacity with the goal of screening five to 10 million at-risk people within the next few years, he said.

**Macular disease**

Dr. Ianchulev and his team have also developed a web-based Amsler grid-based assessment tool to detect alterations of macular function that might indicate the presence of macular degeneration or diabetic macular edema.

This test, similar to the glaucoma test, presents an Amsler grid at various color and intensity settings, asking subjects if the lines are straight or wavy. The test is also novel in a number of ways—it is not simply an Amsler grid, but an all-around macular function test with grid perimetry, hyperacuity metamorphopsia scanning, and dynamic saturation grid displays. A brief tutorial before the test demonstrates wavy distortions to provide a reference for recognizing the desired endpoint.

Neither the glaucoma nor macular tests are meant to be diagnostic. Abnormal test results emailed to the subject simply state that there may be an issue and he or she should follow up promptly with an eyecare provider.

For people who have low vision due to macular degeneration or diabetic retinopathy, the iPad may be able to help.

“The iPad has 10x image magnification ability,” said Shailesh Gupta, MD, University of Florida, Jacksonville. “We conducted a study to evaluate the iPad as a low vision aid in improving the reading ability as well as quality of life of patients with poor vision.”

They evaluated 228 patients with best corrected visual acuity <20/200, in whom the median distance acuity was 20/400 and near acuity was N30 (worse than 20/200). Subjects read an article from the New York Times on the iPad and were instructed to magnify the image to a comfortable reading size.

“With the assistance of the iPad,” said Dr. Gupta, “94% of subjects were able to read N8 (approximately 20/50) or smaller text.” This was a statistically significant improvement (p<0.01). Likewise, quality of life assessed by the reading ability subscale score on the modified VF-14 improved from 2.0 to 4.4 (p<0.01).

“The iPad is an effective low vision aid,” Dr. Gupta concluded.

**Mobile eye exam**

One key limitation of screening for eye disease is the relative non-portability of the equipment necessary for a comprehensive ophthalmological examination.

A free app downloadable to both Apple and Android smartphones is changing this. Called the Eye Handbook, this multifaceted app provides clinicians with the tools necessary to assess near visual acuity, color vision, contrast sensitivity, nystagmus (using a virtual OKN drum), fluorescein staining of the ocular surface (using a blue light for illumination), and fusion (using the Worth 4-dot test), among other tasks.

The app provides basic patient education on a host of ocular conditions, and also offers representations of the visual consequences of eye diseases—for instance, it depicts diplopia, metamorphopsia, and floaters from the affected patient’s perspective.

While this app may be useful for screenings conducted by healthcare providers, there is no built-in interpretation platform, rendering it not useful for lay person self-screening.

**Clinical impact**

Technology is changing the world, and as evidenced by the tools described above, advances in technology have the potential to change the way we identify people at risk of vision loss and blindness.

These applications and web-based services have obvious and direct clinical relevance and preview what can happen in the technology space with minimal investment.

From a public health standpoint, investment in screening using tools and concepts like those described above may be more cost effective than developing the next round of me-too drugs or advanced imaging technologies that can spot a single water molecule under the macula or detect the loss of a single nerve fiber layer axon.

Editors’ note: Dr. Ianchulev has financial interests with KeepYourSight Foundation, Transcend Medical (Menlo Park, Calif.), and Tullis Health Investors (Stamford, Conn.). Dr. Gupta has no financial interests related to this article.

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Important questions for important decisions

You may be too close to the situation to make a wise choice in your own best interest.

You’re an ophthalmologist in practice for many years, and during that time, you have seen many changes. With roughly 80% of cataract surgery now taking place in ambulatory surgery centers (ASCs), you probably perform most or all of your cataract procedures in an ASC; you may even have an ownership interest in that ASC. As necessary, you have invested in new technology and adapted your practice to new requirements imposed by insurers and government regulation.

If you perceive the rate of change as accelerating these days, you are not alone. Electronic health records (EHR), the Affordable Care Act, and new ICD-10 codes are probably all on your plate right now, and you may not be prepared to make important decisions at this point in your career. If retirement is visible on your horizon, your choices will no doubt be different than if you were considering a longer timeline. While it may seem that the future is backing you into a corner, you do have options. You could:

• Meet the challenges head on by continuing to invest in the practice as needed.
• Opt out of the brave new world of medical practice by retiring early.
• Sell your practice and let someone else worry about it.
• Merge your practice and share the financial risk and responsibility for decision making with others.

You may be too close to the situation to make a wise choice in your own best interest. This would be a good time to seek an expert opinion from someone who has helped

continued on page 10
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<th>MRSA</th>
<th>S. epidermidis</th>
<th>S. haemolyticus</th>
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<td>NovaBay i-Lid™ Cleanser</td>
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\(^{a}\) Data on file

\(\text{The In Vitro Antimicrobial Activity of Wound and Skin Cleansers at Non Toxic Concentrations, Russell Hoon, Suriiani Abdul Rani, Ramin Najafi, Lu Wang, Dmitri Debabov; Advances in Skin and Wound Care, February 2014.}\)
others in your position, someone who will keep you from making the worst choice—which is not making a decision at all.

