7 steps to venture into oculoplastics

3 specialists share their expertise on how to add the subspecialty to your practice
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A re you considering delving into oculoplastics to expand your patient base? It may be an opportune time to add this subspecialty to a practice because there’s an upswing in the number of related procedures performed. But oculoplastics takes some patience and unique panache both surgically speaking and in the way that you interact with patients. Check out the feature article in this edition of Ophthalmology Business for 7 useful tips from 3 specialists. If you’re not sure that you want to perform these procedures but instead want to start off by offering skincare products in your practice, be sure to read “What can I do about … ?” You’ll learn how to manage patients’ eye-related skincare questions and get skincare product recommendations from experts.

This edition of Ophthalmology Business also contains information you may find useful for building a team in your practice. Just because you call your group of employees a team doesn’t make it one. Read “The team myth: 5 steps of successful team building” to learn more. Once you have established a team successfully, you’ll want to be sure you are providing feedback regularly. Unlike an evaluation, feedback primarily focuses on performance or technical proficiency and how it can be improved. However, delivering it can be tricky. Some leaders fear that if the feedback is negative, the employee will become defensive, angry, hateful, or depressed. John Banja, PhD, medical ethicist at Emory University, provides a list of “do’s” and “don’ts” that you can use in developing your feedback communications.

You may have heard that in addition to the most popular and recognizable domain extensions such as .com, .net, .org, .edu, .info, and .gov, the first of more than 1,300 new extensions were introduced in late 2013, including .vision, .doctors, .docs, .health, .healthcare, and .surgery. But before you jump in to buy up desirable domains within these new extensions ahead of your competition, there are some questions you should ask, including the price and how much the new extensions really matter. Read “.com, .doc, .vision: Does it really matter?” to find out the answers to these questions.

These are just some of the articles you will find here. If there is a topic you would like to see covered in Ophthalmology Business in the future, please email Stacy Majewicz at stacy@eyeworld.org. Thank you for reading!
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ECG-1227941 Rev. 1/15
Imagine being able to help patients without them actually coming to your office. AppVisit, an app that’s part of the company AppMedicine, has created a way to do this. AppVisit is a tool that patients can use to get the opinion of their doctor remotely and without the hassle of scheduling an official appointment. **Harvey Fishman, MD, PhD**, Fishman Vision, Palo Alto, Calif., developed the app, which can currently be used with iPhone, iPad, and Android. It can be used within the ophthalmology profession, as well as other medical specialties.

“It lets the ophthalmologist do a fairly comprehensive external and vision exam on the patient,” Dr. Fishman said. The app can check visual acuity and has an Amsler grid, enabling physicians to easily assess patients without them coming into the office.

“As we’re moving toward more online medicine, which is growing like crazy right now, the number of companies offering digital medicine is increasing,” he said. One of the problems with digital medicine is that patients need to be directed in a way that allows the physician to make an easy diagnosis. If patients just text pictures or don’t take them correctly, physicians aren’t going to get the information they need. It could turn into a very long experience for both parties.
“With AppVisit, we have a very robust back end.” Not only is the front end of the app presented well for the patient, but the back end interface allows physicians to design the app and customize it. It’s not locked into a particular set of questions, Dr. Fishman said.

“A lot of apps have terrific details and offer great features, but one problem is getting them into the hands of the patients,” he said. “We can sign patients up easily and [have seen] a high level of satisfaction” because it’s easy for patients to use.

“Different practices have different patient populations and ways that they interact with patients,” Dr. Fishman said. “You can design your app the way you want your patients to use it.”

There is also a built-in billing module. Since this technology is not yet covered by insurance, doctors can offer it to patients as a non-covered service. The service can then be billed through the app.

The communication that the app allows is advantageous for both patients and physicians. With these “e-visits,” last-minute visits that can complicate a physician’s schedule and make for longer patient wait times will be reduced. “With this app, we’re able to triage the patient,” Dr. Fishman said. If it’s reasonable for the patient to come in another day, he or she can schedule an appointment. Dr. Fishman added that patients using this service are all patients who have previously seen the doctor, not new patients.

Dr. Fishman uses the app for follow-up visits in his dry eye clinic. That is a case where diagnosing a patient and then seeing him or her again in several weeks or a month doesn’t provide enough information. “It’s such a benefit for the patient to be able to get the information back to the doctor before the next appointment.” This can help reduce unnecessary disease progression, he said.

Now that digital medicine is becoming popular, the app is getting quite a bit of use. “We’ve done about 1,000 visits from various providers, myself included,” Dr. Fishman said. Specialties including family practice, dermatology, psychology, chronic medicine, and ophthalmology are using AppVisit. 

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What can I do about...?

by Vanessa Caceres Contributing Writer
You’re in an exam with a patient to talk about cataracts, a refractive procedure, or perhaps dry eye, and there’s another question the patient asks: “What can I do about my dark circles? My crow’s feet? The puffiness under my eyes?”

Patients may ask you these questions because you are a trusted professional, and you are also an expert in the eye.

Although you don’t need to become certified in dermatology, it’s a good idea to gain some knowledge in the area of eye-related skincare, so you can provide a knowledgeable answer to these frequent questions, said Erin Shriver, MD, assistant professor of ophthalmology and visual sciences, University of Iowa Carver College of Medicine, Iowa City.

