Innovation in the delivery of eyecare

How private equity is playing into ophthalmology

P. 16
In 2015, Millennials surpassed Baby Boomers as America’s largest living generation.1 Born from 1981 to 1997, these young adults are candidates for LASIK — they can enjoy a lifetime without the hassle of glasses or contacts. With a population of 75.9 million,1 they represent an opportunity to grow your LASIK business for years to come. The key is in understanding how (and where) to connect with Millennials to attract them to your practice.

Meet the search-savvy generation.

Sometimes called the “Social Generation,” Millennials are digital natives that grew up with the Internet. It should come as no surprise that 86% of adults age 18-29 use at least one social media site.2 The dramatic shift in technology that put everything at their fingertips has created an expectation for instant answers. To help meet this need for constant access to information, Medical Eye Center features a 24/7 live chat on their website.

“If they’re researching LASIK during the day, they’re less likely to pick up the phone and call our office,” said Patty Casebolt, Clinical Director for Medical Eye Center. “They want to research and get their information electronically.”

With social lives that are always on(line).

A strong social media presence is a must for vision practices that want to attract Millennials. It’s all about having a conversation with your patients. “It’s not necessarily about coming in to have LASIK, it’s becoming part of their conversation in their social group,” said Cathi Lyons, administrator for Gordon Schanzlin New Vision Institute, a TLC Laser Eye Center.

While social media can be a fun way to share your practice’s unique culture, it’s important to communicate to your team what is appropriate to post. “Millennials love that social media isn’t serious all the time. But they’re still patients and they expect staff to be professional,” Casebolt said.

The in-practice experience still matters.

Millennials may spend a lot of time online, but they still value good customer service. They want to feel like their concerns are heard and their needs are met. “Millennials want to know they’re being cared for, that they’re getting the best value for their money,” said Lyons.

Cost is a common concern that can keep patients from scheduling their LASIK procedure. A recent study found that 48% of consumers 25-34 said they are more likely to delay an elective procedure because of cost.3 Financing options like the CareCredit health, wellness and personal care credit card may help patients move forward with their procedure.

To learn how to engage effectively with every age group, call the CareCredit Practice Development Team at 800-859-9975, option 1, then 6 to request Generational Insights Series Quick Guides.

1 Millennials Overtake Baby Boomers as America’s largest generation, Pew Research Center, April 25, 2016. 
3 Generational Health and Well Being Research, 2016, Conducted by Chadwick Martin Bailey on behalf of CareCredit. 
4 2015 State of the Connected Patient, Salesforce.
any physicians agree that the business side of ophthalmology is changing. While medicine's primary focus is still patient care, various factors have physicians thinking more about how to manage and grow their practice. On the flip side, investors are looking at the healthcare practice space, including ophthalmology, as never before. “Healthcare has become a business, and people think about it and run healthcare like a business. As a result, that's created a lot broader interest in a bigger group of players in the healthcare industry, such as private equity and corporations,” Rajesh Kothari told Ophthalmology Business. In this month's feature article, “Innovation in the delivery of eyecare,” we explore the perspectives of practices and private equity on this topic.

In this issue, we also look at the concept of “alert fatigue.” With electronic health record systems, alerts listing alternate medications, potential side effects, medication conflicts or allergies, and more pop up dozens of times a day. However, physicians often find the information clinically inapplicable or irrelevant, and have become prone to glossing over the alerts. This situation can become a patient safety issue when an important piece of information gets lost among all the noise. Read more in “How ophthalmologists are impacted by ‘alert fatigue.’”

Online advertising is crucial for a business, but it can be complicated. One of the most difficult aspects of online advertising is sorting out the terminology—search engine marketing, pay-per-click advertising, cost-per-click, search network and display network ads, and Google AdWords. It is important to learn what these terms mean, how they are related, and how to correctly incorporate them into an ophthalmic business' online marketing strategy. Doing so could significantly improve marketing return on investment and attract patients. Learn more in “Reaching more patients with Google AdWords search engine marketing.”

A study was recently published in the Journal of Cataract & Refractive Surgery that assessed resident training and preparedness for cataract surgery. A survey was sent to all ophthalmology residency programs within the U.S. and asked about an array of tools, from simple steps such as reviewing the charts in preparation for surgery or having a traditional didactic lecture to spending time in the wet lab and using pricey surgical simulators. The results may surprise you. Read about them in “Training residents for success.”

You will find these articles and more in this issue of Ophthalmology Business. If you are interested in writing for the magazine, please contact us to share your ideas. As always, thank you for reading!

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How ophthalmologists are impacted by ‘alert fatigue’

by Liz Hillman, Staff Writer

Reducing alerts and alarms, making them more relevant to dial back on this potential patient safety issue
A patient needs an eye drop medication. You hop onto your electronic health record system and order the medication, click “sign,” and—pop—up comes an alert in the middle of your screen. The alert provides a long list of alternate medications, medications in that category, potential side effects, any medication conflicts or allergies specific to the patient, and more.

Sound familiar? Alerts and alarms occur dozens of times a day when it comes to prescriptions, procedures, diagnoses, and other situations. Physicians, however, often find the information clinically inapplicable or irrelevant, and have become prone to glossing over the alerts or ignoring alarms in something called “alert fatigue.” This situation can become a patient safety issue, however, when an important piece of information gets lost among all the other noise.

“The more you pay attention to something and continually find it to be a nuisance and waste of your time, the more you tend to start, subconsciously, ignoring it,” said Ray Areaux, MD, clinical informaticist and assistant professor of pediatric ophthalmology and strabismus, University of Minnesota, Minneapolis, and medical director, Minnesota Lions Children’s Eye Clinic. “That’s the concept of alert fatigue: that buried in the noise of all the alerts will be something significant, and there’s a potentiation of the end user, the physician or provider, to click past it quickly because they’ve never seen a significant alert. That’s the real problem.”