Here is what an advisor will take into consideration:

- **Your age**
The average retirement age for ophthalmologists hovers around 70, and that number has been on the rise for a number of reasons. Did you have a retirement age in mind when you started practice? Has that number changed over the years? If so, why?

- **Your health**
How well is your body handling your current situation? How many more years do you think you can maintain this workload?

- **The value of the practice**
Is your practice really worth what you think it is? Be prepared to handle the news that your buyout and the value of the practice’s equipment and real estate may not be what you thought it would be. What types of things could you be doing to make your practice more attractive to a potential partner or buyer?

- **Long view vs. short view**
If you take the long view, you are more likely to continue investing in your practice. Are you willing to live with the effect these investments may have on your personal income? Are you more comfortable with taking the short view at this point in your life? Challenges and opportunity are two sides of the same coin; is your view too myopic to see opportunities on the “flip side” of your situation?

- **Financial readiness for retirement**
How much have you saved to finance retirement? What are your accountant and financial planner telling you about how much you can safely afford to withdraw every year? Will that be enough to maintain what you consider an acceptable lifestyle? If not, how well will you and your family adjust to the change in income?

- **Your personal attitudes**
How much do you like—or dislike—what you are doing now? Are you addicted to your work? How much would you miss it if you were to retire? If you had the support of a group practice, how would you feel about stepping away from surgery and limiting your practice to medical ophthalmology? Do you “play well with others,” or do you have difficulty sharing? Do you have active interests that will keep your mind engaged in retirement? Have you taken the time over the years to nurture friendships?

- **The competitive environment**
As a specialty, entry into ophthalmology remains highly competitive; the number of qualified applicants still exceeds the capacity of residency programs. Even so, a MarketScope study projected that the number of ophthalmologists will increase less than 0.3% between 2012 and 2015, while overall the disease/procedure per ophthalmologist ratio will increase by 5%. Nonetheless, the number of specialists, their subspecialties and reputation as well as the technology available in a given market may make it more or less competitive than the average. Take a look at your competition. Do you share a similar culture with any of these practices? Are there any among them you would want (or could at least tolerate) as partners?

The environment in which you will need to be making decisions that affect the trajectory of your career and your practice will never be without unknowns. Important decisions must be based on incomplete information, which makes it all the more important to get answers to questions that do have answers. Many factors are unpredictable or not under your control. It’s never too early to work closely with trusted advisors—your CPA, your attorney, the manager of your retirement investments, and perhaps a practice consultant—each of whom will approach your options from a different perspective. One caution: Airing your concerns to members of your staff will accomplish nothing, but it will make them anxious about their job security and increase staff turnover. Don’t do it.

You should, however, consider attending the ASCRS•ASOA Symposium & Congress. Attend relevant courses and symposia, and take advantage of the opportunity to speak with your peers and learn how they are handling these challenges, then seek out and interview consultants to find one you can call upon when the need arises. OB

**Reference**

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Read it, Watch it, Share it
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You board a commercial airplane trusting that your pilot will do a good job and deliver you safely to your destination. As you buckle yourself in for the long haul, the pilot announces that the GPS system is out of commission and that the autopilot controls are broken. The pilot then declares that he is an excellent pilot and only requires a compass and a runway to safely fly the airplane. Do you stay on the plane? Just like boarding a plane without truly knowing the skillset of the pilot, a cataract patient enters the ophthalmologist’s office without an understanding of how good that surgeon is. Likewise, as the GPS and autopilot system provide a level of security to the airline passenger, laser cataract surgery helps assuage a patient’s fear over the element of human error and provides a virtual safety net.

Converting patients from traditional to laser cataract surgery has been an easy transition for me. I discovered quickly that my patients want this technology; they find comfort and reassurance in knowing that their surgeon is using the best technology.

The laser safety net

Utilization of the laser has the potential to make a great surgeon better by simplifying the procedure and reducing surgical time while producing consistent, good outcomes. Patients also enjoy having their astigmatism corrected during the procedure, producing a better outcome than can be achieved with manual surgery.

Learning to use the laser was quite easy for me. I have extensive experience performing LASIK surgery and am accustomed to the suction ring going around the eye, as well as the process for acquiring centration around the cornea. However, I have witnessed surgeons who have never performed LASIK pick up the process in one training session without any difficulty. This short learning curve speaks to the ease and efficiency a quality laser interface is capable of providing.

Our femtosecond laser for cataract surgery performs four moderately difficult steps with ease and perfection. The initial step is the incision of the eye; a surgeon must go by “feel” when performing this manually. The laser eliminates the variability associated with using a blade and going in either too soon or too far. The surgeon avoids complications such as iris prolapse, often associated with making the incision too short, or having a difficult view by making the incision too long.

Second, a quality laser performs a perfectly round capsulotomy, exactly sized and centered, in just 1.5 seconds. Manually, the capsulotomy takes 30 seconds to one minute. When performing this step by hand, particularly when you are learning, the capsulotomy can often
go radial. If this occurs, the cataract may drop to the back of the eye, or it can result in vitreous prolapsing into the anterior chamber. If these complications occur with a patient that has selected a premium lens, the surgeon must abort and insert a different kind of intraocular lens.

