As director of optometry at a surgical center where almost all of our patients are referred by their ODs, high-level co-management is part of what I do every day. My colleagues and I think this is the future of health care: ophthalmologists focus their skills and experience in the operating room while optometrists fulfill the full scope of their abilities to comanage diseases as patients' primary eyecare practitioners. When these two specialists work together, each doing what they're best trained to do, patients benefit.

One of the most common surgeries we comanage with referring ODs is cataract surgery. We work with referring ODs so they are aware of the latest options for this ever-evolving procedure, which helps them refer patients at the right time, having educated patients about their options. At that point, our office takes over preoperative care, education, decision-making, and finally surgery. Postoperatively, patients return to their optometrists for follow-up care. In comanaging patient care after cataract surgery, we all help ensure that patients have the best possible outcomes.

Educate patients on eyelash enhancements
By Alex Delaney-Gesing
Associate Editor

Today's global cosmetics market is worth an estimated $532 billion with projections for it to reach $863 billion by 2024. The false eyelashes industry—just one segment of the marketplace—is expected to reach over $1.7 million in the next four years. Consumers around the globe have adopted the eyelashes trend in the last decade as part of a popular South Korean skincare movement called "K-beauty," says Bridgitte Shen Lee, OD, during a lecture at SECO 2019 in New Orleans. This category of aesthetics includes four eyelash trends: extensions, lifting, curling, and volumizing. Each has pros and cons that practitioners should consider when discussing options with patients.

Pros, cons of private equity buyouts
By Chris Wroten, OD

In my previous article, "How to overcome barriers when buying or selling a practice," (December 2018), I discussed a colleague who wrestled with a retirement decision before eventually concluding it was finally time. This practice owner approached his associates about his plans and to offer them a fair market purchase price—based on well-established practice valuation methods—for his shares in the practice. He was shocked when his associates declined the offer and told him they wanted to buy the practice themselves.

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Cataract surgery guidance from the other side

By Derek N. Cunningham, OD, FAAO

As director of optometry at a surgical center where almost all of our patients are referred by their ODs, high-level co-management is part of what I do every day. My colleagues and I think this is the future of health care: ophthalmologists focus their skills and experience in the operating room while optometrists fulfill the full scope of their abilities to comanage diseases as patients’ primary eyecare practitioners. When these two specialists work together, each doing what they’re best trained to do, patients benefit.

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See Cataract surgery on page 21

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Earlier this year, I was chatting to colleagues at a committee meeting when the topic of continuing education came up. It’s always interesting to compare notes: how much do you have to get in your state, when does your CE cycle start over, and the like.

I have seldom left a live meeting without having gained something

A subtopic of CE came up during that conversation, and I heard it mentioned more and more often: virtual or online CE. That’s right, learning about the human eye in the comfort of your own bedroom slippers (yes, even the fluffy beer can ones your spouse won’t let you take the trash out wearing).

Maybe I’m an old soul, but I have seldom left a live meeting without gaining something from the in-person experience. There is just something about having discourse in real life that the Internet cannot palpatate. Maybe it goes back to just being a human being.

Lecture vs. basketball

However, in the spirit of being open-minded, I will share with you a story that happened to me a few years ago. I was lecturing to a group of ODs. I didn’t say whom, where, or when in order to protect the guilty.) When I noticed a group of people in the back sharing a laptop. Were they following along with my riveting lecture on meibomian gland dysfunction by simultaneously reading copies of my slides? No. They were not. They were checking the score of a basketball game.

Now, to their defense, I was in the same state as the team they were watching, and I suppose they could have just as easily (or more easily) stayed home in their bathrobes and minimized the screen of a virtual course in order to watch the game.

However, I recently had to take an online course unrelated to optometry during which a timer stopped when I minimized the window (which, of course, I would have never tried to do—wink, wink). I was also open-book quizzed afterward.

On a similar note, I recently learned of certain surgical procedures recently approved in the U.S. which are taught via webinar.

Captivating audience

Admittedly, I haven’t yet discovered how to make meibomian gland dysfunction more exciting than basketball, and I think the bottom line is the fact that CE requirements exist and must be fulfilled—and with good reason. However, whether live or virtual, captivating an audience can be tricky, and you need more than a catchy title to do so.

I am interested to hear how your state association handles CE. How many hours are allowed online, and how many must be in a live format? What are your thoughts on my preferred format of in-person CE or CE with the cat on your lap?

Find out more on managing crosslinking. Turn to page 16.
Dr. Michael Brown recounts the tale of two relatives crossing state lines for multiple diagnosis referrals and explains why eyecare professionals should be doing more to maximize their patient care.

OptometryTimes.com/Blog/CookinKitchen

How to calculate your compensation as a practice owner

New blogger Dr. Mick Kling explores the common financial traps ODs fall in when operating their practice and how practice owners can determine how much to pay themselves.

OptometryTimes.com/Blog/CalculateComp

TOP SOCIAL

1 Increase contact lens comfort by paying attention to the lids
OptometryTimes.com/CLiQflip

2 Selling glasses online may not be answer for ODs
OptometryTimes.com/OnlineGlasses

3 How air pollution affects the ocular surface
OptometryTimes.com/AirPollution

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April 2019

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Educate patients on eyelash enhancements

Continued from page 1

Eyelash extensions
Eyelash extensions involve gluing a cluster of false lashes onto human eyelashes—a process typically taking three to four hours. An initial session can cost as much as $400, Dr. Shen Lee says.

Customers should ideally return for a refill every two weeks, costing $50 per visit.

Common ocular surface complications found extension users include:

- Dermatitis
- Conjunctivitis
- Blepharitis
- Demodex (eyelash mites)
- Dry eye symptoms (burning, watery, itchy, irritated eyes)
- Meibomian gland dysfunction (MGD)
- Madarosis (natural eyelash loss)

Women who develop such complications likely do not clean their eyelashes and lid margin and wear makeup over the extensions, according to Dr. Shen Lee. “They often do not want to pay $50 to get a refill [of eyelashes] more often when they should,” she says.

If these patients continue to practice unhealthy eyelash management, their worst case scenario is developing madarosis—natural eyelash loss

Eyelash falsies
Falsies are a cluster or whole strip glued onto the eyelid margin, going over the lashes.

Nowadays, eyelashes are often glued under the natural eyelashes to create more of a “lifting” effect, Dr. Shen Lee says.

One of the safer procedures with falsies uses a magnetic eyelash to avoid side effects similar to those of eyelash extensions.

This involves placing two strips of eyelashes with tiny magnets at the top and bottom on either side of a human eyelash.4

However, the glue used to attach falsies onto human lashes are made with cyanoacrylate (as an adhesive) and formaldehyde or formaldehyde derivatives.

The chemicals are major culprits behind ocular side effects—similarly seen with extensions—on the skin and eyes.

Additional side effects can include corneal abrasions, keratitis (from chemical contact), and compensating incomplete blinks (from weight of lashes).

Lift and tint
Patients with naturally long eyelashes and fairer skin interested in lash enhancement are recommended to receive eyelash lifts (also referred to a permanent waves) or tints.

Lifts involve using alkali chemicals like ammonium thioglycolate to semi-perma-

If patients continue to practice unhealthy eyelash management, their worst case scenario is developing madarosis—natural eyelash loss

nently curl or “lift” lashes on cylindrical rod.

Tinting involves dyeing lashes using para-phenylenediamine (PPD)—part of a chemical class called aromatic amines—commonly found in permanent hair dyes. An alternative form of eyelash lift is known as “Japanese lash perm,” in which a speed bump-like device is used to lift the lashes up from the base.4

Unlike extensions, these processes are typically repeated every two to three months as opposed to bi-weekly.

Recommend patients to use a reputable beauty salon and seek care with their OD (not urgent care) if they develop ocular irritation.

Growth serums
Dr. Shen Lee noted several growth serums currently on the market: Latisse (Allergan, Rx-required prostaglandin), popular over-the-counter (OTC) lash enhancers (non-Rx), and Boost Lash Intensifying Serum (OCu-Soft, non-Rx).4

Latisse is made with prostaglandin, a main ingredient in some glaucoma medications. Potential side effects associated with use of prostaglandin include:

- Conjunctival and eyelid hyperemia
- Burning or irritation

If these patients have dry symptoms and you have meibography, take a baseline photo the first time you see them and track their meibomian glands over the years.”

Over a dozen OTC lash enhancers are available in the current market, according to Dr. Shen Lee.

These feature synthetic prostaglandin (isopropyl cloprostenate) as a main ingredient with similar potential side effects associated with that of the prostaglandin-made Latisse.

Boost Lash Intensifying Serum by Ocu-Soft includes a patented polypeptide as a main ingredient. No long-term prostaglandin side effects have been reported by users, Dr. Shen Lee says.

“For women who use eyelash serum, it’s important for them to continue to use it—just like skincare products; you can’t just use one bottle and then stop,” she says.

Most eyelash serums work within a few weeks, Dr. Shen Lee says.

See Eyelashes on page 8
Introducing

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*in solution
Eyelashes
Continued from page 6

It’s important for women who use lash serums to understand potential ocular surface side effects and stop using them as soon as they notice the symptoms. For ODs, it’s helpful to obtain baseline meibography, slit lamp photos, and ocular surface exam findings to track changes over time. These office visits are billed as medical exams.

Side effects treatment
Depending on the ocular complication a patient develops, Rx and non-Rx medications are available, Dr. Shen Lee says.

Conjunctivitis/red eye
- Lumify (brimonidine, Bausch + Lomb): it’s important to treat initial underlying ocular surface disease (OSD)symptoms first
  - Rx steroid drops: Alrex or Lotemax (Bausch + Lomb)
  - Rx combination drops: Zylet (Bausch + Lomb); Tobradex (Alcon)
  - Overall OSD/dry eye management

Conjunctivitis/red eye
- Lotemax ointment (Bausch + Lomb; Rx)
- Tobradex ointment (Alcon; Rx)
  Keep the lids and lashes clean can help with treating blepharitis and demodex, Dr. Shen Lee says. She recommends using scrubs and foam wash products such as:
  - OCusoft
  - Cliradex (Bio-Tissue)
  - We Love Eyes
  - Oasis
  - Zocular
  - Blephex

Hypochlorous acid
Dr. Shen Lee advises adding hyperchlorous acid to the lids/lashes cleaning routine to help reduce biofilm. These products are available:
- Avenova (NovaBay; Rx)
- Acucyn (Sonoma Pharma; Rx)
- Hypochlor (Ocusoft)
- OcuBliss
- Zenoptiq (Focus Laboratories)

The goal, Dr. Shen Lee says, is to catch patients at the beginning of their eyelash extension sessions, teach them proper management

IN BRIEF
B+L launches Lotemax SM

BRIDGEWATER, NJ–Bausch + Lomb has begun supplying its Lotemax SM (loteprednol etabonate ophthalmic gel) 0.38% to U.S. pharmaceutical distributors.

The company received final approval by the U.S. Food and Drug Administration (FDA) on Feb. 22, 2019.

According to the company, Lotemax SM is a new gel drop formulation of loteprednol etabonate, which was designed with novel SubMicron (SM) technology for efficient penetration to key ocular tissues at a low preservative (BAK) level and a pH close to human tears.

Lotemax SM is indicated for the treatment of postoperative inflammation and pain following ocular surgery.

“Lotemax SM is the culmination of our clinical experience with the loteprednol etabonate compound for more than two decades,” says Joe Gordon, U.S. president, Bausch + Lomb.