Another good reason for ophthalmologists to gain some product knowledge is so they are aware of helpful or harmful ingredients in over-the-counter products patients might use, said dermatologist Ellen Frankel, MD, Rejuvaderm MediSpa, Cranston, R.I.

Kimberly Cockerham, MD, FACS, Zeiter Eye Medical Group, Stockton, Calif., is commonly asked about eye and skincare products by both her female and male patients. Having products on display can help get the dialogue initiated. In addition, digital frames with recommended products intermixed with before and after photos is an excellent passive marketing tool.

How does an ophthalmologist begin to get familiar with eye and skincare products, including makeup, to recommend to patients?

**Good research**

Just as you might do with a new piece of technology, the first step is to research possible products, Dr. Shriver said. Ask colleagues or friends who are knowledgeable about skincare what product brands they would suggest. Start to research one or two product lines initially so you don’t feel overwhelmed by the volume of choices out there. Even Dr. Shriver, who works with the oculoplastic, orbital and oncology service at the University of Iowa, said she can get overwhelmed by the eye cream, makeup, and skincare options presented in women’s magazines or via marketing materials she receives.

Get in contact with reps for the products you are researching and ask for peer-reviewed papers that show the benefits of the products, Dr. Shriver advised.

Once you have chosen a product or two (or a product line) you think would work for your practice, the experimental phase begins. Including staff members in trial product use can be a way to boost morale, Dr. Shriver said. She will do one-eye trials of products so she and her staff and even patients can see how certain products work.

As you try out products, consider how long it might take to work. You may feel something is lackluster after a month when it actually needs a longer time to be effective. Also, think about how individual product lines may work differently with each person’s skin. “There was one line of products with a good reputation that [my skin] just couldn’t tolerate,” Dr. Shriver said.

**Selling products**

It might feel awkward to bring up skincare products in a salesman-like manner. Good research can help get the dialogue initiated.

In addition, digital frames with recommended products intermixed with before and after photos is an excellent passive marketing tool.

How does an ophthalmologist begin to get familiar with eye and skincare products, including makeup, to recommend to patients?

**Skincare products recommended by MDs**

Kate Ross, MD  
**Makeup:** Jane Iredale Mineral Makeup (Great Barrington, Mass.)

**Over-the-counter skincare and makeup:** Almay (good for patients with contact allergies), Neutrogena (Los Angeles; good for sensitive skin)

Ellen Frankel, MD  
**Eye creams:** Avène Soothing Eye Contour Cream (Parsippany, N.J.), Lumiere Neocutis (Switzerland; good for dark circles, fine lines, and puffiness)

Kimberly Cockerham, MD  
**Sunblock:** Zinc powder sunblock (Colorescience, Carlsbad, Calif.)

**Blepharitis:** Blinc lash primer and mascara (Boca Raton, Fla.)

Erin Shriver, MD  
**Eye creams:** Youth Eye Serum (iS Clinical, Burbank, Calif.), Age Intervention Eye Cream (Jan Marini, San Jose, Calif.)

**continued on page 10**
way, but there are gentler ways to approach the topic.

You could ask patients if they have any questions about their eye-care routine and see if they express an interest in treating crow’s feet, puffiness, or using better quality makeup. This is an approach similar to that taken by Dr. Frankel in the dermatology world. “We’ll do a total skin check, and I’ll ask if they have any concerns. Patients will mention that they need moisturizer or that they have crow’s feet around the eyes or dry skin,” she said.

Another approach is to have a technician ask before the exam if the patient would like to learn about skin-related products, Dr. Shriver said. If the answer is yes, the aesthetic coordinator in her office will speak with the patient about what products they have.

Many offices have a technician who may have a special interest in learning more about skincare, and taking the latter approach is the perfect way to boost their knowledge and broach the subject with patients, Dr. Shriver said.

Next, patients need to be able to see the products displayed around your office. “Display, display, display,” Dr. Cockerham advised. “Use trifolds, digital frames, posters, and framed information on current specials in the restrooms, waiting room, and in exam lanes.” Passive marketing is extremely effective, she said.

An easy place for ophthalmologists to display products is in their optical shop, Dr. Shriver said.

Beside Dr. Frankel’s check-in area, there is information about items like Botox, sunscreen, and eye creams. The TV loop in the waiting room talks about products, and there are posters and brochures in her exam room. Dr. Frankel will write down recommended products for a patient on a prescription form so they have the name with them. Many times, patients decide to buy the products.

At the office of dermatologist Kate Ross, MD, LA Plastic Surgery and Dermatology, Bradenton, Fla., there are displays in the waiting room and products in the esthetician’s room that generate interest, she said. When the esthetician uses a product on someone, it often generates more interest or sales, Dr. Ross added.

Other skincare tips
If asked about over-the-counter products, Dr. Ross cautions patients to stay away from highly publicized skin and cosmetic product lines that can have harmful ingredients, such as formaldehyde. Paraben and other preservatives extend the skin products shelf life but can be harmful when used on a daily basis, agreed Dr. Cockerham. Many of the products available in the U.S. are actually banned in Europe and other countries.