Hundreds of papers have been published on the topic of alert fatigue. A 2009 report looked at medication safety alerts—also called decision support systems—generated on an electronic prescription system by 2,872 physicians between Jan. 1, 2006 and Sept. 30, 2006. More than 3 million prescriptions were electronically written during this time period, 6.6% of which generated an alert. The researchers found clinicians overrode most high severity drug interaction and allergy alerts, with 9.2% and 23% alert acceptance rates, respectively.

Other research has found “clinicians became less likely to accept alerts as they received more of them, particularly more repeated alerts.” Yet another study reported more than half of drug allergy alerts (more than 600,000 collected from two Boston academic centers from 2004–2013) were overrode due to irrelevance; this research also showed providers were more likely to override repeat alerts.

Impact on ophthalmologists

The idea of clinical alert pop-ups for electronic health record systems goes back many years with the thinking that it would make care better and safer, said Michael Boland, MD, associate professor, and director of information technology, Health Science Informatics, Wilmer Eye Institute, Baltimore.

Dr. Areaux said that while ophthalmologists might be “shielded” from alerts more than general practice physicians, electronic health records are often shared among specialties. When a healthcare institution decides to roll out an alert for a certain screening or lab test, the alert is sent to everyone system-wide, whether it’s relevant to them or not.

“The impact that has on a primary care doctor who may see 10 patients in a half day is very different from the impact on the ophthalmologist who may see 20 to 25 patients in a half day. Even though it’s just one alert, we get twice as many in a smaller period of time when we’re trying to be more efficient and focus on one organ system,” Dr. Areaux said.

Naveen Rao, MD, assistant professor of ophthalmology, Tufts University School of Medicine, Boston, described the two most common examples of alerts he sees on a regular basis:

“(1) When I am scheduling a patient for a follow-up appointment, I see a warning that they already have an outstanding follow-up order previously entered with someone in our department. This could be useful to prevent duplicate appointments, but the warning does not let me easily see when the appointment is and who it is with. I don’t care if a patient has an appointment with a glaucoma or retina specialist in our practice if I want them to see me for a cornea follow-up. I often click away these messages without reading, although they may be useful,” he said.

“(2) Medication-related advisory messages are the worst offenders for causing alert fatigue. If I’m entering orders for an antibiotic eye drop for a patient with a corneal ulcer, and if I want the drops to be used every hour, I always get an alert saying this exceeds the recommended dosing

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frequency of four times a day. The message requires me to enter some justification before proceeding, so I always enter ‘Benefit outweighs risk.’ It takes a significant amount of effort to have our EMR analysts suppress these messages, and sometimes it is not possible to do so, since much of the medication data comes from third party vendors, and we have no easy way of contacting them. It’s much easier to click away the alert, which just takes a moment, but in aggregate, every extra second and every extra click adds up fast.”

Dr. Areaux said: “The majority of the time we’re prescribing eye drops, they are not having a vast systemic effect. However, eye drops often contain the same generic compounds that are in a lot of other systemic medicines, like blood pressure medicines, so they’re associated with the same alerts about changing heart rate or blood pressure or cross reactivity with other medications or [a dose that is too high]. There are a lot of pop-ups that we get that are extrapolated from the systemic forms of medication that are often inapplicable to our clinical situations. We do end up closing and ignoring those regularly.”

The potentially inapplicable alerts are not only annoying, but they disrupt workflow and thinking, Dr. Areaux said.

“Disruptive alerts force you to divert from your current workflow, address them, and then revert back to your workflow. Every time we do that we’re disrupting physician thought,” he said. “The problem is if we’re constantly interrupting good patterns of thinking for useless alerts, people start to click past them faster, and at best we get no benefit. At worst, we may be diverting the physician from something important for the patient, something that could be missed.”

Impact on the patient

Dr. Boland said he can’t recall any reports at Wilmer where alert fatigue has been implicated in an adverse patient event. According to the Patient Safety Network of the Agency for Healthcare Research and Quality, “there are few studies that quantify adverse events related to alert fatigue.”

The Boston Globe, however, found in an investigation that there were more than 200 patient deaths in hospitals across the country from June 2005 through June 2010 that resulted from unheeded alarms on patient monitors.

Robert Wachter, MD, University of California, San Francisco, wrote a book—The Digital Doctor: Hope, Hype, and Harm at the Dawn of Medicine’s Computer Age, which was excerpted in the digital magazine Backchannel in 2015—that reported a specific and extreme example of how alert fatigue severely impacted one patient. In it, Dr. Wachter recounted the true story of how in 2013 a 16-year-old with a rare genetic disease was given not one antibiotic pill at the hospital but 38.5 of them. A problem with the default setting in the dose unit in the electronic health system caused the pharmacist to prescribe the dose in milligrams per kilograms (the default used for pediatric patients less than 40 kilograms) instead of milligrams. As one might expect, a pop-up alert was issued when this overdose was entered.

As Dr. Wachter put it, “With her task list brimming with dozens of unchecked boxes and more sick kids in need of her care and attention, [the admitting physician] assumed that the alert she received after signing the Septra order was yet another annoying one with no clinical significance, and so she clicked out of it. With that, the order for 38½ Septras now ricocheted back to the pharmacy, having been signed and validated by a licensed physician.”

The number of pills, dispensed by a pharmacy robot (Dr. Wachter’s article pointed out that a human dispensing the pills might have found something off about it and raised a question) and administered by a nurse who only had experience giving the antibiotic as a liquid or intravenously, meant the full prescription was taken by the patient. As a result of the 39-fold overdose, the patient had a grand mal seizure and stopped breathing, but he lived.

Dr. Rao said he can see how alert fatigue could lead to physicians inadvertently ignoring an important alert among the other noise.