A third benefit of laser cataract surgery occurs during the hydrodissection stage. Performed by hand, this step is conducted with fluid while you try to cleave the cataract away from the capsule so that it will spin easily. If a lens will not spin, problems such as zonular stress and dehiscence around the capsular bag may occur if you try to force the lens to rotate. The laser makes gas pockets within the capsular bag that help dissect the lens away from the cortical layer. This “pneumodissection” is gladly welcomed each time and helps reduce the importance of cortical cleaving hydrodissection. I have had several cases where I have bypassed hydrodissection and the cataract has been extremely mobile.

Fourth, the laser fragments the lens, obviously significantly reducing the use of phaco, or ultrasound energy. Less energy is safer on the corneal endothelium and on the iris. In addition, the laser makes a perfect crack down the middle of the lens, thus simplifying the step of manual cracking and fragmenting. The surgeon can also customize the laser grid pattern to take into account the density of the lens, further eliminating ultrasonic energy delivered inside the eye.

**Patient education**

Patients entering our office often do so with trepidation, expressing fear that their surgery will not be successful due to variable factors such as movement or difficulty holding the eye open. To educate our patients on their options and to help build their confidence in us, we have implemented a simple patient education program.

When potential cataract surgery patients book an appointment with us, we mail them a brief cover letter and brochure about our laser and lens options. Our cover letter welcomes them to our practice and informs the patients about the only two decisions that they will need to make. The first decision is about how to remove the cataract, either manually or with the laser, and the second is about what type of lens will replace the cataract.

When patients arrive at the office for the initial consult, we show a five-minute video on an iPad while their eyes dilate. Afterward, I meet with the patients and discuss their options. I have found that the majority of my patients are already sold on the laser after reviewing the brochure we sent previously and viewing the video. They want the peace of mind the technology offers them, regardless of the additional expense. We then discuss the additional cost that is not paid by insurance and explain that as a bonus, this price includes correction of astigmatism. We also discuss lens selection, which includes a lifestyle assessment. From there, the patients work with our surgery coordinator.

**Economics**

When considering the purchase of a laser cataract machine, due diligence is a key factor to confidently selecting the right machine for your practice. Of great importance is the economic impact this investment will yield. There are several factors to consider including fixed costs, per case costs, amortization, and variable costs. In addition, we wanted a quality laser that we could rely on and know that it truly was improving patient outcomes without increasing complications. In our particular case, we calculated that we would need to perform 16 laser cataract procedures per month in order to achieve a satisfactory return on investment. We projected a 30% to 40% conversion rate to meet this quota. However, we have far exceeded our expectations with a 75% conversion rate less than two months after installation of the laser. As a result, we will reduce amortization costs due to early repayment.

**Marketing**

Our practice is part of a university hospital located in a rural area of North Carolina. With the nearest metropolitan area over an hour away, our demographic is by no means wealthy. Still, we have not found it necessary to invest in television, print, or radio ads. Marketing has occurred primarily through word of mouth by our satisfied patients. I also attribute our high level of conversion to our excitement as surgeons about the laser. Once we began doing cases and seeing positive outcomes, it became quite easy to promote the laser to potential cataract surgery patients.

**Conclusion**

The addition of the laser cataract machine to our practice has been a positive and natural transition process. We credit our high conversion rate to several key factors, including the safety benefits offered to the patient, successful outcomes generating positive word of mouth marketing, and our own enthusiasm for the machine that has made the cataract surgical procedure simpler and safer.

Dr. Walter is associate professor of surgical sciences, Wake Forest University Eye Center, Winston-Salem, N.C. He has financial interests with Abbott Medical Optics (Santa Ana, Calif.). Dr. Walter can be contacted at kwalter@wakehealth.edu.
Private practice fellowships

by Michelle Dalton Contributing Writer

Depending on where a resident’s interests lie, a private practice fellowship may be advantageous, say three physicians who offer them

For young ophthalmologists, the decision about which fellowship—if any—to pursue may be a difficult one. For those offering fellowships, however, it’s a no-brainer, said several physicians who have been offering private fellowships for more than a decade.

“For me, the decision to offer a fellowship was an intrinsic decision I made when I went into this specialty,” said Eric D. Donnenfeld, MD, partner at Ophthalmic Consultants of Long Island, Rockville Centre, N.Y., and clinical professor of ophthalmology, New York University Medical School, New York. “I wanted to actively give back for all the teaching I’d received.” He firmly believes it is the responsibility of physicians to train younger doctors and that the field of ophthalmic surgery can only advance when people with the ability to teach choose to do so and pass along their knowledge.

For Richard L. Lindstrom, MD, adjunct professor emeritus, University of Minnesota Department of Ophthalmology, and founder of Minnesota Eye Centers, Minneapolis, “doing a year or two of a fellowship for most ophthalmologists will be the most valuable time spent in their training. It’s significant both in terms of ‘joy of practice’ and from a technical expertise perspective.” Dr. Lindstrom has offered fellowships in an academic setting but predominantly at his practice for the past 25 years and personally finished two fellowships—one in an academic setting and one in a private practice setting.

Daniel S. Durrie, MD, professor of ophthalmology, University of Kansas Medical Center, and president, Durrie Vision, Overland Park, Kan., began offering private fellowships in 1985, a time when ophthal-
mologists with an interest in refractive surgery were unable to pursue those interests in institutional settings.