Arnica montana and other herbal oral topicals can be helpful for the eyelids and skin. Arnica can help reduce bruising and swelling; fish oil and other omega 3 and 6 sources can help with dry eyes; and biotin can help fortify the skin, hair, and nails.

In addition to eye and skincare products, there are other ways that ophthalmologists can help patients protect their eyes, eyelids, and skin from the damaging effects of the sun.

“Ten percent of melanoma is in the eye, so I’d recommend the use of polarized sunglasses,” Dr. Ross said. UVA and UVB coating is important not only on sunglasses but also on the windows of your car; we get the majority of our sun exposure while driving, Dr. Cockerham said.

Dr. Frankel espouses the use of sunblock, moisturizer, and washing skin with a gentle cleaner. She also talks about the value of using gloves and scarves seasonally not just to stay warm but also to protect the skin.

Ophthalmology and dermatology working together
The goal of giving skincare product recommendations is not to step on local dermatologists’ toes, Dr. Shriver said. In fact, by becoming aware of skin issues on the face or near the eye, you may find more reason to refer to those colleagues.

“Dermatologists can work hand in hand with ophthalmologists,” Dr. Frankel said.

One tip off for a referral is a questionable rash. “I’d like to see someone if they have a rash that hasn’t gone away for more than 2 weeks,” Dr. Frankel said.

If Dr. Shriver suspects malignant or systemic disease or conditions such as severe acne or rosacea, she will refer to a dermatologist. Because she does more work in the area of oculoplastics and skincare, she sometimes feels comfortable prescribing a skin-related product and then referring to a dermatologist for a follow-up.

Dr. Cockerham, an oculoplastic specialist, also feels comfortable managing diseases of the skin in partnership with her local dermatologic colleagues. However, general ophthalmologists should refer patients with skin lesions on the face that change in appearance, itch, or recurrently scab to an appropriate specialist. Patients with persistent dermatitis, rosacea, or melasma can also benefit from referral. If performing a biopsy of a suspicious eyelid lesion, always take a photograph. It will help identify the precise location of the lesion and show whether it is malignant and requires additional surgical excision and reconstruction by a dermatology or oculoplastics colleague. OB

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Shriver: erin-shriver@uiowa.edu
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Jon Voeller  910.685.7745
Mike Montgomery  910.798.1215
Spring is in bloom. For many of us spring means the much-awaited arrival of crocuses, green grass, and the Masters Golf Tournament at Augusta National in Georgia. This very exclusive event represents the Holy Grail for the golf world. While every major golf course around the world has its promoted signature hole, Augusta National boasts a corner consisting of not 1 but 3 very tough (but stunning) signature holes.

“Amen Corner” was the term coined by Herbert Warren Wind in his 1958 Sports Illustrated article chronicling that year’s tournament. It’s the stretch of holes on Augusta’s famed back 9 that starts with a downhill second shot on the 11th hole and continues through the tee shot on the 13th hole. But the rest of the 13th hole is often where the Masters can be won or lost on Sunday. The first of 2 par-5 holes on the back 9, the 13th hole—aptly named “Azalea”—is the ultimate risk/reward hole.

Famed golf course designer Robert Trent Jones called Azalea “perhaps the best short par-5 ever built.” In 2002 the tee box was pushed back to lengthen the hole to 510 yards, but in today’s game it’s considered relatively short. There’s a tributary, Rae’s Creek, that runs down the left side of the hole and swings around the front of the green, providing a formidable water hazard. It’s because of these hazards that the 13th is the scene of high drama every year.

In 1994, Jeff Maggert scored a double eagle 2 on the 13th. Nick Faldo ended Greg Norman’s bid for the Master’s fabled green jacket in 1996 with a laser 2-iron shot to the
There are plenty of things that could derail this market. But simply put, we are in a wealth accumulation mode and the most important thing we can do is simply make sure our actions are consistent with that risk status.

There will always be those investors who want to wait until everything lines up before they put their money to work in the market. They dream of opening up the Wall Street Journal and seeing an “all roses” alert at the top of the front page, coupled with a U.S. economy that looks like someone put rocket fuel in its gas tank, and the heads of state in the Middle East all joining together for one big group hug.

The reality is that isn’t going to happen (and if it did, it would probably represent a market top rather than a bottom). Low-risk opportunities in equities are typically not met with “all roses,” but rather something more similar to the view from the fairway on Azalea at Augusta after that perfect tee shot. A tough second shot, but one with many potential options that offer the possibility of very positive outcomes.

You can choose to play it safe and lay-up as Zach Johnson did to win the Masters in 2007. But now is not the time to just stare at this potential market with knees knocking, too afraid to pull something—anything—out of the bag.

