

01/15/07

📅 04:06:24 pm, Categories: [General](#), 399 words 

Scheduling Fits (Scott Jens)

It is finally winter in Wisconsin. We had our first real measurable snowfall in the last 24 hours after three months of pretty much constant-October... 40 degrees, hearty golfers hitting approach shots to a "brown" rather than a green, and no ice on the lakes. And a couple of colleagues told me that patients actually canceled their appointments today because of 4 inches of snow... in Wisconsin!

This led me to a thought: how do optometrists vary in their approach to schedule issues such as cancellations, no-shows, and rescheduling? I know of a colleague who shared a policy with me that outlines the charges that will be applied to a patient if a cancellation occurs within 24 hours of an appointment, a policy that wouldn't be accepted in my community but evidently works for that practice.

We make an effort to provide "reserved appointment times" one or two years in advance. Yes, this is the "pre-appoint" system. But we have moved our lingo toward the appointment being a legitimate appointment that just needs confirmation as the date approaches a year or two down the line. This program can be successful with close attention from the staff with a good plan for postcard follow ups, phone calls, or emails.

The system has increased our booking rate and decreased our no-show rate. At the same time, the staff frowns when we tell them we are going to be out for a ten day vacation if it wasn't planned more than a year in advance, and it never is! So the issues are not insignificant with whatever scheduling model you choose.

The question is, what if weather or other patient issues give your schedule fits?! Do you overbook patients who chronically no-show? We don't because we don't want to reduce the attention and service that any patient receives. Do you charge cancellation fees to no-shows? Again, we don't, because we just don't have the market for it in our locale.

Viewpoint: Staff must be the managers of the schedule, and they must know what fits into the schedule as much as what gives your schedule fits. Provide them with the responsibility to manage the schedule, be compassionate even when patients are clearly making a story to fit their issue, and know that your system can endear yourself to your patients.

Do you have advice for optometrists about scheduling. Let them be known!

Until next time,
Scott

In response to: [Scheduling Fits](#)

Jim Spears [Visitor]

Scott,

I live on the other side of the lake from you--Lake Michigan, that is. Being on the eastern side of the lake, we tend to get "lake effect" snow storms. Some days can be very bad. You know, when the news lists about 100+ school closings due to snow or ice. Those are often my most busy days in the office. First thing in the morning, call each and every patient to confirm their status on whether they are coming or not. Now you know who you can count on to be there, and you have given an "out" to all the chickens that don't want to drive in this weather. So this gives you open slots in the appointment book. Now, sit back and wait for the moms to call. They have three kids at home and need eye exams and they have 4-wheel drive. I have seen this same scenario work for at least 15 years.

Jim Spears



01/16/07 @ 09:59

In response to: [Scheduling Fits](#)

Daniel DeWinter OD [Visitor]

Scott I do not pre appoint.....but One thing you may try is not to pre appoint into a specific spot.....just tell the patient we will see you in one year (with no date and time). Your office puts their name and number into the book or onto a computer list..... you can break it up into months or weeks.....when the year is up....your receptionist calls and says Mrs Jones it's time for your exam we have you schduled for next friday at 2:00 does that time still work for you??? Your receptionist picks next friday a 2:00 because that spot has not been picked yet. If she says yes you but her in a that day and time.....if she says no your receptionist picks another day and time. That also allows you to plan vacations.....she just does not offer those dates to patients. So essentially let's say your doing feb 07 recall and you have all last years Feb patients on a list....the receptionist just starts calling last years patients and filling up this years Feb book. If you have the third week off that week is just not offered. You also don't have the hassel of booking around people that were schduled last year and may reschdule to another date and time anyway. I heard this from a practice consultant once I think it was Gary Gerber. Dan



01/15/07 @ 17:29



[2 comments](#)

12/28/06

08:28:10 am, Categories: [General](#), 559 words

Flex Plan Planning (Scott Jens)

It's December 28 and most optometric practices are already approaching the end of their flex plan season. Although the term flex plan is being used for simplicity, it refers to those cafeteria plan/medical savings account/pre-tax dollar health spending plans that we have all come to appreciate. Historically, the year-end rush

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of patients who needed to receive services or purchase products to use their dollars before they were drained from their accounts has been significant. This year, I sense a change in that rush.

New federal laws have allowed some employers to modify the terms of their flex plan expenditure deadlines. Therefore, it is not a certainty that every patient with a flex plan must make their purchases prior to Dec. 31. This appears to be an adjustment made for a minority of the patients that we see using their flex plans. But it does appear to have had an effect on the number of patients crashing into the office at year-end.

