Carving a path for female ophthalmologists

Opportunities and challenges abound for new women physicians P.8
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According to the American Medical Association, the number of women physicians among all specialties leaped from 195,500 in 2000 to nearly 309,700 in 2011. In ophthalmology, the percentage of female physicians increased 63% in that same time period, from 2,628 in 2000 to 4,131 in 2011 (compare that to only 395 in 1975). In this issue’s cover feature, “Carving a path for female ophthalmologists,” contributing writer Vanessa Caceres explores the benefits and challenges that women physicians face. She interviewed women and men in the field and compiled their advice for better managing a new ophthalmic career and trying to strike a work and family balance.

What do you say to a patient who comes to your office excited to have laser vision correction surgery, but tomography shows a flag during preop testing? Or perhaps the patient does not understand that any kind of laser vision correction is not going to prevent presbyopia. In “Managing patient expectations,” four surgeons share what they tell patients who may be less-than-ideal candidates for refractive surgery or who have unrealistic expectations about the surgery.

Through surgical video postings, discussions online about difficult cases, and pearls shared on blogs and other forums, social media sites including Facebook, YouTube, and society pages can provide surgeons multiple ways of connecting and educating. Two ophthalmologists share their experiences with social and digital media websites in “Social, digital media excellent platform for peer, resident education.”

Targeting communities where the majority of residents come from another country or speak a language other than English can be a great way to build your refractive business as well as cataract or routine eyecare. However, you’ll want your marketing efforts targeted toward a niche cultural market to take a thoughtful approach—you can’t just take what you do in English, translate it, and wait for the new business to come. “Grow your practice by attracting a new cultural niche” offers 11 ways to make your marketing to a niche cultural market more effective.

You will find these and more articles in this issue of Ophthalmology Business; we hope you enjoy them. Thank you for reading!
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Managing patient

by Michelle Dalton Contributing Writer

Reeling in unrealistic expectations may mean convincing patients to wait a bit longer or declining surgery altogether

The scenario is all too common—a potential laser vision correction patient comes to the office, excited to be spectacle-free (or at least to rely a lot less on glasses and/or contact lenses), and undergoes the gamut of preop testing. Topography is normal. The patient may have low corneal cylinder and a normal-to-high corneal thickness, but tomography shows a flag. Or a patient presents in his/her late 30s as a high myope, develops a retinal tear that creates a cataract and decreased best corrected visual acuity in one eye. Or a patient does not understand that any kind of laser vision correction is not going to prevent presbyopia.

“I tell patients everyone gets a stiff lens and loses the ability to read, no matter if they have laser vision correction or not,” said Vance Thompson, MD, director of refractive surgery, Vance Thompson Vision, Sioux Falls, S.D. “I’ve even told patients there used to be only two sure things in life—death and taxes. There are plenty of people in the news who don’t pay their taxes, so now I tell them the only two sure things in life are death and presbyopia.”

The “golden rule” of medicine is to give patients the same treatment you would want to receive, said Uday Devgan, MD, in private practice in Los Angeles, and chief of ophthalmology, Olive View – UCLA Medical Center. Dr. Devgan said if any preop diagnostic test came back questionable, “I would want my doctor to tell me I may not be the best candidate in the world for the procedure and here’s why.” If his patients are willing to accept some of those higher risks, Dr. Devgan will usually proceed with the surgery.

“If the patient is at a much higher risk for potential complications and our preop diagnostic tests determined that, I would rather err on the side of caution and opt against any kind of surgery,” Dr. Devgan said.

Borderline cases are often the hardest for Carlos Buznego, MD, in practice at the Center for Excellence in Eye Care, Miami, and voluntary assistant professor of ophthalmology, University of Miami’s Bascom Palmer Eye Institute—especially those that are highly motivated for laser vision correction.

“Telling a patient you’re not sure you have the magic bullet they want can be difficult,” he said. “But don’t give into patients just because they’re insistent. As surgeons we have to be strong and not allow the patient to talk us into something we don’t think is right.” He includes early enhancements among those gray areas.

Technology is not the be-all and end-all, said Y. Ralph Chu, MD, in private practice, Chu Vision Institute, Bloomington, Minn. “It’s not an absolute answer. There is still some aspect that has to be applied to the science and that’s a personal
choice—not just from the surgeon’s standpoint, but the patient has to be an equal partner in the decision since it’s an elective process.”

**Preop patient expectations**

Of the three hypothetical examples first mentioned, Dr. Chu said one of the hardest dilemmas any refractive surgeon will face is when a patient has poor visual potential in one eye.

“I've spent as much as 3–4 months talking a patient down from surgery and into contact lenses if there is little hope for a good prognosis otherwise,” he said. “In that scenario, the dilemma for the surgeon becomes an issue of educating the patient that he is no longer a refractive patient, but a medical patient with a cataract and retinal detachment.” It’s with these patients that Dr. Chu spends the most time mapping out a surgical strategy that may include a combination of laser vision correction, implantable contact lenses, and/or IOLs.

For Dr. Thompson, when preop testing shows a caution, he’s more inclined to recommend PRK rather than LASIK.

“We have a much better understanding of how to lessen haze, too, so for a number of reasons PRK is sometimes a more conservative approach,” he said. “If there’s borderline thickness, there’s always the option of a phakic IOL, too.” If he sees signs of severe eye rubbing, he’ll also dissuade a patient from laser vision correction.

“If they’re really insistent on LASIK I tell them they’ll have to prove they can stop rubbing their eyes first,” he said.