Mr. Balser is the CEO of Balser Wealth Management in Avon, Ohio. He works with physicians to reduce risk in their investment and retirement portfolio to ensure they will not run out of income in retirement. He can be reached at roger@balserwealth.com.
Do your employees understand what performance behavior is expected?

by John Banja, PhD
Providing feedback is an important element of professional life, regardless of how experienced one is or whether one is on the giving or receiving end. Because feedback is primarily information and not praise or blame, its aim is to improve employee performance by focusing on job-related skills or techniques. Typically, that’s the way feedback is defined in the literature: as feeding information back into the system about the system’s performance, especially focusing on technical details that affect whether or not the system’s actual performance meets the desired or hoped-for performance. Importantly, feedback is not evaluation, which usually takes the form of a global assessment or judgment about whether productivity goals or targets were met, e.g., “You did a great job on that project.” Indeed, such a pronouncement is so vague that the employee can only infer that the performance goals were met; all he or she knows with any certainty is that the boss seemed satisfied with his or her performance. Feedback, on the other hand, primarily focuses on performance or technical proficiency and how it can be improved.

We never outgrow the need for feedback, no matter how good we get at what we do. In fact, very high functioning or top level performers often employ coaches or support personnel to provide feedback because virtually all of them reach a point at which they can no longer improve by relying on their own intuitions and perceptions. Many extremely high performing professionals—whether they are physicians, executives, scientists, or athletes—reach a point of “performance blindness” where they have exhausted their capacity to identify behaviors that need improvement or how they might continue to improve. Consequently, they seek out the insights and experience of others. Alternatively, an absence of feedback allows personnel to believe they are doing a good enough job, i.e., “No news is good news.” Many if not most people will typically consider their job performance as at least adequate, even when it isn’t—thus the importance of effective and regularly scheduled feedback sessions for just about everyone.

A central problem with feedback is that it requires skills not everyone has. Furthermore, various psychological and work environment factors can exacerbate the difficulties of giving good feedback. For example, many people fear that if their feedback is in any way negative, the coworker will become defensive, angry, hateful, or depressed. Leaders who are concerned about their popularity may be especially challenged in giving feedback as they fear hurting the other’s feelings and, perhaps most alarmingly, don’t know what to say or do if the other reacts poorly. Not surprisingly, one of the most common recommendations in the literature is to use the “sandwich” model for providing feedback: Start with a compliment or positive observation, then offer the more informational, skill or behaviorally related “meat” about job performance, and end with another positive comment.

In addition to figuring out how to deliver the content of the feedback, one has to think about the form of the communication. For example, feedback should usually occur in a private environment, where sufficient time has been allocated so the communicators won’t be rushed. Obviously, the feedback provider should have good interpersonal skills, and the end goal—which is to inform and improve work-related behaviors—is kept firmly in focus so the communication doesn’t stray into other areas.

The literature offers a wealth of suggestions on providing feedback. I had the opportunity to read a lot of it recently—actually, related to clinical performance—but the lessons of that literature can easily be translated to an office setting. So I’ve included a list of feedback “do’s” and “don’ts” in this article. Perhaps the most salient feature of the entire feedback process, however, is to establish an understanding between feedback providers and receivers that the goal of feedback is a thoroughly constructive, not destructive, one. All employees should accept the idea that their job performance can improve, regardless of how stellar it already is, and that they should rid themselves of their narcissistically based beliefs that no room for improvement exists (or that any criticism of their job performance implies they are worthless). Indeed, if we receive good feedback explicitly, constructively, and regularly—especially as a normal part of organizational operations—we might become better disposed to handle whatever psychological discomfort comes with discussing areas for skill

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improvement and maybe even become eager to seize the opportunity to perform better. I hope you’ll find the following “do’s” and “don’ts” list useful in developing your feedback communications.

**Do:**
- Ensure that the employee understands the performance behavior expected of him or her.
- Elicit the employee’s self-assessment.
- Focus on the individual’s job-related behavior rather than his or her personality, intentions, or thoughts.
- Identify behaviors that you want the employee to maintain and which ones need improvement.
- Explicitly describe, in behavioral terms, what improved behavior would look like, especially by relating it to a concrete action and event.
- Solicit the employee’s ideas on performance improvement.
- Maintain a neutral, nonjudgmental, objective communication style that is in keeping with feedback’s educational and informational objectives.
- Base feedback on direct observation as a non-observer’s feedback may lack credibility.
- Ensure that feedback rests on strong evidence as some employees may be quick to deny what others say about their performance.
- Recognize that feedback given early in a career tends to have the most impact.
- Provide feedback as soon as possible after a problematic act.
- Ensure that the feedback environment is private and respectful.
- Limit the amount of negative feedback, maybe to only one or two items, at a session.
- Elicit the employee’s emotional reaction to the feedback (but explain that the primary purpose of feedback is educational rather than an attempt to embarrass or humiliate).
- Conclude with an action plan that includes explicit behavioral objectives or changes.
- Document the meeting.
- Consider making feedback part of an institutional culture, especially as a normal, routine component of organizational life.