“We are extremely proud to make this new treatment option available, our most advanced loteprednol etabonate formulation to date, to help our customers address the needs of their patients undergoing ocular surgery who experience postoperative inflammation and pain,” he says.

According to the company, Lotemax SM delivers a submicron particle size and provides two times greater penetration to the aqueous humor as compared to Lotemax Gel (loteprednol etabonate ophthalmic gel) 0.5%.2

In addition, Lotemax SM was formulated with:
- Moisturizing ingredients
- pH close to that of human tears
- Low BAK preservative percentage (same percentage as Lotemax Gel [0.003% percent])

“I am excited to now offer my postoperative patients who experience pain and inflammation Lotemax SM,” says Marguerite McDonald, MD, FACS, ophthalmologist and clinical professor of ophthalmology, New York University (NYU) School of Medicine.

“In addition to the improved dosing compared to Lotemax Gel and the established efficacy,” Dr. McDonald says, “Lotemax SM offers a tolerability profile that I have come to rely on from the loteprednol etabonate molecule.”3

REFERENCES

Projected worth of global cosmetics market by 2024

Rx eye drops (dry eye disease)
- Restasis (0.05% cyclopoin, Allergan)
- Xiidra (5% lifitigstrag, Shire)
- Cequa (0.09% cyclopoin, Sun Pharmaceuticals)
- Genesis (amniotic membrane drops, Ocular Science)
- Generic 0.05% cyclopoin

MGD
- LipiFlow (TearScience, Johnson & Johnson Vision)
- Mibo Thermoflow
- Intense pulsed light (IPL, Lumenis)
- iLux (Alcon)
- TearCare (Sight Sciences)
- ThermiEyes (Thermi)

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REFERENCES
Know the connection between vitamin D and dry eye disease

Research looks at prevalence of deficiency, insufficiency in dry eye patients

I am fortunate to practice in a setting where my patient’s full medical and drug therapy is readily available. I have noticed that many patients (including myself) have been prescribed oral vitamin D supplements (cholecalciferol) to boost serum levels of vitamin D.

Vitamin D deficiency (VDD) and insufficiency (VDI) are increasing on a global level. VDD is associated with an increased risk of chronic diseases such as bone metabolic disorders, tumors, cardiovascular diseases, and diabetes.1

Study finds

A retrospective study demonstrated the increasing prevalence of VDD (28.9% percent) and VDI (41.4% percent) from 2001 to 2010. Study participants who were black, less educated, poor, obese, current smokers, physically inactive, and infrequent milk consumers had a higher prevalence of VDD.2

In the dry eye space, a 2018 study in Cornea investigated the efficacy of topical carbomer-based lipid-containing artificial tears (CLAT) and hyaluronate (HU) in patients with dry eye disease (DED) based on serum 25-hydroxyvitamin D (25HD) levels and cholecalciferol supplementation.

Data suggested the effect of topical CLAT and HU was dependent on serum 25HD levels. The authors concluded that cholecalciferol supplementation enhanced the efficacy of topical treatment and may be a useful adjuvant therapy for patients with DED refractory to topical lubricants.3

Epidemiological studies have linked VDD with other ocular diseases, such as myopia, age-related macular degeneration (AMD), diabetic retinopathy, glaucoma, retinoblastoma, and uveitis. However, the underlying mechanism is not yet fully understood.

Case report

Parts of the human eye—including the epithelium of the cornea, lens, ciliary body, and retinal pigment epithelium, as well as the corneal endothelium, ganglion cell layer, and retinal photoreceptors—contain vitamin D receptors (VDR). Intramuscular injections of vitamin D improved tear hyperosmolarity.4

The recently discovered anti-angiogenic, anti-inflammatory, and anti-neoplastic properties of calcitriol (the hormonally active metabolite of vitamin D) have shed some light on vitamin D’s role in the pathogenesis of ocular diseases.5

Interestingly, there has been an isolated, VDD-related case report of a 40-year-old patient with persistent bilateral ocular pain for two years for whom conventional management of dry eye had failed.

Detailed ocular examination, meibography, and tear film evaluation were suggestive of bilateral meibomian gland dysfunction (MGD) and evaporative dry eye. Topical medication failed to alleviate the patient’s symptoms.

Conventional management having failed, LipiFlow (Johnson & Johnson Vision) was performed, and topical therapy with cyclosporine 0.05%, steroids, and lubricating eye drops was initiated with incomplete symptomatic relief.

To identify the cause of pain, imaging was performed with in vivo confocal microscopy and anterior segment spectral domain optical coherence tomography (OCT). Evaluation revealed severe VDD.

With parenteral therapy for VDD, there was a dramatic improvement in this patient’s symptoms. The authors suggested that inflammation aggravated by VDD resulted in an altered epithelial profile, Bowman’s layer damage, recruitment of dendritic cells, and an altered subbasal nerve plexus features in this patient with chronic DED.6

Future for dry eye disease

Should vitamin D serum testing be part of ODs’ DED work-up? Is vitamin D supplementation prophylactic for DED? Conflicting data exists to support this notion.7,8

Awareness of the high prevalence of VDD and VDI among U.S. adults and related predictors could inform behavioral and dietary strategies for preventing VDD, monitoring VDI, and perhaps modulate its impact on/contribution to DED.

Eyecare practitioners hope that with more data they can answer these questions and have yet another avenue of therapy for ocular surface disease patients.

REFERENCES

Focus On RETINA

Case: New protocol for macular hole treatment

Example tracks patient’s positive postop recovery from pars plana vitrectomy

A 55-year-old female had been followed for several months for a macular hole in the right eye. She returned for a scheduled visit and reported no change in visual acuity—the left eye had been and remained uninvolved.

The patient’s medical history was significant for diabetes of an undetermined duration for which she was under the care of another physician. Medication for this condition, as well as for her diagnosis of systemic hypertension, was not revealed.

Visual acuity at the scheduled visit was 20/200 (20/80 EV) OD, and 20/25 OS. Fundus image of the right eye is seen in Figure 1.

Clinical assessment

On clinical evaluation, it was evident that full-thickness macular hole was present even absent the previous diagnosis and visual acuity.

Despite a duration of the diagnosis, however, there was no clinical evidence of a fluid surround—meaning that the full-thickness hole was limited to what was visualized.

Optic cube obtained from optical coherence tomography (OCT) is shown in Figure 2.

Note that while clinical evaluation may allow observation of the hyaloid of the vitreous, the relationship between the vitreous and retina is emphasized in the optic-cube data.

This is a reminder of the presence of the mass of vitreous in relation to its remaining focal attachment at the macular surface.

When interpreting optical coherence data, it may be tempting to analyze cross-sectional scans alone. While this can be useful, it could require interpolation to determine actual horizontal and vertical extent of a lesion.

The optic cube allows an overview that—when combined with the cross-sectional data—gives a more complete perspective.

Of further note is the remaining attachment between the detached vitreous and paramacular area of the right eye.

This OCT finding corresponds with the white dot indicated in the fundus photograph.

The macular hole is full in thickness and lacks a fluid surround. This correlation can be seen comparing the fundus image and the cross-sectional OCT (Figure 3).

The patient was seen in consultation with a retina specialist at this visit and offered a surgical option, which she accepted. The procedure consisted of parsplana vitrectomy with the placement of a gas bubble.

With just 48 hours of face-down positioning instead of the usual two-week interval, the patient tolerated the procedure well.

This new type of protocol is being tried by some retinal surgeons. The patient in this case is one of the first to use the protocol. It has proven to be useful for minimizing post-operative complications as well as producing positive surgical outcomes.

Postop

At the first postoperative visit two weeks later, visual acuity had not improved. However, anatomical closure of the macular hole had been achieved (see Figure 4). At a follow-up visit three months post-surgery, visual acuity improved to 20/40.

Case analysis

Two significant items are present in this case. First is the outside limit—fewer than 12 months—being favorable for surgical success due to the presence of the macular hole.
While this has been reported for bilateral presentations, the results can be extrapolated to the monocular situation.1 Second is that on careful observation of the postoperative OCT, the external limiting membrane had been re-established.2 See Figure 4.

Vitreomacular traction places the patient at a 30 percent risk of macular hole formation in the following five years. This is significant for a good prognosis of visual acuity improvement that occurred in the case. As is consistent with the improved visual acuity, the photoreceptor layer repopulated.

Interestingly, the fellow eye showed the presence of vitreomacular adherence (vitreomacular attachment without disruption of retinal anatomy).3 Vitreomacular traction (adherence between vitreous and retina with anatomical tissue disruption) places the patient at a 30 percent risk of macular hole formation in the following five years.4 Vitreomacular adherence carries a much lower risk of macular hole formation.4

REFERENCES
Pros and cons of private equity buyouts

Continued from page 1

him they weren’t interested in owning the practice because they didn’t see any value in it.

Industry-wide dilemma
Unfortunately, one of the most important but overlooked aspects of practice management is managing a practice sale on the back end of a career.

One of the most important but overlooked aspects of practice management is managing the sale on the back end of a career.

While each situation is different, many ODs are struggling with some form of the same question: “How do I transition out of my practice?”

Some ODs are simply walking away and receiving nothing in return for their practices. This scenario is unfolding more frequently in medicine and other healthcare professions as well, which forces us to ask: Is the traditional sale of a private practice to a new owner in danger of extinction?

On the other side of the coin, some ODs are asking, “How do I transition into practice ownership?” but face difficulty with making it happen.

While there’s no right or wrong position, both situations make for a challenging landscape for sellers.

Let’s discuss one option for those undergoing a practice transition as well as the accompanying challenges faced by sellers—a decision my colleague ultimately chose: private equity.

Private equity
Private equity firms are limited partnerships that utilize capital not publicly listed or traded to buy, streamline/restructure, and resell private companies for profit.1,2

Several years ago, a number of these companies held a surplus of investable funds and were looking for new, high-return investment opportunities.

Eye care was identified as one possibility due to the aging U.S. population and its associated needs; the potential for cash-based, premium eyecare service offerings; and an isolated business landscape that lent itself to consolidation.3

Perhaps the first such transaction in the ophthalmic space occurred in 2014 when Varsity Healthcare Partners recapitalized Katzen Eye Group to form EyeCare Service Partners before Varsity Healthcare Partners profitably exited the entity three years later in a transaction with Harvest Partners.4

Following that success, Friedman Fleischer & Lowe (FFL) Partners recapitalized Clarkson Eyecare and created EyeCare Partners in 2015.5 Several other firms since then have also been actively acquiring ophthalmic practices, including MyEyeDr., Total Eye Care Partners (via Imperial Capital and HW Holdings), and Acuity Eyecare Group (Riata Capital Group).

Interest in these options continues to increase in ophthalmology as well. I recently attended a session at the American Society of Cataract and Refractive Surgeons at which a jam-packed audience assembled in a large ballroom to learn more about private equity transactions.

While several different companies have been mentioned, it is difficult to find a comprehensive listing of all private equity firms currently acquiring ophthalmic practices. But just to provide a measure of the activity, one list published in 2018 includes 31 firms.6

It should also be noted that not all private equity firms are created equal, nor do they operate the same. Some are looking to partner with ODs and have them stay on indefinitely, while others are willing to assist with a doctor’s exit plan. Individual strategies and differences abound, but there are generally two main models of operation: centralized and decentralized.

Centralized model
In this model, the acquiring company assumes all administrative and management functions, including billing, collections, optical, equipment purchasing, and acquisition.