“Our business model is based on a private pay, lifestyle medicine practice. That’s a difficult model to emulate in an academic setting,” Dr. Durrie said.

Those differences aside, all three physicians agreed there are more similarities than differences between the two types of fellowships and that high quality fellowships exist throughout private and academic settings.

But choosing a fellowship program goes beyond just opting to learn surgical techniques, Dr. Lindstrom said.

“When you choose a fellowship, you’re choosing lifelong mentors. They’ll continue to mentor you and represent your interests over the life of your career,” he said, advocating that people considering fellowships visit the facilities to ensure personalities will mesh.

“I’ve been taught by some of the best doctors in the world,” Dr. Donnenfeld said. “They made my career. My responsibility is to give back to the next generation and help someone else’s career.”

With the increased interest in lifestyle healthcare, Dr. Durrie said his fellows are having no problems finding jobs, as many practices are looking to add highly trained lifestyle surgeons, a trend he predicts will continue well into the next decade.

For the most part, Dr. Lindstrom said the lines are blurring and eradicating differences between academic and private settings.

“Academic practices need to be much busier than before; they need to contribute to the setting’s bottom line, which wasn’t always the case,” he said. “It’s becoming easier and less expensive to do clinical research in private practice. There is a strong opportunity to participate in the clinical studies at both types of practices, if that’s someone’s interest.”

For those interested in true basic research, however, private practice fellowships may not present much opportunity, Dr. Lindstrom said.

“Very few practices have cell biology labs, for instance.”

Pros and cons

Years ago, if a physician was strongly motivated toward an academic and research-oriented career, it was considered a significant benefit to have undergone a fellowship at a teaching facility.

“Basic science was pursued in institutional centers, and private practice was more translational science,” Dr. Lindstrom said. These days, that differentiation is not as distinct. Most academic centers don’t have their own ambulatory surgical centers, however, which may be a downside.

“Our fellows are exposed to how to run a business in refractive surgery—they see firsthand what the overall experience is for patients as they go through exams and how that affects the practice once the surgery and follow-up are finished through word-of-mouth referrals. The business side of things is not a general focus at an institutional setting,” Dr. Durrie said.

Dr. Donnenfeld said because his fellows are in private practice, there are fewer restrictions than a university might have in the OR. “We teach all aspects of anterior segment surgery, and our fellows are not only shown the techniques, but perform them as soon as we feel they’re ready. They’ve not only seen the patient, but done the surgery and are now conducting the follow-up. That’s not necessarily how an academic setting would work.”

That’s not to say surgeons trained in private practice are obligated to that career choice—Dr. Lindstrom noted his last three fellows went into full-time academic careers.

As far as Dr. Donnenfeld is concerned, the only disadvantage to a private fellowship is the lack of grand rounds.

“I miss that ability to go to grand rounds with other subspecialists. We don’t have academic talks where we go over the cases like you would in an academic setting,” he said, but private practice fellows do gain a considerable amount of business expertise that is not available in an academic setting.

There are fewer integrated opportunities in a private practice setting, Dr. Lindstrom agreed. Conversely, those who want to use the latest technology will generally be able to so in a private setting long before an academic one has purchased the device.

“Companies tend to find the indirect costs of the university setting are much more restrictive,” Dr. Lindstrom said.

Dr. Durrie agreed: “Femtosecond LASIK surgery didn’t start in an academic setting. Femtosecond cataract surgery also started in the private sector, although Bascom Palmer (in Miami) was an early adopter. In the excimer laser field, the early adopters have always been in private practice, and the opportunity to conduct ground-breaking research has been in private practice as well.”

For these leading surgeons, fellowships are an integral part of any ophthalmologist’s training. But for those seeking fellowships, the lines have blurred a bit regarding advantages of one type over another.

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March 2014 • Ophthalmology Business
Fellowships in academic settings

by Michelle Dalton Contributing Writer

A greater number of potential patients and world-class opportunities to collaborate across subspecialties are benefits for residents considering fellowships in academic settings

Choosing where to pursue a fellowship is often a daunting task—as there are “absolutely superb private and academic settings that offer fellowships,” said Douglas D. Koch, MD, professor and the Allen, Mosbacher, and Law Chair in ophthalmology, Cullen Eye Institute, Baylor College of Medicine, Houston.

The debate between whether or not to choose an academic or private fellowship “is not so much about the type of institution as it is the people you’ll work with and the interactions you’ll have,” said Anat Galor, MD, staff physician, Miami Veterans Affairs Medical Center, and assistant professor of clinical ophthalmology, Bascom Palmer Eye Institute, Miami. “Those types of things can only be determined by the physician choosing the fellowship.”

Some ophthalmology specialties benefit more from a fellowship than others, Dr. Koch said—but added the choice to pursue a fellowship is somewhat personal as well.

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Ethics of Femtosecond Laser Cataract Surgery

Sunday, April 27, 2014
4:45 - 6:00 PM  Program
Course 27-500 – Room 205ABC

Program Chair
Richard S. Hoffman, MD

Panelists
John D. Banja, PhD
Donald N. Serafano, MD
Michael Snyder, MD
Abhay R. Vasavada, MS, FRCS
Sonia H. Yoo, MD

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Ethics of Femtosecond Laser Cataract Surgery

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“The advantage of fellowships is that the surgeon acquires skills and an intense knowledge of the subspecialty,” Dr. Koch said. For a general ophthalmologist, fellowships may not be necessary, but Dr. Koch said for ophthalmologist interested in corneal transplant surgery, for instance, “a fellowship is essential. Someone who’s interested in cataract surgery may be able to head right out after residency, but something more intricate like transplant surgery and complex IOL procedures” mandates more training and specialization than a brief time during residency allows.