**Don’t:**
- Use generalizations or vagaries like “Try to be more careful or considerate” because the listener might not be able to translate the recommendation into a concrete behavior, example, or performance practice.
- Deliver feedback in ways that erode an employee’s confidence, e.g., “Do you really think you’re the person for the job?”
- Provide feedback, especially negative feedback, at a moment that takes the employee by surprise.
- Provide a tsunami of feedback all at once; it’s better to dole out small amounts of feedback more often instead of a huge amount of performance data whose sheer size might be difficult for the employee to digest.
- Phrase feedback in a way that might injure an individual’s self-esteem, e.g., rather than say, “You clearly weren’t in control of that situation, were you?” perhaps say, “Maybe the outcome would have been better if you did X, Y, or Z.”
- Compare the employee’s behavior to others, e.g., don’t say “Everybody else manages to arrive at the office on time; what’s your problem?” Say instead, “Your job responsibilities include being here on time, every workday. If you have special circumstances, let’s discuss them.”
- Fear creating “dissonance” in the mind of the employee; feedback is inevitably “disruptive” as it gets employees thinking about (performance) change.
- Use inflammatory language, profanity, or culturally insensitive remarks.
- Target behaviors that are not remediable or that are beyond the individual’s control.
- Be fearful; most employees are grateful for or don’t respond with hostility to feedback that is respectfully delivered.

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**Suggested readings**


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Dr. Banja is a professor and medical ethicist at Emory University, Atlanta, and a former member of the ASCRS Governing Board. Readers are invited to send comments or cases to him at jbanja@emory.edu.
S-16 Symposium: The Ethics of Femtosecond Laser Cataract Surgery

Sunday, April 19, 2015
4:45 – 6:00 PM Program
San Diego Convention Center
– Room 10

Program Chair
Richard S. Hoffman, MD

Panelists
John D. Banja, PhD
Rosa M. Braga-Mele, MD, FRCSC
Kendall E. Donaldson, MD
Donald N. Serafano, MD
Michael E. Snyder, MD
Abhay R. Vasavada, MS, FRCS

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7 steps to venture into oculoplastics
Eye surgeons looking to enhance their options for patients are increasingly considering oculoplastics.

Some ophthalmic practices are adding an oculoplastics specialist to their existing roster of physicians. Other surgeons are delving into oculoplastics in addition to the work they handle themselves as comprehensive ophthalmologists.

Venturing into oculoplastics is seen as a way to better serve patients’ needs; for example, in the rural community where Jeffrey Liegner, MD, Eye Care Northwest, Sparta, N.J., is located, it’s hard to refer out. So he handles both comprehensive ophthalmology as well as oculoplastics procedures. Dr. Liegner is a fellow of the American Academy of Cosmetic Surgery.

This is also an opportune time to consider adding the subspecialty to a practice because there’s an upswing in the number of related procedures performed.

Some of the most common procedures performed in the subspecialty include treatments for ectropion and entropion, ptosis repair, functional and cosmetic blepharoplasty, removal of tumors around the eyelids, various laser rejuvenation treatments, onabotulinumtoxinA (Botox, Allergan, Irvine, Calif.), and the use of fillers, according to the physicians interviewed for this article. The procedures done can be medically necessary or solely cosmetic in nature.

“The whole world is interested in anti-aging and looking good. This is a fun field to help with that population,” said John J. Martin Jr., MD, Coral Gables, Fla.

Cosmetic surgery statistics

• Eyelid surgery was the third most common cosmetic procedure in 2013, after breast augmentation (#1) and nose reshaping (#2). Eyelid surgery increased 6% compared with the previous year.
• The top 5 minimally invasive cosmetic procedures in 2013 were Botox, soft tissue fillers, chemical peels, laser hair removal, and microdermabrasion.
• There was the largest number of Botox injections to date in 2013—6.3 million.
• $12.6 billion was spent in the U.S. on cosmetic procedures in 2013. That’s a 15% increase compared with the previous year.
• Facial rejuvenation procedures including eyelid surgery, facelifts, forehead lifts, and neck lifts have seen an overall increase.


1. Start slowly and carefully.

The procedures done in oculoplastics may seem simple, but they require practice and some finesse. For instance, “a lot of physicians are sold a bill of goods from their rep that fillers are easy to do, but it takes time to learn, and they are harder than people think,” Dr. Martin said.

He recommends starting with familiar areas of anatomy, such as the treatment of crow’s feet or upper eyelids—the latter of which you would have learned in medical school.

Another approach is starting with ectropion and entropion, then moving on to upper eyelid blepharoplasty in older patients, Dr. Liegner said. Regarding the latter, “it’s an easy procedure but there’s bleeding that can be unsettling at first,” he said. Once comfortable in those areas, the surgeon can move on to try cosmetic blepharoplasty.

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3. Allot more chair time to discuss options and to educate. This extra time allows you to respond to patients’ questions and concerns but also to go over the array of options available to them. For example, a woman who says she wants a facelift may actually be better suited for a certain laser treatment, fillers, or Botox. It takes time to explain each area and then work with the patient on the best selection, Dr. Martin said.

Because oculoplastics patients require more time, Paul B. Johnson, MD, director of oculoplastics at Cooper University Hospital, Camden, N.J., and director of oculoplastics at Soll Eye, with 3 locations in Pennsylvania and New Jersey, blocks out more chair time, averaging about 6 patients an hour compared with 8 to 10 an hour for general ophthalmology.

Dr. Liegner uses a touchscreen educational program specially designed for ophthalmology that can also document a patient’s interest in certain procedures or treatments so the office can follow up and provide more information.