All practices acquired by the firm employ this centralized management model and even utilize the same electronic health record (EHR) system, seeking to increase efficiency, control, and cost savings.

As more practices are acquired, the goal is usually to maximize short- to medium-term profits in order to make the future consolidated sale of the acquired entities as attractive as possible within a three- to seven-year timespan.7

Decentralized model
This model utilizes less centralized management, resulting in a smaller corporate structure.

The acquired practice has more freedom to continue operating the way it was prior to the acquisition, with incentives to grow internally and via additional local acquisitions.

A previous owner may retain more control of the practice’s day-to-day decisions and may receive money and stock in the purchasing entity. This is also an option with some centralized models.8

Exclusions
A variant of these two models employs a much longer term perspective to grow both internally and externally, thereby increasing practice profitability.

An alarming number of ODs are simply walking away and receiving nothing in return for their practices

As additional practices are acquired and incentivized to maximize individual practice profits, the entire purchasing entity grows organically. With this model, ODs invest only in their own practice with no plans of a future sale—similar to a venture capital investment.9

For ODs looking to exit a practice, this model and the decentralized model may not be as applicable.
Xiidra may provide
LASTING RELIEF
starting as early as 2 weeks¹

One drop in each eye, twice daily, about 12 hours apart.
Discard the single-use container immediately after use.¹

Choose Xiidra first for patients with signs and symptoms of Dry Eye Disease

Xiidra reduced symptoms of eye dryness at 2 weeks in 2 out of 4 studies, and in all 4 studies at 6 and 12 weeks. Xiidra also improved signs of inferior corneal staining at 12 weeks in 3 out of 4 studies.¹

The safety and efficacy of Xiidra compared to vehicle were studied in 2133 patients in 4 well-controlled, 12-week trials.¹

Check it out at Xiidra-ECP.com

Indication
Xiidra® (lifitegrast ophthalmic solution) 5% is indicated for the treatment of signs and symptoms of dry eye disease (DED).

Important Safety Information
Xiidra is contraindicated in patients with known hypersensitivity to lifitegrast or to any of the other ingredients.

In clinical trials, the most common adverse reactions reported in 5-25% of patients were instillation site irritation, dysgeusia and reduced visual acuity. Other adverse reactions reported in 1% to 5% of the patients were blurred vision, conjunctival hyperemia, eye irritation, headache, increased lacrimation, eye discharge, eye discomfort, eye pruritus and sinusitis.

To avoid the potential for eye injury or contamination of the solution, patients should not touch the tip of the single-use container to their eye or to any surface.

Contact lenses should be removed prior to the administration of Xiidra and may be reinserted 15 minutes following administration.

Safety and efficacy in pediatric patients below the age of 17 years have not been established.

For additional safety information, see accompanying Brief Summary of Safety Information on the adjacent page and Full Prescribing Information on Xiidra-ECP.com.

Reference:
¹ Xiidra [Prescribing Information]. Lexington, MA: Shire US.

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Because clinical studies are conducted under widely varying conditions, adverse reaction rates observed in clinical studies of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. In five clinical studies of dry eye disease conducted with lifitegrast ophthalmic solution, 1401 patients received at least 1 dose of lifitegrast (1287 of which received lifitegrast 5%). The majority of patients (84%) had ≤3 months of treatment exposure. 170 patients were exposed to lifitegrast for approximately 12 months. The majority of the treated patients were female (77%). The most common adverse reactions reported in 5-25% of patients were instillation site irritation, dysgeusia and reduced visual acuity. Other adverse reactions reported in 1% to 5% of the patients were blurred vision, conjunctival hyperemia, eye irritation, headache, increased lacrimation, eye discharge, eye discomfort, eye pruritus and sinusitis.

Postmarketing Experience
The following adverse reactions have been identified during postapproval use of Xiidra. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.
Rare cases of hypersensitivity, including anaphylactic reaction, bronchospasm, respiratory distress, pharyngeal edema, swollen tongue, and urticaria have been reported. Eye swelling and rash have been reported.

USE IN SPECIFIC POPULATIONS

Pregnancy
There are no available data on Xiidra use in pregnant women to inform any drug associated risks. Intravenous (IV) administration of lifitegrast to pregnant rats, from pre-mating through gestation day 17, did not produce teratogenicity at clinically relevant systemic exposures. Intravenous administration of lifitegrast to pregnant rabbits during organogenesis produced an increased incidence of omphalocele at the lowest dose tested, 3 mg/kg/day (400-fold the human plasma exposure at the recommended human ophthalmic dose [RHOD], based on the area under the curve [AUC] level). Since human systemic exposure to lifitegrast following ocular administration of Xiidra at the RHOD is low, the applicability of animal findings to the risk of Xiidra use in humans during pregnancy is unclear.

Animal Data
Lifitegrast administered daily by intravenous (IV) injection to rats, from pre-mating through gestation day 17, caused an increase in mean preimplantation loss and an increased incidence of several minor skeletal anomalies at 30 mg/kg/day, representing 5,400-fold the human plasma exposure at the RHOD of Xiidra, based on AUC. No teratogenicity was observed in the rat at 10 mg/kg/day (460-fold the human plasma exposure at the RHOD, based on AUC). In the rabbit, an increased incidence of omphalocele was observed at the lowest dose tested, 3 mg/kg/day (400-fold the human plasma exposure at the RHOD, based on AUC), when administered by IV injection daily from gestation days 7 through 19. A fetal No Observed Adverse Effect Level (NOAEL) was not identified in the rabbit.

Lactation
There are no data on the presence of lifitegrast in human milk, the effects on the breastfed infant, or the effects on milk production. However, systemic exposure to lifitegrast from ocular administration is low. The developmental and health benefits of breastfeeding should be considered, along with the mother’s clinical need for Xiidra and any potential adverse effects on the breastfed child from Xiidra.

Pediatric Use
Safety and efficacy in pediatric patients below the age of 17 years have not been established.

Geriatric Use
No overall differences in safety or effectiveness have been observed between elderly and younger adult patients.

NONCLINICAL TOXICOLOGY

Carcinogenesis, Mutagenesis, Impairment of Fertility
Carcinogenesis: Animal studies have not been conducted to determine the carcinogenic potential of lifitegrast.
Mutagenesis: Lifitegrast was not mutagenic in the in vitro Ames assay. Lifitegrast was not clastogenic in the in vivo mouse micronucleus assay. In an in vitro chromosomal aberration assay using mammalian cells (Chinese hamster ovary cells), lifitegrast was positive at the highest concentration tested, without metabolic activation.
Impairment of fertility: Lifitegrast administered at intravenous (IV) doses of up to 30 mg/kg/day (5400-fold the human plasma exposure at the recommended human ophthalmic dose [RHOD] of lifitegrast ophthalmic solution, 5%) had no effect on fertility and reproductive performance in male and female treated rats.
Overall
Regardless of the model, these transactions yield a lump sum of cash for the selling OD up front in exchange for reduced future income. The lump sum is taxed as capital gains, based on current practice profits—earnings before interest, taxes, depreciation and amortization (EBITDA). Additionally, the selling doctor(s) may receive stock in the new entity.

So, what are the pros and cons of a private equity practice transition?

Pros
Private equity transactions may occur more quickly than a traditional sale.

After speaking with colleagues who have gone through both, the traditional practice sale to another OD may take three to five years from start to finish, while a private equity transaction may be fully completed in one to two years—not including additional time the owner may be required to stay on staff.

Additionally, private equity groups seem to be offering more for practices than traditional practice valuation models would suggest, resulting in larger up-front cash payouts.

Specific transaction terms vary and can be negotiated.

However, after the deal is completed in the centralized model, the seller no longer needs to address the day-to-day challenges of running a practice and manage merit-based incentive payment system (MIPS), Health Insurance Portability and Accountability Act (HIPAA), cyber-liability, human resources management, bill-paying, and other administrative tasks associated with owning a practice.

The practice itself may achieve added savings on purchases of contact lenses, frames, spectacles, equipment, and office supplies, by leveraging the collective buying power of all the practices in the private equity firm's group.

Efficiencies may also be gained in billing and collections, purchasing decisions, employee policies and procedures, and other areas of practice management.

Cons
Most transactions require the seller to stay on as an employee of the new entity for a specified amount of time (which can be negotiated as a condition of sale). During this period, the former owner becomes subject to the decisions of the new ownership.

Those decisions may include longer and/or later office hours, opening on weekends, more limited vacation time for the seller, and no longer acting as the primary decision maker for purchases, policies, and procedures—although some of these may be retained in a decentralized model.

The practice may take on a more corporate feel and/or eventually be sold again to another entity over which the original owner has no control.

I spoke to one OD off the record after a private equity transaction. He shared that he had numerous patients in the community tell him, after decades of building a reputation of patient care and trust, they thought the clinic’s new direction was noticeably less patient-centric and more focused on accelerated profits.

For models more focused on maximizing short- to medium-term profits, long-term planning and investment into the practice may become less of a priority.

Profession impact
This begs the question: Is private equity good for the profession?

It’s impossible to blame an OD for selling to a private equity firm, especially if he was unable to find a buyer, offered more than what his practice would have traditionally been valued, or if the rigors of ownership had lost its luster.

Not all private equity firms are created equal, nor do they operate the same

However, it remains to be seen what the long-term impact on the profession will be, and this will largely depend on the private equity firm’s strategy.

The optometric profession has historically been led by those with a keen focus on patient care and who are most vested in their profession.

But some private equity transactions may have the potential to de-emphasize patient care and create a more corporate workplace, possibly reducing those ODs’ commitment to their profession’s success.

Private equity transactions also create a potentially tenuous situation in which only large corporate entities may be in position to purchase consolidated practices from private equity firms when they sell them in the future.

Additionally, private equity takes healthy, viable practices off the market, potentially making it harder for younger buyers to transition into ownership.

Lastly, if a seller miscalculates his timeline and finalizes a private equity transaction too soon in his career (>5 to 10 years before he is ready and/or financially able to retire), he could end up on the wrong end of the financial equation when the loss of future earnings and the foregoing of additional equity built into his practice are taken into consideration.

Wrapping up
Perhaps these private equity ventures will ultimately strengthen the optometric profession—allowing practices to leverage buying power as well as take advantage of economies of scale and best business practices.

Or perhaps these ventures will fail, creating an opportunity for former owners and new buyers to purchase practices for less than their original prices.

Regardless, there’s much to consider when it comes to any practice transition. The first thing to do is to plan an exit strategy now by examining all options and making an informed decision.

REFERENCES
Comanagement

Best practices for comanaging crosslinking patients

CXL provides opportunities for ODs to collaborate on surgical care

By Mitch Ibach, OD, FAAO, and Jeffery A. Sayler, OD

We practice a few blocks from each other in a tertiary-care surgical practice and a primary-care optometry practice, respectively. Although we comanage different types of surgical cases, one of the most rewarding recent developments has been the opportunity to jointly care for patients with keratoconus.

New technology has disrupted the way we approach these patients. In the past, optometrists have mostly watched and waited, trying to keep keratoconus patients seeing well for as long as possible in contact lenses. Historically, as many as 1 in 5 patients with progressive keratoconus have required a corneal transplant, with more than half of those needing multiple transplants within 20 years.1,2

Corneal crosslinking

With the approval in 2016 of corneal collagen cross-linking (CXL) using the Avedro cross-linking suite (Photrexa Viscous, Photrexa, and the KXL System), the paradigm has shifted to one of intervening as early as possible with keratoconus patients. Multiple studies have shown that CXL may slow or halt the progression of keratoconus, providing better visual acuity and decreased corneal bulging up to 10 years post-treatment.3-4

The procedure uses Photrexa Viscous (riboflavin-5’-phosphate) drops applied to the corneal stroma; the drops are activated by ultraviolet A (UVA) light over the course of approximately 30 minutes, resulting in new chemical bonds that stiffen collagen strands in the cornea.7,8

The CXL procedure approved in the United States requires removal of the epithelium; a Phase 3 clinical trial of an Avedro epi-on technique is underway.