Academic settings provide more opportunities to interact with other specialties than private settings might, Dr. Galor said. At larger teaching hospitals, cornea fellows and glaucoma fellows are exposed to grand rounds-type of analyses and discussions that may not occur in the private sector, she said. There are great surgeons and teachers in all settings, but academic settings will have a greater number of potential mentors.

“There’s also the possibility to have more primary responsibility for patient care,” Dr. Koch said, as fellows in an academic setting are more likely to have “their own” patients, following them from presentation through the entire follow-up period earlier in their fellowship than their private center colleagues.

**Fellow considerations**

Perhaps the biggest difference between academic and private settings is the type of research opportunities available.

“If your goal is to get bench experience, there are numerous academic ancillary personnel who are helpful and can assist with study design,” Dr. Koch said.

Baylor has been involved in several clinical studies as an investigator site, but Dr. Koch noted that is not typical of most academic settings. “The barrier for pharmaceutical and device companies is that the Institutional Review Boards at academic settings are usually more onerous than those affiliated with private clinics,” Dr. Koch said.

“Certainly, some private fellowships offer wonderful clinical research opportunities with outstanding mentors.”

Dr. Galor said the clinical volume of an academic center is greater than even some of the highest volume private practices. “Some academic centers (like some private practices) have higher volumes than others, and those will have fellows participating in a lot of the hands-on patient care,” she said. Residents considering either private or academic fellowships should also consider how difficult (or easy) it would be to get surgical time—and how quickly they’ll become fully responsible for each aspect of the surgery.

Fellows are provided extensive time at Veterans Affairs or county hospital settings, Dr. Koch said, and there will be a greater diversity of patients at the larger public hospitals.

“Fellows see them, operate on them, follow up with them with supervision, but have primary responsibility fairly early on,” he said. “It’s one of the aspects of our fellowships that is well received as a great element of our training.” Dr. Koch was quick to add that superb surgical experiences with high surgical volumes can be had in some private settings as well.

“Fellows have one year to be specially trained,” Dr. Galor said. “If research is something the ophthalmologist has a great interest in and he or she enjoys collaboration on various projects, an academic center may be a better fit.”

It all boils down to the individual, Dr. Galor said. “Those considering a fellowship need to ask where they see themselves in five to 10 years. It’s not a ‘private vs. public’ thing. It’s a matter of which institution is right for you and which one ‘gels’ with your personality.”

**Editors’ note:** Both physicians are employed by academic institutions.

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Fraud: Every business is at risk

by Chuck Gallagher
At first when his wife said that Sergeant Willis was on the phone and had some questions, Reverend Bobby thought he might have run a red light and was caught by a traffic cam. Sadly, the actual problem was much graver. The police officer began to question him about Sue Hardy, the church’s treasurer, and the role she played in the church’s business affairs. It seemed that there were some suspicions of financial impropriety and that Sue was the likely perpetrator.

The shock of a collapsing illusion

We hear a lot these days about identity theft, internet fraud, email scams, or Wall Street defalcations, but the truth is most organizations are more vulnerable to fraud than they might think. Whether it is a church, a non-profit, or a small business that you’ve put blood, sweat and tears into, the chance that you’re at risk for fraud is substantial.

The conversation between Reverend Bobby and Sergeant Willis led to the arrest and conviction of what Reverend Bobby once described as a pillar of sainthood in their small but growing church. Sue was a Christian’s Christian. The backbone of the church, Sue gave of her time, taught Sunday school and was the treasurer for years.

Sadly, regardless of the type of organization, most frauds take place from within the company’s own ranks, and more times than not, by trusted individuals that we would never suspect.

By their nature, small businesses, non-profits, or associations are typically run on a shoestring budget, which makes staffing tight and internal controls limited. And while most people are trustworthy, external factors can create a need that, combined with opportunity and a dose of rationalization, create the potential for unethical and fraudulent activity.

When the perfect storm of fraud hits and the illusion fades into reality, it becomes clear the devastation that fraudulent activity creates. Every choice has a consequence, and the consequences of fraud are significant and far-reaching.

What to look for

Let’s use the example of Sue above to frame the discussion about how good people make very bad choices, which leads to fraud.

According to the Association of Certified Fraud Examiners the following are red flags for fraudulent behavior:
1. Most frauds are committed by people who have worked in the organization for a number of years. People who have 10 years or more of experience with the organization cause higher fraud losses. Why? The answer is simple: The longer a person is employed within a company, the greater the trust and responsibility. Likewise, trusted employees are not often considered likely candidates for fraud.
2. Individuals in one of six departments commit the vast majority of all frauds: accounting, operations, sales, executive/upper management, customer service, and purchasing. If fraud occurs in your business, it is likely by someone who has the opportunity; individuals in these six areas have the greatest opportunity to violate trust.
3. Fraudsters displayed one or more of these red flags before or during the commission of the fraud: living beyond means, financial difficulties, unusually close association with vendors or customers, and excessive control issues. Any of these behaviors could be a sign of impending danger.