“I may see an alert like this five to 10 times a day, and usually I quickly click it away. However, occasionally some alerts can be useful, for instance an alert indicating that a patient has an allergy to fluoroquinolones when I am entering the order for ofloxacin, which I use for almost all my cataract surgery patients. Because I am so used to quickly bypassing the irrelevant alerts and have figured out exactly what to click to make the alerts go away, I could potentially miss the valid alert indicating a medication allergy,” Dr. Rao said, adding that while it hasn’t happened yet, it could, “and that stresses me out.”

Reforming the system

Dr. Boland said Wilmer Eye Institute has been working to minimize alerts for more than a decade. “There has to be a compelling reason to turn one on, otherwise we don’t configure them to appear,” he said.

“Considering adding an alert is a balancing act between ‘What is the risk of not warning somebody vs. the burden of having these pop up every 20 minutes during the day?’” Dr.
Boland said, adding that the driving force for alerts will primarily be patient safety.

“If it’s something really unsafe, if there’s an allergy to a particular medication and they shouldn’t receive it, that’s an important warning to pop up. If, on the other hand, it’s ‘This medication is sometimes known to interact with this medication,’ there’s a bit of gray area. We consider a combination of ‘Is it important?’ and ‘What is the severity of the kind of thing we are trying to prevent?—you’re trying to think about those two things carefully,” Dr. Boland said.

Before turning on a new alert, Dr. Boland suggested piloting it to a small group for feedback before rolling it out to the whole practice or institution. It’s also important for physicians to communicate with their vendor or IT department when an alert is not working for them.

“The real solution is not asking users to carefully read them all and respond appropriately, it’s working with your vendor or IT staff and saying, ‘These alerts don’t help us. Can we please get them turned off?’” Dr. Boland said.

Research has shown that reducing alerts can be helpful. A study published in 2017 evaluated the reduction of drug interaction alerts, finding that “targeted DDI alert reductions reduce alert burden overall, and increase net efficiency as measured by think time for all prescribers better than for non-prescribers.”

In addition to reforming the decision support system as a whole, there is software that aims to reduce alert fatigue.

CareConverge (Everbridge, Boston), a critical communications software platform, routes alerts and messages only to those who need them, instead of broadcasting to everyone, as can often happen in large, multispecialty hospitals systems.

“Imagine when a ‘Code Blue’ is called as an overhead page. All the physicians and nurses rush to respond. Patients get r attled. The overhead announcement is vague, disruptive, and unnecessary because not every physician and nurse needs to answer the code,” said Ranya Habash, MD, Bascom Palmer Eye Institute, Miami, and co-founder of HipaaChat, which was acquired by Everbridge and integrated into the CareConverge platform. “Every time they leave for a code, their workflow is disrupted, as is their patient care. I see this happen several times a day with my residents.

“Instead, when a code is activated, Everbridge routes the message only to the people who need to respond: the critical care team caring for that specific patient. There is no overhead page, just a special text alert to specific people, which includes the patient’s information and clinical situation so the doctors/nurses actually know what they’re getting into,” Dr. Habash said. “This is a much better solution for everyone involved.”

Dr. Areaux said software engineering and IT and clinical engagement on the issue of alert fatigue is already improving, but “it’s not a simple problem” and “we’re not there yet.”

“This is the most pervasive and common medical tool that we all use now,” Dr. Areaux said of electronic health record systems. “We all have a responsibility to be engaged in its maturation so we can take better care of patients.”

References

Editors’ note: Dr. Boland has financial interests with Alcon (Fort Worth, Texas). Dr. Habash has financial interests with Everbridge. Drs. Areaux and Rao have no financial interests related to their comments.

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Online advertising is a crucial yet highly complicated task, a fact that more and more ophthalmic businesses are coming to realize as they follow patients online. One of the most difficult aspects of online advertising is sorting out its highly similar terminology. Search engine marketing, pay-per-click advertising, cost-per-click, search network and display network ads, and Google AdWords are some of the most frequently repeated terms, as well as some of the most important to online advertising success. That is why it is so important to learn what these terms—especially Google AdWords—mean, how they are related, and how to correctly incorporate them into an ophthalmic business’ online marketing strategy without getting lost in the jargon. Doing so could significantly improve marketing return on investment and attract more of the right patients at the right time.

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Read it, Watch it, Share it!
In an effort to stay competitive, the AdWords tool allows businesses to:

• Reach out to potential consumers within a few miles of a business or broadcast ads to entire regions or countries.

• Target types of people, which is valuable for ophthalmic businesses looking to target specific groups of patients, such as the average LASIK or cataract patient.

• Track how many people are shown a business’ ads, visit the website, or call the business.

• Tweak ads and test changes to see if they work better.

• Adjust the budget whenever needed with no contract, so businesses can end a campaign any time without cancellation fees.

However, it is because of these and many other helpful features that so many businesses struggle to actually use AdWords. With so many options available, advertisers quickly become overwhelmed.

Demystifying the digital jargon

Search engine marketing: Although search engine marketing (SEM) is technically defined as the process of gaining traffic and visibility from search engines through both paid and unpaid efforts, it has become more commonly used to describe paid search activities. For this reason, it is often used interchangeably with the term “pay-per-click” (PPC) advertising.

Pay-per-click and cost-per-click: Pay-per-click (PPC) is an advertising model designed to drive traffic to websites when an ad is clicked. An advertiser pays a publisher either a fixed amount of money per click, or (more often) they pay per click based on a fixed daily budget. With the daily budget system, click values are determined by things such as competition and search volume.

Cost-per-click (CPC) is a term people often incorrectly use in place of PPC advertising, when in fact CPC is not actually an advertising model but a metric that measures cost per click. CPC is just one part of PPC advertising or SEM.

Search network and display network ads: Search network ads appear on a search engine results page (SERP). Display network ads are displayed on other websites across the internet.

Google AdWords: While individual websites can host a variety of PPC ads, the most common form of PPC advertising involves search engines. Google AdWords is arguably one of the most effective SEM programs. It is designed to help businesses be seen across the web via a variety of PPC ads, including display, video, search, and app ads. Overall, the goals of AdWords are to attract new website visitors, grow online sales, encourage consumer calls, increase brand awareness, and keep consumers coming back for more.