Collaboration opportunity

In many ways, keratoconus is an ideal condition for collaboration among optometrists and ophthalmologists because it presents three distinct challenges that can best be addressed by multiple professionals working together.

The first challenge is detecting keratoconus early before the cornea is irreparably damaged. These patients typically don’t know they have keratoconus and are unlikely to present to a practice that performs CXL; rather, they will visit their primary-care optometrist in the hopes of improving their refractive corrections. That gives the optometrist the opportunity to diagnose and refer the patient for a full corneal evaluation.

Once keratoconus has been diagnosed, the second challenge is to prevent further corneal changes that may otherwise lead to a corneal transplant. We strongly believe that it is important to recommend CXL as soon as there is evidence of progression because it is the only therapy shown to be effective in slowing these changes.9

Finally, the third challenge is helping patients to see better, wherever they are in the stages of keratoconus progression. More vision correction tools are available to us when keratoconus is stabilized earlier in the course of the disease.

As many as 1 in 5 patients with progressive keratoconus have required a corneal transplant, with more than half of those needing multiple transplants within 20 years.1,2

96%+ of commercially insured patients now have coverage for CXL

See Crosslinking on page 18
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Crosslinking
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Early detection case
Optometrists who accept broad-based vision and/or medical insurance plans will be best positioned to attract a broad range of patients to their practices, including those in the demographic in which keratoconus first develops: teens and young adults.

A patient who recently returned for his two-year follow-up visit after CXL illustrates the benefits of early detection. This a 27-year-old male found his contact lens prescription was changing more rapidly in his right eye than his left. Uncorrected visual acuities were 20/40 OD and 20/20 OS. He demonstrated aggressive eye-rubbing in the exam chair.

While he did correct to 20/20 with +0.75-3.00 x 070 in the right eye, there was mild anterior bowing to his inferior cornea in the right eye and sub-clinical findings on his left eye. All other slit lamp exam findings were normal.

Baseline Pentacam (Oculus) tomographies contributed to the diagnosis of progressive keratoconus OD (Figure 1) and forme fruste keratoconus OS (Figure 2).

CXL was performed in the right eye, with planned close monitoring of the left eye. We saw improvements in the cornea and best-corrected visual acuity to 20/20 at six months (Figure 3).

Now, at two years post-CXL OD, the patient continues to be correctible to 20/20 OD and OS with greatly improved corneal tomography (Figure 4). He is able to wear glasses and soft contact lenses and has ceased eye rubbing. The patient’s corneal scans in the left eye have continued to be stable.

Diagnosing keratoconus
In working to identify early keratoconic changes and risk factors for keratoconus, we have learned is that simply raising the index of suspicion is important, independent of any specific diagnostic tools.

Watch for these red flags:
- Inability to correct an otherwise healthy young eye to 20/20
- A large change in refraction over the course of a year
  - 0.50 D myopic change
  - 1.00 D cylinder change
- Habitual eye rubbing, particularly in combination with any of the above

Traditional diagnostic tools such as manual keratometry, autorefractor auto keratometry, slit-lamp exam, and retinoscopy are important first steps. However, accurately tracking changes in corneal curvature over time requires access to advanced topography/tomography technologies such as Pentacam or Orbscan (Bausch + Lomb) that aren’t
available to all primary-care optometrists. We recommend that primary-care optometrists seek out and partner with ophthalmic practices that do have these devices. Technicians at the surgical practice can provide imaging services at the request of the primary-care optometrist. This allows the referring optometrist to make a more informed decision about whether a CXL consult is needed, which can often be done quickly and with less hassle for the patient.

We also recommend erring on the side of caution and making a referral for further diagnostic evaluation whenever there is a reasonable suspicion of keratoconus. **Sharing the care** Once a referral for evaluation has been made, there are a number of steps in the process (see “Logistics of collaborative care for keratoconus”). Patients need to be educated about keratoconus, crosslinking, and the ongoing need for refractive correction.

More than 90 percent of commercially insured patients now have coverage for CXL, but practices often need to seek pre-autho-

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**Logistics of collaborative care for keratoconus**

**CONSULT/PREOP VISIT(S)**

**SURGICAL PRACTICE**

- Diagnostic workup
- Meet with optometrist and/or ophthalmologist in the surgical practice
  - Diagnose progressive keratoconus
  - Educate patient about the condition
  - Explain what to expect from CXL
- Meet with surgical coordinator
  - Obtain insurance preauthorization and/or coverage decision
  - Discuss costs and financing if not covered
  - Schedule CXL procedure

**DAY OF SURGERY**

**SURGICAL PRACTICE**

- Procedure takes about an hour; patient may be in the practice for several hours in total
- Photorexa drops and ultraviolet (UV) light applied to the corneal stroma
- Bandage contact lens applied

**FOLLOW-UP VISITS**

- **1 WEEK** (Surgical or primary-care practice)
  - Consider removing bandage contact lens (BCL)
  - Evaluate cornea
  - Discuss pain management
  - Address short-term management of visual acuity
- **1 MONTH** (Primary-care practice)
  - Evaluate ongoing healing and vision changes
- **3 MONTHS** (Primary-care practice)
  - Prescribe longer-term vision correction
- **6-12 MONTHS** (Surgical practice)
  - Repeat topography/tomography to ensure stability

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Crosslinking

Continued from page 19

Comanagement

Comanagement partners can’t overcommunicate in caring for keratoconus patients. It is very important for the surgical practice to understand the areas of concern and the reason for the referral. Surgical partners should, in turn, communicate their diagnosis and treatment plan, as well as the desired postoperative care regimen. Optometrists should visit the cross-linking practice, seek out more information about the procedure, and be confident in their relationships with the doctors who will perform the crosslinking (see “Comanagement partnership qualities”).

Most surgical practices will send the patient back to the referring optometrist for the first (~one week) or second (one month) postop visit. They may want to see the patient back at six or 12 months to repeat imaging and confirm stability.

It is important to know that doctors can be reimbursed by insurance for these follow-up visits. Unlike cataract surgery, there is currently no global period for crosslinking, so follow-up appointments should be billed as office visits.

Collaborating to provide care for patients with keratoconus is very rewarding for all involved. Not only are there interesting clinical challenges in managing patients undergoing corneal collagen crosslinking, but CXL offers a fantastic opportunity for ODs to improve patients’ long-term visual acuity and corneal health outcomes.

REFERENCES

Transfers after surgery

In our practice model, referring optometrists are in the loop every step of the way of their patients’ journeys—from patient referral and our practice’s initial evaluation, to preoperative care such as treatment in our dry eye clinic, to surgical decisions and the procedure itself, we continually inform and confer with each other. Referring ODs’ ongoing involvement with their patients makes the postoperative transition quite smooth.

The handoff point depends on the optometrist’s comfort level and surgical success; however, many referring ODs immediately assume care by seeing patients for the one-day visit after cataract surgery. Primary care ODs continue to see patients for one-week and one-month examinations to ensure that patients are achieving the desired visual outcomes on schedule without complications or discomfort.

Modern cataract surgery has become so advanced that it is very routine and reliable with low risk for complications. Our surgeons feel confident in sending patients back to their optometrists, knowing that ODs excel at identifying and managing potential complications.

In addition, referring ODs continue the open communication among their offices and ours, sending a mutually agreed-upon report on every patient. Anytime a patient experiences a minor complication, a patients feels dissatisfied about any aspect of the experience, or something unusual happens, our surgeons want to know about it and the referring ODs keep our office updated.

Postoperative medications

Evaluating patients for complications is an essential part of the referring ODs’ responsibility, and one of the most effective ways to prevent complications is to ensure patients are compliant with postoperative medications.

Traditionally, post-cataract patients are placed on a corticosteroid like prednisolone (Pred Forte, Allergan), a non-steroidal anti-inflammatory drug (NSAID) such as bromfenac (Pro-lensa, Bausch + Lomb) or nepafenac (Ilevro, Novartis), and antibiotics such as moxifloxacin (Vigamox, Alcon) and besifloxacin (Besivance, Bausch + Lomb).

The antibiotic is prescribed for about one week, while the corticosteroid and the NSAID are used for one month. If a patient is considered high risk for cystoid macular edema (CME), we might prescribe the NSAID for two months.

In our experience, we have found that it is best not to allow generic substitutions for any of these drugs. We understand that cost is always a concern, but the small savings is not worth the risk. We find that generics are not as reliable and are more likely to induce ocular surface problems or CME.

When we explain these risks, patients rarely choose generics. If they do, we have them sign a waiver attesting that they were warned of the potential consequences.
additional risk and accept responsibility. If the patient cannot truly afford medicine, we will utilize other treatment options.

With the same goals in mind of efficacy and compliance, we follow new medications for cataract patients.

Finding anti-inflammatory therapies that require a lower dosage is one of our primary interests. Patients get frustrated with the number of drops they need to use after surgery, and we have found that when we are able to decrease the dosing frequency of a medication, we increase compliance.

For post-cataract pain and inflammation, we are excited about loteprednol etabonate suspension 1% (Inveltys, Kala Pharmaceuticals). The drug penetrates the tear film mucins, delivering more than 3.75 times of loteprednol etabonate to target ocular tissues compared to traditional suspension formulations in a preclinical study.1 It is the first corticosteroid approved for twice-a-day (bid) dosing following ocular surgery.

The best patient experience

How does this process play out from the patient’s perspective? The patient’s optometrist refers him for cataract surgery, then the patient has multiple visits to our practice and, potentially, several weeks of treatment for ocular surface disease. He has the surgery, then returns to his optometrist for a month of follow-up care.

We work hard to ensure that throughout this process, the patient’s practitioners are on the same page and each doctor or staff member delivers the same message to patients at every step. That consistency is an important part of education within our center and with our referring ODs.

Of course, no patient has a good experience if the visual results are poor, and we do everything we can to ensure that measurements are accurate and surgery is a success.

Consistency is an important part of education within our center and with our referring ODs

Another potential reason for dissatisfaction is discomfort during the healing process.

One way we prevent poor visual results and healing discomfort is aggressively treating dry eye before surgery with prescription medications like cyclosporine (Restasis, Allergan) or lifitegrast (Xiidra, Takeda) and possibly thermal pulsation therapy (LipiFlow, Johnson & Johnson Vision). This ensures accurate biometry and reduces ocular surface discomfort after surgery.

Almost 80 percent of our patients opt for premium intraocular lenses (IOLs) such as Alcon IQ ReSTOR, Tecnis Multifocal, and Bausch + Lomb Crystalens—even minor amounts of ocular surface disease during biometry can skew visual results.

In addition, we need to make sure to pre-
Deliver a consistent message

Our practice spends more than 20 hours a year educating our optometrist referral network. We bring ODs up to speed on new technology and new concepts.

Perhaps the most important thing we discuss is consistent messaging for patients. When patients receive different or conflicting information from their ODs or surgeons, it erodes their confidence in either or both doctors. Conversely, when both doctors use the same message, it gives the patient confirmation, validation, and confidence in the plan and long-term goals.