In his practice, once he explains presbyopia to patients and that patient age is as much a factor as refractive error, most are willing to have a monovision result or get reading glasses. “I have an eye model in the office and show them that while I can reshape the cornea to help them see better, I cannot provide a flexible lens (I call it the ‘reading lens’), and the only way to achieve those outcomes is through refractive lens exchange or cataract surgery,” he said. Until a patient is over the age of 50, Dr. Thompson recommends waiting for refractive lens exchange.

Dr. Buznego repeats tests with anomalous findings. “If a patient is walking and talking and the test says his heart rate is 10 instead of 100, you doubt the test, not the exam,” he said.

Dr. Devgan cautions surgeons about taking on every case, too.

“Sometimes plano is not the best refractive target for patients age 40 or older. Instead, leaving one eye slightly myopic may buy an extra five or 10 years of not needing readers,” he said. “In other cases, such as low myopes of presbyopic age who routinely take off their glasses to read, the best recommendation for the patient may be no surgery at all.” Never be afraid to turn away a patient unless you’re thoroughly convinced surgery is going to help improve vision, he said.

**Postop patient expectations**

Sometimes managing patient expectations is just as difficult postoperatively.

“How many times has a patient complained about an unacceptable outcome but if you push him off for a month or so, suddenly the patient says the vision is great?” Dr. Buznego asked. “Don’t be afraid to say no to a patient. In the end, you’re going to be the one who lives with the decision—and increased patient dissatisfaction—in the long term.” For overly insistent patients, he recommends trying to counsel them by relating anecdotes of other patients in similar situations who had both poor outcomes and good outcomes.

Dr. Thompson explains to patients that he “can do pristine measurements and deliver a pristine treatment with the world’s most sophisticated technology. But I can’t control every cell or your healing response,” he said. Patients who are close to their ideal postop vision may never get there, he said.

“If they’re on the 5-yard line, we can sometimes get the touchdown, but other times we’re going to get stopped on the 1-yard line,” he said. That’s when it’s helpful to re-explain that LASIK (or PRK) “is not about eliminating spectacles, it’s about eliminating dependency.”

Editors’ note: Dr. Buznego has financial interests with Allergan (Irvine, Calif.) and Bausch + Lomb (Rochester, N.Y.). The other physicians have no financial interests related to this article.

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Carving a path for female ophthalmologists

by Vanessa Caceres Contributing Writer
Opportunities and challenges abound for new women physicians

Women physicians have some advantages in ophthalmology—and the requisite challenges.

It’s well known that more females are entering medicine in general as well as ophthalmology. Data from the American Medical Association show that the number of women physicians among all specialties leaped from 195,500 in 2000 to nearly 309,700 in 2011. In ophthalmology, the percentage of female physicians increased 63% in that same time period, from 2,628 in 2000 to 4,131 in 2011 (compare that to only 395 in 1975).

About 50% of residency spots are held by women now, said Eric D. Donnenfeld, MD, clinical professor of ophthalmology, New York University, New York.

“Healthcare in general and ophthalmology are undergoing a transformation led by women,” Dr. Donnenfeld said.

Medical societies are even stepping up to become more inclusive, said Dr. Donnenfeld, the current president of ASCRS. He noted that more than 50% of the members of the ASCRS Young Physicians Committee are women and that there are dynamic women leaders on other clinical committees.

The benefits

Ophthalmology is an attractive specialty for females and males alike who are interested in innovation and care continuity.

“I like the surgical aspects and the continuum of care with ophthalmology,” said Valerie Trubnick, MD, Ophthalmic Consultants of Long Island, Rockville Centre, N.Y. Dr. Trubnick had originally considered another specialty but was lured by ophthalmology’s continuous innovations and the rich potential for future research.

“Ophthalmology is a specialty on the frontier of new and exciting treatments and technology,” said Marsha D. Link, PhD, Link Consulting, Irvine, Calif., a firm specializing in executive coaching and practice development, and president-elect of Ophthalmic Women Leaders (OWL). “The specialty thrives on thinking outside of the box.”

With the Baby Boomer explosion in healthcare and the expansion of premium lenses, females have a great chance to help guide families through their ophthalmic decisions, said Audrey Talley-Rostov, MD, cornea, cataract, and refractive surgeon and partner, Northwest Eye Surgeons, Seattle.

Yet another reason that ophthalmology may appeal to physicians in training is that it’s possible to have a life outside of practice, said Sandra Yeh, MD, Springfield, Ill.

“There are decent office hours, and the specialty allows for a family life,” she said. “I’m usually home around 5 or 6.”

“It’s easier to achieve a work-life balance. There are relatively few emergencies compared with other specialties,” said Dr. Talley-Rostov.

Being female, Dr. Yeh said she has an easier time emotionally connecting with her patients—she can offer a hug to patients or affection that might seem more odd coming from a male ophthalmologist, she said. She also will broach topics in a patient’s personal life if she is aware of them, such as children or a spouse’s illness or death.

Females in ophthalmology are also proud to serve as leaders for the younger generation. Dr. Trubnick said a patient recently brought his daughter to the practice so the daughter could meet a female role model.

... And the challenges

Of course, that doesn’t mean that female ophthalmologists have a cakewalk nowadays—far from it. Practices and conferences are still primarily male dominated, and some old-school thinking still exists, Dr. Donnenfeld said.

Although ophthalmology lends itself better to the elusive work-life balance than some other specialties, finding time for everything is a perennial challenge, Dr. Yeh said. “You’re inevitably juggling two careers—one in the office and one at home,” said Dr. Yeh, who is the principal partner of six offices with 115 employees—and the mother of two children, ages 13 and 19.

