Blurred line, sharp focus

Cataract/refractive surgeons are having to rethink the great divide between the two sides of their practices and how they package cataract surgery

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From the publisher

Femtosecond laser cataract surgery, the ever-widening selection of premium lenses, and various methods of astigmatic correction are driving a fusion of the cataract and refractive subspecialties. A number of practices—including those that already have femto, those that do not yet have femto but are likely to offer it in the near future, as well as those still “on the fence” about femto—are realizing the need to rethink the great divide between the two sides of their practices and how they package cataract surgery. Now is the time to evaluate and change the culture and orientation of the practice, with an eye to rebranding cataract surgery as refractive cataract surgery, regardless of whether you currently offer the femto cataract procedure. William B. Rabourn Jr. and Louis Pennow explain how practices are doing that in “Blurred line, sharp focus.”

Also in this edition of Ophthalmology Business, medical ethicist John D. Banja, PhD, addresses an issue that can be very uncomfortable: confronting a colleague who you suspect is engaging in fraudulent acts. He suggests steps you might take, including collecting and verifying all relevant information, contacting the problem physician and getting his/her side of the story, and developing a plan with a concrete outcome to fix the wrongdoing. While this may be difficult, “If physicians want to maintain the public trust, they must earn it, which can occasionally entail their being brave, putting justice and their patients first, and doing the hard but right thing,” Dr. Banja said.

Are you looking to expand your practice outside of the clinical setting? According to Vance Thompson, MD, founder of Vance Thompson Vision, eyecare professionals may want to explore becoming active in research and product development. Check out the article on page 20 to read why Dr. Thompson thinks this can enhance a business while also increasing professional growth and job satisfaction.

These are just some of the useful articles you will find in this edition of Ophthalmology Business. Please feel free to contact us if there is a topic you would like to see discussed here. Thank you for reading!
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DayClips helps physicians and patients with online scheduling

by Ellen Stodola Ophthalmology Business Staff Writer

The DayClips site is helping patients with online scheduling, according to Michael Reynard, MD, associate clinical professor, Jules Stein Eye Institute, Santa Monica, Calif. He discussed the details of the resource and why he likes it for his practice. “Nowadays we seem to depend on the internet to do many everyday tasks,” Dr. Reynard said. “We make flight reservations and book vacations online. We manage our bank accounts online. We even depend on the internet to find the best restaurants.”

He added that more and more, people are using the internet to find a doctor and book an appointment. “That’s where the DayClips online appointment scheduling and time management system comes in.” DayClips has helped to book thousands of appointments since 2007.

How DayClips works
DayClips does a number of scheduling tasks, including integrating appointments made in person and online into one master calendar. Patients receive appointment confirmations and reminders by email and text message, he said. “With DayClips, there is nothing to download since it is a web-based system,” he said. “All one does is set up an account and access it on the internet from anywhere at any time. DayClips works on desktops, smartphones, and tablets.” It has both a mobile and full site view.

DayClips also works in practices with multiple locations and doctors, Dr. Reynard said. He has found it has helped to cut the no-show rate because of automated appointment reminders. “When no-shows do occur, you can send a notification with a customized message offering your patient an opportunity to reschedule online,” he said. This feature recaptures appointments that would otherwise be lost. Additionally, DayClips can track patient appointment history in a report. Dr. Reynard said DayClips keeps records of all appointments, reminders, and missed appointments.

Notifications
DayClips offers the option of immediate notification alerts. “Unlike many online schedulers, DayClips has a sophisticated but easy-to-use module that sends customizable recall notices by text message and email,” Dr. Reynard said. It will let users know if emails and text messages are going through by flagging invalid information.

Other features
According to Dr. Reynard, one of the top reasons why physicians use
DayClips is because it helps an office become more successful with better tools for appointment management as well as special features that attract new patients and promote appointments directly from a doctor’s website. The “Book Now” buttons can be used to make appointments from doctors’ websites, and offices can also display the different services they offer.

A website widget for DayClips is included directly on Dr. Reynard’s office website, which helps patients schedule their appointments. A search engine optimization page helps both existing and potential patients find his practice online.

Additionally, DayClips helps to keep personal schedules private. “Appointments for personal tasks, surgery, airline travel, and academic meetings are there for the doctor to schedule privately.”

Important information about doctors that patients may want to know, including education, certification, insurance affiliations, and background, is included on DayClips. Reviews are also featured.

“DayClips is adding many new and exciting features that are ahead of the curve,” Dr. Reynard said. The new parking utility will offer patients access to real-time parking information to find the best location when visiting a doctor’s office, and the financial module will allow offices to collect deposits and up-front payments.

“Best of all, DayClips is free for patients and doctors,” he said. 

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Social media

by Matt Young and Gloria D. Gamat Ophthalmology Business Contributing Writers

Ophthalmology companies discover the benefits of social networking

Facebook, LinkedIn, and Twitter may have only been around for less than a decade, but since then these social media tools have changed the way companies conduct business both online and off.

Professionals now are using these social networking sites as tools for brand marketing, interacting with customers, exploring partnership opportunities, bringing team members together, and checking out market competitors.

While Facebook’s success in attracting users for various personal activities is immeasurable, LinkedIn and Twitter are penetrated by various key influencers. Here, company executives are not only pushing their brands, but also building their community by exchanging bright business ideas.

While social media has turned into a powerful tool for opening up a new level of business opportunities that otherwise wouldn’t have existed, conservative companies that have not taken a bite of this apple are falling behind their competitors.