We want to make sure that patients hear a consistent message and language from the optometrist, the ophthalmologist, and our respective staffs, including these important points:

- Cataract surgery is a significant, valuable step. Although cataract surgery has been commoditized, as well as reduced to about 10 minutes, it is not a cookie-cutter procedure. It is a significant surgery that requires preparation. In addition, it can be customized to meet patients’ individual visual needs. The optometrist and surgeon partner with patients to agree on the best treatment.
- Preparation for surgery may take time. In this patient demographic, almost all patients exhibit some type of significant ocular surface disease. Doctors will evaluate and treat the problem to produce better vision and maintain healthier eyes. Our optometrist network tells us we get far better results than our competitors, and a large part of that is a result of taking the time and effort to treat ocular surface disease before surgery and manage it long term.
- Patients have a lot of choices. We want patients to know that multiple vision options are available for most patients, but we won’t know the best option until the surgeon completes a full evaluation. Patients also should understand that whatever option they choose, they are likely to be very happy. The surgeon won’t offer any “wrong” choices—it is a matter of their preferences in terms of activities and desired freedom from glasses.

Patients are part of the eyecare team. Eyecare practitioners rely on patients to tell them about vision and comfort. When it comes to cataract surgery, not only will patients need to consider the aforementioned choices, but they will also need to attend appointments and comply with pre- and postoperative medications and instructions. Including follow-up visits, the whole process will be over in a matter of a few months, and their effort will pay off.

80 percent of our patients opt for premium IOLs—even minor OSD during biometry skews visual results

scribe medications that adequately control pain and inflammation after surgery, and then, of course, make sure patients are complying with the drops.

Our patients tell us that they have received an exceptional level of care. They appreciate that we make group decisions with their optometrists, and they like that we take more time before surgery to take multiple measurements and discuss their needs to produce better results.

We have learned that when patients see referring and comanaging doctors taking their roles in cataract care seriously, they put more effort into their own role, complying with pre- and postoperative care. Their help and their satisfaction help the comanagement process succeed.

REFERENCE

Dr. Cunningham is director of the Dell Eye Institute for Dry Eye Research. He has a special interest in sports vision and performance and provides vision training services to several college and professional sports teams. He is the co-founder of SportsVisionPros.com and spends some of his free time in the broadcast booth helping announce for the University of Texas Longhorns football games. Dr. Cunningham serves a consultant to Kala Pharmaceuticals, Valeant, Alcon, Shire, and Eyevance Pharmaceutical Companies. He is also a consultant to Johnson & Johnson Vision, TearLab, BVL, and Nike.

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IN BRIEF

Transitions debuts
Signature Gen 8

PINELLAS PARK, FL—Transitions Optical will launch the next generation of its Transitions Signature lenses—Transitions Signature Gen 8.

According to the company, the lenses are engineered with new proprietary technology, that delivers the best overall photochromic lens performance.

Transitions Signature Gen 8 lenses will launch in the U.S. in July 2019 and in the fall in Canada.

The next generation of Transitions Signature lenses comes six years after the launch of the company’s Transitions Signature VII lenses.

The performance of photochromic lenses is linked to two components: the matrix in which the dyes reside and the photochromic dyes themselves. The Transitions Signature Gen 8 lens technology incorporates a reinvented matrix and new photochromic dyes, which has not been done since the launch of the company’s Transitions V lenses in 2005.

Transitions Signature Gen 8 lenses were developed using technology that combines a disruptive nanocomposite matrix and a new generation of ultra-agile photochromic dyes, according to the company.

The nano-composite matrix in Transitions Signature Gen 8 lenses is a nano-structured material which mimics a semi crystalline structure. This matrix creates free zones for improved dye mobility. The dye moves more freely, and it is also more stable and consistent in its performance.

Not only are Transitions Signature Gen 8 lenses faster in activation and fadeback, they are even darker than previous generations, says Transitions Optical. The lenses block 100 percent UV and help protect from harmful blue light indoors and out.

“Our mission is to provide better vision and protection to everyone,” says Chrystal Barranger, president of Essilor Photochromics and Transitions Optical.

“We are proud to introduce a new technology, bringing a new level of performance, based on consumer’s needs,” she says. “With Transitions Signature Gen 8, we are confident that we will recruit new wearers and grow the category.”

We want patients

Deliver a consistent message

Our practice spends more than 20 hours a year educating our optometrist referral network. We bring ODs up to speed on new technology and new concepts.

Perhaps the most important thing we discuss is consistent messaging for patients. When patients receive different or conflicting information from their ODs or surgeons, it erodes their confidence in either or both doctors. Conversely, when both doctors use the same message, it gives the patient confirmation, validation, and confidence in the plan and long-term goals.

We want to make sure that patients hear a consistent message and language from the optometrist, the ophthalmologist, and our respective staffs, including these important points:

- Cataract surgery is a significant, valuable step. Although cataract surgery has been commoditized, as well as reduced to about 10 minutes, it is not a cookie-cutter procedure. It is a significant surgery that requires preparation. In addition, it can be customized to meet patients’ individual visual needs. The optometrist and surgeon partner with patients to agree on the best treatment.
- Preparation for surgery may take time. In this patient demographic, almost all patients exhibit some type of significant ocular surface disease. Doctors will evaluate and treat the problem to produce better vision and maintain healthier eyes. Our optometrist network tells us we get far better results than our competitors, and a large part of that is a result of taking the time and effort to treat ocular surface disease before surgery and manage it long term.
- Patients have a lot of choices. We want patients to know that multiple vision options are available for most patients, but we won’t know the best option until the surgeon completes a full evaluation. Patients also should understand that whatever option they choose, they are likely to be very happy. The surgeon won’t offer any “wrong” choices—it is a matter of their preferences in terms of activities and desired freedom from glasses.

Patients are part of the eyecare team. Eyecare practitioners rely on patients to tell them about vision and comfort. When it comes to cataract surgery, not only will patients need to consider the aforementioned choices, but they will also need to attend appointments and comply with pre- and postoperative medications and instructions. Including follow-up visits, the whole process will be over in a matter of a few months, and their effort will pay off.

80 percent of our patients opt for premium IOLs—even minor OSD during biometry skews visual results

scribe medications that adequately control pain and inflammation after surgery, and then, of course, make sure patients are complying with the drops.

Our patients tell us that they have received an exceptional level of care. They appreciate that we make group decisions with their optometrists, and they like that we take more time before surgery to take multiple measurements and discuss their needs to produce better results.

We have learned that when patients see referring and comanaging doctors taking their roles in cataract care seriously, they put more effort into their own role, complying with pre- and postoperative care. Their help and their satisfaction help the comanagement process succeed.

REFERENCE

Dr. Cunningham is director of the Dell Eye Institute for Dry Eye Research. He has a special interest in sports vision and performance and provides vision training services to several college and professional sports teams. He is the co-founder of SportsVisionPros.com and spends some of his free time in the broadcast booth helping announce for the University of Texas Longhorns football games. Dr. Cunningham serves a consultant to Kala Pharmaceuticals, Valeant, Alcon, Shire, and Eyevance Pharmaceutical Companies. He is also a consultant to Johnson & Johnson Vision, TearLab, BVL, and Nike.

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IN BRIEF

Transitions debuts
Signature Gen 8

PINELLAS PARK, FL—Transitions Optical will launch the next generation of its Transitions Signature lenses—Transitions Signature Gen 8.

According to the company, the lenses are engineered with new proprietary technology, that delivers the best overall photochromic lens performance.

Transitions Signature Gen 8 lenses will launch in the U.S. in July 2019 and in the fall in Canada.

The next generation of Transitions Signature lenses comes six years after the launch of the company’s Transitions Signature VII lenses.

The performance of photochromic lenses is linked to two components: the matrix in which the dyes reside and the photochromic dyes themselves. The Transitions Signature Gen 8 lens technology incorporates a reinvented matrix and new photochromic dyes, which has not been done since the launch of the company’s Transitions V lenses in 2005.

Transitions Signature Gen 8 lenses were developed using technology that combines a disruptive nanocomposite matrix and a new generation of ultra-agile photochromic dyes, according to the company.

The nano-composite matrix in Transitions Signature Gen 8 lenses is a nano-structured material which mimics a semi crystalline structure. This matrix creates free zones for improved dye mobility. The dye moves more freely, and it is also more stable and consistent in its performance.

Not only are Transitions Signature Gen 8 lenses faster in activation and fadeback, they are even darker than previous generations, says Transitions Optical. The lenses block 100 percent UV and help protect from harmful blue light indoors and out.

“Our mission is to provide better vision and protection to everyone,” says Chrystal Barranger, president of Essilor Photochromics and Transitions Optical.

“We are proud to introduce a new technology, bringing a new level of performance, based on consumer’s needs,” she says. “With Transitions Signature Gen 8, we are confident that we will recruit new wearers and grow the category.”
4 ways to use eye tracking in your practice

Go beyond vision therapy by incorporating functional vision testing

By Randall Fuerst, OD, FAAO

I am part of a large, full-scope optometry group practice with access to a wide range of diagnostic and treatment technologies. Eye tracking is a technology that our practice has been exploring recently—and I believe it has great potential to help patients and practices of all sizes.

We initially added eye tracking as a way to quantify the impact of vision therapy, which has been offered in our practice since the late 1960s. However, after seeing many other applications beyond vision therapy, we are now offering eye tracking as part of specialized exams for reading evaluations, sports vision, and concussion care (generally on referral) and as an add-on to regular eye exams, based on patient complaints or interests.

I am considering whether to integrate eye tracking more broadly into my vision exams for all patients. Increasingly, it makes sense for ODs to go beyond visual acuity to assess functional vision more comprehensively. That would include not just how well the eyes focus (acuity) but binocular vision, whether the two eyes work together adequately, and how well the brain processes visual inputs.

Our practice uses the eye tracking system from RightEye. It is a portable system that tracks eye movements and correlates them to functional vision concerns, and it provides a wide range of applications.

Although all optometrists are taught to evaluate pursuits, saccades, and convergence, our normal methods of doing this are rudimentary, time consuming, and subjective. We have found that the RightEye system gives us the ability for the first time to test these functions in a quick, comprehensive, and objective way. It includes the RightEye EyeQ tests, reports, and training aids in specialized exams and can drive treatment plans.

TAKE-HOME MESSAGE
ODs are able to assess functional vision to evaluate kids and reading, sports vision, concussions and brain health, and vision training and therapy via technology. Data from eye tracking testing aids in specialized exams and can drive treatment plans.

Figure 1. Patient H, an autistic young man who has always struggled with reading, underwent vision therapy and showed significant improvement in his RightEye test results, with circular pursuits (1A) and vertical tracking (1B) shown here. He has begun reading for pleasure, which he has never done before.

Figure 2. Patient M is a 13-year-old, right-eye amblyope. He plays baseball year-round and has had improvements in both hitting the ball and reading following his visual improvements. Shown here are circular pursuits (2A) and horizontal speed and tracking (2B).
tools. The reports from each specific test (reading, sports vision, functional vision, and brain health) have been key for our practice because they make it very easy to demonstrate areas for improvement to patients, parents, and other professionals.

**Kids and reading**

Our most common utilization of eye tracking is in evaluating reading and vision-related learning difficulties in children.

With the Reading EyeQ test, we are able to record eye movements as a child reads an age-appropriate passage of text. This is extremely helpful in showing parents that even though their child has 20/20 vision, there may still be functional vision problems. The child may not be processing visual information efficiently and productively.