In looking back on the situation, Reverend Bobby could have seen disaster coming. Sue was a trusted member of the church, holding her position for more years than Reverend Bobby had been there. Not that longevity is a bad thing, but church leadership could have required a change of roles from time to time disrupting the natural flow of funds. Typically when things change inappropriate behavior comes to light.

But beyond Sue’s tenure, she was quite protective over the money and monetary processes for the church. Excessive control is a significant sign that something might be amiss. When people are unwilling to let go of their control, take a vacation or insist that only they can do the task, leadership should step back and examine the role and function more carefully.

Finally, in Sue’s case, there never seemed to be enough. Sue received calls often from creditors. Consistently she would either quickly hang up, showing her dissatisfaction with the call received, or take the call on her cell phone, out of ear shot, and return to work irritated at the interruption.

Final outcome

In the end, Sue embezzled more than $200,000 from the church where she was trusted. The discovery was both a shock and disappointment to Reverend Bobby and the entire congregation. Every choice has a consequence. Sue’s choices—made over time—created significant consequences. Today she is serving a prison sentence that will leave a permanent scar on her and those close to her.

Bobby shared that he now understands the importance of his role in this whole troubling problem. As management, Bobby has a

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When it comes to running an ophthalmology practice, innovation and efficiency as well as providing good customer service are key. Southern Eye Center in Hattiesburg, Miss. has implemented different tactics to make the practice efficient and workable for patients, doctors, technicians, and administrators alike. Chris Crawford, COA, clinic development manager, and Lynn B. Mcmahan, MD, founding member, discussed some of the tools Southern Eye Center uses to improve efficiency and customer service and keep patients happy on a daily basis. Among these are: a one-day business model where patients can have the preop exam and surgery on the same day, cross-trained staff, iPads used for electronic health records (EHR), and OD referrals.

**One-day business model**

Typically, the one-day model mainly applies to cataract procedures, Mr. Crawford said. “We do offer the same-day model for all procedures, but cataract is the driving force behind the one visit.”

When patients are referred, they will receive a packet that includes consent forms and information on the physicians and practice. It also includes a DVD, which has information on preoperative and postoperative care, as well as specific information on toric and premium IOL options.

Mr. Crawford said with the packet, patients are already familiar with the consents and lens options when they first come to the practice. Before seeing a physician, they will see a technician who can answer questions. The physician would then come in and review the information, talk to patients about lens choices, and confirm a cataract diagnosis. The technician finishes the consent and record process with patients after the physician leaves.

Next, patients go to the scheduling office to confirm financial and insurance aspects of the procedure and after that to the calculation room for any photos or testing the physician needs before the procedure.

Following that, patients head to the surgery center. Everything for the procedure is done at once. While patients are in the surgery center, the physician will choose the lens based on calculations previously done, and that lens can be taken directly to the physician to perform the surgery.

Mr. Crawford said that on an especially efficient day, a patient can be in and out of the practice in about three hours. Since the facility has a clinic and surgery center in one location, this helps with scheduling and allows for the doctors to rotate between seeing patients in the clinic and the OR.

He said a similar process will be done with the second eye, but it will not be nearly as lengthy as the first because calculations have already been performed, and patients have some sort of expectation as to what they will be paying. “Usually a second eye patient is in and out in about an hour and a half.”

Dr. Mcmahan said this one-day model helped him and his patients in what was a very full and hectic schedule when he was first starting out. “Within a few years of going into practice, I found myself so busy that patients often had to wait several months for an appointment,” he said. Because of the overwhelming schedule, Dr. Mcmahan decided to switch up his services and focus on only medical care rather than including services for routine exams and glasses.

“I closed my optical and began accepting only patients with medical problems,” he said. “Strangely my
practice became even busier, and I was doing what I really wanted to do.”

Changing his surgery schedule also helped with this one-day process and allowed Dr. McMahan to become more efficient. By switching his surgery cases to the afternoons, it allowed for more space for surgeries and more time to see patients in the morning who were seriously considering surgery. Many of these patients would decide to go ahead with their surgeries on the same day, and this was particularly attractive for those traveling long distances.

“Now when patients call to schedule a consultation, we offer them the option of having ‘one visit is it,’” Dr. McMahan said. They can take or leave this option, and Dr. McMahan said the system has continued to improve over the years to make the process even more efficient.

**Cross-trained employees**

In the practice, the experience and training of technicians is incredibly important.

“Our office is divided into three separate pods: cataract, retina, and cornea/plastics, with four teams plus special testing that exists on its own,” Dr. McMahan said. “Each person has a specific team he/she is responsible to.”

Dr. McMahan said all technicians have basic skills like being able to check vision, get general history, and do exams. “We require all techs to pass the home study exam within two months and be certified at one-year eligibility,” he said.

Mr. Crawford said that each pod is set up with its own waiting area, testing rooms, exam lanes, and nursing station. The central hub for the practice has doors leading to each of the separate pods.

This means that the 30 or so technicians in the office are divided up into specialty teams. Each technician is basically a subspecialist in his own right, Mr. Crawford said.