Google AdWords’ lead generating potential

Google AdWords is an SEM leader and is highly recommended for ophthalmic businesses for several reasons. Perhaps its most obvious strength is the size of its audience. With a 77% marketing share lead over competing search engines according to a 2017 report by Net Market Share, Google is not only the most used search engine but a leader whose popularity continues to rise.¹

In addition to holding the largest audience, Google has ensured that its AdWords SEM platform is one of the best. The bulk of Google’s total revenue comes from its advertising service, meaning that maintaining and improving AdWords is and will remain Google’s top priority.²

In the same way that an ophthalmic business is most successful when its management team fully understands how the practice runs, an AdWords campaign will generate the best results when those in charge of it know
how all of its features work together. Even advertisers who have used AdWords before can benefit from taking a step back to review a simplified overview of this ad placing system.

**Campaign setup:** One way to proactively keep an AdWords campaign from becoming overly complicated is to tailor it to match a business’ goals and to focus on the features most relevant to it. AdWords allows businesses to do this by breaking campaigns into a hierarchy of components: a campaign name, ad group, ad type, and ad sub-type. A campaign name generally represents the general subject of the ads within it, such as a business’ service or product. An ad group divides a campaign into more specific subject categories and allows the advertiser to select keywords for each group. Keywords are words or phrases that people are most likely to look up when searching for specific products or services. Ad type determines details such as where the ads can appear to consumers on Google’s advertising networks, as well as in which formats they can be presented. Finally, a sub-type determines how many settings and options are available to use for a campaign.

*Example:*  
–Campaign: LASIK  
–Ad group 1: LASIK quiz  
Keywords: LASIK, laser surgery, LASIK surgeon Missouri, etc.  
–Ad group 2: About LASIK  
Keywords: LASIK, laser eye surgery, cost, LASIK procedure, etc.  
–Ad type: Search network  
–Ad sub-type: All features

**Auction and bidding:** These terms relate to how a business gets its ads to appear on a SERP, among other places. AdWords runs an auction every time it has an ad space available, allowing advertisers to place bids for their ads. The winner’s ad will show at that moment in that space. Bidding is simply selecting how much a business is willing to pay for their ad to be interacted with over a certain period of time. This bid is just one of several factors that Google’s algorithm considers when selecting winners and ranking ads on a SERP. There are several ways people interact with ads and therefore several bidding options. The bidding option an advertiser selects depends on what an ad is designed to do (convince people to visit a website, view a logo, watch a video, etc.). Cost-per-click bidding, in which an advertiser pays only when the ad is clicked, is the default bidding option businesses see when making an ad, and it is often a good starting strategy. Other options include cost-per-impression, cost-per-view, cost-per-acquisition, and more.

*Example:*  
–CPC budget: $16/day for LASIK quiz ads

**Ad ranking:** Ads that are ranked higher, based on Google’s complex algorithm, appear closer to the top of a SERP, making them more visible to people searching and, therefore, more likely to receive clicks. Higher ranking is determined by analyzing an ad’s quality score, bid, and other ad features. The auction and ranking system create competition to ensure that the best, most relevant ads are rewarded.

Once advertisers are confident they understand the basics of placing ads, they should begin to utilize the analytic features to review ad strategy results, make adjustments, and optimize the return on their investment.

Online advertising is constantly changing. While it may yield a significant profit if done well, an ophthalmic business must dedicate time and resources appropriately. Many businesses achieve this profit by enlisting the help of an AdWords specialist. Selecting one who understands ophthalmology is particularly advisable, as they not only know how AdWords functions and the best strategies for creating high-ranking ads but also how those strategies should be adapted to incorporate an eye-related business’ needs. Others who think that consistently adjusting and maintaining an AdWords account is too large of a commitment to handle in-house may outsource all of their AdWords efforts to online advertising consultants. With the help of those who specialize in analyzing the digital market and its resources, the consumer, and the current state of a business, a business can simplify the process of developing the most effective strategy. OB

**References**


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Training residents for success

by Maxine Lipner, Contributing Writer

Spending time in a wet lab getting hands-on experience is perceived as valuable by residents for building confidence.

Source: Shameema Sikder, MD

Which methods help most

Everyone wants residents to be as prepared as possible to perform cataract procedures, but are there certain training methods that may be perceived by residents as more useful than others? That’s what investigators set out to determine, according to Shameema Sikder, MD, assistant professor of ophthalmology, Johns Hopkins University School of Medicine, Baltimore. The study was published in the *Journal of Cataract & Refractive Surgery.*

Investigators wanted to hone in on the latest technology and its role in resident education. “At Johns Hopkins, we have an interest in surgical education and how we can use technology to promote surgical competency and create the best surgeons,” Dr. Sikder said. “But the real driving factor for this paper was the fact that there are so many different tools available to help residents prepare.”

As part of the study, a survey was sent to all ophthalmology residency programs within the U.S. “We had a total of 116 residents who completed the survey,” Dr. Sikder said, adding that investigators asked about an array of tools, from simple steps such as reviewing the charts in preparation for surgery or having a traditional didactic lecture to spending time in the wet lab and using pricey surgical simulators.

Surprisingly, use of state-of-the-art technology did not necessarily translate into the greatest sense of preparedness. “The surgical simulator, which is often the most expensive tool that we have on the market, didn’t uniformly equate to a sense of preparedness,” Dr. Sikder said. “Certainly, the surgical simulator was found to be helpful, but it wasn’t a case that if you had one you could sit your resident in front of it and hope that the resident would be competent by the end of the simulation use.”

Instead, it was hands-on supervision from a more experienced practitioner that proved to have the
Upon a time the adage, at least at Hopkins, was, ‘See one, do one, teach one,’ and times are changing; patients are savvier,” she said. “They are aware that there are resident surgeons and attending surgeons and they want to know who is doing their surgery and how competent they are. The burden is on us to produce the best surgeons as quickly and as efficiently as possible.”