For example, he may comprehend the passage reasonably well, but he may correctly track only six of the 10 lines of text. Even a lay person can easily see from the report that the eyes are darting around, taxing accuracy and taking longer to read.

Or, we may see how the two eyes start to diverge as the child scans a paragraph. The evaluation helps us determine the problem and identify a path forward to improve reading efficiency.

**Sports vision**

In a sports vision evaluation, we use eye tracking to test aspects of an athlete’s visual function relevant to performance, such as dynamic visual focus, eye movement speed, reaction times, visual concentration, and peripheral awareness. The Sports Vision EyeQ test compares their performance to others and identifies strengths and weaknesses that can be added to a training program.

Recently, there has been a proliferation of new technologies for sports vision practices. Two that we have incorporated are Dynavision D2 (Axtion Fitness Tech) for testing and training athletes on reaction time, visual awareness, and hand-eye coordination; and the Vivid Vision virtual reality system.

These are complementary to eye tracking, which will continue to be the centerpiece of our sports vision evaluation. Concussions and brain health

**Concussions and brain health**

The opportunity to look at brain health in patients who have had concussions is exciting because ODs can make such a difference in patients’ recovery process. Concussion and other traumatic brain injuries commonly have associated visual and vestibular symptoms.

There are now at least three systems that have been cleared by the U.S. Food & Drug Administration (FDA) for use in evaluating eye tracking and that have applications in concussion care, including RightEye, EyeBox (Oculogica), and Eye-Sync (SyncThink).

Visual symptoms post-concussion may be ignored by other healthcare professionals, but eye tracking can illuminate the deficits. I recently saw a patient who had been hit in the right eye with a snowball. We could see a clear difference between the right and left eyes on her eye tracking exam.

I am also beginning to use RightEye Brain Health EyeQ testing to help me counsel elderly patients and their families on driving fitness. As seniors age, determining when they should stop driving is difficult, especially if ODs try to make a determination based on visual acuity alone.

With eye-tracking data, I can include other aspects of visual function that contribute to the ability to drive safely, such as peripheral awareness and reaction time. I recently tested an 83-year-old gentleman whose brain health assessment score was 27. Given that the functional range is 60+, I was confident in recommending he stop driving.

**In a sports vision evaluation, we use eye tracking to test aspects of an athlete’s visual function relevant to sports performance, such as dynamic visual focus, eye movement speed, reaction times, visual concentration, and peripheral awareness**

I believe that in many cases, tests of visual function such as eye tracking and visual-evoked potential are more effective ways to assess brain health than magnetic resonance imaging (MRI). Relative to expensive imaging procedures like MRI, these are cost-effective tests that can be administered efficiently without going to a hospital, and they provide ODs with data to understand how brain processing may be altered.

**Vision training and therapy**

We also offer patients the opportunity to click on a link in their eye tracking report to EyeQ Trainer exercises. Although our practice offers vision therapy, these self-directed training exercises have proven to be an excellent first step.

For busy patients with mild deficits due to a concussion, for example, the linked training program may be all they need. For others, it can be a precursor to more comprehensive vision therapy or a quick way to measure the progress of vision therapy.

For providers who don’t offer vision therapy, training tools that work on functional vision skills lower the barrier to entry and make it easier for patients to do something, even if it isn’t a full course of vision therapy.

**Elevating optometry**

I see optometry filling a void and participating in evaluating the visual system and its role in brain health. With new tools like eye tracking, ODs can truly be part of the team, along with sports vision physicians, neurologists, physical therapists, and others who treat patients with traumatic brain injury.

I suspect that integration of eye tracking will be similar to that of retinal imaging, which began as a novelty device in one office in our practice and is now offered to every patient because of the compelling information it provides and its ease of use and appeal to patients.

Prescribing glasses and contact lenses will remain at the core of optometric practice. However, the ability to use technology to evaluate functional vision presents opportunities for elevating optometry to provide care that goes beyond vision correction.

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**Our most common utilization of eye tracking is in evaluating reading and vision-related learning difficulties in children**

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Dr. Fuerst is a partner at EYEcenter Optometric, with 5 locations in and around Sacramento, CA. He does not have a financial relationship with the companies mentioned.

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How to see 50 patients a day at your practice
Adapt to a changing profession by implementing efficient, time-saving tricks

By Alex Delaney-Gesing
Associate Editor

Most ODs are not seeing as many patients per day as they think they are, says Peter Cass, OD, at SECO 2019 in New Orleans.

At the end of the month, when an OD calculates the number of comprehensive exams by how many hours he was in the office, the number of patients seen is often much lower than was expected.

ODs today are seeing approximately 1.2 patients per hour.1 With the average income per patient visit around $300—eye exams being the biggest revenue generator—adding just two more patients per day can increase an OD’s monthly gross to $12,000, and lead to an average net of $3,600 each month.

Dr. Cass sees an estimated 50 patients per day.

This high number is largely due to one key component he and his staff have implemented at his practice: efficiency.

Efficiency is just one necessary adjustment Dr. Cass has had to make in order to keep up with the constant changing landscape taking over the optometric profession and more traditional form of office visits.

Technological advancements
Services such as at-home vision testing—particularly in the large metro areas—and self-service healthcare stations are offering alternative options for patients outside of traditional in-office visits.

There are those patients who still want that personal touch, that experience of going in and trying frames in person. And there are a lot who are going to favor a private practice doctor

Kiosk service stations have popped up outside of local pharmacies using Food & Drug Administration (FDA)-cleared and Health Insurance Portability and Accountability Act (HIPPA)-compliant medical devices, receiving funding from major healthcare organizations like Novartis and the National Institutes of Health (NIH). Smartphone applications have even developed retina imaging and visual acuity tests.

These advancements lead to one question, Dr. Cass says: Why is health care changing so much?

Changing landscape
A few significant factors come into play, such as:
- Rising cost of conducting business
- Increase in state, federal, and professional compliance concerns
- Increase in payer system complexity
- Decline in reimbursement

Along with these changes comes a need for adaptation.

“There are still opportunities in wellness care,” Dr. Cass says.

As the nation’s population continues to grow, there are fewer doctors graduating from optometry school and more insured patients, and there is a gap, he says.

These advancements lead to one question, Dr. Cass says: Why is health care changing so much?

Online threats are real for ODs, but only a percentage of patients choose to buy online. “There are those patients who still want that personal touch, that experience of going in and trying on frames in person. And there are a lot who are going to favor a private practice doctor.”

Some patients will always opt for lower-priced products and services, while others know they get what they pay for.

“We don’t put cheap frames in our office, and we don’t use cheap lenses because they are not the best,” Dr. Cass says. “I want to provide the best eye care—hire the best staff and personnel—and provide the best service.”

There is more medical care needed and opportunities to service discerning patients. Capture that, Dr. Cass says. Offer comprehensive and individualized care to these individuals.

Manage—do not refer, Dr. Cass advises. “There is so much stuff in optometry that gets referred out when it shouldn’t be. Manage it and keep it in-house,” Dr. Cass says.

Practice efficiency
Be creative and aggressive in the ophthalmic product options you offer, Dr. Cass says.

He emphasized four key points that have allowed him to increase the number of patients he sees per day, and operate his prac-

Number of children ages 6 to 16 who have been reported as not having an eye exam in the last two years

Thirty percent of children ages 6 to 16 have been reported as not having an eye exam in the last 24 months.2 By 2050, the number of people with visual impairment or blindness in the U.S. is expected to double by more than 8 million.3

“There is a huge rural OD manpower shortage,” Dr. Cass says. “In my (rural) town, it’s pretty hard to find somebody. There are about 400,000 people—so it’s not tiny, but it’s...
The American Academy of Optometry and the World Council of Optometry are joining together to offer a global platform where practitioners, students, researchers and educators can share expertise and engage in the development of optometry’s future. All in one of the top tourist destinations in the world – Orlando, Florida.

FOR MORE INFORMATION VISIT
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#ACADEMY19  #WCOCONGRESS19

Registration opens May 6, 2019
50 patients
Continued from page 26

tice with optimum efficiency:
- Manage the schedule
- Hire staff with great personalities
- Leverage technology
- Optimize workflow
- Fully delegate tasks

An alternative advantage of increasing patient volume per day: freeing up an extra half-day or full day to use at the OD’s discretion.

A few key areas are crucial to increasing efficiency at your practice, Dr. Cass says.

Scheduling

Electronic health records (EHR) help the most with efficiency, according to Dr. Cass. Most EHR programs have templates with color coding that enables an OD to block out certain times of day. Train staff to handle this, Dr. Cass says.

Even with an average jam-packed schedule, Dr. Cass says he is able to leave the practice each day within 30 minutes of office hours closing.

“It’s pretty rare for me to be there later than that,” he says.

It’s all about having a good staff, putting procedures in place, and making better use of your time, he says. To handle a busier patient schedule, Dr. Cass recommends hiring additional staff members.

While more staff means more costs, bringing in just one or two more patients a day can cover expenses and still result in higher profits

While more staff means more costs, bringing in just one or two more patients a day can cover expenses and still result in higher profits, according to Dr. Cass.

No-show patients are common at any practice—data reports as high as 25 percent in optometry. Well-controlled, it’s hard to get that number below 5 percent, he says.

Dr. Cass suggests minimizing the profit loss from no-shows by double-booking certain appointment slots.

“You know you’re going to have some no-shows happen,” he says.

Appointments

“Patients tend to get antsy if they have to wait,” Dr. Cass says.

A typical wait time is 10 to 15 minutes at his practice. Patients are required to complete medical history forms prior online prior to arriving for their appointments.

“It is more thorough and saves us a ton of time,” he says.

Dr. Cass typically allots five minutes for patient check-in and five minutes until his staff brings a patient to the first exam room. As the practice has gotten busier, he says, he has designated one assistant to take a patient to the pre-test room, address the chief complaint, perform pre-testing, and then escort the individual to a second waiting room. From there, a second technician handles the remaining tests.

He and his technicians can usually complete both pieces in less than 10 minutes—often even less than that, especially on an established patient, Dr. Cass says.

Exam time slots are set to no more than 15 minutes, although they typically take less than that, according to Dr. Cass.

“I can routinely see patients in five minutes or so, without being rushed,” he says.

Optical exams are timed at 15 minutes as well, with an entire patient visit lasting no more than one hour.

“That’s our goal,” Dr. Cass says. “People don’t want to be there forever.”

Staff

For a practice to be efficient, an OD needs a solid staff.

The most important thing to look at is personality, Dr. Cass says.

“Hire for personality and train everything else,” he says.

Dr. Cass uses the American Optometric Association (AOA) training program for his staff. He offers his staff a monthly bonus if they are certified.

“You want everybody in your office to be certified,” he says.

Delegating certain tasks to staff allows for quick and efficient patient visits, Dr. Cass says. The types of duties staff can handle depends on state regulations.

For example, Dr. Cass’s staff handles the following areas (admissible under Texas law):
- Medical history
- Binocular vision
- Pupils
- Cover test
- Visual test
- Color vision
- Stereo vision
- Mental status
- Review of systems (ROS)
- Height/weight
- Blood pressure
- Dilatation
- Astigmatic keratotomy (AK)/anti-reflective coating (AR)

Technology

Up-to-date equipment can speed up patient visits and efficiency.

A solid auto refractor and auto keratometric machine is the best way to speed up refraction, Dr. Cass says. If you have an auto refractor that is not accurate, get rid of it—a faulty machine is a time waster.