In fact, according to the 2013 CEO, Social Media and Leadership Survey by BRANDfog, which helps CEOs become more influential in social media, 80.4% of survey respondents said it was important for CEOs to engage with customers in social channels, and more than half of the respondents stated that they believe social media engagement makes CEOs more effective leaders.

While Facebook’s success in attracting users for various personal activities is immeasurable, LinkedIn and Twitter are penetrated by various key influencers. Here, company executives are not only pushing their brands, but also building their community by exchanging bright business ideas.
In ophthalmology, companies such as Alcon (Fort Worth, Texas), Abbott Medical Optics (Santa Ana, Calif.), and Allergan (Irvine, Calif.) are utilizing LinkedIn and Twitter for business updates that solicit interaction from the industry. But be forewarned that these interactions take place not just with customers, but with competitors as well—even if this trail is a bit more invisible.

**Trending on LinkedIn**
Alcon, a global leader in eyecare and the second largest division of Novartis, continues to benefit from its LinkedIn updates.

When the company posted updates on World Glaucoma Week in March, one status update gained almost 200 likes quickly, while others got between 50 and 100 likes.

That update led to a trending—or people talking heavily about a topic on social media—over at Alcon’s LinkedIn page, whereby patients were commenting on links about glaucoma myths and facts, glaucoma risk factors, and the glaucoma overview that the company shared from its website.

Patient information on company websites such as Alcon’s that otherwise appear to be one-way communication mediums instantly build an interactive following by simply sharing the links as status updates on LinkedIn.

That’s just one way to turn static into savvy.

**Reenergizing an internet presence**
Allergan’s Twitter account (@Allergan) currently has more than 9,500 followers.

The company’s tweets, ranging from conference participation information to updates on CEO David Pyott’s new blog, have turned into a better and more active replacement of RSS (Really Simple Syndication) feed subscription—a technology used by web users worldwide to keep track of their favorite websites.

CEO blog posts that used to be “dormant” on company websites are getting attention when posted as tweets.

A recent Allergan tweet mentioned the company CEO’s blog, which shared some interesting insight from a J.P. Morgan Healthcare Conference, including the big change that social media brought to the conference.

“Another change—one that has exploded on the scene in just a few years—is the role of social media,” Mr. Pyott said. “In the past, the daily news out of the conference tended to be dominated by one or two major announcements and mainstream business media. Yet now, social media has seen a major uptick in activity in a relatively short amount of time.”

Abbott (@AbbottNews) is also using Twitter to disseminate information on its many worldwide advocacy and community service efforts. The company’s tweets on hurricane preparation week and its volunteering efforts are some examples of how social media can be utilized for mankind’s greater good.

Networking opportunities as well as pooling resources for relief efforts are now blown into a magnitude of immense proportions by quite possibly sending one tweet.

**Making conferences social**
By following company tweets such as those by Allergan and Abbott Medical Optics, consumers and market competitors alike become privy to company information in real time.

In addition, company keynote speakers to major events and conferences get to test the waters first by tweeting about their seminar’s topics. For example, when Alcon posted its Keynote Series for the 2014 Association for Research in Vision and Ophthalmology (ARVO) annual meeting in Orlando, Fla., on the company’s LinkedIn page, the responses received provided a preview of how this seminar series was going to be received at the conference.

In effect, seminar Q&As are happening online long before the speakers step on the podium to present the topic to their peers.

Indeed, it is clearer than ever that social media is an essential part of doing business, ophthalmology companies included.

Talking further about the impact of social media on the recent J.P. Morgan Healthcare Conference, Mr. Pyott mentioned on the company’s blog: “We can look at Twitter as an example of the growth in social media around the conference: in 2010 there were a total of 620 tweets; in 2014 there were more than 10,000. While most of this Twitter activity has come from reporters and other observers, as social and digital media have and will become more prevalent, we are also seeing more companies use social media as part of their own communications initiatives at J.P. Morgan.”

From CEOs to interns, social media is turning into a part of professionals’ daily work activities. The world—including the ophthalmology world—is communicating like it never did before.
Many people hold false ideas or myths about investing. Some even believe in a “magic formula” that can avoid risk and provide a high return, or that a conspiracy drives the market and fudges prices, or that investing is a way to get rich. At the same time, there are a lot of true things about investing that many people don’t know or don’t believe. Here are the truths:

1. In the 230 years that equity markets have existed in 16 countries, there has never been a 20-year period of time when they have shown a negative rate of return.

2. There have been only two periods when stocks underperformed bonds on the average for 30 years. Those periods were the time ending in 1865 (and including the American Civil War), and today.

3. On the other hand, the markets have shown negative returns quite frequently for shorter periods of time. For that reason, you should be investing in the market with a long timeframe in mind.

4. When you invest, know your risk tolerance precisely. This means expressing it as a number, not just a phrase like “I am conservative” or “I am aggressive.” By what percentage can you accept your portfolio declining during a year? Although you can reasonably expect the value of your portfolio to increase over time, fluctuations downward will happen and there will be periods when it will lose value. How much of this fluctuation are you willing to accept?

5. When you invest, you should have a clear idea for what you are investing. Is it to pay for college in 10 years? Are you on the brink of retirement and concerned with having enough income for the next 30 years or more? Whatever it is, the purpose for which you invest will determine a lot of your decisions.

6. Inflation matters, even when it is low—as at present. It’s never zero, and that means your income from investment needs to grow by at least enough to cover the loss in the value of money over the period you’re investing.

