Is it time for telemedicine?

Telemedicine services in ophthalmology today and in the future

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Many consultations for refractive surgery follow the same routine. A patient calls to schedule an appointment. On the day of their consultation, the doctor performs an exam and discusses the refractive surgery options. The patient pays for their consultation and leaves with information to schedule their surgery at a later date. It's an easy habit to get into. But what happens when the patient doesn't call back? For many patients, concerns about the cost of the procedure and how they will pay for it keeps them from committing. Talking about financing options in the consultation may help you see increased treatment acceptance and more scheduled appointments.

Show patients you understand their concerns about cost.

Patients spend on average 141.5 days to make a decision to purchase vision surgery.1 By the time a patient walks into your practice, they have already done extensive research on the procedure and cost. In fact, 79% of patients research payment options or consider finances when deciding on refractive surgery, but only about one-third actually ask their provider about financing options.1 Letting them know you offer flexible payment solutions could mean the difference between a patient accepting the procedure they want, and an alternative. Promotional financing options with the CareCredit credit card* can help remove the cost barrier by making it possible to fit precise vision into their budget.

Still not convinced? 71% of patients said they prefer to know exactly how much they need to pay each month to better budget for it.2 By showing patients you understand their budget concerns, you can help accelerate their choice and get a commitment during the consultation. If you make financing part of your new routine, you could increase your conversion rate and revenue.

Move past assumptions about patients and fees.

Many practices routinely make assumptions about which patients “need” financing that can lead to even lower treatment acceptance. Patients want the flexibility of paying monthly, even if they have the money available. It may be earmarked for something, so financing options can help them better plan how to pay for their procedure. You may also hesitate to offer financing because of transaction fees, which you perceive as increased overhead or reduced margins. Instead, you may offer options like a cash payment discount, even if it’s higher than some transaction fees. 51% of patients said they would consider financing options if it meant they could receive treatment right away.1 Rather than discounting your services, offer a solution like CareCredit.

You receive the value for your expertise and the patient receives the optimal care you’ve recommended.

Turn routine touchpoints into more procedures.

To ensure every patient gets the information they need to move forward, introduce financing options early and often throughout their search. These are three of the key moments where discussing financing options may have an impact on the patient’s decision:

• When patients call to make an appointment.
• During the consultation when patients learn they are eligible for vision surgery.
• At the time of the price conversation prior to scheduling their procedure.

The language you use at these touchpoints can lead to “Yes.” Asking questions like, “Do you need financing?” or “Do you need financial assistance” can put them on the spot, leading to snap judgements and “No.” It’s all about creating a dialogue. Instead, try this: “Many of our patients choose to take advantage of our special financing options. Is that something you’d be interested in?” Learning more about financing options during the consultation can empower patients to accept your best recommendation. A small shift in your routine can have a big impact on turning indecision into more appointments and revenue.
n this issue of *Ophthalmology Business*, we explore the current state and the future of telemedicine services in ophthalmology. Telemedicine is currently being used most for diabetic retinopathy and retinopathy of prematurity screening, but “informal” uses are becoming more common. “When a patient wakes up in the morning with a swollen eye or conjunctivitis and he or she doesn’t know what to do, you’re able to triage the patient. If you don’t know what’s going on, then you bring the patient into the office—it’s not a replacement for good care, it’s an adjunct,” said Ranya Habash, MD, Bascom Palmer Eye Institute. Read more about the uses of telemedicine as well as the possible barriers in “Is it time for telemedicine?”

Imagine this frustrating scenario: The instruments are prepped, implants and machinery are ready, but then the patient doesn’t show up, or he or she does arrive but is deemed medically unsuitable for surgery. Same-day surgery cancellations are an inconvenience for the surgeon, the center, the patient, and the person accompanying the patient. What are the primary reasons for these cancellations and how can you avoid them? Read “Cutting down on cancellations” to find out.

With so many people watching YouTube and other video sources nowadays, it's only natural that ophthalmologists would turn to videos for patient education. Well-chosen videos have several advantages to improve the patient experience, but this requires a thoughtful approach to choice, length, and content. “Videos advance patient education” presents tips for how a practice can maximize its use of videos, including adding a personal touch, making sure the message is clear, planning where to show the video, and more.

Also in this issue, John Banja, PhD, medical ethicist and professor of rehabilitation medicine at Emory University, explores the topic of mindfulness in clinical practice; Roger Balser, managing partner and chief investment officer of Balser Wealth Management, shares how to get into position for a market hit; and much more. We hope you find information in these articles that you can apply to your practice today.

We would also like to take a minute to thank the loyal readers of *Ophthalmology Business*, and let you know that we would like to hear from you. If you have a comment or idea for a future article, please feel free to contact us.

Don Long, Publisher
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Cutting down on cancellations

by Liz Hillman, Staff Writer

Reasons for same-day surgery cancellations and how to avoid them

The instruments are prepped, implants and machinery are ready, but then the patient doesn’t show up, or he or she does arrive but is deemed medically unsuitable for surgery.

Same-day surgery cancellations are an inconvenience for everyone involved. From the surgeon and center’s perspective, it’s a scheduling disruption and loss of productivity. From patients’ perspective, should they arrive and be rescheduled for another day, it’s another day of anxiety, possibly another day off work for them and the person accompanying them, and another day without a procedure they need to improve their quality of life.

Ocular surgery cancellations at the ambulatory surgical center of Massachusetts Eye and Ear, Boston, from 2001 through 2003 were analyzed with results published in 2006.1 Of the 7,153 cases during that time period, 5.35% were cancelled within 24 hours of surgery. Of these, 41% were considered “preventable,” 45% “unpreventable,” and 14% did not have a reason. Cancellation rates were higher in winter months and among pediatric cases. These late cancellations at Massachusetts Eye and Ear were estimated to cost at least $100,000 per year.

“Having a patient cancel at the last minute disrupts any doctor’s schedule and represents a missed revenue opportunity,” said Donna Damiano, Laser Center manager, Northeastern Eye Institute, Scranton, Pennsylvania.

From Ms. Damiano’s perspective, fear is a leading cause for same-day surgical cancellations for conditions that are not an emergency.