Because of the time crunch, one thing that often gets short shrift is networking with optometrists who could potentially send business Dr. Yeh’s way. She tells the story of a
golf event among optometrists and ophthalmologists; she couldn’t attend the golf event so she decided to come to the dinner. She arrived for the dinner and “everyone had already teamed up. They were pre-networked and pre-cliqued. I never went back,” she said. She finds it awkward to network at all-male events, and she doesn’t have the time for golf that some of her male colleagues seem to have.

Dr. Yeh takes other networking moves to connect with potential referrals (see next section of the article).

Although the number of female ophthalmologists is increasing, it’s not yet completely evident at conference podiums, said Dr. Talley-Rostov. “When female colleagues and I go to conferences, a number of us are on national and international committees, but we’re heavily outnumbered,” she said. “It’s multifactorial but probably stems from women not being as visible or not being invited.”

Dr. Link said she also sees a challenge for women in deciding how to orchestrate their ophthalmology career. “There are many talented women who come out of training and are accustomed to hard work, study, and competition. They are driven and competent, but often fail to take the time to define their own definitions of success and intentionally create plans to achieve it,” Dr. Link said.

Then there’s the day-to-day challenge of being recognized—literally—as a physician and not another caregiver. “I do a rotation at the VA and someone once said to me, ‘Hey nurse, can you bring me the comma?’” said Dr. Trubnick. That has not happened to her husband, who is a neurologist.

Dr. Yeh has experienced the same issue of getting mistaken for a nurse. She will wear special clothing to distinguish herself from others in the office.

True advancement for women in ophthalmology won’t happen until both men and women come together to discuss where improvements are needed and develop more understanding of each other’s perspectives, Dr. Link believes. “We need to get both to the table to talk about opportunities and challenges. Otherwise, we won’t make real headway,” she said.

Advice for new women ophthalmologists

There are great opportunities for women in ophthalmology if they thoughtfully plan their career and make efforts to get their work known, said the sources interviewed by Ophthalmology Business. Here’s some advice to better manage a new ophthalmic career—and try to strike a work and family balance.

1. Reach out to potential role models and mentors. A female ophthalmologist new in her career should contact a fellow female colleague who is a few years further along to find out what work and family decisions she has made—and how and why they made them, said Dr. Donnenfeld.

Joining groups like OWL can help female ophthalmologists network and meet more women colleagues, Dr. Donnenfeld said.

Finding a mentor is an ideal way to learn from that person’s experiences and identify new opportunities, said Dr. Link. “The women I know got where they are because of a mentor. They were smart enough to leverage the mentorship to get where they want to go,” she said.

2. Find new ways to network. Because Dr. Yeh does not have time to network via more traditional routes, she does something that an older ophthalmologist once taught her. During the holiday season, she’ll personally take a tray of cookies or other goodies to her optometrist referrals to say thank you for the business. She tapes her card to the tray. She also offers to help with clinical education for the optometrists as often as possible. “They lack the educational tools that we have,” she said.

3. Consider some different items for your exam room. Dr. Yeh has available in exam rooms a pamphlet-size brochure that includes her picture, so patients know that she’s the physician—not another caregiver. She also has photos in exam rooms of her two children. The photos break the ice for small talk and help to identify her as a real person, not just “the doctor.”

4. Do your salary research. When you join a new practice and make salary arrangements, make sure that your work is properly valued compared to both male and female colleagues, Dr. Talley-Rostov advised.

5. Get involved in studies, speaking engagements, and other opportunities outside of the practice. Consider state, national, and international involvement in ophthalmology when you can, said Dr. Talley-Rostov—even though it may be harder to do at certain points in your career and family life.

“I think women are poised now to increase their visibility, but they have to be intentional about it,” Dr. Link said. “They have to carve out and create a network. Unless they think about that carefully, they won’t know how to get there.”

Having a supportive partner—and extra help at home for chores or watching the kids—can help female ophthalmologists balance their time better, Dr. Yeh said.

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Dear Friends & Colleagues

After the overwhelming success of the 26th APACRS in Singapore in July 2013, the APACRS is moving on to the second most populous country in the world, India. As we have seen in recent cataract and refractive surgery meetings, there have been many significant contributions to the scientific literature and film festivals from the Indian subcontinent. It is timely therefore that we return to India for the first time in 17 years.

We have deliberately chosen the city of Jaipur, the capital of Rajasthan as the venue for the meeting. Jaipur is at the heart of the “golden triangle” in Indian tourism, the other two points of the triangle being Delhi and Agra where the unmissable Taj Mahal is located. The meeting will be held in the wonderfully designed Fairmont Jaipur which is reminiscent of an old Indian fort. It is near the famous Amber Fort and nature reserves. We have chosen 13-16 November 2014 as the date of the meeting as the weather is at its finest then, warm in the day and cool in the night.

Come join us in Jaipur for the best of cataract and refractive surgery in the Asia-Pacific in a setting where you will see and experience the wonders of Incredible India for yourself!

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... and more
Everyone these days, it seems, has a Facebook page, many for staying in contact with family and friends. But the social media site, as well as other social and digital media websites, can be an effective way for surgeons to connect and educate.

Through surgical video postings, discussions online about difficult cases, and pearls shared on blogs and other forums, social media sites including Facebook, YouTube, and society pages can provide surgeons multiple ways of connecting and learning.