7. Investing is not a do-it-yourself, instinctive, by-the-gut endeavor. Our instincts evolved to avoid danger in a primitive environment, and many sound investment decisions go against that...
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mindset. A good investment manager can help with this, as that manager is one step removed from the emotional impact of shifts in the value of your investments. But many managers can fall into the same trap. Even more than portfolio products and construction, therefore, you need an evidence-based, rules-based system that is sophisticated in its simplicity.

8. You will not get rich in the stock market. You already may be rich. If not, you should not place your savings at risk of the price fluctuations. Investing in the stock market is a good way to protect your assets from inflation and ensure long-term appreciation, but the prospect of turning modest means into great riches is a myth. It almost never happens.

9. It is impossible to predict exactly which company, manager, industry, geography, or asset class will outperform the market average. This is why it’s important to diversify.

10. Shares in small companies outperform shares in large ones, over time. At the same time, they fluctuate more in value and so may present greater risk (which goes along with their higher average return). How much small company ownership depends on your risk tolerance, your time horizon, and the purpose for which you are investing.

11. Disciplined, strategic indexing will provide you with a solid portfolio—the core. This should be at least 50% of your portfolio. And it leads to the virtue of buying low, while selling high.

12. Fees, taxes, and expenses count, and they count a lot. Saving a mere 1 or 2% in these costs can have a huge impact on the value of your portfolio over 20 to 30 years (the average retirement expectancy). For this reason, we want low turnover in our portfolios. The less frequently you buy and sell company shares, the lower your transaction costs. If you are tempted to “micromanage” your portfolio so as to only hold shares in any particular company when they are increasing in value, keep this in mind. Every purchase or sale carries a cost, and those costs can easily outweight any gains from time-hopping, particularly since that’s unlikely to work well anyway.

13. Opportunity costs also matter a lot. Expenses, taxes, and other lost funds count for more than their face value, because they also cost you what they could have earned if they had not been lost in the first place.

14. Government intervention affects the economy more than it does your long-term investment. The same is true of major economic events such as a recession, even on the scale of the Great Recession. Such things may affect your portfolio’s short-term values, and the panic that sometimes sets in among investors can affect it even more, but remember that you should be investing over a long time scale. Watch the world, not the West, and concentrate on the companies, not the countries.

15. Sequence of returns is not important while your assets are accumulating value, but it becomes critical when you reach the distribution phase of your investments. When you are receiving distributions from your investments, a short-term dip in value can have a major negative effect because you may still have to take the distributions in order to maintain your lifestyle. This puts further downward pressure on your account balances.

Other strategies, in addition to investments, may be called for to offset this. While you are not actively taking distributions from the investment accounts, however, what the early or late returns are doesn’t matter much. You are concerned mainly with the long-term trend and net investment return.

16. The best time to start investing is 20 years ago. The second-best time is now. Always keep your investments aligned with your long-term strategy, your risk tolerance, your time horizon, and your goals—not someone else’s or some arbitrary figure that may have been supplied by an “expert” who doesn’t know your situation.

There are other details to the science of investing, of course, but these 16 truths lie at the heart of an evidence-based, rules-based, disciplined system that can guide your investments. Those rules and that system are not intended to avoid risks or short-term losses (which inevitably will happen and are unavoidable), nor to let you turn modest amounts of capital into great wealth (which is virtually impossible and certainly can’t be made to happen), but will help you to invest for the reasons investment is a good idea. It will help you to safeguard your assets against inflation, provide you with an income for whatever purpose you need it for, and let you achieve a measure of financial security in retirement.
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Confronting fraud

A shorthand definition of fraud is “theft by deception.” I defraud you when I intentionally deceive you in a way that results in my benefiting (usually economically). An essential characteristic of fraud is intent, which differentiates it from “abuse.” So fraud occurs when a physician or a clinical practice bills for services that the practice knows weren’t provided, or intentionally alters records or documents to increase insurance reimbursement, or submits claims for services that the practice knew weren’t necessary. “Abuse” might involve occurrences like these if the practice didn’t knowingly intend the wrongdoing, but the wrongdoing nevertheless occurred in the form of failing to meet standards of care or providing services that weren’t medically necessary.

Unfortunately, fraud is rather common in healthcare and ophthalmology is not excepted. At a presentation in 2013 for the National Health Care Anti-Fraud Association, Carrie Ward, an accredited healthcare fraud investigator, listed the following ophthalmology examples:

- An ophthalmologist had records showing a few patients received cataract removal with IOLs up to four times per eye.
- Another ophthalmologist had 69 patients receive a YAG procedure with no history of a cataract removal or lens replacement and another 27 who had no history of any cataract removal.
- Another ophthalmologist billed patients up to 6 times per eye over a 4-year period for lysis of
in ophthalmology

adhesion, where no prior history of cataract surgery, no prior history of a comprehensive eye exam or refraction occurred.

• Another ophthalmologist billed for external ocular photography on everyone he saw during the investigation period, even though there was no documentation that ptosis existed, he didn’t perform blepharoplasty, and he didn’t refer to another physician who did.

Also, as in virtually any other medical specialty, there are a host of ophthalmology examples where the act in question seems very close to fraud or abuse, such as:

• An ophthalmologist who doesn’t make any effort to refund patient’s excess payments, i.e., payments above allowables;

• An ophthalmologist who bills for a lot of surgical hours but has his physician assistant do most of the surgical procedure, such as opening the incision, performing a part of the surgery, and closing the incision, often without the surgeon in the operating room.