Reference

Editors’ note: Dr. Sikder has no financial interests related to her comments.

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Innovation in the delivery of eyecare

by Liz Hillman, Staff Writer

How private equity is playing into ophthalmology
The business side of ophthalmology is changing. Twenty years ago, healthcare in general was not the business that it has evolved into today; healthcare was solely about the delivery of care, said Rajesh Kothari, mergers and acquisitions (M&A) specialist and managing director, Cascade Partners, a growth capital investment banking and private equity investment firm with offices in Michigan, Illinois, and Ohio.

While medicine’s primary focus is still, of course, patient care, various factors have physicians thinking about how to manage and grow their practice. On the flip side, investors are looking at the healthcare practice space, including ophthalmology, as never before.

“Healthcare has become a business, and people think about it and run healthcare like a business. As a result, that’s created a lot broader interest in a bigger group of players in the healthcare industry, such as private equity and corporations,” Mr. Kothari said. “In ophthalmology, this is a much newer phenomenon. If you go back 4 to 5 years, there was no real private equity in this market. Today, there are nearly a dozen major market participants, and that number is accelerating faster than I’ve seen it in any other sector in the healthcare space.”

The topic of private equity partnership and “mega-practices” was discussed at the Ophthalmology Innovation Summit before the 2017 ASCRS•ASOA Symposium & Congress (OIS@ASCRS) in Los Angeles. Bruce Maller, president and CEO, BSM Consulting, Incline Village, Nevada, said at the meeting that “no less than 20 to 25 private equity investment firms are seriously interested in the ophthalmic space, and it begs the question, why?”

“Because of the aging population, we have an increased prevalence of eye disease, whether you’re talking about cataract, glaucoma, or retina, so from an outsider’s perspective, the changing demographic landscape equals an opportunity,” Mr. Maller said, adding that the increased complexity of the regulatory environment and changes in the payer landscape are leading to “a tremendous amount of consolidation. Whether from mergers or acquisitions, our bigger practices are interested in strengthening their footprints. As such, there is a tremendous amount of transactional activity taking place in many markets across the country.”

Where private equity comes into play, Mr. Maller continued, is they can facilitate market consolidation by providing a source of capital for these transactions.

“From the standpoint of a private equity investor, they’re looking to align with high quality individuals who share common values and who have the desire to build a great business. They’re looking for a business with an operating platform that can be scaled up. ... They’re also looking for strong physician leadership that is committed to building a great business,” he said.

Mr. Kothari said private equity is showing interest in ophthalmology because unlike other specialties, there are many different revenue channels that can be built and grown from combining ophthalmic practices with ambulatory surgery centers, optometric practices, retail, or any combination thereof. His firm advised on a transaction involving a private equity firm and Grand Rapids Ophthalmology in Michigan earlier in 2017.

From the physician’s perspective, private equity helps provide financial backing for current and future practice infrastructure, as well as expertise in business efficiency. It also provides new succession plan options for doctors as they start considering retirement and getting a return on their practice investment.

The practice perspective
A variety of factors led Brett Katzen, MD, president, Katzen Eye Group, Baltimore, to partner with a private equity firm. Varsity Healthcare Partners acquired Katzen Eye Group in May 2014 to form EyeCare Services Partners, and in May 2017, a majority share was purchased by Harvest Partners. Dr. Katzen had built a large platform that encompassed all subspecialties in ophthalmology. Business was growing, but it started to get squeezed financially due to various factors, including the economic climate, unexpected loss of a major contract, and electronic medical record compliance. Dr. Katzen experienced his bank changing its covenants, therefore making it more difficult for him to borrow money and grow his business.

Wanting to continue the practice’s projected growth, Dr. Katzen said he looked at several strategies and partnerships that he felt could sustain the business. It took 2 years and meeting with at least 15 private equity companies to find a company that he felt aligned with his goals.

Brent Wilde, president, Minnesota Eye Consultants, Minneapolis/St. Paul, said his group’s primary goal in partnering with private equity was to grow and to get more business-focused minds at the table.

Richard Lindstrom, MD, Minnesota Eye Consultants, Minneapolis, said as moderator of the OIS@ASCRS session that as a senior partner at the practice, private equity was also attractive as a monetization opportunity. The traditional succession plan involves selling shares to a younger associate, but this is often at a low value for the “tremendous value” the senior partner has built. “Private equity allows us to gain some fairer value,” he said.

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Mr. Wilde said that on the flip side, younger physicians, coming out of training with hundreds of thousands of dollars in debt, do not seem as keen to take on more debt to buy into a practice as they have in the past.

In May 2017, the American Medical Association (AMA) alluded to this trend, reporting that for the first time the majority of physicians working at least 20 hours per week (and not employed by the federal government) were not practice owners.

According to data from the AMA’s Physician Practice Benchmark Survey, 47.1% of physicians are practice owners; only 27.9% of physician practice owners are under 40 years old. Providing some comparison points, the AMA stated in a press release that 53.2% of physicians were practice owners in 2012 and 76.1% were owners in 1983.

Finding the right fit
Before starting to pursue a partnership with private equity, Mr. Kothari said a practice needs to review its goals.

“You need to honestly assess your situation, future plans, and your financials. If you are not interested in growth, pursuing private equity may not be for you. But if your goals are in focus and your practice is positioned for expansion and/or consolidation in your medical practice marketplace, the returns are rewarding,” he said.

Dr. Lindstrom explained at OIS@ASCRS that his practice had looked at creating a “mega-group,” but the other doctors they spoke with in the area had their own brand and culture and wanted to maintain that. Still, seeing a lot of opportunity to work together, Dr. Lindstrom said private equity provided the model for them to do so while maintaining their own brands.