“I think [social media] is the best way to [present] education material, and for ophthalmologists whose primary job is not education, it’s also a great way to educate their patients. I think for those reasons, it’s powerful,” said Thomas Oetting, MD, University of Iowa Hospitals & Clinics, Iowa City. “It’s a way for us to learn and grow as ophthalmologists. It’s also a great way to learn from each other.”

Dr. Oetting helps run EyeRounds.org, an educational website from the University of Iowa Department of Ophthalmology and Visual Sciences, which is his longest running project in the field, a “Cataract Surgery” page on Facebook, which has well over 14,000 likes, as well as a blog called “Cataract Surgery for Green Horns,” which has more than 180,000 page views. He said the online concept was started by then-resident at the university, Andrew Doan, MD, who Dr. Oetting called the “grandfather of digital ophthalmology” because he recognized the all-important future for ophthalmology in social and digital media.

The website, Facebook page, and blog cater to surgeons in a “for surgeons, by surgeons” format. This approach has worked effectively, Dr. Oetting said, with Facebook allowing for the most interactivity of the three.

“What I have found, particularly on the Facebook site that we have, when we post a video [of a case] that was tricky for us, an interesting or a common problem that surgeons encounter, we get all kinds of feedback, and it’s productive feedback,” he said.

**Benefits, concerns**

Jorge Arroyo, MD, Beth Israel Deaconess Medical Center (BIDMC), Harvard Medical School, Boston, started a vitreoretinal web video series called “The Endoscopic View” to educate students and surgeons, offered through the BIDMC website.

“The process of learning, at least in medicine, not just in ophthalmology, and especially in surgery, is essentially a communal process,” he said. “It’s a process that involves more than one person’s experience, more than one person’s thoughts, more than one person’s education.”

Dr. Arroyo said the morbidity and mortality conference, or M&M, is an important part of student education, facilitating discussion among physicians about the various challenges, stakes, and issues in surgery. He started the endoscopic video series in January as an experiment, to see if education similar to live M&M conferences could be successfully achieved digitally.
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“I believe we’re approaching a new era. We’re on the cusp of hopefully taking a step where the traditional M&K conference can be expanded to a global scale,” he said.

Social media has both its benefits and concerns, with one benefit being its expanded reach around the world; one concern is, with the expanded reach, those without adequate training or experience might enter the space as authorities, Dr. Arroyo said. “I don’t think that opening up that process to everyone is beneficial. I think it might actually be counterproductive. Figuring out mechanisms for who should or can participate is one of the issues that comes up,” he said.

Social media has been especially beneficial, Dr. Oetting said, in helping promote the “just in time” educational approach that has become popular with residents. He said the approach provides two to three minutes of directed education. For instance, if a surgeon or resident is looking to implant or learn how to implant a Malyugin ring, he or she can go online and watch several videos of it being implanted.

“It’s clearly the way [education is] going,” Dr. Oetting said. “There’s too much to learn for our residents—there’s too much to learn for all of us, really. You can’t waste time with intellectual inventory that’s not useful. You can’t burden yourself with that.”

He said when surgeons need more educational assistance, they can seek it online through peer videos and commentary that presents information about surgical issues they are encountering.

“Now what you can do is, the night before you’re going to use a new lens or a new instrument, or [a procedure] you haven’t done in a while and you want to refresh yourself, you can find this ‘just in time’ little pearl of information,” he said. “There’s so much content available now along those lines that it’s changed everything.”

How to get involved
For physicians interested in taking a bigger part in social and digital media, Facebook or video-sharing sites are a good place to start, Dr. Oetting said. While it takes work to record a video in the operating room, edit it, and upload it onto the internet, the effort is worth it, he said.

“If you put a nice video online that is narrated and people think it’s worth two or three minutes of their time to look at it, oftentimes they’ll comment and then everybody gains. I think that’s the coolest thing about it—that you can learn yourself and you can help others to learn,” he said.

Dr. Arroyo said that one of the biggest incentives for him in running “The Endoscopic View” is that editing his videos has made him a better surgeon.

“It provides important feedback for me, which I think has led to me making better decisions and having better results,” he said.

Dr. Oetting said that the American Academy of Ophthalmology and ASCRS forums also can be excellent places for surgeons to enter into the social media space, taking part in discussions there, and sharing pearls and tips. In addition, posting videos on Eyetube or YouTube can be helpful, he said.

Another idea is to start a blog, an easy-to-do-process through blog hosting websites, where surgeons can directly reach an audience on their subspecialty or interest.

“Let’s say you encountered some interesting complications with the femto-laser and you want to have an unbiased forum about that,” Dr. Oetting said. “That would be a nice thing to start a blog on. You could start writing about your experiences on that [while] other people are going through the same thing, but maybe you’re six months ahead of the learning curve, and you can help people. I think if you do it because of a desire to educate, a desire to help, it will succeed.”

Editors’ note: Drs. Arroyo and Oetting have no financial interests related to this article.

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The greatest smart money secret to financing ophthalmic equipment and other major capital outlays

by Mitch Levin, MD, CWPP, CAPP
e ophthalmologists have very large capital equipment needs. Only radiology comes close to our level of expenditures. Further complicating things, we have the added expense of significant and rapid technologically upgrades, as well as a level of commercial competition that most other specialties cannot fathom. So how do the most successful ophthalmologists win and keep winning financially?

First of all, from a capital standpoint, they understand that you finance everything you purchase. This is a very simple, yet very important concept that most fail to grasp. So, I repeat: You finance everything you purchase.

You finance everything you purchase.