Additionally, patients are becoming more cautious about their budgeting. They feel as though the year-end push when dollars were left over created unnecessary spending. You do not see many situations where one patient is coming to make year-end purchases year after year after year. They get smart and tend to under-budget their plan in a year after they have missed their estimates and had to "use it or lose it."

While my staff continues to evolve with flex plan planning with our patients, we have learned that we should talk about flex plans year round. Some things to consider:

- 1) Patients who use flex plan dollars for laser vision correction are in your chair every day of the year, so discussing the necessary planning for ensuring good candidacy should be part of every patient encounter. When a patient has interest in laser vision correction, recommend that they get the necessary screening testing (Orbscans, pachymetry, wavefront analysis, scotopic pupil size evaluation) so you can note in the chart the patient's candidacy. There's no sense in waiting to do such testing until a fall flex plan budget deadline is looming.
- 2) Offer your patients a chance to get a fee quotation for services or items that they might not be compelled to purchase at their examination. Patients who are good contact lens candidates, or who would benefit from polarized Rx sunglasses, might not buy today because they consider those purchases to be possible items for flex plan dollars, so give a fee quotation and plant the seed that the patient might consider budgeting for next year's visit, or once their flex plan dollars are available.
- 3) Recognize that some patients will need to use flex plan dollars at a non-traditional time, such as by the end of the first quarter of the year. Train your staff to be prepared for questions about flex plan spending even though the new year will have started, so they are not taken back by any patient inquiries.

Viewpoint: Flex plan planning means year-round discussing the use of pre-tax dollar accounts that are established by employers. Patients appreciate the assistance you give them to make purchases that "cost" them less of their take-home dollars. Giving them good advice about how the purchases of services and products from your practice will endear patients to you and ensure their ongoing commitment to your practice.

Happy New Year to all!

Scott

No comment yet...



[Leave a comment](#)

11/22/06

📅 03:16:23 pm, Categories: [General](#), 339 words 

Reveyes in Practice (Scott Jens)

After a lengthy absence, the Eye Dream, Eye Believe blog is making a return. One of the factors in the absence is the development of our software application, which has taken an incredible amount of time. But this blog is not about the app, instead it focuses on the subject of patient wellness and practice management. I invite you today to comment about the discontinuation of Reveyes.

I started using Paremyd solution for dilation in the early 1990's, because I felt that it gave sufficient dilation with minimal cycloplegia. When Reveyes came to the market, I felt confident that it would be a welcomed offering to patients despite its reddening effect and stinging. Patients wanted, or should I say expected, to have a chance to shorten their dilation effect.

When Paremyd was taken off the market, some colleagues and I found a compounding pharmacist to make up an equivalent solution of 0.25% tropicamide/ 1.0% hydroxyamphetamine; I still use his solution today. With the reported demise of Reveyes, I am facing another challenge to a significant part of my daily practice. While the compounder looks for options, I am using up the remaining bottles that we found for twice the original cost.

My patients won't suffer greatly if we discontinue Reveyes use, and we are reminded of that with the patients who have ducked away from Reveyes over the years. But I like it, so it makes me annoyed to think about changing my protocol.

Viewpoint: Optometrists are respected by their patients because we generally take the patient's opinion in stride while we deliver their care. That's not an implication that other health care providers do not consider the patient's opinion, but practicing in a profession that is so tied to the patient's subjective attitude, optometry just cares more about changes that they impart on their patients.

How do you deal with the patient views about dilation? What pharmaceuticals do you use most? Do you use Reveyes, and will you miss it or not? I know I will.

Until next time,
Scott

No comment yet...



[Leave a comment](#)

📅 08:21:37 pm, Categories: [General](#), 533 words 

ECR v4.0: Optometrists Give Their First Impressions (Scott Jens)

The EyeCodeRight Team gave a rather in-depth demonstration of the EyeCodeRight version 4.0 application at the Annual Meeting of the Wisconsin Optometric Association last week. While this blog's primary purpose is to promote wellness care by optometrists, the subscribers of the blog also occasionally ask about our forthcoming online electronic health record (EHR) that will be part of an all-encompassing practice management system (PMS.)

While I could write endlessly about the features of ECR 4.0 that would hopefully create a lot of questions and discussion, the best topic to offer is "first impressions." According to the general feedback that we have received, the doctors who have seen the application are genuinely intrigued by the online aspect of the system (no servers in the doctor's office(s), no IT specialist to pay a monthly retainer, access from any computer at any place at any time.) Another common comment is the easiness of the user interface, with many doctors saying that it is nice to see a system that doesn't have four hundred empty fields on the page... just information that you need and most of it right at the fingertips, one click away.