“The eyes are a sensitive organ and a vital part of anyone’s daily life, so it’s no surprise that patients are anxious beforehand, even when the procedure can significantly improve their vision, such as LASIK surgery,” she said, adding that she and her team “go to great lengths to make each patient feel comfortable, and this includes frequent check-ins leading up to the procedure to answer any questions and address any concerns.”

David Norris, MD, Wichita Anesthesiology, Wichita, Kansas, said from his perspective as an anesthesiologist, surgeries are cancelled most often because patients have not complied with nil per os (NPO)
guidelines or they have uncontrolled glucose or blood pressure levels when they arrive.

A study published in the European Journal of Ophthalmology for elective cataract surgery between 2001 and 2003, involving 1,952 patients, found 12% of cases were cancelled with the main medical reasons being systemic hypertension and improper control of diabetes.2

“Regardless of the type of anesthesia they’re going to get, whether it’s a general anesthetic or a block, we usually like to have those things under better control before we go to the OR,” Dr. Norris said.

Kumar Dalla, MD, Vitreo-Retinal Consultants, Wichita, Kansas, agreed that other health issues are often the driving factor for surgical cancellations, which he noted occur in about 5 to 10% of his cases each month.

If possible, Dr. Norris said he’ll try to normalize these patients to only delay their surgery until later that day, rather than cancel and reschedule it.

“If there is time in the day, we’ll try to rearrange the order of the cases…. Push them toward the end of the day, rearrange the schedule, and try to get their blood sugar, for example, under better control. That’s just our philosophy; I know some other anesthesiologists might disagree with that,” Dr. Norris said. “We want to get [patients’] surgeries done to the best of everyone’s ability.

 “[Cancellations are] an inconvenience for everyone. We lose out on the room time. We usually don’t have another case to put in, so there is lost productivity. Then there is the inconvenience for the patient and their family. They either took a day off work or someone took a day off work to come with them, so it’s more than just us or the surgeon [a cancellation is] inconveniencing,” he said.

While reorganizing the schedule is, of course, not ideal, Dr. Dalla said it’s better than cancelling completely and having a wasted spot. Not only does it save the patient time in the long run, but Dr. Dalla noted that a surgical kit might have already been opened or a special lens ordered, so keeping the surgery on the same day, if possible, is an advantage.

While patient safety is the number one priority, Dr. Dalla said if the patient’s health condition can be managed and re-evaluated, the case could possibly be done the same day with some scheduling shuffling.

Other reasons for cancellation include a conflict in the patient’s day-of-surgery caregiver’s schedule and weather/transportation issues. Yet another possible reason for cancellation, Ms. Damiano said, is an inability to pay.

To further prevent issues that could cancel or delay surgeries, Dr. Norris said about 10 years ago he helped establish a preoperative assessment anesthesia clinic, which includes an in-person meeting or phone call with the patient a couple of days ahead of surgery. This meeting instructs the patient on NPO guidelines, medications they should or should not take, and more. Timing of the surgery day-of will also be scheduled based on the patient’s needs to better ensure it goes off without a hitch. Children, diabetics, and others who need more medical management are scheduled for surgery earlier in the day.

Dr. Dalla said a good scheduler is also critical.

“If you have someone who is a smart scheduler, like I have, they can pick up on pitfalls ahead of time. You need someone with the right personality and attention to detail,” he said.

A scheduler should not only have a good understanding of the patient’s ophthalmic needs, but also his or her systemic health conditions. If a patient is on dialysis Monday/Wednesday/Friday at a location 4 hours away from the surgery center, for example, the scheduler should know not to schedule surgery on those days.

“The person scheduling the cases is key,” Dr. Dalla said.

With all of these measures in place, Dr. Norris said it’s rare that a surgery gets cancelled. If he deems it necessary to delay or cancel a surgery, he said it is a “simple, honest, direct conversation” with the ophthalmologist.

“They know if we come to them with a concern, it’s not that we want to cancel a case or get out; we just want to do what’s best for the patient and what’s best for them as a surgeon,” Dr. Norris said.

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Editors’ note: The sources have no financial interests related to their comments.

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The shifting role of the modern ophthalmic administrator

by William B. Rabourn Jr. and Louis Pennow, MBA

The field of ophthalmic medicine is constantly shifting. Often comparable to a high-stakes game of Tetris, where new technology and regulations emerge frequently, find their place within the industry, and reshape the landscape, medicine’s perpetual additions create a variety of complications and opportunities for patients, doctors, and staff alike. The resulting excitement surrounding this continuous shifting often distracts medical professionals from the less obvious, often overlooked changes taking place within their own practice, specifically those related to the ophthalmic administrator’s mounting responsibilities.

As eyecare evolves, so does the ophthalmic administrator. Their role is radically different compared to 5 to 10 years ago. Those in this position in 2017 may find themselves carrying a bucket of responsibilities larger than ever before due to a demanding practice environment, today’s medical landscape, and government requirements. However, caught up in the need to keep up with their own changing role in the practice, some doctors and others in charge of selecting these managerial figures have unrealistic or undefined expectations for those filling the lead administrative position. Many are not even aware of how much the role has changed or how much many administrators are struggling to keep up with their modern job requirements.
Lower the bucket, not your expectations

It’s time to accept the difficulty of finding an administrator who has a comprehensive understanding of every single area of medical management required to run a practice today—and one who has the time to add to that already extensive and ever-growing bucket of responsibilities. Depending on the size of the practice, this bucket may be filled with responsibilities such as:

- HR (payroll, compliance, new employee recruitment including professionals, overseeing the corporate 401K plan)
- Budgeting, forecasting, equipment procurement, A&Ms, satellite starts
- Financial management, both micro and macro
- Marketing, staying ahead of the ever-changing delivery modalities
- Maintaining contracts, insurance, BSA, tertiary services
- Community outreach, both in the local referring community and in the local commerce market
- Tracking and keeping up with governmental regulatory changes
- Managing the managers
- Board duties
- Legal and ethical oversight, including social media complaints and positive score oversight

If an ambulatory surgery center or optical department is involved, administrators can expect to see these responsibilities double or triple.

Every administrator may bring a different skill set to the table, specializing in one or several of the responsibilities listed above but not all. While one person may excel as an optical department administrator, knowing how to manage these specific employees and teaching them to sell and understand the patient/buyer’s needs, another person may have little to no experience managing this kind of team but may have an impressive background in accounting. Another may have extensive IT knowledge, while yet another excels at tracking and ensuring compliance with regulatory changes such as the ICD-10 switch.