4. Plan for a bang-up website. State-of-the-art ophthalmic practices often have excellent websites. When adding oculoplastics to a practice, the information on your website should be similarly comprehensive and perhaps even more elaborate, Dr. Martin said. Some information to include on the website would be procedure details, how to schedule a consultation, before and after photos, and how to order any skincare products you might carry.

5. Get creative with your marketing. Soll Eye uses internal marketing with email blasts as well as monthly promotions, Dr. Johnson said. The practice also hosts a monthly Night of Beauty with a talk from Dr. Johnson and food for attendees. These all garner more interest in oculoplastics procedures.

Having handouts throughout the practice about your oculoplastics procedures is an easy way to get customers interested, Dr. Liegner said. He also has started to work in-house with someone who does permanent makeup using micropigment and tattoo techniques, and that’s created more traffic to the office.

Going forward, as more millennials have cosmetic work done, you will likely find that more patients will want to share their before and after results via social media or patient portals, Dr. Liegner said.

6. Carry quality skincare products. Patients will often turn to their cosmetic surgeons for skincare guidance, so you’ll want to get to know one or two quality skincare lines and stock their products. There’s a display case of Obagi Medical Products (Valeant Pharmaceuticals, Irvine, Calif.) at 2 of Soll Eye’s offices, Dr. Johnson said. Plus, if a patient asks, he’ll do a skin care analysis to see which products are best suited for him or her.

Dr. Liegner carries the Teoxane Cosmeceuticals available through Alphaeon (Irvine, Calif.).

7. Be patient. “It takes 5 years to build to a full oculoplastics practice. Don’t be discouraged,” Dr. Johnson said. He started 4 years ago doing almost all general ophthalmology and then gradually transitioned into oculoplastics. It takes consistent marketing efforts and education on the surgeon’s part regarding procedures.

Editors’ note: Drs. Johnson and Martin have no financial interests related to their comments. Dr. Liegner has financial interests with Strathspey Crown (Newport Beach, Calif.).

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What’s in a name? That which we call a rose by any other name would smell as sweet.

This oft-quoted passage from Shakespeare’s Romeo and Juliet applies particularly well to what is being called the biggest change to ever hit the Internet landscape.

What is changing?
Domain names are governed by the Internet Corporation for Assigned Names and Numbers (ICANN), and until just recently, there were only a handful—25 or so—of generic top-level domain (gTLD) name extensions available; the most popular and recognizable ones include .com, .net, .org, .edu, .info, and .gov. Beginning in late 2013, however, the first of more than 1,300 new extensions were introduced, with the others scheduled to become available in the very near future. These new domain extensions open up thousands of names currently unavailable within the very crowded .com marketplace. Among them are extensions that may have you reaching for your wallet, including .vision, .doctors, .docs, .health, .healthcare, and .surgery, to name only a few. This change also makes it possible for companies and organizations to register, manage, and maintain their own domain extensions (see box).

Before jumping in to buy up desirable domains within these new extensions ahead of your competition, take a deep breath and ask some questions.

How well are these new “opportunities” selling?
While you may expect a boom in the market for domains that make it possible for web users to recognize what your business does, actual demand has been disappointing. Of the 4 million or so domains now registered that include these new extensions, nearly 20% are part of a bulk purchase of a very generic “.xyz” extension by a party that used them as promotional giveaways—hardly indicative of a thriving, extensive, or high-volume market. The predicted “land rush” has not materialized.

How much should I expect to pay?
These new domain extensions are more expensive than traditional domain extensions. Many of the health-related prices range from $40 to $70 each per year, a cost intended to discourage bulk purchases that have tied up traditional domains in the past. While companies that handle the registration of new domains would have you believe that you need every option of every relevant extension, the sheer number of new domain options makes that strategy ineffective, cost prohibitive, and (as you will see) hardly necessary. With a carefully considered strategy, you may be able to spend as little as $15 and $30 per year for each of only one or two .com domains.

The new extensions do solve a problem, however. A number of desirable domain names are registered but not actually in use; they
have been purchased by individuals who “park” them for resale at inflated prices. The sheer number of new domain extensions and higher registration costs will likely make this type of speculation less lucrative in the future.

**How much do these new domain extensions really matter?**

At this writing, not much, yet the new naming landscape presents an interesting strategic challenge. While having an easy-to-remember domain name is almost always preferred, we can’t assume that new extensions will be well understood by the general public. The .com extension inspires a certain level of trust that may not transfer to unfamiliar domain extensions, even ones that are particular to medicine and healthcare. A domain name with a .vision extension may actually confuse patients and very generic extensions (.xyz, for example) even more so. It’s easy to imagine a perplexed user adding .com to the end of an unfamiliar extension, invalidating the domain name and compounding frustration.

Another benefit widely hyped by those who market the sale/registration of domains that include new extensions is search engine optimization (SEO). Currently, this benefit has not and—according to Google engineer and recognized SEO authority Matt Cutts—may not materialize in either the short- or long-term future. “You shouldn’t register a [g]TLD in the mistaken belief that you’ll get some sort of boost in search engine rankings,” he says, debunking claims that a domain with one of these new extensions will be favored by Google over a .com equivalent.²

Websites will not receive any preferential treatment based on the domain extension alone, and high quality relevant content will likely remain the best practice regardless of extension. In fact, as new domain name extensions eventually gain more recognition, SEO will become more important than ever for the discovery of information. Currently, users recognize and can remember addresses based on their .com or .net extension, but placing more domain extensions into use tends to minimize the importance of each individual extension. Relevant content and quality search engine optimization techniques will most likely have much more impact than the domain extension itself. If your website is already well optimized, adding a new extension to the mix will not improve its search engine ranking. Content remains king.