Here is how: You either forego interest and returns when using your own money or you pay someone else interest to use their money. In doing so, you lose what that foregone interest or return could have earned; we can call this your “opportunity cost.”

When repeated, this behavior becomes very expensive. Whenever you borrow money and there is a fixed payment schedule, you pay something called amortizing interest. Each payment includes a little more principal and a little less interest. This continues until the payments of principal, plus the interest, equal the term of the loan.

Thinking of leasing equipment? Please do not be fooled into thinking that leasing equipment is less expensive. It is not. It is much more expensive than common bank financing, no matter what the lease “factor” is. When quantifying the imputed interest rate, most capital leases are in the 9-15% range. Leasing may be good for your cash flow; however, it is not less expensive.

Leasing may be good for your cash flow; however, it is not less expensive.

Compounding the issue of utilizing inefficient or expensive resources, too many of you mask your financial mistakes with your high cash flow.

Think about it, have you ever made a financial decision where the results were unexpected or disappointing? You are smart, sophisticated. Why does this happen? Could it be that you based your decision on misinformation, missing information, myth, or a misconception? There is a better way. Let’s explore this a little further by returning to the amortizing discussion.

Remember this: Compounding interest always outruns and outperforms amortizing interest. It works best over time and works great when it is uninterrupted, untaxed, and undelayed (because it works best over time). You may say you knew this already, yet are you practicing this in your business decisions? Is there evidence of this knowledge in your behavior when funding your capital equipment needs?

There is an alternative for making that capital purchase through leasing or paying for it out of your own pocket, one that is used by the smartest investors and consequently, some of the most successful ophthalmologists.

It begins with building your “collateral capacity.” Do not be embarrassed if you are not familiar with this term because if it were common, you would already be doing it—and so would your competition. Building your collateral capacity usually takes place in an asset protected account.

We will call this account your Private Capital Reserve (PCR). Important note: PCR is a strategy, not a product. Also, it is a savings strategy, not an investment.

Private Capital Reserve is a strategy, not a product. Also, it is a savings strategy, not an investment.

This strategy creates conditions necessary for your account to grow and to compound without delay, without interruption, and without taxation. With this strategy, you are using dollars for which you have already paid tax.

You can access this account for any reason, at any time, without penalty, and with no tax. The account will continue to grow and to compound, while you retain liquidity, use, and control of the money.

There are limitations. Considering the safety of this strategy, your potential for growth will be lower than the markets. You also will not take on the risks associated with the markets. In fact, your money is always there and your principal protected. As long as you follow a few simple rules, you can never lose your money.

While you neither take on the market risk nor access the compara-
ble potential for growth, you will get competitive rates of return. Currently, many accounts are paying 3–4.5% tax-free, with a guarantee usually on the order of 1–2%. These rates could go up and they could go down. However, you will never lose the money in your PCR. As you build your PCR, your account continues to grow.

Another potential limitation is time. It typically takes four to nine years to build a really effective PCR.

It typically takes four to nine years to build a really effective PCR.

How does it work? After you have built your collateral capacity sufficiently, say by saving $100,000 per annum, you will have approximately $745,000 in seven years. This money will continue to compound at a solid rate.

Now, let’s say you need to purchase a new laser with a price tag of $375,000. It has a technological life of five years. Had you leased this, the payments might cost you $8,500 per month and it would likely be near obsolete five years from purchase.

Now that you will pay cash (not your cash), you have negotiated the price down to $350,000. This is already a savings of $25,000. That savings can earn a significant amount of interest for you, adding again to your already growing collateral capacity; however, for the sake of staying focused on this article, we can discuss that another time.

Put simply, you lien your PCR to access the cash, saving you money off of the top and buying you tons of opportunity in the future. Then what?

You reduce the lien by paying it down and you choose the amount you would have paid had you leased the equipment—the same $8,500 per month for 60 months.

This is not a structured loan. You can skip payments for a very long time if you must.

What if you skip a payment? Not a problem. This is not a structured loan. You can skip payments for a very long time if you must. It is better, though, not to.

Soon you have the original $700,000 in your account, plus the interest it earned, plus the amount you used to reduce the lien, totaling a whopping $1,050,000.

To review:
• You have all the money you put into the account.
• You have all the payments you would have paid to a bank or leasing company.
• You own the equipment.

Rather than benefiting the banks or the leasing company, you build your personal wealth and security by using the safe and tax-advantaged Private Capital Reserve strategy.

You can achieve this by simply utilizing the power of the velocity of money multiplier to your benefit. Rather than benefiting the banks or the leasing company, you build your personal wealth and security by using the safe and tax-advantaged Private Capital Reserve strategy. We’re talking about your practice and your passion; doesn’t it make sense to pay yourself for growing it?

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The agency advantage:
Better management of the revenue cycle

by Erin Malloy
here are now more than 5,200 ambulatory surgery centers in the United States. 1

The number of ASCs continues to grow because surgeons are attracted to the prospects of an additional income stream and enhancing the quality of their work environment. In reality, however, too few physician owners are actually receiving additional income. Problems with cash flow and ASC management concerns often overshadow any improvements in work environment and direct energy away from growing their own practices and delivering quality care to their patients. This happens all too often; approximately one-third of ASCs are profitable, another third are barely breaking even, and the remaining third are actually losing money and may be at risk of a hospital or management company buyout. 2

Why do the advantages of ASC ownership fail to materialize? There are a number of reasons why an ASC fails to deliver on its promise—or fails altogether—but most are characterized by failure to adequately manage and control the revenue cycle. In light of the disparities in reimbursement (an ASC is reimbursed at only 56% of what a hospital outpatient department receives for the same procedure) and margins (smaller for the ASC, relative to the hospital), leaving money on the table is a recipe for ASC failure. Control of the revenue involves efficient billing and collections, effective insurance contracting, and keeping abreast of government regulations. All three of these critical functions require specialized attention, something not always readily available to an ASC without outside assistance. Access to these specialists may be one of the best reasons for physician-owned ASCs to outsource revenue cycle management.