However, the modern administrator need not be the person with the most specialized skills but the one most able to manage a wide variety of outsourced skill. In other words, lower the bucket so that others may reach in and carry the load, but make sure the bucket is held by an administrator qualified enough to keep track of these specialized helping hands.

Choosing successful outsourcing contacts

While some doctors may be hesitant to agree to outsourcing work traditionally handled solely by the administrator, the fact is that doing so in 2017 could be the best way to streamline the business side of a practice, eliminating inefficiencies by relying on experts for certain resources and increasing cash flow overall.

The trick is deciding which resources to outsource. Each administrator’s individual knowledge base and background, as well as the skill set of those currently reporting to the administrator, will determine what is best outsourced within a practice. Some of the most commonly outsourced resources include:

- Billing
- Collections
- IT
- Accounting
- Coding
- Marketing
As it becomes increasingly more unrealistic for the ophthalmic administrator to be the sole bearer of the towering responsibilities placed in his or her bucket, he or she must consider transitioning away from being the “doer” and move more prominently toward the role of “manager.” This does not mean that the administrator should no longer have any hands-on roles within the practice, simply that he or she may be better able to meet all the needs of the practice by delegating and overseeing certain responsibilities while focusing more fully and efficiently on the unique skills that he or she, and direct employees, bring to the practice.

By accepting that the ophthalmic administrator’s role has changed and adapting accordingly, a practice takes crucial steps toward modernizing and optimizing its business.

Perks of outsourcing to one comprehensive company vs. multiple

The decision to outsource practice needs to one comprehensive group or to several separate companies will also depend on the skill sets present within a specific practice. Although, by selecting a single company that offers comprehensive medical business services, or at least all of the services that a practice is looking for, it is possible to increase efficiency and make management of outsourced resources more convenient.

Keep in mind that this efficiency is dependent upon the administrator selecting a group that is already knowledgeable about the ophthalmology business. In fact, whether a practice decides to use one or multiple companies for outsourced services, it is important to seek out those who are familiar with the eyecare industry. Otherwise, in addition to handling matters of business within the practice, the administrator may be unintentionally taking on the task of training those outside of it.
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Read it, Watch it, Share it!
F or at least the last 5 years, patient safety experts have been voicing a deep concern that the production pressures that shape the delivery of today’s health care have become so onerous that they are frankly jeopardizing patient safety. Whether care occurs in a family practice clinic, an ICU, or an ophthalmologist’s office, the fear is that the pressure to produce (and conserve) revenue makes for excessive stress, distractions, and cognitive lapses that cause clinicians to breach the “edge of the hazard envelope.” Once that happens, clinicians will be flying by the seat of their pants because they are no longer in reasonable control of the variables that can precipitate disaster. Usually, disasters are averted by clinicians paying close enough attention to their environments so that they can detect and extinguish safety threats before they materialize. But when there is excessive cognitive noise, disruption, or overload—too many patients to be seen, not enough staff, inadequate documentation, unreliable or complex technology, unworkable policies, unfamiliarity with a procedure or a particular patient’s symptoms—one’s performance will become much more vulnerable to errors, mistakes, lapses, standards deviations, and shortcuts that go unnoticed until they morph into nasty adverse events.

Since the Institute of Medicine’s “To Err Is Human” report appeared in 2000, patient safety has moved to the forefront of our professional consciousness, making the safety-productivity tradeoff even more glaring. Not surprisingly, numerous strategies have been offered to ease the tensions connected with high consumer demand, its economic sustainability, and quality care. This article will focus on a particularly challenging but interesting one: mindfulness.

Mindfulness is often characterized in the psychological, meditative, and religious literatures as an in-the-moment awareness combined with a nonjudgmental acceptance of one’s emotions and thoughts. These practices are complementary in that people allow themselves to be immersed in not only their patients’ descriptions of their symptoms but also how they are dressed, talk, express anxieties and concerns, what they do for a living, and what they value (and hate; you can tell a lot about a person by finding out what he or she hates). Furthermore, the mindful practitioner (MP) couples this awareness with an open mind and a reluctance to evaluate or judge what’s happening. The MP lets go of his or her biases that might cause misinterpretation, assumptions that might be unwarranted, and the temptation to feel unreasonably confident despite inadequate evidence—in short, all the stuff that can skew our thinking, cause us to leap to hasty and unwarranted conclusions, and miss things. Because space is short in this article, I’ll list some of the more common strategies of the MP that apply to any practice setting.

**Techniques of the mindful practitioner**

**Practices humility.** The MP is exquisitely impressed with Herbert Simon’s notion of “bounded rationality”—that is, that our environments, our knowledge, and our cognition are imperfect, flawed, and limited. That acceptance is based on humility, and allows much of the rest to occur.

**Frequently steps outside of and objectively observes his or her performance.** The MP is extremely self-critical but not in a self-disesteeming way. Rather he or she realizes that endless and relatively mindless immersion in task performance will not improve its delivery. Consequently, the MP practices stepping outside his or her performance and imagining how it is perceived and evaluated by an independent observer. Often, this occurs after a task is performed and the actor reflects on how it went and how he or she could have done better.

**Implements cognitive forcing strategies.** Here the MP is particularly concerned about not succumbing to the ways automatic and relatively mindless task execution can dispose to errors and lapses. Forcing strategies are ways that the agent—while performing the task—can check the tendency to rush through it uncritically. Thus the clinician will ask him or herself things like, “What do I not want to miss here? What am I..."
assuming, and are my assumptions reasonable or defensible? What are reasonable diagnostic or treatment alternatives? Do I have enough information to go forward?"

Seeking feedback. The MP knows that performance is in the eyes of beholders, who are colleagues, supervisors, and consumers of care. So, the MP is eager for feedback since he or she knows that without it, it is very difficult for performance to improve. The MP takes a page out of the professional athlete’s handbook: always seeking instruction and sometimes even coaching, no matter how experienced he or she is. Again, left to our own devices, our performance will eventually hit a ceiling beyond which we won’t improve. The only way to get better is with independent, objective, and expert instruction and advice.