If bringing in private equity could further your practice goals, then Dr. Katzen and Mr. Wilde discussed the importance of picking the right partner.

“You want to focus on—beyond dollars and cents—what is the reputation of your potential private equity partners?” Mr. Wilde said. “Ask a lot of questions, do a lot of reference checks.”

A big driver for the decision to partner with Waud Capital Partners, Mr. Wilde said, was when they asked the firm what their measure of success would be within the first year or two after partnership. The firm’s representatives didn’t come back to them with a dollar figure; instead, Mr. Wilde said, they responded that they would consider the partnership a success if the physicians were happy and said they would do it again.

“Four or 5 months in, that is still the driving force,” Mr. Wilde said.

David Alpern, partner, Varsity Healthcare Partners, Los Angeles, said at OIS@ASCRS that it’s important to do your homework on private equity firms you’re in discussion with, contacting other ophthalmic practices they’ve partnered with and other businesses outside of the specialty as well.

“If you don’t end up feeling like there’s alignment, good partnership, and transparency, go in another direction,” Mr. Alpern said, adding that while there is a lot of capital out there, it’s more difficult to ascertain which partners will help you get to where you want to be.

Chris Graber, principal, Waud Capital Partners, Chicago, echoed this thought but added that he would recommend partnering with a firm that has done this before. Mr. Wilde said it’s important to have a strong transaction/legal counsel representing you.

Mr. Maller said it’s important to make sure that not only are the principals at the investment firm aligned with the partners of the practice, but the partners need to be doing it for the right reasons as well.

“Another thing I want to know, from the group’s perspective, is if the business model you’re creating and the partner you’re choosing is going to position your practice so that you have a stronger, more sustainable business model that will foster you staying as independent practitioners in the future,” Mr. Maller said. “For your business model to be sustainable, you must have an eye on the next generation of surgeons. You

No less than 20 to 25 private equity investment firms are seriously interested in the ophthalmic space, and it begs the question, why?”

—Bruce Maller

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have to ask yourself, is the structure we create something that’s going to be attractive to those younger surgeons?”

Dr. Katzen said negotiations took about 6 months until his deal was complete. Mr. Wilde said from the idea to partner with private equity to selecting a partner and completing the deal took about 18 months for Minnesota Eye, but he foresees this process going faster in the future for practices as more in the space enter into these partnerships.

**Private equity’s perspective**

Mr. Alpern and Mr. Graber shared their thoughts on why ophthalmology is garnering private equity’s interest at OIS@ASCRS.

Mr. Alpern said there will be a supply and demand imbalance, correlated with the aging population. This, he projected, will spur rapid growth in the eyecare space with a relatively small workforce to treat it.

“As an investor, you look for places where there is going to be reliable growth uncorrelated with the economy, and I think that’s very much ophthalmology,” he said.

The fragmentation of the ophthalmic industry affords private equity the opportunity to help individual practitioners manage their practices better, which Mr. Alpern thinks will result in better patient care.

Mr. Kothari said there is a misconception among some physicians that bringing private investment in will shift the focus from quality of care to growth. He finds that’s not true as private equity has learned that “you can’t grow unless you have really good quality.”

**Managing growing pains**

It’s important for physicians used to running the business of their practice to realize that after this partnership, “you’re not the boss anymore,” Dr. Katzen said. “You have to be willing to let your new partner’s management team hire and manage your staff and run the revenue cycle with your partner overseeing the whole process.”

He added that it took him some time, after managing the business aspect for so long, to decompress from that and focus solely on being a doctor.

“I think the biggest thing is the hassles are gone. The problems that we used to face every day about employees or staff or other issues that were not part of healthcare that do grind on you are gone. It lets doctors be doctors. … I spend more time with patients than I ever did,” Dr. Katzen said.

Some might see the loss of complete control that comes with a private equity partnership as a negative, but Mr. Graber said it’s a misconception to think that the private equity firm is unilaterally running the business.

“It’s still the people on the ground who are responsible for running the organization, both the clinical leadership as well as the administrative and executive leadership,” he said.

Mr. Wilde said that private equity relationships also might want to move quicker than physicians are used to.

“The speed with which you do everything goes to a different level—in a good sense,” he said. “You need to be prepared that the cadence is going to be amped up.”

Mr. Alpern said practices need to realize that it’s a misconception that private equity can come in and make something that was marginally good into something exceptional. “We cannot do that,” he said.

“At the end of the day, our job with you as partners is to make multiples on our capital; the way we do that is to grow an organization the right way with the right people and preserve the entrepreneurial culture that was there at the beginning … and most importantly not get in the way of a great clinical product. If all those things come together, you can be successful,” Mr. Alpern said.

Mr. Wilde thinks the trend toward private equity partnerships and other mergers is showing “no sign of slowing down,” in part because ophthalmology is still relatively fragmented.

“My encouragement would be for folks to at least start thinking about this. Private equity or some other form of partnership, consolidation is inevitable. You are best served by preparing your processes … to be ready for that consolidation to come. You want to be in the driver’s seat on that,” Mr. Wilde said.

“Just be ready to hold on,” Dr. Katzen said as a final piece of advice for those considering such a partnership. “It is an exciting time in the business side of ophthalmology.”

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Boiling the frog
by Roger Balser

W e’ve all heard the old fable about the “boiling frog.” In the story, a frog is placed in a large pot filled with cold water. He’s very content with not a care in the world. Then someone comes by and fires up the burner. The water in the pot slowly begins to get warmer and warmer, but the frog is not concerned, as he finds the warmth refreshing. The heat keeps gradually rising until the frog has become so relaxed he falls asleep, never to awaken.

This story reminds me of today’s investors, including individuals with IRAs, 401(k)s, and other retirement accounts. In the past year we’ve seen the stock market jump to record levels. Today, the Dow Jones Industrial Average has surpassed the 20,000 mark, a notable milestone in the present investor world.

You could say that the investment waters are getting warmer and warmer, with relaxed, content investors not paying close attention to their investment portfolios.