And what about the temptation that more and more ophthalmologists will experience to offset their declining monofocal lens reimbursements by “encouraging” certain patients to purchase premium lenses when 5 years ago that ophthalmologist would have deemed those very patients unsuitable for a premium lens?

Psychologists tell us that human beings are superlative at rationalizing their misbehaviors. Psychologists might also point out that there is a touch of the “fraudster” in nearly everyone. We’re always watching out for No. 1 and considering strategies to advance our self-interests. It’s human nature. We are hard-wired to survive and if we can get away with an occasional cheat that redounds to our benefit—such as not declaring all our income on our income taxes—many people will not hesitate. But chronically, blatantly fraudulent individuals are people who have probably lost their ability to control their acquisitive desires. Not only might they believe they “need” or “are entitled” to that additional, fraudulently gained income to survive—think of Bernie Madoff who couldn’t stop his Ponzi scheme—but once a fraudulent act is successful, that success tends to reinforce the behavior. There’s even some evidence that chronically fraudulent people get something of a “high” from the experience. Diederik Stapel, for instance, became the dean at Tilburg University School of Social and Behavioral Sciences in 2007 after a meteoric rise from defending his doctoral dissertation only a decade earlier. Yet, it was later discovered that beginning with that dissertation and over the next 15 years, Stapel had altered or fabricated data in as many as 65 publications. Stripped of his position, his publications, his honors, and his doctoral degree, Stapel proceeded to write a memoir titled “Derailment” describing how his penchant for fabrication and fraud took hold.

The issue that ophthalmology practices should be concerned about is developing sound and effective practices for confronting people who engage in suspicious or seemingly fraudulent acts. That perception may easily occur in an ophthalmology (or any medical) practice where the physician strongly suspects an unwitting patient was defrauded or harmed in some way.

Of course, a physician’s confronting the problematic work of another colleague can be very uncomfortable, but it comes with the territory. It seems impossible to go through a career in medicine without suspecting or hearing about another colleague’s problematic behaviors, but physicians typically don’t get high grades on policing their profession. Stories abound about physicians whose problem behaviors were known for years but who continued to practice until there was a near or frank disaster. So let us consider some reasonable steps that a physician might take who is concerned about another colleague’s questionable behavior.

The first, most important step is to collect and verify all the relevant facts and gather all the relevant “stories.” This will especially include all the patient’s relevant medical records. Probably the worst thing a physician can do is speculate on what occurred and then make uninformed allegations or spread rumors. Indeed, because many physicians understand and appreciate the need to verify the accuracy of their suspicions but because the verification process might be laborious and time-consuming, a good deal of anecdotal evidence suggests that many physicians take no action at all. Yet, Principle II of the American Medical Association’s Code of Ethics states that, “A physician shall uphold the standards of professionalism and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to
9.031 of the AMA’s Council on Ethical and Judicial Affairs states that, “Physicians have an ethical obligation to report impaired, incompetent, and/or unethical colleagues in accordance with the legal requirements in each state.” Consequently, even if a physician is reluctant to confirm his or her suspicions about a fraudulent (or malpracticing) physician, at least 3 items should be considered: 1) codes of ethics anticipate that the physician will follow up in an ethical manner; 2) if the patient knew that his or her physician suspected wrongdoing but did nothing about it, the patient’s trust and respect for that physician would likely diminish considerably; and 3) especially in instances of fraud, a physician’s failure to attend or call attention to the possibly fraudulent practices of another doctor might seem like complicity (through silence) and invite problems for that physician.

Consequently, a physician who suspects a fraudulent colleague should gather data from relevant sources (again, including the allegedly wronged party and his or her medical records), verify its accuracy, and perhaps confer with colleagues on the legitimacy of suspecting fraud or wrongdoing. If legitimate suspicions persist once the facts are in, the physician should then, in my opinion, do the difficult thing: Contact the problem physician and get his or her side of the story. This can be a very uncomfortable undertaking, so the physician who contacts the problem doctor should 1) rehearse the language of his or her suspicions, 2) know precisely the questions he or she is going to ask, 3) consider the likely answers the physician might give (including evasive or unpersuasive ones), and 4) have some idea in mind as to responding ethically along with a follow-up plan. The need to contact the problem physician directly is critical because when all is said and done, he or she might have a legitimate explanation for what occurred that will put the matter to rest, or have no idea the event occurred and be entirely ready and willing to make things right. But if the suspecting physician complains directly to the medical board or to an insurance fraud hotline, less onerous and more collegial strategies that could have occurred through a personal communication will not be given a chance.

As a feature of the physician-physician communication, the calling physician who continues to suspect wrongdoing should have a plan with a concrete outcome in mind. That plan might involve a communication with the patient—by either the problematic or the suspicious physician—to explain what happened along with a proposal that will reasonably right whatever wrong has occurred. In instances of fraud, the latter might involve either reimbursing the patient for any economic loss he or she has incurred, or contacting an insurance company or state or federal payer and working out an arrangement.