Resists being overly optimistic. Excessive optimism is one of the most pernicious causes of disaster. Because it is difficult to approach and correct a colleague whose performance is poor, clinicians often rationalize their reluctance to speak up or take remedial measures by becoming excessively and unreasonably optimistic. The frequently heard excuses are, “Nothing bad has happened so far;” “It isn’t my job to fix poor work habits;” “I don’t have time;” “He usually gets through, and he’s been here a long time;” and so on. The fact that everything is fine so far, however, doesn’t mean it will stay that way.

Expecting things to go wrong. The mindfulness counterweight to excessive optimism is what James Reason described as a “feral” or “twitchy” vigilance. Given the MP’s embrace of Herbert Simon’s bounded rationality, he or she expects that things will often go wrong; indeed, as Richard Cook opined, systems always run in a degraded mode. The MP is always exercising “foreseeability” by imagining how factors affecting work operations might invite disaster and then goes the extra yard to fix them.

Knows where the landmines are. The MP develops important knowledge through his or her learning trajectory in knowing where opportunities for disaster lurk. This oftentimes only comes with considerable experience wherein the MP is exposed to numerous preventable adverse events and learns what can be done to avoid them.

Committed to life-long learning. The MP realizes that he or she is on a life-long learning curve and that one of the reasons for disaster is the unceasing innovation occurring in health care through new technology, drugs, devices, regulations, policies, and standards of care. The MP therefore understands life-long learning as inevitable and resigns him or herself to the relentless cognitive demands that innovation requires.

Reviews, studies, and teaches botched cases. This is painful, but reminding oneself of how things went wrong and what could have been done to avert crises is part of most training curricula in high-risk occupations like airline safety or police work. It is well recognized that the best people commit error. Also, disaster occurrences usually require multiple people making multiple errors. Consequently, a good strategy for reviewing botched cases is with a group. And teaching such material, especially by seasoned veterans, suggests to learners that no one performs flawlessly.

Humility. It is remarkable how an attitude of humility underlies mindfulness. Without it, our psychological defenses, which are typically unleashed when one perceives his or her self-esteem under threat (such as from error commission), tend to get in the way. Paradoxically, while mindfulness seems a solitary and socially detached undertaking, much of it works best with others, who can help analyze the forces at play, maintain a just culture, and develop strategies for balancing the always present safety-productivity tradeoff. Again, the above recommendations apply to all clinicians. However, as ophthalmology practice is hardly immune to the production pressures that beset contemporary medicine, perhaps mindfulness techniques can be especially helpful in delivering quality ophthalmologic care and maintaining excellent relationships with patients as well as among office personnel. 

Suggested readings


Videos advance patient education

by Vanessa Caceres, Contributing Writer

Videos advance patient education

A series of videos on various procedures and conditions. For patients who will have cataract surgery with the Catalys Precision Laser (Abbott Medical Optics, Abbott Park, Illinois), links to the videos are sent to patients before they visit the practice as well as on the day of the visit, prior to their workup.

“When patients come into the lane, it’s obvious who has seen the videos and who hasn’t based on the questions they’re asking,” Dr. Brockman said. “The ones who have seen the videos are educated and are asking the proper questions. That has been a big bonus for both parties.”

Videos also give physicians and staff a starting point to facilitate a discussion of ocular pathology and surgical procedures, said Inna Ozerov, MD, Miami Eye Institute, Hollywood, Florida. Her practice uses videos from Rendia (formerly Eyemaginations, Baltimore), YouTube, and the app Sight Selector (Patient Education Concepts, Houston).

Because patients can play them as often as needed, videos enhance the patient’s educational potential on a topic. “Someone can go back and hear a message multiple times until the point sticks. There are only so many times a doctor or health provider can say something in a standard appointment,” said Dan Farkas, lecturer of strategic communication, Ohio University, Athens, Ohio.

Videos with spoken words also can help low vision patients, who may struggle with reading written materials, said Julia Rosdahl, MD, PhD, Department of Ophthalmology, Duke University, Durham, North Carolina.

When used as part of other educational efforts at a practice,
videos help address concerns about health literacy. “Generally, videos are thought to be a useful means of increasing health literacy as well as improving patient engagement, activation, and knowledge,” said LaKesha Anderson, PhD, assistant director for academic and professional affairs, National Communication Association, and part-time faculty, communication MA program, Advanced Academic Programs, Johns Hopkins University, Washington, D.C. In fact, the U.S. Department of Health and Human Services’ Health Resources and Services Administration recommends the use of videos to help overcome health literacy barriers, which can include the use of words patients do not understand, lower education levels, cultural barriers, and limited English proficiency, Dr. Anderson said.

The downsides?
Still, videos aren’t always a perfect solution.

First, providers must carefully select the ones they will use. “I think the biggest hurdle is choosing the right video at the right time for each patient,” Dr. Rosdahl said. “For example, a video about glaucoma surgery is not useful for a glaucoma suspect patient and might scare her, and a video generally about glaucoma is likely boring for a long-standing glaucoma patient.”

Videos also still challenge patients if the images or spoken words are not at the right health literacy level for patients, Dr. Rosdahl said. While it’s easy to assess the readability of a written document, this may be harder to do with a video if a transcript is not available.

Additionally, videos still require explanation. “The videos are just the starting point. We use them as a way to prepare patients for what’s to come and to give them a more in-depth understanding of their condition and the procedure,” Dr. Brockman said.

6 tips for video use
Here is how your practice can maximize its use of videos for better patient education.

1. Don’t feel the need to make your own if you aren’t ready to do so. There are a lot of high-quality products out there already, Dr. Rosdahl said. Some video sources that physicians in this article like include ones from Rendia, pharmaceutical companies, YouTube, Sight Selector, and the American Academy of Ophthalmology.

That said, Dr. Brockman said his office has been happy with the videos that it created as it makes patients feel more connected to the practice and the doctor before they even visit.

2. Watch the videos yourself. “Quality varies,” Dr. Rosdahl said. When you watch, make sure they are appropriate for your patient mix, and check for length. “Nowadays, the attention span for videos is 2 to 3 minutes. Shorter is better,” she said. The videos you choose also should help illustrate concepts that are hard to explain—for example, a video can perhaps better show how aqueous fluid is made and drained and what happens in high pressure glaucoma, she added.

3. Plan where to show videos. Patients in Dr. Rosdahl’s office can watch them in the clinic while they are dilating, on video monitors, and at home. The office provides short URLs that can be inserted into the patient instructions document. You can also show videos in your waiting area, but choose carefully. A video about retinal detachment may frighten some routine patients; videos about instilling drops are great educational tools, but keep in mind that instructions may vary by providers and types of surgeries.