The possibility of outsourcing billing and collections may be suggested as the “cure” for an ailing ASC’s cash flow. Before making a decision, consider what is involved in managing the revenue cycle, as well as the relative merits of keeping them in-house or outsourcing.

**Billing and collections**

**Upfront collection** is one critical—and often neglected—step in this aspect of managing the revenue cycle. High deductibles and co-payments are becoming increasingly common, and collecting from the patient can be more difficult and time consuming. To get out in front of the process, many facilities require patients to pay the amount for which they are responsible on or before the day of surgery. In our experience, facilities that collect on the day of service report a much lower percentage of bad debt than those that wait to see what insurance pays then send a statement to the patient 30 to 90 days after the date of service.

- A billing agency can assist with this process from offsite by verifying the patient’s insurance before the day of surgery and calculating the patient’s estimated financial responsibility. They communicate this information to the patient or to the ASC staff before the day of surgery so that all parties are aware of what will be collected at the time of service. The check-in process is smoother and the focus turns to patient care rather than money.

**Accurate coding is essential.**

Unlike professional services that bill using a Super Bill that the physician or scribe has completed, the facility claim is typically coded using the Operative Note dictated by the surgeon. Experienced coders are not all that easy to find and can expect to be well-compensated for their training and experience, but an incorrectly coded claim can be responsible for leaving money on the table and may result in legal liability.

- Agencies generally retain experienced coders, require them to be certified, and guarantee the accuracy of their coding services.

**Follow-up** of a rejected claim often proves to be the weak link in the process. Discomfort with asking for payment, working with aging balances, time constraints due to workload, and the attitude that the claim will still be there tomorrow to work on—or not—all result in significant disruptions in the revenue cycle. The number of claims requiring follow-up and the total dollar amount they represent add up quickly.

- An agency assigns experienced personnel to work this essential step of the process. Persistence, attention to detail, and dedication to this function keeps those numbers as low as possible.

Reporting is a key element in determining how well your facility is doing. Many trade organizations publish statistics and industry benchmarks to which performance can be compared. Days in A/R, collections to charges, and the percent of A/R in each aging category are a few of the more common ratios and averages to monitor monthly, quarterly, and annually.

- An agency provides monthly financial reporting that makes it easier for owners to track those numbers and benchmarks and measure how well they are doing.

**Contracting**

Medicare and other government payers use the CMS allowable based on location and do not negotiate pricing, but your contracts with commercial payers dictate what your

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income can be. This important responsibility should not be left up to an ASC’s coder or insurance clerk.

The agreements are typically lengthy and include terms that may be difficult to comprehend. These agreements MUST be read in full and broken down in a way that ensures that you understand what you are signing. The administrative tasks involved in the contracting process can be very onerous and time consuming. The process often involves repeated attempts to get the paperwork needed to negotiate terms and come to agreement. Even contact information for the appropriate provider representatives can prove elusive. If an ASC cannot allocate resources toward this function, a contract can very easily fall through the cracks.

- Many billing agencies employ staff that are quite competent in the area of contract review and negotiation and perform these services for their clients. Often the agency has already worked—and established a good relationship—with the commercial payer’s representative on behalf of other clients.

**Government regulations**

Keeping abreast of evolving government regulations has always been a headache and source of anxiety. Many ASCs are gearing up for ICD-10 and expansions to quality reporting. Owners and staff know all too well how overwhelming these changing regulations can be.

- For the most part, dealing with these issues can be outsourced to a billing agency, which will free management to direct its attention to patient care issues.

**How much does outsourcing cost?**

Depending on the agreed-to contract terms between the agency and ASC, the agency will be compensated based on a percentage of collections, a flat fee, or a combination of the two. The percentage of collections method often proves most advantageous to both parties because it motivates the agency to collect as much—and as efficiently—as possible. Most ASCs pay between 4 and 8%, depending on the facility’s size and specialties. The cost of outsourcing to an agency most often looks quite competitive when compared to the cost of keeping these functions in-house, particularly if the agency’s services improve the effectiveness of the revenue cycle management.

The more important question may be how much does it cost to keep billing and collections in-house?

Consider staffing needs. Many ASCs find it difficult to find candidates with the expertise and personal traits needed to excel in billing and collections positions, more so if the facility is located in a rural area. The work is detail oriented and requires a strong work ethic, knowledge of medical terminology, and the ability to work assertively when dealing with insurance companies and patients. Even if you are fortunate to fill these positions with experienced, proficient staff able to get the job done, sooner or later that person will go on vacation, take a leave of absence, or accept a position elsewhere, causing significant disruption of the process. An agency minimizes the risk inherent to employee turnover by having multiple trained individuals on staff who can cover for a vacancy.

When it comes to managing your revenue cycle, don’t make an impulsive decision. First, decide what services and results you want an agency to provide, then interview several agencies and select one that is tailored to meet the needs of your ASC. Coordinate with them to keep your ASC performing in the top third of facilities, then enjoy the perks that made owning an ASC an attractive proposition.