Because deciding on a remedial course of action can be complex, physicians who are keen to do the right thing should take advantage of numerous sources of information and support. A concerned physician might contact his or her state medical or licensing board, insurance fraud reporting line, or Medicare fraud line for advice. But before doing so, the physician should know the practice or expectation of that entity when complaints or inquiries are made. For example, will the physician be asked to identify him or herself or can he or she remain anonymous? Will the entity refuse to take any complaint or allegation seriously without something in writing and signed by the inquiring physician? Will the reporting physician’s anonymity be preserved if an investigation ensues? Can the health professional call a “hotline” and simply ask for advice? He or she might describe a hypothetical scenario and, without providing any identifiers, ask for guidance. It’s highly recommended to do this kind of homework so that the physician who is trying to do the right thing isn’t taken unawares and ultimately comes to regret his or her decision. And, of course, having trusted and ethical colleagues available who can offer informed advice can be priceless.

We probably need to do a better job in our medical training programs of equipping physicians with the skill set to confront fraudulent behavior when it is suspected. It is perfectly abhorrent to penalize health professionals who take action against the problematic behaviors of other physicians, yet there are plenty of cases where right-minded professionals have been unjustly harmed (such as through retaliation) for trying to act ethically. One wants to think that contemporary ethical sensibilities and ethics training, whistleblower protection laws, and enlightened medical boards will support physicians trying to do the right thing. After all, fraud in medicine has utterly no place. If physicians want to maintain the public trust, they must earn it, which can occasionally entail their being brave, putting justice and their patients first, and doing the hard but right thing. OB

Dr. Banja is a professor and medical ethicist at Emory University who recently completed his term as the first public member of the ASCRS Governing Board. Readers are invited to send comments or cases to him at jbanja@emory.edu.
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When women own businesses

by Michelle Dalton Ophthalmology Business contributing writer

An Ophthalmic Women Leaders breakfast discussed the pros and cons of entrepreneurship

Being a business owner is never easy, but those who choose to undertake the daunting challenge “devote our lives to our own companies,” said Ellen Troyer, MT, MA, chief executive officer and chief research officer of Biosyntrx, Colorado Springs, Colo. She moderated a panel on the topic during the 2014 ASCRS•ASOA Symposium & Congress. The Ophthalmic Women Leaders (OWL)-sponsored meeting brought together female business owners to discuss the “joys, pains, and creative highs of entrepreneurship,” she said. Other panelists included Cynthia L. Barratt, president and chief executive officer of OcuSoft, Rosenberg, Texas; Marsha D. Link, PhD, principal in Link Consulting, Steamboat Springs, Colo.; and Tamara Evans, vice president of marketing at Ceatus Media Group, San Diego.

“There are not a lot of female-owned companies in ophthalmology,” Ms. Troyer said, “but I’m having a great time. We’ve formed a sisterhood of sorts.” Biosyntrx works with eye care providers to develop formulations designed to meet the micronutrient needs of the eye. Ms. Troyer said one of the aspects of being an entrepreneur in ophthalmology is witnessing how her company’s products change someone’s vision and improve his or her life.

Ms. Barratt co-founded her company in 1986 and introduced the first commercially available eyelid cleanser in 1987. From the start, she said giving back to her team and to the community were high on her list of priorities.

“My favorite part of owning a business is the opportunity it gives me to give back to my team, as well as our local, national, and professional communities. I have been blessed, and I have an obligation to give back as much as I can,” she said. Once a month her company has some sort of activity to thank its employees for their dedication. This year, OcuSoft treated employees to a chili cook-off and a Super Bowl party; years past have seen pool parties, pajama day in the office, and holiday luncheons. Perhaps as a result of the company’s commitment to its employees, retention is extremely high, she said.

“Some members of our executive team have been with us for more
than 25 years,” she said. “As such, we have second-generation team members.”

Privileges of ownership
The upsides of owning and creating a company from scratch are several-fold, Ms. Troyer said. Aside from being a parent, “birthing a concept is the ultimate in creation, particularly when we are wildly passionate about the project,” she said. “We get to surround ourselves with the best people we can afford to hire, with the hopes of building a strong and sustainable team.”

But as a consultant/owner of a small practice, “it is often ‘feast’ or ‘famine,’” Dr. Link said. “When I first started, I was not expecting this kind of ebb and flow, and it took me awhile to realize that cultivation of clients sometimes takes longer than one might expect.”

Perhaps more difficult was the realization she had to cultivate her own patience as well—“I had to remain confident that what I offer is valuable but realize it would take some time to build my clientele to the point that reached my business goals.”

When bottom line responsibility and risking your own money are factored in, Ms. Troyer said the lessons she learned in ophthalmology are not all that different from best-selling author Sheryl Sandberg’s Lean In: Women, Work, and the Will to Lead.

“We learn how to ‘lean in’ every day. We put the key in the door every morning with a goal of doing good, while doing well,” she said. “If we have investors, it’s also our responsibility and privilege to see that they make a reasonable return on their investment.”

Wishing someone would have told her owning a company is a 24/7 job “that never ends,” Ms. Barratt said she might have been better prepared. “For 28 years, OcuSoft has been my ‘baby’ and my life,” she said. “I have no regrets. We’re changing people’s lives with our products. I love hearing their testimonials and the satisfaction of knowing our company makes a difference.”

According to Ms. Troyer, “high-potential women” working in business want to help others and have reached out to other women to help them as well. She said OWL has reinvigorated its mentor program to follow suit. And as Ms. Sandberg notes in her book, “when women business leaders brainstorm about business and tout one another’s achievements, all of their businesses grow.”

Pangs (and pains) of ownership
Being an owner means you’re more vested in the overall business, much like being a physician-owner in an ambulatory surgical center. While the rewards are greater, the potential downsides are heavier, too. When companies are first launched, it’s the owner who has to put out all the fires, from underperforming suppliers to insurance issues to ever-changing regulatory requirements—while doing the hiring/firing.