**Carefully weigh the benefits**

All this does not mean that these extensions should be completely avoided. It has been increasingly difficult to find an appropriate and memorable name for a website with a .com extension. These new extensions undoubtedly present opportunities for those who, until now, have not been able to purchase the domain name of their choice. A profile website for a specific doctor using the .doctor extension, for example, could be quite effective within the right context.

Likewise, a healthcare-related domain extension may be useful for a quality, well-optimized website for a surgery center. New extensions can support existing domain properties, and a highly relevant domain with one of the new extensions can be of value in supporting existing marketing efforts, as long as quality SEO and appropriate social media practices are also utilized.

As Shakespeare’s immortal line implies, the quality of your web presence matters more than its name. A carefully crafted strategy can protect it from the fate that befell his star-crossed lovers and keep it smelling like a rose. **OB**

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**What’s in a (domain) name?**

For example, what's in the name of this publication’s website?

**What the Internet sees:** 74.121.193.162

The rest of us see that number translated into a much easier to use URL (Uniform Resource Locator): [www.ophthalmologybusiness.org](http://www.ophthalmologybusiness.org).

The top-level domain name extension component of the address (often referred to simply as an “extension”) is .org. Familiar extensions, such as .com, .org, and .net, as well as the newer .doc, .vision, etc., are called “generic” top-level domain (gTLD) name extensions.

With a hefty financial investment, anyone can create and register their trademarked brand name as a proprietary extension. This makes it possible (but not necessarily advisable or cost-effective) to change this URL to [www.ophthalmologybusiness.ascrs](http://www.ophthalmologybusiness.ascrs).

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The team myth

by Gerry Sandusky

The 5 steps of successful team building

The NFL has 32 teams, not groups. Teams. All teams are groups, but not all groups are teams. Calling a group a team doesn’t make it one. That’s the team myth. Too many practice owners think of “team” as a label. It’s not. A “team” is an achievement—a dynamic process that includes talent, focus, motivation, and sacrifice. It has a personality, preferences, and a unique culture.

The team myth leads practices to think they can borrow a word or a label from sports that can replace or expedite a process. You can call the people who work in your practice a team, but that doesn’t mean they’ll act like one—until they commit to the 5 steps needed to form a team.

Step 1: Assemble a talented group of people

Talent matters. Every NFL head coach knows that the more talent he has on his roster, the smarter he becomes. Identifying and recruiting talent is only the first step. Talent alone is never enough. Every year in the NFL, talented teams fail to make the playoffs. It works that way in your practice, too. Talent is the starting point, not the finished product. Identify the talent you need. Bring that talent together. But don’t even think about calling that talent a team yet.
Step 2: Build everything around a clearly defined goal or series of goals
All teams organize around specific objectives. In the NFL, every team builds around the goal of winning the Super Bowl. To do that, teams map out a series of goals, with each goal moving the team farther along in the direction of the one major goal:
• Win each week’s game
• Qualify for the playoffs
• Win its division
• Earn a bye week to start the playoffs
• Earn home field advantage throughout the playoffs
• Win its conference title
• Win the Super Bowl

On successful teams, every member knows the primary goal or goals. It is communicated thoroughly and consistently. The goal provides a direction so powerful team members know when they have drifted off course. Everything a good NFL team does—from its practice schedule to its travel itinerary to its off-season conditioning program—should push the team in the direction of increasing its chance of winning the Super Bowl. And everyone on the team should understand that singularity of focus. What is the clearly defined goal or goals that will help reshape the talented individuals you have brought together into a team?

Step 3: Create a clearly defined and shared success benefit for each team member
No one on an NFL team shows up to practice every day focused on earning the head coach a new contract. Everyone arrives motivated by his or her wants, desires, and hopes. Harnessing that broad spectrum of ambitions and motives requires clarity.

Every member of the winning Super Bowl team gets a ring—a big, shiny ring unique to that team and that season. They have to earn it—together. There are plenty of other more vague benefits to success: endorsement deals, a new contract, national recognition, etc. But vague doesn’t galvanize individuals into teams. Ironically, neither do salaries. Salaries are part of step 1, attracting talent. The success benefit for a team has to extend beyond each team member’s salary and each member’s individual motivations. Salary is a personal benefit. Successful teams revolve around shared benefits. What is the shared success benefit for your team members?

Step 4: Every team member buys in with a specific and shared sacrifice
A team has members who sacrifice something important, something they all surrender. That surrender creates a buy in, the foundation of a merit system. No one gets to play right tackle for the Cleveland Browns just because his father played right tackle for the Cleveland Browns. The right tackle earns his job both on his individual merits and on the price he pays as part of the team. Every NFL team holds training camp, a month long grind of long days, hot practices, intense competition, and meetings that stretch into the night. Every team member gives up free time, pleasure, and family for the duration of camp.