**References**


**Consultant Erin Malloy**

monitors the financial health and efficiency of ASCs and oversees Medical Consulting Group’s accounting, billing, and management coordination teams that enhance their profitability. She can be contacted at emalloy@medcgroup.com.
How to increase patient conversion through online tracking

Your practice has its own website, it’s on Facebook and other popular social media sites, and you’re advertising online, but are you targeting the right people and successfully converting them into patients?

Kay Coulson, founder of Elective Medical Marketing, Boulder, Colo., said it is important to understand every step of the process from generating initial interest through to the patient visit in order to optimize your practice’s marketing efforts.

Understand who’s considering you

“So much of the [marketing] activity has gone online that we’re making sure from a pay-per-click standpoint, with all advertising done through Google, Bing, and Facebook, that we understand the interest that we’ve generated and that we can track it,” she said.

Through the use of dynamic phone numbers, practices can track how many calls were generated from advertising. Ms. Coulson said her company uses a call tracking service that will identify the keyword someone used to make a search and from that keyword what ad was generated, what landing page was visited, and whether the person made a call to schedule.

“It’s the same with form submissions. If forms are submitted online for someone requesting a visit, we’re able to track and attribute that visit to advertising,” Ms. Coulson said.

Google Analytics can be used to monitor who’s visiting the practice’s website, who’s viewing pages for the first time, who’s a repeat visitor, and whether these visitors are in the right geographical area.

“[Practices] may find that the parameters they’ve set for the type of people they’re attracting to their site are too wide. They might be national when they really need to be targeting within a 20 or 30 mile radius of the practice to make sure those people have a reasonable likelihood of scheduling a visit,” Ms. Coulson said.

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A transformative process

Ms. Coulson uses call recordings to help the staff learn to handle inquiries properly. Doctors often wonder if they’re getting any return from their marketing efforts, she said, and her team is now able to definitively answer what the return from marketing is and how that conversion is working by tracking inquiries to the practices.

“Our integrated effort has indicated most of the time, it’s not that practices need more inquiries, it’s that they need to do a better job with those they’re generating,” she said.

Being able to monitor conversations through call tracking and form tracking has been transformative for practices Ms. Coulson works with because they had previously believed that they were handling calls well, when in reality, they weren’t.

“Often, practices will find that when people are contacting them, they’re not doing a good enough job with these people—they’re not answering the phone well, they’re rude, they’re putting people on hold, or they don’t know the answer to the question. In effect, that marketing has been ill-spent because the practice couldn’t handle the inquiry properly,” she explained. “Real-time call monitoring allows us to train and improve staff skills, on a one-to-one basis, which seems to greatly improve their retention of proper phone techniques.”

During the shift from traditional media like newspapers and radio to computers, practices became more geared to online contact coming via web forms, Ms. Coulson said. Now, with the shift toward mobile devices, the pendulum has swung back.

“Phone inquiries outpace forms 5 to 1, on average, as people on tablets and smartphones want to click-to-call, not to use a tiny screen to fill out a form,” she said.

Most practices are not ready to handle that shift, Ms. Coulson said; they still don’t realize that their website is, in effect, their yellow pages.

“A practice website needs to provide driving directions and a quick contact phone number [because] that’s what it’s primarily going to be used for,” she said.

Beyond that, any advertising that is done needs to direct people to landing pages that are very specific to that advertising.

“They don’t want to look at your whole website, they want to look at the one thing that your ad attracted them to,” she said.

This conversion tracking into lead acquisition gives practices the ability to monitor the effectiveness of a marketing campaign and adjust strategies accordingly. At the same time, it allows them to keep track of the quality of service the practice is offering at the time of inquiry and improve it if needed.

Form tracking is free with Google Analytics while call tracking costs very little. For most practices, it would cost less than $350 a month, Ms. Coulson said.

While some may have a phone system that records the calls coming in, the key for a practice is not to monitor every call—certainly, not the calls about what drops patients should be using or when their next appointment will be, she said.

What a practice does want to know is if they are spending ad dollars, what leads result directly from those ad dollars.

Optimizing your website

It is also important to understand what people are viewing when they are on the site. Practices can do this with Google Analytics as well.

Contact information needs to be clear, and the three most visited pages should be optimized.

Practices have to get past thinking they need 60 or 70 pages of a website that educate people about procedures. People don’t want to know that, Ms. Coulson said, they want a quick hit so that they can schedule an appointment.

“Every doctor thinks [patients] want to know all this detail about the doctor and the procedure,” she said.

While it is true that occasionally people will go four or five pages deep because they are educating themselves, Ms. Coulson said, “If you look at the page-visit funnels that Google Analytics provides, you will find that people will only go two pages deep into a website and then they will leave or they will call you.”

Very few people want to look at a lot of information these days; it’s a wholesale shift. “I don’t know if this is because we’re moving to such a mobile society that people would rather just click to call. Once they figure out they are interested, they’re going to call for the visit rather than spend a lot of time online,” she said.

If practices change their focus to thinking how they can use their online activity to generate more people to schedule instead of to educate, they would certainly find their calendars filled with more of the right patients, Ms. Coulson said. OB

Editors’ note: Ms. Coulson has no financial interests related to this article.
Grow your practice by attracting a new cultural niche

by Vanessa Caceres Contributing Writer

Thoughtful approach could yield a surge in business

Don’t let language or cultural barriers stand in the way of establishing your practice as the go-to place for eyecare in your local niche cultural markets.

Targeting communities where the majority of residents come from another country or speak a language other than English can be a great way to build your refractive business as well as cataract or routine eyecare, said consultant Shareef Mahdavi, SM2 Strategic, Pleasanton, Calif.