4. Add a personal touch if you can. If you decide to make your own videos, consider adding brief video bios about your team of doctors, Dr. Brockman recommends. “We share tidbits about our lives and some of our favorite things, like our favorite sports teams and food, so our patients can relate to us on a more personal level,” he said.

5. Make sure the video’s message is clear even if the person is only listening. “Many people simply listen to a video and glance away from their phone, tablet, or computer…. I assume one-third of my audience can’t hear my message and one-third can’t see my message. If those people can still get the gist of my message, I’m in good shape,” Mr. Farkas said.

6. Plan how you will show the video—and what technology you may need. This requires ample space and equipment if patients watch videos at your office, Dr. Anderson said. At Dr. Ozerov’s office, the availability of tablets has been a perfect medium for patients to access videos and apps.

Outside the office, you’ll want to make sure patients know where to find your videos and confirm they can access them, Dr. Anderson added. Keep in mind that not all patients will want to watch them. “This may be especially true of older individuals who are less knowledgeable about technology or more skeptical of the trustworthiness of technology,” she said. OB

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Editors’ note: The sources have no financial interests related to their comments.

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Is it time for telemedicine?

by Liz Hillman, Staff Writer
Ranya Habash, MD, Bascom Palmer Eye Institute, Miami, had more than a dozen patients in her office when she received a call from the emergency room of the local hospital. She was asked to come immediately to evaluate an orbital fracture for surgery.

Unable to leave her busy clinic at the drop of a hat, she asked for a texted picture of the patient’s CT scan and arranged a video call on her phone to discuss with the ER physician and the patient.

“Thirty seconds later we ascertained the patient wasn’t entrapped and didn’t need surgery. [They] sent him home on oral antibiotics, got all the orders started, and that was it. I hung up my cell phone and went about my business,” Dr. Habash said.

A couple of days later, she got a call from the hospital’s compliance officer: This exchange was not HIPAA compliant.

“I said, ‘I don’t understand: I’m happy, the patient was happy, the ER doctor was happy, everyone was happy,’” Dr. Habash said.

With that in mind, Dr. Habash, a TopLine MD consultant, soon thereafter spoke with her brother, a software engineer, who told her that he could make her a HIPAA-compliant app that was as easy to use as regular texting and video chatting.

So HipaaBridge (originally HipaaChat, which was acquired in 2014 by Everbridge, [Burlington, Massachusetts], a global software company for which Dr. Habash is now the chief medical officer) was born. HipaaBridge is by no means alone in the market of HIPAA-compliant communication apps or programs, which seek to make telemedicine more accessible and applicable to physicians.

**Current state of telemedicine**

In ophthalmology, Christina Weng, MD, MBA, assistant professor, Baylor College of Medicine, Houston, said telemedicine is currently being used most for diabetic retinopathy and retinopathy of prematurity screening, but more “informal” uses, such as the case Dr. Habash described, are becoming more common.

“For instance, part of my clinical effort is spent at the Ben Taub General Hospital, one of the country’s busiest county hospitals. We recently purchased a device that attaches a tablet to a slit lamp to take photographs and upload them to the patient’s electronic medical record. The residents and fellows frequently consult me using a patient’s slit lamp or funduscopic photographs. This allows me to teach and contribute to the management plan even when I am unable to be there in person, sparing the patient a delay in care or an extra trip back to the clinic to see me. Even photographs taken on cellular phones are often used today to share data, either patient to provider or provider to provider,” Dr. Weng said.

Dr. Habash also offers telemedicine for some follow-up visits.

“As patients are leaving the office, my receptionists will have them download the app and we confirm them just like a regular patient and put them on the schedule for 1 week later. At that time they’re at home sitting at their desk at work and we do a quick follow-up. It has been invaluable to me in an outpatient setting,” she said.

While Dr. Habash might have integrated telemedicine into her practice, she doesn’t think it is being fully utilized in the field.

“We’re so equipment heavy and people might feel like if they don’t have their equipment, they’re not doing a good exam. But there are many examples where you can triage patients in 30 seconds and tell them what is going on. Those are the types of things that people don’t think about doing, but it’s so easy,” Dr. Habash said.

**Retinopathy screening and beyond**

The American Academy of Ophthalmology and the American Diabetes Association recommend diabetic patients receive a dilated funduscopic exam every year to screen for retinal issues. However, of the millions of Americans who have diabetes, Dr. Weng said only an estimated 50% to 65% receive such screening.

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Telemedicine is already helping close this gap and is expected to increase screenings for these patients as well. According to Dr. Habash, Bascom Palmer offers teletenital screening for diabetic patients at the time of their primary care visits. Massachusetts Eye and Ear partnered with Massachusetts General Hospital to do the same.

“Trained radiology technicians capture images with a flash-based, non-mydriatic fundus camera using the Joslin 3-field technique,” said Brian Song, MD, Massachusetts Eye and Ear, Boston. “These images are uploaded to a secure server where they are read by a Mass Eye and Ear ophthalmologist or optometrist, and a note describing the findings is placed in the patient’s electronic health record. The patient’s primary care doctor is copied on the note and made aware of the findings. If a face-to-face examination is needed, then the readers work with the primary care doctor to facilitate an appointment with an ophthalmologist.”

Dr. Weng said she thinks there is great potential for telemedicine to branch into glaucoma, too.

“Glaucoma is another silent blinder and one of the most common causes of vision loss in the world. The optic nerve’s cup-to-disc ratio is fairly simple to image. Better yet, if retinal nerve fiber layer optical coherence tomography could be integrated with the camera technology, screening for glaucoma would become even more reliable and potentially save countless people from blindness,” she said.

Telemedicine is already being used in some cases to expand access to specialist care for those in rural settings or underdeveloped countries and also for second opinions.

“Its applications are even being evaluated by NASA for use in outer space. The possibilities are endless,” Dr. Weng said.

In addition to expanding care, Dr. Habash explained how telemedicine can help the health care system, using the orbital fracture patient as an example.