Of all of the questions we have gotten, a common one is "Why is it called EyeCodeRight?" The more that I've thought about that question, the more that I feel that it needs to be addressed as part of this wellness forum. In the time that I have spent talking with optometrists about their practice habits of documentation of care and billing of services, it is frighteningly obvious that ODs are unsure of themselves. I suspect that many health professionals are unsettled by medical coding.

As the EyeCodeRight Team has worked to reorganize the company in order to build the most unique EHR/PMS in optometry, we certainly had a discussion about the application's name. It would have been fun (and probably pretty expensive) to name the product with a jazzy, perhaps quirky name. But EyeCodeRight says it all, "I code right."

Optometrists should spend time thinking about improving the documentation of the care that they provide in order to properly convey the services and their fees to the payer. While I fear that this next statement may be perceived as self-serving to EyeCodeRight, I believe that ODs should consider spending as much of their capital improvement budget on a computerized recordkeeping/practice software system as they do on patient care equipment (OCT, HRT, and GDx can necessitate \$20K to \$40K in one swoop.)

Of course, the systems that are on the market right now have offered correct coding and excellence in documentation, and EyeCodeRight will be in that same arena by the end of 2006. The most important part of the purchase of these types

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of applications is that it might reinvigorate the doctor and his/her staff to truly "code right."

Viewpoint: My first impression of the first impressions of EyeCodeRight? That we were wise to name the application as it is. Optometry can commit to correct coding with or without the ECR 4.0 product, and I compel each of you who read this to take the "code right" challenge. It will be good for your patients, and good for your practice.

Scott

No comment yet...



[Leave a comment](#)

09/10/06

🕒 02:16:14 pm, Categories: [General](#), 353 words 

Optometric Podcasting (Scott Jens)

At EyeCodeRight, we have been committed to an optometric community presence since 2005 with ongoing attention to our "Community Center." In February 2006, Dr. John Warren started the first optometric podcasting with interviews with various individuals from the optometric world and industry. As the next six months progressed, we continued to be committed to community offerings but podcasting took a back seat to our newsletter features.

If you have opened your newsletter (please do if you haven't!), you might have noticed that EyeCodeRight is now committed to a regular monthly podcast! We have switched our newsletter's monthly forum, More Than Meets The Eye, into an audio version. To our knowledge, this is a first in the optometric community. We are committed to use of novel technology and we believe that the optometric community will appreciate podcasts as an easy-to-access feature... just click the link and let your Windows Media Player stream the audio feature. You can listen between patients or during those ten minute chunks of time when you do charts in the morning or evening, or during your lunch time.

Podcasts in the medical community are widely available by visiting iTunes. The EyeCodeRight community might be very interested in a tremendous podcast series in ophthalmology done by Josh Young, MD, called "As Seen From Here." Dr. Young's program can be found at www.asseenfromhere.com and on iTunes. Dr. Young does interviews with authors of key pieces of ophthalmologic literature to gain insights about the subject matter of important studies. Recently, he even interviewed an optometrist, Dr. Sue Cotter from SCCO, about her involvement in amblyopia treatment studies (see podcast #71 at the ASFH website.)

Gaining information via audiocasting, or "podcasting," is a growing trend. Videocasting is also possible, and EyeCodeRight is committed to that expanding

technology as well. Dr. Warren has broken this ground with this month's newsletter in the Case of the Month section. Check it out!

If you have feedback about the subject matter that you would like to hear on our More Than Meets The Eye podcast, please email me at sjens@eyecoderight.com with your ideas.

Until next time,
Scott

08/22/06

📅 10:21:45 am, Categories: [General](#), 344 words 

Blade-free LASIK and TLSS (Scott Jens)

I hope that the title of this blog grabbed your attention and got you to click in... TLSS is Transient Light Sensitivity Syndrome which is associated with blade-free flap formation using the Intralase laser. In this week's TLC e-newsletter (Eyes Forward, Volume 1, Number 8), Dr. Erik Polk from the St. Louis center authored an article about TLSS and its management.

Although noted as a rare complication (1/200 cases), the number of patients who report some degree of light sensitivity following LASIK with Intralase seems to be anecdotally higher in my experience. However, the true photophobia associated with TLSS is significant and generally occurs as a new symptom after a couple of weeks of otherwise normal post-operative course.

Dr. Polk recommends aggressive treatment for TLSS: 1% prednisolone acetate drops every hour for 1 to 2 weeks. He reported one case that required systemic steroids to demonstrate the potential severity of the condition. As expected, he recommends tapering as soon as symptoms have resolved to avoid risks associated with long-term use. The condition is not likely to recur, so patients can be reassured of that fact.