The physician has to have 100% confidence in his staff because physicians see so many patients; from an efficiency perspective it’s not conducive to spend 20 minutes talking about conditions, drops, vitamins, etc., Mr. Crawford said. Technicians are trained to spend as much time as possible with the patients to ensure they are obtaining all the information and can convey this to the doctor.

**iPads for records**

iPads have become a very important patient tool and way to keep up with EHR at Southern Eye Center. Mr. Crawford said that the practice uses Management Plus (Salt Lake City), and has its own iPad app, designed by its software programmer, which works directly with Management Plus.

All the consent forms, patient questionnaires, insurance information, etc., can be entered on the iPads, which in turn deliver this information to the practice’s EHR.

Although there was some debate on how secure an iPad is for this information, Mr. Crawford said they are all protected with the practice’s Wi-Fi and security measures and are only equipped to handle one patient at a time, so there is no residual information left once a patient enters his or her information.

He said the practice has never had an iPad broken or stolen, and viewing options like big fonts and big touch boxes make it easier for patients to see and enter the data with ease.

Dr. McMahan said the use of iPads helps maximize efficiency because it has the patient entering personal information, rather than leaving this to the doctor or staff to transfer into the practice’s electronic records.

“We were initially concerned that many of our patients could not use the iPads, but our programmer prepared a short video demonstrating how to use the iPad, which patients see first,” Dr. McMahan said. After each correct answer, a big eye winks at the patient before proceeding to the next question, he said.

“When the doctor is through with the exam, the history and physical and informed consent are completed and signed by patients on the iPad before this is downloaded directly to the ASC,” Dr. McMahan said. “Everything is seamless. No paper is used at all.”

**OD referrals**

“We have a very large referral base,” Mr. Crawford said. “We’re the only multi-subspecialty practice in the southern part of the state.” He said this includes about 40 optometrists that recommend patients on a routine basis, and he estimated that the practice co-manages with about 20 of those.

The practice keeps up a relationship with the optometrists who provide referrals by doing continuing education and offering biannual seminars. Mr. Crawford said this is very important to nurture the relationship with the ODs. Included in his job are frequent visits to optometrists’ offices. He travels to different regions to visit and check in.

“Because we don’t do glasses exams or routine checkups, all our patients are referred to an OD postop for those services,” Dr. McMahan said. “So our ODs not only get the patients they send, but they also get new patients to care for from then on.” The practice works hard to maintain relationships with ODs and recognizes the important role they play in patient outcomes. **OB**

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How the dwindling number of doctors will affect eyecare

You’ve no doubt heard the numbers about a projected primary care physician (PCP) shortage—and the increasing need for their services. Because of both an aging population and a general population growth, a 2012 report from the *Annals of Family Medicine* predicts the total number of office visits to PCPs will increase from 462 million in 2008 to 565 million in 2025.¹

The same study said the United States will need almost 52,000 additional PCPs by the year 2025. “Population growth will be the largest driver, accounting for around 33,000 additional physicians, while 10,000 additional physicians will be needed to accommodate population aging,” the study investigators reported. Insurance expansion will add another 8,000 physicians to the increase.

An editorial from Association of American Medical Colleges president Darrell G. Kirch, MD, published on the association’s website in December 2013, estimates that the United States will need a total of 91,500 new doctors by 2020 and 130,600 by 2025. “Contrary to what many believe, the coming shortage is divided nearly evenly between the need for more primary care physicians and the need for surgeons, oncologists, cardiologists, and other specialties,” he wrote.²

There’s a graying of physicians as well. One third of practicing physicians is 55 or older, and many are projected to retire in 10 or 15 years. A survey from Deloitte Center for Health Solutions shows that more than half of the physicians will retire earlier than originally planned.³
But just what do all the grim PCP shortage statistics mean for ophthalmology? And will there be a shortage of ophthalmologists as well? How will practicing ophthalmology change in the future due to any projected shortages?

**Changing the ophthalmic practice model**

First, the news for an ophthalmology shortage: “Over the last decade, there’s been an 11% drop in ophthalmology residency slots,” said John B. Pinto, president, J. Pinto & Associates, San Diego. “Thirty years ago, there was a 2 to 3% increase each year in the number of ophthalmologists.”

However, that drop is countered with a material increase in the number of optometrists now being trained and delayed retirements by ophthalmologists who may have planned to retire but are sticking around either for love of the profession or lack of retirement funds, Mr. Pinto said.

Looking ahead, Mr. Pinto does not see a frank labor shortage within eyecare as a whole. Instead, over the next 20 years, he sees the eyecare practice model changing. “Someone who is 75 years old in 2025 or 2035 will get the needed eyecare, but they may get that care a little later than they do today and from a provider with a different level of training,” he said.

So instead of a glaucoma subspecialist seeing a routine glaucoma patient, a general ophthalmologist or optometrist might see that patient. A bilateral pseudophake who is postop cataract will be followed more often in the future by an optometrist rather than a cataract surgeon, Mr. Pinto said.

There are signs of this practice shift already. “Most vanguard practices are using mid-level providers much more often now,” Mr. Pinto said, noting that surgeons will commonly report that nearly a third of the work that they perform today can be done by an optometrist. By the same token, optometrists and ophthalmologists are both also delegating more work to technicians, Mr. Pinto said.