“[That patient] would have waited 5 hours for me to finish my clinic and then come to the hospital to assess. Instead, the patient was able to have orders started and get an answer within 30 seconds. That’s invaluable. Not only is that beneficial for the patient—and for me—it’s also a benefit to the hospital because there are CMS Core Measures that the hospitals need to follow, and one of them is the ED throughput time. That means they have a finite amount of time to see a patient from presentation to the ER to discharge from the ER or admission into the hospital. The biggest chunk of time that is lost is in waiting for the providers to call back or waiting for orders to be started. When you can expedite that, you are helping the workflow of the whole system, which decreases costs and increases efficiency for the providers, the hospital, and the patients themselves.”

Possible barriers

While there are more than 30 CPT codes that apply to telemedicine, Dr. Weng said only two codes are specific to teleophthalmology: one for remote imaging for detection of retinal disease and another for remote imaging for monitoring and management of active retinal disease.

“Sadly, the current reimbursement levels preclude many smaller practices from offering teleophthalmology services,” Dr. Weng said, noting that the capital for some equipment and personnel to conduct telemedicine programs can be substantial.

On the flip side, how are doctors reimbursed for “e-visits” using free, yet HIPAA-compliant, apps? That’s where a parity law—one that requires private payers to reimburse physicians in states with this legislation as if an e-visit were conducted in person—comes into play. According to the American Telemedicine Association, 29 states plus Washington, D.C., have telemedicine parity laws, one has a partial parity law, and several have proposed legislation. In states that don’t have a parity law, Dr. Habash said it is up to the private payer to decide whether or not telemedicine services will be covered.

“In my experience, it has been widely covered,” she said. “Some of the payers are making telemedicine contracts with the physicians at the hospitals and other telemedicine services because they realize it cuts costs for the health system if you can keep patients healthier without having them come into the hospital.”

What about liability if, for instance, a patient argues that a misdiagnosis occurred because an evaluation was performed remotely via telemedicine rather than in person? Dr. Habash said most malpractice carriers offer telemedicine coverage.

Dr. Weng predicts liability standards will become more defined over the next decade, but for now she stressed the importance of informed consent from the patient, HIPAA-compliant storage and data transfer, and knowledge of state regulations if services cross state boundaries.

While telemedicine might be increasingly demanded by the highly connected millennial generation and beyond, Dr. Weng thinks it will be a necessity just to meet the needs of the aging population as fewer eyecare professionals are available.

“Telemedicine can be tremendously helpful in these circumstances by identifying patients at greatest risk for vision loss, thereby optimizing the utilization of in-person evaluations. Still, in-person visits will always be the core of medicine. Ophthalmologists should not be fearful
that they will be replaced by telemedicine; rather, they should view it as an adjunctive technology that will allow us to better serve our patients,” Dr. Weng said.

“We are just beginning to scratch the surface of how telemedicine might be helpful in ophthalmology,” Dr. Song said. “Developing standardized methods to remotely monitor patients with chronic eye diseases, such as glaucoma, has the potential to change how we deliver health care and may be part of the solution to deal with over-crowded clinics and long wait times so that only the most acute and sick patients have to be seen via a traditional face-to-face encounter. Teleconsultation (i.e., second opinion) services are just beginning to gain traction and allow patients to receive expert opinions from other institutions without having to leave the convenience of their home. As technology improves and telemedicine tools become more portable and accessible, patients may be able to begin screening themselves for vision-threatening eye conditions like macular degeneration and glaucoma. One day, physicians may even be able to provide certain treatments remotely, like laser photocoagulation or laser trabeculoplasty.”

Editors’ note: Dr. Habash has financial interests with Everbridge. Drs. Weng and Song have no financial interests related to their comments.

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Imagine a scenario where the market drops 20% this year. Sounds drastic, but in fact it did just that in 2001, again in 2002, and once again in 2008. Back then, many investors used the majority of the next big move up just getting back to even instead of making money.

But suppose in this scenario you were able to avoid the “big hit” and experience a flat return or just a minuscule loss. You’d be in good shape going into the next move up in the market.

Back in the 1980s and 1990s, absorbing just a small loss in a year where the market dropped 20% would be called “significant performance” relative to the rest of the market. This is because folks in the market back then were more interested in “relative returns” and not “absolute returns.”

The reason so many were interested in “relative” returns was simply because throughout the 1980s and 1990s, we were on a tear in a secular bull market. Every pull back was simply a great buying opportunity. You were labeled a hero if the market dropped 25% in 1 year and you only lost 10%.

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At Balser Wealth Management, we’re not that interested in “relative” returns, and you shouldn’t be either. What we are interested in is absolute returns.

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How to get into position for a market hit

that haven’t yet given buy signals. At 40%, there’s plenty of room on the upside.

But say 80% of all stocks are on buy signals. Then there aren’t many stocks left to produce buy signals. So the odds of the market moving much higher become fairly slim.

That means almost all stocks are now on buy signals. At that point, there’s only a few left that haven’t given buy signals. So anyone that wanted to get into the market is most likely already in. At this point, demand is beginning to dry up.

What we want to watch for is when the bullish percentage starts falling off from those levels because that signals that supply is now starting to come back into the picture.

So where are we today? Basically everything’s calm right now. The New York Stock Exchange Bullish Percent, our main indicator, is on offense with good field position. This means that there is possibly more room for the market to run. But we’ll certainly hit rough waters some time in the future, and we’ll want to have a game plan because there’ll be no time for deliberating, only time for action. OB

also wasn’t raining when Noah built the Ark.

I like to be prepared for the worst, rather than make emotional, snap decisions about investments. (Those are almost always bad decisions.)

Wouldn’t it be better to have a clear indication of the trend of your investments before we make a decision to sell? Hopefully you won’t need to take defensive steps right away. But eventually, you’ll need to use some of these action steps.

First, there are times to play “offense” in the market and times to play “defense.” Playing offense (meaning to stay invested in the market 100% of the time) is just not a game plan. Playing offense 100% of the time (never selling) means you’ll ride the roller coaster all the way to the top and then all the way down.

Why go through the harrowing roller coaster ride when we have tools that tell us, very clearly, when supply starts to control the market? Anything with too much supply sees a price decline. That’s not theory or even a fact. It’s a basic economic principle.

Although I can’t guarantee you’ll be getting out at the very top, I have clear signals when demand has dried up and supply begins to take control.

Remember, the main objective when we play defense is to sidestep severe losses in your portfolio and stay in the game.