“If you have an idea what the prescription should be before a patient gets in the chair, that is going to make life easier,” he says.

Dr. Cass uses a customized workflow in his practice’s EHR with tabs like “chief complaint” and “medical history.”

Hiring a scribe if an OD is unable to do this will save time and impress patients, Dr. Cass says.

Auto-promPTing and auto-fill saves time when working in EHRs and often works without complications, he says.

“Nine times out of 10 I don’t have to change anything,” he says.

Dr. Cass recommends integrating all technology in the practice. He uses the Zeiss Forum ophthalmology software to network all images and data stored on the server.

Retinal imaging and optical coherence tomography (OCT) machines Dr. Cass uses include viewing software that allows him to map and access patient data from any exam room.

Quick efficiency tips

Predilating

Predilating patients has been found to have minimal effect on accommodation readings, with phenylephrine often used for quick results. If this is not enough, have staff dilate a patient and attend to another patient in the meantime before coming back, Dr. Cass says.

“Patients are going to dilate fast and good because they are already pre-dilated,” he says.

Cyclopentolate

Dr. Cass’s protocol for pediatric patients who have never worn glasses but measure +2.00 -1.00 and +3.00 -4.00, he will not attempt to refract. Instead, staff will apply cy-
clopentolate (Cyclogyl, Alcon) and record the autorefraction, making for a faster exam.

Office flow
Use two rooms that have identical full lanes, Dr. Cass says, as well as one room for special procedures and testing (OCT, visual fields, optic nerve fiber analysis, pachymetry, specular microscopy).

You don’t have to sacrifice service. You need to get smarter about it and be more efficient

Office flow plays a key role in keeping patients happy. Dr. Cass has found that two waiting rooms has been helpful in keeping patients moving and less impatient (one for pre-exams and another for after exams).

Routing slips
Dr. Cass says his staff treat routing slips like work orders.

When a patient calls to make an appointment, a staff member inserts the information in their program software. Information for insurance and certification is then completed.

After printing, a technician can grab the slip, input the work-up, and make the slip available for Dr. Cass to pick up and view with the patient. When a technician brings the patient up to the front for frames or contact lenses, his notes are viewable for which type of frames or lenses he recommends.

Room prep
Have your staff prep exam rooms for you, Dr. Cass says. Assistants can save time by having a charts open, patient’s visual acuity chart set, and the potential prescription ready to view in the refractor.

By the time Dr. Cass meets with the patient, he needs only to review the patient’s history, conduct a refraction and health exam, and discuss next steps before paging a staff member to conclude the visit.

Staff delegation
Employing and training a solid staff enables an OD to pass off tasks such as:
- Patient education
- Supplying samples
- Contact lenses handoff (apply, fit, adjust)
- Soft contact lenses fit (pull lenses, troubleshoot soft fits, order trials)
- Rigid gas permable (RGP) lenses (pull/prep, clean/store, document, order)
- Spectacles handoff
- Special testing (external/internal photos, topography, intraocular pressure [IOPs], specular microscopy)
- Referral letters (write and print, send to OD to review and sign)
- Patient forms (fill out, send to OD to review and sign)
- Pharmacy calls
- Prior authorizations
- Patient calls

Conclusion
Change won’t happen overnight. Dr. Cass advises ODs to think about what adjustments will work for their practices, then change just one or two things at a time.

“You don’t have to sacrifice service” he says. “You need to get smarter about it and be more efficient.”

REFERENCES

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Universal Digital SLR Camera Adaptor for Slit Lamp Imaging
Digital Photography Solutions for Slit Lamp Imaging

Universal Smart Phone Adaptor for Slit Lamp Imaging

Sample Images

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5 marketing tips to grow a practice without breaking the bank

Grow your brand and set your practice up for success with these suggested tips.

Marketing is an important part of any business. ODs who use this process to build their practice’s brand awareness can motivate patients to refer new patients, increase sales, grow their business, and engage with new patients.

Unsure of where to start? Follow these five tips to get the marketing ball rolling at your practice.

1. **Signage and point-of-purchase materials**
   
   **Cost:** Free to $25
   
   Quality over quantity is always best.
   
   Be mindful of signage on display at the practice—this will avoid cluttering the reception desk and overwhelming patients.
   
   A good rule of thumb is to always have point-of-purchase (POP) material that is current.
   
   Do not display a faded counter card or a picture of a frame that has been discontinued since 2015.
   
   What is better than POP? Customized signage for the office.
   
   Personalize signage and ensure it looks professional. Online resources for do-it-yourself (DIY) signage are Canva, Avery, and Vistaprint.
   
   All websites are easy to navigate and allows the use of practice’s logos and images, as well as integrating with social media accounts.
   
   Vistaprint offers promotional items such as wall posters, counter cards, and flyers.
   
   Canva and Avery enable users to print from their computers.
   
   However, I personally opt for having the company print for me because I think it looks more professional.

2. **Design a custom brochure for your practice**
   
   **Cost:** $40 for 100
   
   This may be the best opportunity for ODs to showcase what they do best as eye-care professionals.
   
   What unusual services do they provide patients; do they offer visual therapy or treat dry eye?
   
   Do they specialize in prescribing hard-to-fit contact lenses; do they have an in-house lab and can make glasses in the same day?
   
   Mention these services in the practice brochure.
   
   Do they carry distinctive elite eyewear?
   
   Add pictures in your practice brochures to help patients visualize a practice’s style.
   
   Any specialized services an OD offers should be mentioned.
   
   When a patient takes this informational brochure home, an OD has the opportunity to reach other members of his family.
   
   A CTA should be included in the brochure. Something as simple as, “Do you know someone with dry eye? Give us a call for a consultation (insert phone number here).”
   
   An OD can include a picture of herself, her associates, and her staff. This makes the brochure more relatable for patients when they see it again in their homes.
   
   It might be surprising how many times we have asked new patients, “How did you find us?” and they mention seeing our brochure in the backseat of a car or at a friend’s house.

3. **Join CareCredit**
   
   **Cost:** Free
   
   CareCredit is a credit card for healthcare payments. It can be used to help patients pay for their treatments, follow-ups, and eyewear.
   
   CareCredit also encourages patients to purchase multiple pairs of frames—offering them a no-interest payment plan if they qualify—and even emails a list of local ODs in the area the potential patient can call for an appointment.4
   
   As a CareCredit provider, a practice will be viewable by all the company’s credit card holders to see. When they are ready to find an eye doctor or purchase glasses, they will find a practice or OD on the list.
   
   CareCredit emails its cardholders and encourages them to use their credit for annual exams, including eye health.
   
   Many patients new to our practice have found us on the list of providers accepting CareCredit and bring their family with them.
   
   This is one counter card ODs may want to display in their offices, saying, “We accept Care credit” or “Apply for CareCredit today.”

4. **Social media**
   
   **Cost:** Free
   
   ODs know that online retailers do an excellent job bombarding patients on a regular basis via social media platforms,
television, and even those annoying retargeting ads that pop up on computers’ sidebars.

Because ODs usually see patients only once a year, it is essential to have a social media presence to stay in contact and in view all year long.

It is also essential to have a presence on social media. Display appropriate signage in the office to encourage patients to connect with the practice.

Not sure where to start? Pick two social media platforms and focus on those for now. Do not get overwhelmed. Ask ideal patients which social media platform they prefer. If they are mostly on Facebook and Twitter, post there. If they hang out on Instagram and Twitter, then focus on those two.

5 Promotional products
Cost: $0.10 to $25 each
People like free things. What better way to market your practice than by providing meaningful, useful gifts with a practice’s logo? These do not have to be expensive!

See 5 marketing tips on page 33

Xavier Garcia launches acetate, metal collections

Xavier Garcia launched its latest 2019 collection of acetate and metal frame models.

CAMILA exhibits an octagonal shape in a crystal and bright acetate combination.

XOSE displays a rectangular shape with a combination of crystal and colors along the frame front.

ENEA features an octagonal shape with a metal block model in satin colors.

MOLINS includes a rounded shape made with thick metal.
Zyloware launches five styles for May


**Sophia Loren 1564** features a lightweight TR-90 thermoplastic frame in a full-rim, geometric shape. Three color options are available: black, tan fade, and red. All colors feature metal temples offset with a textured finish and crystal décor in a mix of shiny yellow gold and satin gold.

![Sophia Loren 1564](image1)

**Sophia Loren M300** exhibits a full-rim metal frame with a square silhouette. This comes in two colors: burgundy, with a shiny finish on the front, mauve pearl horn temple tips and a pearl accent on the temple; and cognac, which features a shiny gold base on the front with brushed finish on the endpiece and temple and a transparent cognac over gold pearl horn on the zyl temple tips. Both colors feature a pressed starburst design on the wrapping metal endpiece and temple with an oversized pearl in cream and crystal décor.

![Sophia Loren M300](image2)

**Stetson Zyro-Flex 722** displays a full-rim metal and rectangular-shaped frame. This style is offered in two colors: gunmetal, with a dark gunmetal finish and black temple tips; and brown, with a matte finish and tortoise temple tips.

![Stetson Zyro-Flex 722](image3)

**Stetson XL 37** features a full-rim metal available in gold and gunmetal. Both colors display a shiny metal front with a defining top bar and mix of shiny and matte finishes on the temple.

![Stetson XL 37](image4)

**Via Spiga Altea** exhibits a full-rim zyl with a modified square. These frames are available in black/crystal, tortoise/crystal, and red/crystal. Comfort fit features include spring hinges for easy adjustments and the ability to accommodate progressive lenses.

![Via Spiga Altea](image5)

**Via Spiga Tiziana** features a cat-eye frame, sloping browline, and full-rim style available in black and natural. Zyl temples in confetti patterns contrast a solid metal front.

![Via Spiga Tiziana](image6)

**Via Spiga Valeda** displays a full-rimmed combination frame in a rectangular silhouette. These frames are available in two colors: black and navy. The black frame layers black acetate over white stripe and beige horn and repeats the pattern on the elongated temple tips. Navy frames also incorporate stacked acetate but in a combination of opaque blue over white stripe and tan horn, repeating on the elongated temple tips. A metal design with raised arrows wraps from the metal endpiece to temple.

![Via Spiga Valeda](image7)
Shaquille O'Neal Squad 514M features a full-rim, round metal frame with a lightweight metal bridge. Two colors are available: black/blue and black/red. Black/blue includes a shiny matte front with black, navy, and crystal zyl temples, while black/red has a shiny front and black, white and red layered zyl temples.

Daisy Fuentes Zanita displays full-rim metal frames with a rectangle silhouette. These frames are available in purple and brown. Purple features a matte dark purple base with raised areas in shiny violet. Brown pairs a dark brown base with light shiny brown raised areas. Both colors have a wrapping metal endpiece with animal print cut-outs over the temple with a row of crystal accents separating the zyl tips.

**5 marketing tips**

Continued from page 31

Sive; everyone needs a pen or a keychain.

PopSockets’—customizable grips and mounts for smartphones—seem to be popular these days with the younger generation.

Place a practice’s logo on a PopSocket, and it will be featured on younger patients’ phones everywhere they go.

At my practice, we gift a branded folder to patients’ households and tell them to use it for their vision information and paperwork.

This folder is a walking billboard, and we receive multiple calls a week for appointments because someone noticed it.

These promotional items can range in cost from pennies to $25—if an OD decides to gift a high-end product like a Yeti thermos for her top referring patients.

Sheena Taff from Optician About Town gives her patients an eyeglass-shaped bottle opener keychain.