“Most successful self-employed women (and men) tend to work much longer hours than they did when they reported to someone else,” Ms. Troyer said.

As a consultant with clients spanning the globe, Dr. Link said being an entrepreneur can be lonely. “After working in companies where there were always lots of people around, starting a consulting firm with only myself and an assistant didn’t quite fill my affiliation needs, especially being an extrovert,” she said. Once her company was established, however, “those feelings subsided and now I sometimes am overwhelmed in the other direction. I am not complaining, however!”

There’s a “false belief” that innovation happens with “lots of money and resources,” Ms. Troyer said, but in reality, it’s the lack of resources and money that truly creates innovation.

For those contemplating becoming an entrepreneur, small businesses are where big ideas happen.

“You intangible assets make up half, or more, of the value of your company,” she said, and too many entrepreneurs undervalue themselves.

Regrets?
While none of the panelists have any regrets about becoming entrepreneurs, they all agreed networking and a good support system in the beginning is what kept them at it.

“As an entrepreneur, I have the privilege of being in control and designing the company to be what I want it to be and how I want it to be,” Dr. Link said.

Ms. Troyer said most entrepreneurs would do it all over again if given the choice, and she has no regrets.

“I love being able to translate my passion for nutrition science to eye doctors and their patients,” she said. “That keeps me from burning out and getting discouraged.”

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Ms. Troyer is the new chair of the OWL Business Owners Interest Group and would like to invite all female ophthalmic business owners or co-owners to join. The group will be meeting at the 2014 American Academy of Ophthalmology (AAO) annual meeting in Chicago on Saturday, Oct. 18 at 2:00 p.m. Please email etroyer@biosyntrx.com for additional information.
Expanding a practice outside

by Vance Thompson, MD

In order to truly expand our practices, eyecare professionals may want to explore becoming active in research and product development. My experience has shown that when eyecare professionals play a role in bringing ophthalmic products from concept to market, we enhance our practice as well as experience professional growth and job satisfaction.

It’s good for business

Utilizing one’s expertise and clinical experience for the benefit of product development saves pharmaceutical and device companies a tremendous amount of time and money. When organizations are developing new products and studying them for safety and efficacy, enlisting the help of someone who is actively performing eye examinations and surgeries bridges the gap between industry and patients.

This gap is one that cannot be overlooked in product development — companies need and want to understand the true clinical utility of a product, how physicians are going to use the product in everyday practice, and what the unmet need is in the marketplace. Oftentimes in development phases a product idea...
can appear to be attractive on paper. However, when that idea is put into the real world, it may not translate. These are things that can only come from the clinician.

At a time when reimbursement from health insurance (public and private) is shrinking, we are consistently seeking alternative practice-building opportunities. Getting involved in product development and clinical research has allowed our practice to be on the forefront of the latest technologies and procedures, leading to significant increases in areas like premium surgeries. Our involvement contributes to the progression of eyecare treatments while also generating revenue from companies that value our services.

**It’s good for self worth**

Some of the greatest joys of my career have come from assessing and studying new technologies. That sense of satisfaction helps keep the practice of medicine fresh for me. After many years of practice, some eyecare professionals may feel like their desire to practice has become stagnant. Advising companies through product development and research and working with patients who are also interested in contributing to the process adds an exciting dynamic to our profession that energizes us. It leads to conference calls, writing opportunities, and lectures, forcing us to hold ourselves to a higher standard and practice medicine to the best of our ability. When we are involved in research projects, we are well read and participating in stimulating conversations with other surgeons and researchers. It keeps our skills sharp.

**Relationship with industry**

Relationships with industry representatives, like any other relationships, are built on trust. We are more likely to be asked to participate in a project if the company knows our values and our ethics. Therefore, an important component to relationship development is keeping in touch. As a result, when opportunities for involvement arise in our areas of expertise, we are thought of.

In addition to my direct relationships, I have been exposed to many new companies through my consultative relationship with Ora (Andover, Mass.), an ophthalmic research and product development firm. The firm has been paramount in my ability to build industry relationships by connecting me with companies who are conducting research that align with my team’s interest. I also consult with Ora for advice on how to set up the proper research framework in our practice.

**Build a team**

Clinical research and product development takes a commitment of time and resources. When companies are considering us for involvement, they are looking for an infrastructure in our practice that can handle a large commitment. I have a research team of 5 that consists of a director of research and 4 other individuals who are dedicated to ensuring that protocols are being followed precisely. It’s not unusual for us to have 5 to 7 active protocols at once, and my team completes the necessary paperwork, works with patients in the examination room, and sits in on surgical procedures for documentation.

**Don’t do it alone**

My practice is currently working with Euclid Systems in Herndon, Va., on a rigid gas crosslinking technology for corneal reshaping with contact lenses. The technology is designed to reshape the cornea with a reverse geometry lens called Ortho-K technology. The company’s goal is to reshape the cornea with the contact lens and then instill an eye drop that locks the cornea into shape so that Ortho-K becomes a non-surgical method for correcting nearsightedness. Euclid Systems and I receive guidance from Ora. Our involvement with Ora was paramount as they represented us at the FDA hearing to ensure that we initiated our clinical trial in a way that maximized our chances of success. Ora is currently involved integrally in the preparation of the preclinical trial.