Step one is to know whether we’re on offense or defense. The way I know this is by monitoring the bullish percent charts. These insightful charts simply show the percentage of stocks on buy signals. If only 40% of stocks are on buy signals, we know there are a lot of stocks around

steps to protect your investment and/or retirement dollars at that time.

Losing money affects your returns for many years, not just 1 year. That’s because if you have a year where you lose 20%, you’ll need to make 25% to get back to where you started. So it’s important that you do your best to avoid big losses in your account, whether that account is your regular brokerage account, your 401k at work, or some other retirement plan.

What should you do to avoid big losses when the market starts falling?

Well, the market is not falling now (as I write this article), but it

Mr. Balser is managing partner and chief investment officer of Balser Wealth Management, Avon, Ohio. He can be contacted at roger@balserwealth.com.
8 merger and acquisition trends that your practice should keep in mind

by Vanessa Caceres, Contributing Writer

Buyers, business partners eye ophthalmology's attractive demographics

An ophthalmologist may consider a merger or an acquisition by another practice for several reasons. A larger-sized practice offers economies of scale during purchasing and gives practices more ability to meet regulatory requirements such as PQRS, Meaningful Use, Value-based payment modifier, and the Merit-based Incentive Payment System (MIPS), as well as engage in larger clinical trials, said Brenda Laigaie, an attorney with Wade, Goldstein, Landau & Abruzzo, Berwyn, Pennsylvania. Practices also can maintain their patient base while expanding their geographical scope. Some ophthalmologists are interested in mergers and acquisitions as a vehicle for succession planning. Here are eight trends within mergers and acquisitions (M&A) in health care and ophthalmology as shared by health care M&A experts.

1. The M&A field within health care—including ophthalmology—has seen a whirlwind of activity the past several years, said Steve Wybo, senior managing director, Conway MacKenzie, Birmingham, Michigan. Mr. Wybo specializes in helping distressed businesses and is a certified turnaround professional. “2015 was the biggest year ever for health care mergers and acquisitions, with $500 billion in sector investments,” Mr. Wybo said, citing data from the trade magazine Modern Healthcare. Since the passage of the Affordable Care Act (ACA), M&A for medical practices continued to rapidly increase, with the exception of dips in 2012 and 2013 amidst further reform initiatives. The shift to newer health models, including population health and value-based reimbursements, has factored into the M&A activity, Mr. Wybo said.

Ophthalmology arrived late to the M&A table but is catching up, said Michael Gurman, an attorney and partner, Abrams Fensterman, Lake Success, New York. “Solo ophthalmologists are realizing it’s becoming harder for them to survive due to decreased reimbursement and rising costs. Joining larger group practices has allowed them to continue their business autonomy to an extent while obtaining the benefits of a large practice,” he said.

2. There is an increasing number of contractual arrangements in addition to—or instead of—mergers and acquisitions. Within the subspecialty of retina, Ms. Laigaie saw a downturn of M&A activity in 2016. “All of a sudden, we’re seeing a pause in the merger and acquisition world,” Ms. Laigaie said during a presentation at the 2016 American Academy of Ophthalmology annual meeting. However, she now sees more lease arrangements, personal service arrangements, patient-centered medical homes, and even accountable care organizations interested in retina practices. “The mergers may have slowed down, but contractual affiliations are continuing,” she said.

Mr. Wybo has noticed a similar trend throughout ophthalmology in general. “Ophthalmic specialists and small practices are seeing increasing costs and decreasing revenues from recent regulations, causing many to think about consolidation. This leads us to a new trend in health care involving strategic mergers, partnerships and joint ventures for the first time in a long time between hospitals and ophthalmic practices,” he said.

3. Buyers consider ophthalmology more closely nowadays due to appealing demographics. The large and growing number of senior patients seen by ophthalmologists
attracts the attention of health care practice buyers, Mr. Wybo said. It also helps that a number of patients are willing to pay out of pocket for premium eye services, therefore reducing the risk of a potential revenue shortfall if insurance payers continue to withhold/reduce reimbursements that fail to meet ever stringent quality and value standards.

Despite these advantages, practices will need to stay lean if they want to be considered for a merger or acquisition. “Medical practices that can stay ahead of the curve by reducing costs and implementing electronic health record systems and data analytics for quality measurements will maximize their reimbursement potential and be more attractive in the marketplace,” Mr. Wybo said.

4. Ophthalmic ambulatory surgery centers (ASCs) are attractive to hospital buyers. Although hospitals once viewed ASCs as competitors, the increasing emphasis on cost cutting and providing value in less costly settings has led hospitals to recognize the benefits of ASCs, Mr. Wybo said. “This has contributed to the recent appeal of ophthalmic ASCs that have become increasingly qualified and experienced at providing safe, efficient, and high-quality care at much lower costs than hospitals,” he said. Ophthalmic ASCs can benefit from hospital affiliation with better negotiating power with non-government insurance carriers and a larger pool of skilled employees; they also can leverage the hospital name for successful marketing. Mr. Wybo cited the St. Johns Providence Health System in Michigan, which recently formed a partnership ASC with ophthalmologists to form the Eye Surgery Center of Michigan.

5. Hospitals and larger practices aren’t the only entities purchasing practices. Private equity involvement has made inroads in the purchase of practices, Mr. Wybo said. “Private equity interest in specialty providers is growing due to increased competition for facility-based organizations like traditional hospitals and surgical centers, which is in turn driving up prices and forcing investors to explore other opportunities,” he said. Private equity firms have had a particular interest in dermatology, pain management, and dentistry due to the high reimbursement potential. In some markets, deals with private equity or corporate management companies have a purchase price more than 10 times their earnings before interest, taxes, depreciation, and amortization, Mr. Gurman said.

6. Optical sales are less valuable for ophthalmologists in acquisitions. “Those who sell these products are sometimes seen to be in competition with potential referral arrangements such as optometrists or other retail locations,” Mr. Gurman said. “The referral of cataract patients and other procedures is viewed to be more valuable than the profits derived from the sale of eye glasses.” Sometimes, medical practices with optical sales are less valuable for large practices to acquire, he said.