Since 2011, we have had four small corrections in the market, but not one ever went past a 10% reduction. So, is this market gradually becoming overheated? Are you about to become boiled?

If you look back to 1999 and 2007, many folks were floating along, content and relaxed in the increasing warmth of the market, but failed to even think about an exit plan. Then in 2000 and 2008 there came a plague of boiled frogs.

A smart frog will not be lured to sleep because it will have a plan to jump out of the pot when the heat gets turned up. A frog without a plan will turn into the proverbial frog soup.

There are many ways for the frog to jump out of the water. After all, any plan to jump out is better than no plan at all. Similarly, there are many ways for investors to retain their profits, or at least not lose their money the next time the market heads down.

And trust me, the market will head down. That is, unless history decides to stop repeating itself.

At Balser Wealth Management, we do not rely on forecasts, but instead rely on point and figure charts to guide us. Charles Dow came up with the point and figure chart concept nearly 130 years ago. Dow was the first publisher of the Wall Street Journal and founder of the Dow Jones Industrial Average that bears his name. Dow kept listening to all of the “experts” who were quick to spout out their fundamental reasons why particular stocks hypothetically “should” go up or “should” go down.

Dow’s answer to speculation came in the form of a simple method to plot the price movement of desired stocks. This price plotting gave him a broad picture of stocks that were in demand and stocks that were in supply, and provided a much clearer view than what the analysts could ever predict.

His charts showed that anything “in demand” would see a price increase, and anything “in supply” would see a price decline. Frankly, that’s not an economic theory—it’s a law. It’s called the law of supply and demand, and even a fourth grader can understand it.

The moral of this story is that any fool (or frog) can buy, but it’s the wise man (or smart frog) who knows how to sell and escape the pot. The market waters are heating up. Don’t fall asleep and become a boiled frog. OB
When pharmacists change prescriptions: How and why they do it

by Liz Hillman, Staff Writer

Perspectives on the practice of ‘therapeutic substitution’

A few years ago, T. Hunter Newsom, MD, Newsom Eye, Tampa, Florida, noticed a change in how prescriptions he wrote were being filled.

“It doesn’t matter what prescription I write, patients come back with whatever their insurance pays for,” Dr. Newsom said. “We used to have ‘dispense as written,’ and you couldn’t substitute anything ... all of the sudden, it didn’t matter what we wrote. Patients would go to the pharmacy and the pharmacy would switch it. It seemed like ... they would change from one product to another because of what insurance would cover.”

Most of the time, Dr. Newsom said, these swaps, which usually involve going from a brand name to a generic, don’t bother him. There is often not enough difference in efficacy, he said, adding that he understands choosing what is affordable for the patient.

In rare circumstances, however, changes without a physician’s knowledge could have negative consequences on a patient’s health. A survey conducted a few years ago revealed patients aren’t too keen on these changes occurring without their doctor’s knowledge either.

According to the Federal Trade Commission, “Each state has a law allowing pharmacists to substitute generic drugs for many brand-name products as long as your doctor doesn’t specify that the brand-name drug is required.” Other state-specific laws govern how pharmacists might make prescription changes as well.

In California, for example, Sally Rafie, PharmD, pharmacist specialist, University of California San Diego Health, is legally allowed to change from a brand to generic or vice versa because they’re considered equivalent medications.

“It can always be interpreted as brand or generic, and if [a doctor] wants something in particular, they need to indicate that,” Dr. Rafie said, noting that generics are FDA approved as equivalent.

In California, Dr. Rafie said the only time a prescription has to be filled as written is if the physician indicates “dispense as written”; otherwise it’s open, she said.

In her experience, Dr. Rafie said changes are made most often to provide patients with their insurance-covered or most affordable option, but in some cases, it’s the patient driving the request.

“Occasionally, patients will say they tolerated a particular product better—it may be a particular generic even. Sometimes when a medication becomes available in its generic form, there may be a handful of manufacturers who make the generic product and patients may find, for whatever reason—it may be the inert ingredients—that they do better on one...”

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vs. the other, so we’ll always try to accommodate,” Dr. Rafie said.

If the pharmacist needs to change from one type of drug to another, they make a call to the physician’s office, Dr. Rafie said.

“If the physician prescribes one statin but the insurance wants a different statin or different medication within the same class to be covered, then we would call the physician and say, ‘The patient’s insurance covers this one, can we switch it?’” Dr. Rafie said.

Diana Graalum, PharmD, clinical pharmacy manager, MedSavvy, Portland, Oregon, said that per Oregon statute ORS 689.515, in some cases it could be within a pharmacist’s legal scope to change the mode of delivery for a drug, depending on the circumstance. For example, if a child were prescribed an antibiotic, it could be changed from a pill to a suspension or chewable tablet of the same drug at the same strength.

Dr. Rafie said they might also change quantity depending on insurance coverage. For example, if a doctor prescribed a 1-month supply with 12 refills but insurance covers a 3-month supply at a time, pharmacists could defer to the latter.

The American College of Clinical Pharmacy (ACCP) released its position statement on the Guidelines for Therapeutic Interchange in 2004, supporting the practice as a “synergistic combination of the expertise and knowledge of pharmacists and physicians whose common goal is to ensure optimum patient care.” The guidelines, however, “should not be interpreted as ‘bestowing independent prescribing authority on pharmacists,’” the statement read.

A survey by the National Consumers League (NCL) in 2008 found that nearly three-quarters of people taking prescription drugs said they would be concerned if a pharmacy changed their doctor’s prescription to another medication for the same condition. The NCL described the situation as switching one prescribed medication to one in the same therapeutic class for the same condition but not the chemical or generic equivalent, dubbing it “therapeutic substitution.”

“For some conditions and treatments, it may make good financial or medical sense to swap out one prescription for another,” Sally Greenberg, NCL executive director, said in a press release. “But as consumers reported in our survey, it’s essential for them to be a part of this process, to know their doctor is aware and supportive of the switch, and to feel confident that their health and treatment—not financial incentives—are top priority.”