This gift is a mindful and useful item that will cause patients to remember her services every time they open a bottle or grab their keys.

Sheena can be followed online for inspiration on all things eyewear and optical fashion on her blog www.OpticianAboutTown.com and on Instagram at Optician.about.town.

**Bonus**

**M&S Technologies Smart System**

Cost: Over $1,000

If the marketing budget is larger than average, consider investing in technology to impress patients. No one likes to be kept waiting and staring at a blank wall or boring eyechart.

M&S Technologies Smart System computerized vision testing systems is a high-tech, alternative to chart projectors.

Its computerized vision testing systems are optimized with a variety of randomizable charts, contrast sensitivity protocols, and multimedia functions to deliver comprehensive and accurate vision testing.

My favorite aspect of this projected eye chart is the ability to play customized videos while the patient is waiting in the exam room.

This system is compatible with software like Rendia, previously known as Eyemaginations.

Informative videos about vision as well as videos customized to the practice can be played.

One of the best things my practice began doing was uploading our Facebook Live videos to the M&S system. Facebook allows users to download live videos from a business page.

However, this is accessible only if a practice has a business page—not a personal page.

When patients see a Facebook Live video of ours in the exam room, they often engage and follow us.

Additional marketing strategies include posting outside signage and creating business cards.

All practice marketing materials should be designed with a CTA to make an appointment as well as branded to reflect a practice’s style.

**Conclusion**

Not all ODs have a juicy budget to hire a public relations and marketing agency to handle their marketing. These marketing ideas can be implemented by ODs themselves to grow their practices.

Most patients see ODs once a year. Others come in more frequently or bring in family and friends.

Regardless of the frequency, ODs need to make a phenomenal impression.

Use this time to maximize marketing and inspire patients to use word of mouth to refer more patients and grow the practice.

**REFERENCES**


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Dr. Canto-Sims is CEO and founder of La Vida Eyewear, designed for Latinos by a Latina. She is a member of Transition Optical’s advisory board and Change Agent group. dianacanto@hotmail.com
BPI® Tint protective lenses in minutes
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BPI’s mission for the last 50 years has been to benefit society through the development of technologies that capture, measure, and filter various types of light that enhances human vision and functionality while maintaining cutting edge quality across thousands of products.

Sunlight contains UV and blue light. UV light is part of the non-visible light spectrum that we are exposed to every day. It can cause damage to our eyes, particularly the surface and deeper layers of the cornea and the crystalline lens of the eye by cataract formation as well as the increased potential for dry eyes, dystrophies, pinguecula and pterygium of the cornea. Blue light, which is part of the visible light spectrum, may also be a cause for concern. It reaches deeper into the eye than the UV and its cumulative energy effect can cause irreparable damage to the retina. Blue light is one of the main causes of damage to our eyes as we age and is an important factor that can cause the worrisome loss of sight-enabling pigmentation in the back of the eye.

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- Absolute Spectrum, the intensity of light received at each wavelength, plotted as a graph, and the basis for all other measurements.
- Illuminance, the human perception of the brightness of visible light received at the eye (lux).
- Chromaticity, the color of light based on the wavelengths and intensity that combine to make a color.
- Correlated Color Temperature, the temperature of a black body light source that would produce similar shade of white to the measurement - how blue or red and white light appears.
- Color Rendering, how truthfully a color is shown by the light measured compared to if the color was lit by bright sunlight.
- Flicker, the speed and characteristics of repeated changes in light intensity particularly noticeable with LED lighting.
- Equivalent Melanopic Lux, a measure of the light intensity in wavelengths that promote alertness (melanopic range), which can cause sleep and health problems.
BPI® Tint therapeutic lenses in minutes
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Reduce the scattered blue/violet light within the eye with BPI® Blue Filter Vision 450™. A saturated yellow tint that blocks blue/violet light with wavelengths shorter than 450nm. It blocks a minimum of the visible spectrum.

Macular Degeneration. BPI® Total Day™ is a tan colored tint that provides blue/violet attenuation with minimal color distortion.

Night driving. BPI® Total Night™, a light saturated yellow tint, is especially useful in blocking the blue/violet component of HID headlamps encountered in night driving.

Retinitis Pigmentosa, Macular Degeneration. BPI® Diamond Dye 500/550™ is an orange to red/orange tint, which blocks wavelengths shorter than the 500nm to 550nm range.

Blue light absorbing BPI® Blue Filter Vision 480™. A true sunglass brown with no color distortion that blocks light further into the visible spectrum.

Useful in bright light situations, BPI® Blue Filter Vision 540™. A dark amber brown tint that blocks wavelengths shorter than 540nm. A sunglass color that blocks violet and blue.

Red / Green color blindness. BPI® Deep Red Monochrome 600™ has long been used to allow those afflicted with red green color blindness to differentiate between red and green.

BPI® Eva Tints
Eye strain reduction, BPI® EVA™ tints are often used when viewing computer monitors, cell phones and other devices where removal of a small portion of the blue/violet is desired while essentially not affecting color balance.

Donna Williams, author of “Autism: an inside out approach”, has observed that some tinted lenses have helped her and others afflicted with autism. Among those tints that she mentions are BPI® Sahara™ (brownish tan), BPI® IR Blue™ (blue/black), BPI® Signal Green™ (a pure green) and BPI® Signal Blue™ (a pure blue).

BPI® Melanin Tint
BPI® Melanin™ is a yellowish-brown tint which mimics the absorption spectrum of natural melanin. This color reduces the destructive high-energy side of the visible spectrum while allowing passage of enough blue light to provide natural perception of color. Typical Tv = 65%

This tint absorbs most of the harmful UV radiation as well as some of the annoying blue/violet spectrum which produces scattered light within the eye. This reduced spectrum decreases chromatic aberration and enhances contrast due to reduced scattering from sources external to the eye.

This tint may be applied directly to prescription lenses as an alternative to clip-ons or other melanin filters or filtering goggles.

Tint your own or let BPI® do it for you
Reduce photosensitive epilepsy seizures with BPI® Deep Blue Zero™. The dark blue tint was found to reduce the number of seizures dramatically in about 95% of the patients using it (see a study in Epilepsia, 2006 Mar;47(3):529-33; “Suppressive efficacy by a commercially available blue lens on PPR in 610 photosensitive epilepsy patients.” by G. Capovilla, et al).

Reduce eye strain, blepharospasms and migraines! BPI® FL-41™, a rust redpink tint, has proven useful in reducing the incidence of blepharospasms and migraines.

Helpful with brain trauma and also useful for patients with dyslexia, BPI® Omega™ is magenta in color.

May help patients with dyslexia, BPI® Mu™ needs to be applied to tintable prescription lenses. It is lime green in color.


Parkinson’s Disease Tremors, BPI® Electric Blue™ has been beneficial to those suffering from tremors such as those sometimes associated with Parkinson’s disease.

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Costa debuts performance ophthalmic frames

Costa announced new additions to its optical frame collection with Ocean Ridge 300 series and Pacific Rise 200 series. Of note, the Pacific Rise collection debuts a line of stainless steel metals accented with the brand’s topographical temple tip pattern, wire core temples, and Hydrolite rubber.

**Ocean Ridge 300** (top) and **301** (bottom) feature co-injected bio-resin nylon material with a matte black frame front and colored temple sleeves in Hydrolite rubber. The styles are available in three colors: blackout, matte black with blue rubber, and matte black with gray rubber.

**Ocean Ridge 310** (top) and **311** (bottom) are designed in a rectangular shape with wire core temples, Hydrolite nosepads, and temple sleeves. The frames are available in matte black with blue rubber as well as matte black with gray rubber.

**Pacific Rise 200** (top) and **201** (bottom) feature full-frame, stainless steel frames in a rectangular shape. Thin and lightweight, this style includes Hydrolite nosepads and temple tip sleeves. Both frames are available in matte black, matte brushed dark gunmetal, and matte brushed warm gunmetal.

**Pacific Rise 210** exhibits a round, full-frame stainless steel construction. Available colors include shiny brushed light gunmetal and shiny brushed pale gold.

**Pacific Rise 300** (top) and **301** (bottom) exhibit a stainless-steel chassis with an injected bio-resin nylon frame front. These rectangular frames are available in matte translucent dark gray, matte translucent gray, and matte translucent dark brown.

**Pacific Rise 310** feature a cat-eye shape with Hydrolite rubber temple sleeves. This style is available three colors: shiny taupe crystal, shiny translucent dark plum, and shiny translucent pale blue.
Costa launches new core performance styles

Costa has added on to its sunwear collection with four new frames: Spearo, Waterwoman, Broadbill, and Tico. These new styles feature bio-based nylon material, integral hinges with locking CAM system, slip-resistant Hydrolite over-injected temple pads, and inset nose pads, as well as a colored keeper hole.

As a large frame with a sculpted large wrap, Broadbill features a broadbill swordfish frame that is available in matte black, matte midnight blue, matte gray, and matte reef.

Tico exhibits wide, chiseled temples. These frames are available in matte black, matte midnight blue, matte gray, and matte wetlands.

Spearo features a lightweight and sturdy frame available in blackout, matte black + shiny tortoise, matte tortoise, and matte reef.

Waterwoman exhibits a medium frame with angled temples. The thick-rimmed temples feature hand-painted sketches. Available colors include matte shadow tortoise, shiny palm tortoise, shiny wahoo, and shiny blond crystal.
Sharing space, the front line of primary care, & Motorcycle Weekend

**Q**: Why private practice now? The real story is that I’m crazy. [Laughs] I was at the VA for 22 years, it was a labor of love for me. I’ve had a private practice and been full time at the VA for that entire tenure. About halfway through my time at the VA, I started consulting work. I am also a bit of a fighter and became involved in organized optometry. I’m a past state president and have been involved with the AOA for 25 years. I love seeing patients! I get to visit with interesting people everyday. In a rural area, there’s a real need. I have a lot of elderly patients with complex eye diseases.

**Q**: How do you educate patients that overall health affects ocular health? The conversations I have with patients are simple. Don’t smoke. Eat your fruits and veggies. Little bit of wine is OK, not too much. Drink water. Go outside. It’s that simple. [Laughs] Even if you get dealt a bad hand, eating fruits and vegetables everyday in a good quantity can slow these diseases down and prevent devastating visual effects.

**Q**: Has working for industry changed your approach to patient care? I work for Zeiss Meditec; it is the primary business that I consult for right now. When I opened my new office, I wanted the latest technology for my patients. I opened what I’m terming the Zeiss Center of Excellence. Working for industry has influenced the decision-making process: Should I buy this equipment, should I wait, if that costs too much money can I make it worth it.

**Q**: Why are you passionate about charitable organizations? To whom much is given, much is expected. I try to live my life by that statement. It’s been a privilege that I accidentally got to live all over the world, I had a step up on education, and I have the ability to do something with that education. Lots of people don’t have those opportunities. Every time I have helped someone, become involved with an organization, or raised money, it has paid me back in some way. Not immediately and not my expectation, but looking back, I’m glad I became involved in that or that I met this person who I wouldn’t have met if I hadn’t stepped out.

**Q**: What’s the craziest thing you’ve ever done? Motorcycle Weekend is a big bike rally. I was in New Hampshire for only a few weeks when this rally took place. It was literally in front of my house. I’m like, “Oh my God, this is New Hampshire? This is pretty cool!” I’m not sure that all my clothes stayed on for those rallies in my twenties! [Laughs] I’m glad there were no [camera] cell phones at the time! [Laughs]

—Vernon Trollinger
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