7. Disrupters may affect health care M&A. The merging of technology with health care—and just about everything else—has started to affect M&A activity, Mr. Wybo said. He explained how companies like CVS and Walgreens, technology firms like IBM Watson, and large insurers increasingly use their capital, technological expertise, and advanced databases and data analytics to “disrupt” health care and better target and retain the loyalty of health care consumers. Telemedicine is another disrupter that alerts the doctor and patient interaction, he added. This focus on big data, big capital, and big cash flow will continue to influence all of health care, including M&A trends, Mr. Wybo said. Kenneth Kaufman, chair of the Skokie, Illinois-based firm Kaufman, Hall & Associates, has done a good deal of research in this area, Mr. Wybo said.

8. Changes under the new presidency may not change current M&A trends. President Donald Trump has said he may repeal elements of the ACA, leaving it uncer-

Three questions to ask during a merger or acquisition
Take the above trends into consideration if you are considering a merger or acquisition of your practice—and make sure to ask three questions before you make a commitment.

What’s the end game? “Too many ophthalmologists are focused on finalizing the deal that is immediately in front of them without considering the future,” Mr. Gurman said. This question is key both for buyers and sellers. “Medical practices are like custom puzzles. Each medical practice can choose how they want their puzzle to look in the end, but if they don’t think about the end result, the pieces may not all fit together,” he said.

Who’s part of your deal dream team? For successful M&A deals, you’ll want a seasoned mix of physicians, attorneys, accountants, consultants, and internal management personnel, Mr. Gurman said. If any of these roles are not properly handled, the deal may fall apart or the venture could be unsuccessful.

What sort of financial synergies, cost savings, and growth will the practice achieve through M&A? “Practices should use data obtained through due diligence and forecasts to compare projections with long-term strategic and financial objectives to make more informed business decisions,” Mr. Wybo said.

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Overcoming patient transportation obstacles
by Liz Hillman, Staff Writer

One of the barriers to nonemergency medical care, which includes many ocular services, is getting a ride to and from appointments and surgical procedures. “Believe it or not, getting a ride to surgery is a big hindrance for the patient,” said Ranya Habash, MD, voluntary assistant professor of ophthalmology, Bascom Palmer Eye Institute, Miami. “It requires a family member or friend to take the day off work and is particularly tough on patients who live alone.”

In fact, a 2005 study published in the Transportation Research Record: Journal of the Transportation Research Board estimated that 3.6 million people in the U.S. miss medical care opportunities due to a lack of transportation.¹

Medicaid covers some measure of nonemergency transportation as a benefit. However, some of the specifics of this benefit—who can qualify, prior authorization, etc.—are left up to the state to implement. There are still challenges facing this benefit, including cost and oversight.² In addition, patients often face long wait times and no-show drivers, causing some to ultimately miss the care they were scheduled to receive.

As such, some programs are establishing relationships with alternative ride programs like Uber and Lyft. Dr. Habash said she has been looking to bring such a service to Bascom

Ride services help to increase appointment retention, improve care, and reduce costs

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Palmer in the future, calling it a possible “godsends for surgical and clinic patients.” There are nuances, however, especially for surgical patients who undergo anesthesia.

“You can’t let a patient who was under anesthesia take an Uber home,” Dr. Habash said, citing possible safety and legal issues. “[However,] a lot of medical centers have started using a third-party consultant to provide malpractice insurance or coverage [for these situations]. It’s a third party that keeps track of the patient from the facility to home. It makes it much more feasible to send them with someone who is affiliated with the medical center in some way but is still part of one of these services.”

In January 2016, Lyft and National Medtrans Network announced a partnership to bring transportation to Medicaid beneficiaries in New York City. In a blog post, Lyft stated that it was providing up to 2,500 rides per week to senior patients in New York. With some in this demographic not owning smartphones—and thus the app through which Lyft drivers are arranged—the company’s Concierge program allows third parties to request the ride for them.

Later in 2016, Uber announced the pilot of a similar program—Circulation—at Boston Children’s Hospital, Mercy Health System in Pennsylvania, and Nemours Children’s Health System in Wilmington, Delaware.

Michael Ruiz, MedStar Health vice president and chief digital officer, said since partnering with Uber, patient satisfaction seems to be high and it costs significantly less than calling a cab.

“Among our favorite patient stories is one of an elderly woman who relied on taxi cabs to transport her to her routine radiology appointments,” he said. “She would call for a cab, then start doing her hair while waiting for the cab to arrive, since the wait time was 45 minutes on average. The first time she called an Uber to transport her to her appointment, he arrived within 10 minutes to find that she was still in her robe and curlers.

“Another patient was scheduled to have surgery at MedStar Washington Hospital Center and discovered the day before the surgery that he no longer had a ride, at which point he was routed to Uber for help with transportation,” Mr. Ruiz said. “Because of MedStar’s effort to enable access, the patient arrived for his appointment on time and received the medical care he needed.”

For ophthalmic services, Mr. Ruiz said Uber can be particularly useful.

“Eye procedures generally don’t allow patients to drive so they’re required to rely on either public transportation or family/friends for transportation. Utilizing Uber enables ophthalmic patients to conveniently travel to appointments without taking unnecessary risk behind the wheel or being at the mercy of someone else’s schedule,” he said.

Mr. Ruiz said ride services like Uber have allowed patients, especially those with chronic conditions, to receive care on a regular basis. It also eliminates the burden of finding a parking spot and a long walk from the parking garage.

“Uber has also helped our hospital system as a whole because it has been effective in reducing missed medical appointments,” Mr. Ruiz said. “Generally, missed appointments are a result of unreliable transportation for those who either don’t have their own mode of transportation or those who rely on others to drive them to appointments. Utilizing Uber enables these patients to consistently arrive to their scheduled appointments. This also translates to cost savings because we don’t spend as much money treating patients who are able to routinely access preventative care.”

Mr. Ruiz advised practices or hospital systems interested in providing ride services to patients to work with an Uber-like partnership as a supplementary process to an existing process for vouchers for taxis and public transportation, so as to not have to reinvent policies.

“The health care industry as a whole needs to work together to further explore how we can bring about regulatory change to better leverage technology from other industries to provide improved access to health care and an overall better patient experience,” Mr. Ruiz said.

In the older community, Dr. Habash said ride services like Uber and Lyft are spreading “like wildfire.”

“One person in their residence or community takes an Uber ride and is so happy with the result, they tell all their friends,” she said.

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Editors’ note: The sources have no financial interests related to this comments.

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