Being involved in product development and research in clinical trials is exciting, but it is also intimidating. It can be a frightening concept for a single practice to interface with a large company. However, we can be successful by building an internal research team and aligning ourselves with a clinical research and product development firm. We can then add a component to our practices that is career changing, motivating, and energizing.
Blurred line,

Femtosecond laser cataract surgery—while many cataract/refractive surgeons are taking a wait-and-see stance before making a decision, both those with and those without femto cataract technology are having to rethink the great divide between the two sides of their practices and how they package cataract surgery.
A sharp focus

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

At this point, femtosecond laser cataract procedures account for only slightly less than 5% of cataract procedures performed in this country, but don’t let that number fool you.1 Despite the cost, the understandable caution with regard to the uncertain future of reimbursement, and the common perception that the femto procedure will take longer to perform, there appears to be more than enough interest—on the part of both surgeons and their patients—to ensure that this technology will gain greater traction during the next few years. In the meantime, while many cataract/refractive surgeons are taking a wait-and-see stance before making a decision, both those with and those without femto cataract technology are having to rethink the great divide between the two sides of their practices and how they package cataract surgery.

While this new technology may be blurring the line, the ever-widening selection of premium lenses as well as various methods of astigmatic correction are also driving a fusion of cataract and refractive. According to Market Scope, strong demand for toric IOLs has made these lenses “the fastest growing segment of the US IOL market over the past four years,” and the much anticipated combination multifocal toric IOLs will provide even more momentum when they enter that market.2

The synthesis of refractive and cataract takes place against a backdrop of a loss of momentum in LASIK volume experienced by many practices. Since 2007, the number of procedures performed has dropped 57%, and when compared to 2012 refractive procedure volumes, 2013 numbers declined by 6.6%.3,4 Beginning in Q3 and Q4 2012, the close correlation between the Consumer Confidence Index and procedure number ended, with the number of refractive procedures dropping and the index continuing its climb.5 Extreme weather conditions and the change in FSA rules are believed to have contributed somewhat to the drop. Reduced marketing efforts, too, have taken a toll, as refractive procedure numbers have been driven by the competitive market. Dwindling marketing expenditures have reduced the “buzz” associated with word of mouth from LASIK patients who are delighted with their outcomes. We see the consequent loss of momentum as responsible for at least as much of the decline in numbers as the current state of the economy. People are still saying that they are interested, but in the absence of this momentum, they are less likely to have the procedure and enjoy the benefits of LASIK. Fewer patients means less word of mouth and even less momentum for the refractive side of the practice.

A number of practices—including those who already have femto, those that do not yet have femto but are likely to offer it in the near future, as well as those still “on the fence” about femto—have been adapting the lessons learned from marketing LASIK and premium lenses and are integrating the refractive aspect into their cataract offerings, particularly the widening range of toric and astigmatic correction options. The refractive slow-down can give a practice the time and opportunity to evaluate and change the culture and orientation of the practice, with an eye to rebranding cataract surgery as refractive cataract surgery, regardless of whether it currently offers the femto cataract procedure.

A number of practices in “wait-and-see” mode take the view that the technology, while already impressive, can be expected to improve down the road. Concerned about high acquisition cost, reimbursement that hasn’t kept pace with the added cost, and CMS threats to actually reduce reimbursement, these physicians feel that it’s just too soon to know if they can make this work. We’ve seen this pattern before—the introduction of femto bladeless LASIK technology, controversy as to the actual value to the patient, early adoption by some and “wait-and-see” stance by others—and we all know how that situation eventually played out. With the current ubiquity of femto LASIK technology, the public typically assumes that the LASIK technology offered by a practice is “bladeless,” to the point that the word has lost much of its impact for marketing.

While the “wait-and-see” approach may or may not be prudent, inaction is not. Leadership at a growing number of practices across the country has recognized and responded to the blurring line between cataract and refractive

continued on page 24
Practices typically have an impression—"Stop selling "upgrades""

Practices typically have an impressive array of optional lenses and procedures to offer patients, but these patients are often more confused than impressed. They are in your office because they are no longer willing to tolerate the limitations that cataracts have imposed on them. They are ready to see better and return to life as usual but may be unprepared to face some of the decisions that stand between them and their goal. It may seem some-what illogical on the surface, but the same patient who says “no” to the out-of-pocket costs of a premium lens and/or a recommended astigmatic correction actually may have been willing to pay for the results he or she desires.

This is where cross training refractive and cataract counselors pays off. On the cataract side, counselors typically present premium lenses and other vision correction add-ons as “extras,” while refractive coordinators, with fewer options in play, have traditionally sold results.

Reorienting our thinking about cataract surgery to refractive cataract surgery shifts the focus to results to a degree not generally seen in the past. As a surgeon, you have always been focused on giving your patient the best possible results, but even a low-key sales orientation can cause a subtle but significant shift in the patient’s mind, from results to expense, and open the door to anxiety that may interfere with the decision-making process.

Start by asking questions

A frank discussion of desired results and the routes to achieving those results should always precede any mention of cost. Once you determine that the patient would benefit from a particular adjunctive technology, any discussion of a femto alternative or appropriate lens options should begin with you or a counselor asking a simple question: “Will you be content with wearing glasses after your surgery or do you want to be less dependent on glasses?”

For both femto and non-femto practices, the answer to that question points to the pathway (or pathways, as in the case of astigmatic correction) that will lead to the refined surgical outcome that will delight this patient, with emphasis on the value that awaits at that destination.