While negative reactions to a change in prescription might be rare, one story published in The Columbus Dispatch in 2009 gave an example of the possible consequences of such a practice. It described two cases where epilepsy patients who had their condition controlled on one prescription saw seizures return after the pharmacy changed their prescriptions without their or their doctor’s knowledge.

A response to proposed legislation in the U.K. published in the British Medical Journal in 2011 expressed the view that changing a doctor’s prescription without his or her knowledge could be “ethically improper” with the potential to “compromise pharmacological vigilance.”

“Two medicines with the same drug may have different toxicity and effectiveness, because the process of chemical synthesis and production of pharmaceutical formulation determines the degree of purity of the active ingredient, the presence of impurities or contaminants, and even the dosage of the active ingredient, which all may affect the effectiveness and safety,” Fernando Martins do Vale, MD, Institute of Pharmacology and Neuroscience, University of Lisbon, Portugal, wrote in his response.

If a medicine is switched by the pharmacist without the doctor’s knowledge, Dr. Martins do Vale said the doctor might report an adverse effect associated with his originally prescribed medicine when the patient was really taking a different medication provided by the pharmacist.

Dr. Graalum said her experience is that the pharmacist will work collaboratively with the physician to find the safest, most effective, and most affordable option with the least chance of an adverse reaction to the patient.

“In the spirit of collaborative patient care, the pharmacists should communicate with a physician if changes need to be made and close the loop of communication by sending a ‘chart note’ to the physician when an agreed upon change has been made, with the description of the final product sent home with the patient,” Dr. Graalum said.

References
5. Martins do Vale F. Re: Pharmacists may be allowed to change prescriptions without consulting prescriber. BMJ. 2011;343:d7067.

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

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Specifically, in order to have 20% growth year to year, a practice must significantly invest in marketing and outreach. Such investments can include sophisticated websites, affiliations with well-known companies and personnel, and physicians taking time outside of practice hours to manage the marketing campaigns and growth of their business.

Mergers and acquisitions

The size and internal capacity of the practice can determine whether it should consider adding other offices or merging with other practices to achieve market share goals.

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Steven Wybo, senior managing director, Conway MacKenzie, Detroit, said, “If a mature practice is looking to grow at a rate just above the industry growth rate, it may be more cost efficient to squeeze more revenue from current customers.”

Employing text messaging or other effective forms of communication to remind patients of checkups or contact renewals could increase scheduled and attended appointments. Implementing an advanced, efficient scheduling system is vital as well, according to Mr. Wybo.

“A practice could also alter its strategy to be more surgically focused, and defer lower revenue services to optometrists in order to free up ophthalmologist practitioner capacity to schedule more high revenue/margin surgeries,” Mr. Wybo said.

A major concern in the ophthalmology industry is that demand for services is forecasted to exceed the current supply of ophthalmologists. This may seem troubling, but may offer a new growth vehicle for ophthalmology practices by collaborating with optometrists through either formal partnerships, mergers, or acquisitions, Mr. Wybo noted.

Optometrists are expected to grow in number by 2–3% annually to meet the rising demand for eyecare.¹

“Forming strategic partnerships has the potential to increase referrals, expand capacity, and add and/or retain highly specialized yet scarce practitioners to your labor force,” Mr. Wybo said.

“Through integration, capacity constraints could be alleviated enough to allow ophthalmologists to increasingly focus on surgical procedures that generate more revenue per customer. By co-managing and being involved in the entire continuum of care from examination to post-surgical rehabilitation, practices are more likely to retain or attract patients who may have previously received surgery at one practice and received rehab at another, due to convenience in location or price,” Mr. Wybo said.

Alternatively, increased compliance requirements and expenses as well as decreased payments for services may mean growing a practice is the best way to maintain profitability.

“A key in this climate is access to patients,” Mr. Gurman said. “The larger the practice, the harder for insurance companies to drop your practice and the less expensive it is to operate due to economies of scale.”

An aging U.S. population led Mr. Gurman to advocate acquisition, or the “tuck-in” model, as one of the best ways to grow a practice and increase market share.

“I don’t know if there is a specific size or goal that should lead to considering a transaction,” Mr. Gurman said. “Any forward-thinking physician who wants to ensure the continuation of the practice and avoid being bought out by a hospital system should be looking to join a larger group or merge with several smaller groups in their locale to create stability and potentially increase their income by reaching economies of scale.”

Other considerations

An ophthalmology practice looking to grow its local market share should first start with a strategic planning process, according to Mr. Wybo.

A practice should identify and analyze its target market and population demographics. A practice may want to determine the age composition of its local market and whether that population is increasing.

“An increasingly aging population in the U.S. is currently leading to overall increasing demand for medical and surgical eyecare due to a higher prevalence of chronic diseases,” Mr. Wybo said.

Other important analyses include determining the local insurer mix, the share of the population that is likely to seek care but lacks insurance, and whether new legislation will increase the uninsured rate.

Additionally, practices should use metrics to analyze and benchmark their service lines to market, according to Mr. Wybo.

Practices should determine the demographics and age groups of their target market and calculate the number of cases per one thousand people that occur for a particular procedure and/or product to determine a market estimate of total cases. Practices can find market figures by utilizing publicly available data from the Centers for Medicare & Medicaid Services, the U.S. Census Bureau, and other government sources or industry publications.

Practices should compare their own financial figures to the market to determine market share for each service line. Advanced, integrated electronic health record systems are important to accurately track and gather this data, according to Mr. Wybo. Performing such an analysis annually will allow management to determine service line growth or decline.

“After all the data is analyzed and summarized, the practice’s stakeholders should determine a feasible yet challenging goal for market growth,” Mr. Wybo said. “The practice must either procure new customers or improve revenues per existing customer.”

Reference


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