As the season progresses, every NFL team has a leader in rushing yards, receiving yards, tackles, and sacks. On the best teams, those distinctions take on considerably less weight because the individuals who lead those categories see their efforts as a way to bring their team to a higher level of shared accomplishment. Ironically, on losing teams the statistical leaders often draw more attention to themselves. It becomes an individual focus. And that tears a team apart into a group, a group of individuals.

Have the members of your team paid a price to belong? Name the price. People value what they pay the most for.

Step 5: Hold the team to a specific time period
Groups, associations, and organizations are open ended. Teams are not. Teams have a specific start and end date. The first 4 steps help your team reach the start date. The fifth step, the end date, helps push the team with a sense of urgency, purpose, and focus. After this year’s Super Bowl, every one of the season’s NFL teams ceased to exist. The Baltimore Ravens, Chicago Bears, Philadelphia Eagles, Seattle Seahawks, and Green Bay Packers will all continue on as organizations. But the 2014 Philadelphia Eagles ended. That team ends the minute it plays its final game—and every team member knows it.

After the season, many of those 2014 team members will try to position themselves back at step 1: becoming part of the talented group the organization assembles for the 2015 season. Your team needs a specific time period that drives it toward achieving excellence. Is it a month? A quarter? Half a year? Two years? You decide. Make sure your team knows the date of its Super Bowl.

These 5 steps will transform your group into a team, and your team can transform your practice into a superior one. But just because you embrace the team approach doesn’t guarantee success. That’s the last part of the team myth. Thirty-one teams in the NFL fail to win the final game of the season. All 32 set out to build a stronger team the next year. OB
The changing ophthalmic practice

by Ellen Stodola Staff Writer

The ophthalmic practice has seen a number of changes recently, some of which impact how physicians interact with staff and patients on a day-to-day basis. These changes were highlighted in a session at the 2015 Hawaiian Eye meeting in Maui. A series of audience response questions were posed to see if physicians are as compliant as they think they are.

Alan Reider, JD, MPH, Washington, D.C., discussed the anti-kickback statute and what ophthalmologists must consider when giving anything of value to referral sources. He asked the audience what they consider things of value, including education opportunities, meals, and tickets to events and activities. The anti-kickback statute protects against giving anything of value in exchange for referrals. Ophthalmologists should be weighing all the risks and benefits when dealing with their referral sources. Factors to consider include what’s being offered, if you are offering it for free or for a charge, and if you are offering it to everyone or just referral sources. Mr. Reider also recommended not accepting financial support from industry when offering education programs to referral sources. He suggested that many potential compliance risks might be avoided by offering support to an independent third-party professional society, which would be responsible for the education program.

Mr. Reider addressed the topic of patient transportation. Patient transportation raises issues relating to the statutory prohibition against patient inducement, for which violators may be subject to civil penalties or exclusion from Medicare and federal healthcare programs. But for the past several years, the Office of Inspector General (OIG) has issued a series of advisory opinions approving of certain patient transportation programs, as long as certain criteria were met. According to Mr. Reider, the most important is that the provider not promote the transportation services; the provider should not offer transportation services until after the patient has confirmed his or her appointment. Mr. Reider reported that recently the OIG proposed safe harbor regulations for patient transportation services, which contained certain criteria; if these criteria were followed by a provider, the provider would avoid any risk of violating the patient inducement prohibitions. Among the criteria proposed were a limitation of transportation to a distance of 25 miles, limiting the service to established patients, and prohibiting the use of luxury transportation. These criteria may be changed when the final rule is issued in the future.

EHR

Candace Simerson, COE, Minnesota Eye Consultants, Minneapolis, and chair of the ASCRS•ASOA HIT Committee, discussed electronic health records (EHR), highlighting some of the “traps” involved with EHR, the first of which was password protection. “HIPAA privacy and security rules require that each user have a separate login and password in order to identify and track user identity,” she said. The practice must implement procedures for monitoring login attempts. She said practices must ensure they are doing this and mentioned that many electronic records programs have specifications requiring each user to have a different login.

It’s important to monitor who is signing off on chart notes as well, Ms. Simerson said. This becomes key in determining if the doctor actually saw a patient. If a staff person is signing off on a chart and not the doctor, the accuracy of the documentation may be questioned. If something were to go wrong, this becomes even more critical. Without a doctor signing off on the chart, there is also the chance that a prescription could be written without any checks and balances.

Another key point with EHR is the role of order and timing. Since everything is noted electronically by time, you need to carefully ensure that surgeries, tests, and other actions are documented in the order they happened. “You want to be as efficient as possible … and you want to think about your workflow and make sure that you’re doing it appropriately,” she said.

If charts are not handled correctly or electronic records are not accurately kept, there could be legal implications, compliance concerns, meaningful use failure, inability for patients and doctors to access medical records, compromised patient care, reimbursement and billing issues, and a number of other problems.

Editors’ note: Mr. Reider has no related financial interests. Ms. Simerson has financial interests with Alcon (Fort Worth, Texas) and Allergan (Irvine, Calif.).

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Key Features

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