“It is absolutely the right thing to do,” said Mr. Mahdavi. “Consumer decision making is easier when it’s enabled in one’s native tongue.”

Here’s one reason why it’s a smart move: In a number of niche cultural markets, such as in Hispanic communities across the U.S., there’s a second or even third generation that is young, upwardly mobile, increasingly well-educated, and has the buying power to invest in luxuries like LASIK. “This is a very attractive market that’s looking for something more premium,” said Felipe Korzeny, PhD, professor and founder/director, Center for Study of Hispanic Marketing Communication, Florida State University, Tallahassee, Fla.

“Every population has an interest in self-improvement,” Mr. Mahdavi said.

Here’s another reason: Word-of-mouth recommendations are especially important in community groups newer to the U.S., as they get to know the U.S. culture better. If you make one person from the community happy, they’ll tell their friends and family.

However, you’ll want your marketing efforts targeted toward a niche cultural market to take a thoughtful approach—you can’t just take what you do in English, translate it, and wait for the new business to come. Here are 11 ways to make your marketing to a niche cultural market more effective.

1. Decide what cultural market you will target, recommended Dr. Korzeny. Is it recent immigrants who are still learning English and are not yet acculturated? Or is it the second or third generation that’s lived here for a long time and may speak both English and their native language well? Knowing who your target market is will make a difference in how you plan to design your marketing efforts, Dr. Korzeny said. For example, if your target is the younger population, your ad might be in English but contain a witty phrase or a play on words in their first language to attract their attention, he said.

2. Think of 20% as your tipping point, said Mr. Mahdavi. In other words, if 20% or more of your patients come from the target niche community, then it would be wise to invest marketing and promotional dollars to attract even more patients. This might include more advertising or having your website translated into the target language.

3. Learn about the culture to help mold your marketing and outreach efforts. In the Hispanic culture, for instance, ads tend to be more expressive or targeted toward emotions. “If you did a commercial in the typical...
‘American way,’ it might be boring for them,” said Mr. Mahdavi.

People from many Latin American countries may have had a more personal relationship with their physicians when they were growing up; physicians might have even come to their house and stayed for coffee to catch up. Although that approach won’t usually work in today’s volume market, the lesson is that many older Hispanic patients might expect their doctors to be more personal, Dr. Kordzenny explained. You can find out about your niche market’s approach to doctors and medicine and train yourself and your staff accordingly.

Another example: At The Eye Specialists Center on the outskirts of Chicago, medical staff members see patients of diverse backgrounds, including Muslim, Spanish-speaking, Palestinian, Greek, and more, said Benjamin Ticho, MD, Chicago Ridge, Ill. Staff members noticed that some devout Muslim patients who were waiting for appointments needed a quiet area for their afternoon prayers. They now make available a more private area of the practice space so, if requested, these patients can complete their afternoon prayers.

4. **Tap into your patient base to help design your marketing campaign.** Let’s say you’re targeting the Chinese market in your area. Form a small advisory board with existing patients who can review drafts of your marketing efforts. Pay these patients a small honorarium for their time. They’ll tell you if your efforts will likely attract more business, Mr. Mahdavi said.

5. **Don’t overlook traditional media.** Although social media and website advertising are the focus these days for obvious reasons, niche cultural markets still rely heavily on radio, newspaper, and even TV stations geared toward their communities. These could be good places for your ads.

In your ads, invite members of your target community to an open house or to just drop by your practice and take a look to make them feel more comfortable, Dr. Kordzenny suggested.

6. **Hire someone bilingual.** Again, if 20% of your patients or more speak another language, then you should have at least one staff member who can communicate with them. However, Mr. Mahdavi believes this person can serve various roles in your office. He/she might work as a refractive counselor as well as a technician. Or he/she might work at the front desk. At Dr. Ticho’s practice, they always make sure that at least one Spanish-speaking person is in the office. The important thing is that physicians and other medical staff have access to their linguistic help as needed.

7. **But don’t assume that patients cannot speak English,** Dr. Ticho said. In fact, many of the patients his offices serve may have another native language, but they are bilingual. If they’re not, they’ll usually bring a family member with them who can speak English well. Even if these patients can speak some English, they usually like the comfort of getting medical care issues explained to them in their native tongue, he said.

8. **Rely on professional translation help for your marketing materials.** Say you’re targeting a local Mexican community and you have someone in your office from the Caribbean who speaks Spanish. Although the two groups can obviously communicate, they have word- and phrase-level differences, so written materials can get lost in translation, not unlike the difference between American and British English. You’ll want to rely on a translator or translation organization that knows the nuances of the language.

9. **Use a cultural insight that you can include in your marketing,** Dr. Kordzenny suggested. One example: Is diabetes or glaucoma more common in the population you are targeting? That’s something you could mention in your ads and focus on the importance of regular exams or using targeted medications.

“Find a cultural insight to show that you’ll treat them better than the competition,” Dr. Kordzenny said.

10. **Learn a few phrases.** Dr. Ticho has learned a few eye exam-related phrases in Greek, Spanish, and even Chinese. “I’ll tell them it’s the one thing I know in their language, but patients really appreciate it, and it provides comic relief,” he said.

11. **Think long term.** Some of the patients that Dr. Ticho’s offices serve are on public assistance, which can create some payment and reimbursement headaches. However, his office sees patients of all ages, and they’ll often find that patients will return with other family members who may have insurance or be in better positions to pay for their eye-care. “We want to be as welcoming as we can,” he said. OB

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