A value focus becomes particularly important when premium services or lenses will be required to achieve the desired result. Once value is established, cost can be logically and rationally viewed in context. Bonnie An Henderson, MD, suggests characterizing a toric IOL as a “long-term investment rather than a one-time cost,” an “opportunity” rather than an “option,” advice applicable to other services and options as well.

Take a look at the scripts your counselors are following and the printed materials you are giving cataract patients now. Whether your practice is a “have” or a “have not,” there are any number of ways to configure the organization and printed presentation of the cataract options offered. Avoid stratifying offerings into classes that imply that the options with the highest price tags give the most desirable results; this tends to characterize the “traditional” cataract procedure/monofo-cal lens option as inferior to other available alternatives. Avoid prepackaged sales promotions or any strategy that focuses on anything other than patients’ individual needs and circumstances, and position your practice’s technology as a means to an end. The most desirable result is—both literally and figuratively—in the eye of the beholder/patient, and nothing you say or do should imply otherwise.

Until you make your decision

A one-size-fits-all approach doesn’t work well for your patients, and it doesn’t work when reconfiguring to a refractive cataract surgery structure. We have helped a number of forward-looking practices across the country to reconfigure in ways that take advantage of the amazing technology currently offered and that which may be added in the future. No two of these reconfigurations have been exactly alike, and each is well suited to its respective practice. They all build on that first question—“Do you mind wearing glasses...
after your surgery or do you want to be less dependent on glasses?—and focus on how to get from the problem to the desired result. If you currently have femto or are ready to adopt this technology in the near future, we recommend that you consider this strategy. If you are still in “wait-and-see” mode, a refractive cataract surgery orientation could be a good fit for your practice whether or not you adopt the technology, so there’s no reason to wait. Regardless of your decision, the blurred line between cataract and refractive can mean sharper focus for more of your patients.

References
5. Ibid.

Mr. Rabourn is founder and managing principal of Medical Consulting Group in Springfield, Mo. He can be contacted at bill@medcgroup.com.

Mr. Pennow has 25 years of experience in managing high-volume refractive and cataract practices. He is the financial and operations officer of Hollingshead Eye Center, Boise, Idaho. He can be contacted at lpennow@hollingsheadeyecenter.com.
Engage staff in 5 easy conversations

by Kim Seeling Smith

Did you know that only a fraction of your staff bring their “A game” to work every day? According to companies like Aon Hewitt and the Gallup Organization, this number is about 1 in 5.

Countless companies dedicate a sizeable chunk of their annual budgets to solving their employee engagement issues, when in reality most engagement issues (as well as performance and behavioral problems) can be solved through conversation.

But most managers don’t talk to their staff frequently enough, or don’t know how to talk to them or what to talk about. Managers are unaware as to how to plug into their employees’ minds and figure out what they really want and what they need to be fully engaged and productive. Getting into the minds of your employees to glean the information needed to increase engagement and productivity in your workforce can be as simple as conducting the following 5 FOCUSed conversations.

Conversation 1: Feedback

There are two types of feedback that fall under this conversation. First, give praise where praise is due. Studies have shown that a vast majority of employees do not feel appreciated enough for the job they do. Praise is a scarce commodity in the workplace. If your staff is doing a good job, be sure to let them know. Conversely, one of the key factors in employee engagement is the ability to have your say. Be receptive to your staff’s feedback. They may come up with a brilliant idea that makes a huge difference for the practice.

Conversation 2: Objectives

Most performance issues stem from a disconnect between what the manager perceives as meeting objectives and what the staff member perceives as meeting them. To drastically reduce performance issues, managers must both clearly define and articulate expectations. Your employees need to know what they must do to be successful in their jobs and how that success will be measured. You need to have a clearly defined yardstick by which to objectively measure performance. Aligning their expectations with yours will result in less frustration and anxiety on both of your parts.

Conversation 3: Career development

Many studies list career development within the top 3 factors that employees gauge to determine whether to stay with their current employer or look for another job. Helping staff manage their careers makes good business sense. Ensuring that they understand what opportunities exist within your practice will inhibit them looking outside of it.

Find out what your employees’ priorities are and have open, honest conversations around how your practice can help them achieve them—even with any constraints you may have. Suggest and recommend internal opportunities to learn, grow, and develop.

Conversation 4: Underlying motivators

The underlying motivators conversation helps to uncover those intrinsic factors that science has shown to be much more highly motivating than extrinsic ones such as pay and benefits. By tapping into those intrinsic factors for employees, you will help uncover what they need to “go the extra mile.” Conversely, once they do, they need to be recognized appropriately for it. The old adage, “Praise in public, correct in private” is only half true. Many people don’t respond well to public recognition. Identify the drivers of each individual staff member to unlock productivity and unleash potential.

Conversation 5: Strengths

Strengths can be defined as the innate abilities or behavioral patterns that are neurologically hard-wired into our brains between the ages of 3 and 15. The context of the behavior will change over time, but the patterns remain the same. So those children who share their toys in the sandbox at the age of 5 may very well become 15 year olds who volunteer at the local charity. And 20 years on they may become the 35-year-olds who are the most collaborative in the workplace.

Strength identification also requires a very minor time commitment; as little as 2 hours per week can make a world of difference.

If you can help your staff determine behaviors that come naturally to them you will find that their stress is decreased, they become more engaged and more productive. There is no reason to spend mass amounts of time and money on “engagement” programs when all it takes is tapping into the minds of your personnel. By first hiring the right staff and then employing the five FOCUSed conversations, managers will significantly increase overall employee engagement.

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