This shift in practice patterns may help keep ophthalmologists more focused on the medical and surgical work that they truly want to do, Mr. Pinto said. However, with a growing patient demand and declining reimbursement, ophthalmologists of the future will need to work longer and harder than they do now to increase or even preserve income, he said.

**How the PCP shortage affects ophthalmology**

Ophthalmologists also must face some consequences of the projected PCP shortage. One consequence is a potential problem seeing patients who must be handed over by their PCP. “Specialists need primary care docs to take care of our patients’ medical problems,” said orthopedic surgeon Barbara L. Bergin, MD, Texas Orthopedics, Austin. Although Dr. Bergin is not an ophthalmologist, she said her specialty and others face a similar relationship with PCPs.

“Many of our patients need medical clearance before they can have surgery. Sometimes it takes a long time for patients to see their primary care docs for medical clearance,” she said.

“We know PCPs are gatekeepers. To get to specialists, we need to get them through the gate,” said Saralyn Mark, MD, president, SolaMed Solutions, Washington, D.C. Dr. Mark is an endocrinologist, geriatrician, and women’s health specialist involved with organizational and legislative efforts to increase the re-entry of physicians back into medicine as a way to help bridge the shortage.

Although nurse practitioners and physician assistants play a critical role in meeting with patients, even those healthcare team members need to rely on PCPs, Dr. Mark said.

Dr. Mark predicts that the dwindling number of PCPs may lead to specialists taking on a little more primary care-related responsibilities than they had planned. Matt Jacobson, CEO and founder of the concierge model SignatureMD, Santa Monica, Calif., made the same prediction. “If patients can’t get to their doctor and they have a cold, they may go to an ENT specialist and get billed at a higher rate. Or they may have pink eye and go directly to an ophthalmologist instead,” he said.

Mr. Pinto estimates that only 3 to 5% of an ophthalmologist’s patients come from PCP referrals. However, he does predict that it will be harder in the future for ophthalmologists to get PCPs on the phone to coordinate care. Still, he noted those phone conversations are a rare occurrence, even if they are a good idea.

Technology will play a role in helping ophthalmologists and PCPs manage any workload shifts due to shortages, said David Goldman, MD, assistant professor of clinical

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ophthalmology, Department of Corneal and External Diseases, and founder of Goldman Eye, Palm Beach Gardens, Fla. Dr. Goldman is also ophthalmology team lead of anterior segment for the electronic medical record (EMR) system called EMA (Modernizing Medicine, Boca Raton, Fla.).

“I think EMRs will be essential as we will have too many patients to keep track of them all. An EMR will make them easily trackable,” he said. EMRs already enable ophthalmologists to automatically send diagnosis and treatment information to patients’ PCPs, Dr. Goldman said.

“We can convey information quickly, efficiently, and legibly. Getting the doctor on a phone is not practical,” he said.

In the future, EMR systems in different offices will have an ability to communicate with each other to integrate patient data, he explained.

Although he acknowledged that it can be difficult for offices to transition to EMR use, he believes they will become essential once practices learn how to use them.

You may also find that a number of PCPs will turn to the concierge care model, sad Mr. Jacobson, whose concierge offices are in about 20 states. Patients pay anywhere from $1,500 to $3,000 a year to become one of 300 to 600 patients seen by a primary care provider.

Although concierge models can be successful in primary care, Mr. Pinto has only seen a small number of ophthalmologists turn to such a model because of the specialty’s heavy reliance on Medicare and traditional insurance.

Of course, the Affordable Care Act affects the overall demand for medical appointments as well, due to a growing number of patients who have insurance. However, Mr. Pinto said it’s still too early to say the effect that may have on eyecare.

Providing—and finding—relief
With all physicians facing such drastic changes in how they practice due to shortages and declining reimbursements, there are still ways to find relief and help your local PCPs.

“I think primary care doctors in the future will behave more like quarterbacks,” Dr. Goldman said, noting that more of them will refer patients for appropriate specialized care that they may not have time to handle. Ophthalmologists (and even optometrists) can let PCPs know they are there to help with specific eye conditions, Dr. Goldman said.

Burnout may be more common as the demands on physicians increase, Dr. Bergin said. “We went to medical school to take care of patients, not to fill in blanks and click boxes,” she said. “Our hearts are in it, and we want to take the best care of our patients as possible, but we’re hitting our heads against a hard wall, and we can only do that for so long.” Although Dr. Bergin is frustrated by where medicine is heading, she believes specialists would do a great service by educating patients more about the prevention of disease, with the long-term goal of fewer doctors’ visits.

If physicians—PCPs, ophthalmologists, or those from any specialty—feel they truly cannot bear the burden of today’s clinical system, Dr. Mark encourages them to consider related work in teaching, policy, leadership, research, or biotech. “They have to be honest about why they’re doing what they do, how they are motivated, and if they are happy to be with their patients and colleagues,” she said.

References

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responsibility to understand the three components of unethical and often-illegal behavior: need, opportunity, and rationalization. Most importantly, Bobby knows that with some minor changes Sue might have, although tempted, been prevented from making those dangerous choices, which led to an outcome that no one wanted.

As a manager of your organization, what steps are you taking to protect your most valuable assets—your employees—from making dangerous decisions that impact them and your organization? OB

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