With essentially no personal history of diagnosing TLSS and therefore no history of treating it with such aggressive steroid therapy, I am unsure of whether this steroid treatment might cause risk of refractive shifts if initiated within the first two weeks of surgery. Do any of you have any anecdotal evidence of concerning refractive shift associated with steroid treatment of TLSS?

Viewpoint: I'm a proponent of blade-free LASIK and our patients have had uneventful procedures for sixteen months since the Intralase laser was put in our local center. I do hear complaints about light sensitivity and would expect that any OD who is managing post-LASIK patients would be cautious about determining the actual existence of TLSS prior to an aggressive treatment.

As LASIK technology continues to evolve, patient satisfaction is at an all-time high. I hope this note spurs you to do additional research on the subject so you can continue to provide your patients with the highest quality of care.

Until next time,
Scott

In response to: [Blade-free LASIK and TLSS](#)

Jim Owen [Visitor]

I believe the incidence of TLSS is variable from laser to laser. We have used the Intralase laser for over two years on over 4000 patients and have only 5 cases TLSS. Other centers within my region report higher incidence with the same settings, while some report the same incidence as our center.

TLC La Jolla



08/22/06 @ 19:06



[1 comment](#)

08/07/06

📅 07:18:28 am, Categories: [General](#), 271 words 

CCT in daily practice (Scott Jens)

Since the OHTS, most of us have heard many theories about how to apply CCT in daily practice. Clearly, the predominant agreeable opinion is that all ocular hypertensives and glaucoma suspects should undergo a CCT measurement in addition to any glaucoma patients. The variability of opinions on how to apply that measurement to patient management decisions continues to amaze me.

The development of instruments to measure intraocular pressure while considering corneal dynamics such as rigidity might be the answer, although those instruments have not yet made their way into the practices of many practitioners. In due time, they may become the standard (or some might argue they are the standard, but not all ODs are meeting that standard.)

In the latest edition of PRIMARY CARE OPTOMETRY NEWS (August 2006, pgs. 36, 38), Murray Fingeret has written a very helpful overview article about CCT called "Classifying corneas simply as average, thin or thick." He suggests that thin is <535, average is 540-560, and thick is >565. Included at the end of the article is a very comprehensive "suggested reading" list of references that include current articles for those who are interested in the literature on this matter.

Viewpoint: Dr. Fingeret suggests that calculating "corrected" IOPs is not as helpful as recognizing the actual Goldmann IOP in conjunction with consideration of corneal thickness as thin, average, or thick. I agree that this is the best way to manage our patients because algorithms all make assumptions. But like most practitioners, I am going to continue to consider the new technology that gives different viewpoints on IOP.

Do you have insights to share about CCT in your practice?

Regards,
Scott

In response to: [CCT in daily practice](#)

Elliot Kirstein, OD [Visitor]

Scott:

I believe that the new technologies are a forgone conclusion. The body of recent scientific evidence has shown us that GAT is pretty close about 90% of the time. There are litanies of problems that ensue when we deem this value acceptable. Additionally, corrective algorithms have the proven potential to commonly cause one to correct in the wrong direction! My paper in "Optometry" (9/05), along with several by other more astute authors, helps to substantiate that notion.

In the absence of newer and more accurate tonometers, such as the Pascal, it is natural and logical to rely more heavily on other parameters such as nerve and field. The shortcoming of this well intended practice is analogous to waiting for a stroke before diagnosing and treating cardio-vascular disease. Our direct observation of nerve damage is likely to be late in the disease timeline. For example, when we observe a 50% c/d at an initial routine exam, how certain could we be that it was not 30% just 2 years ago. Remember that, according to Quigley, about 1/2 the nerve has to be dead before HFA thresholds go south. Indeed, closer observation of OHTS data has shown us that many of those who were initially deemed ocular hypertensives, actually had ongoing POAG at the onset of the study.

The bottom line is that continued use of 50 year old tonometry technology delays diagnosis.

Current science has clearly shown us that our beloved old yardstick (GAT) is a little crooked. There is a better way.

Thanks,

Elliot
U.S. Research Coordinator
Ziemer Ophthalmology



09/10/06 @ 18:42

In response to: [CCT in daily practice](#)

jwarrenod [Member]

Scott,

I've been doing pachymetry on all of my patients who present for comprehensive eye exams. I've been doing this for just over a year. I'm going to be compiling the data for analysis to get the "normal" reading for my practice.

I agree that the idea of a "corrected IOP" is not much use. To me, a cornea is thin, thick or normal and will enter into my target IOP selection when starting Glaucoma treatment and will also factor into my decisions about changing treatment. I've

never bothered to calculate a "corrected IOP." There's not even any accepted standard scale for conversion....

John Warren, OD
Pachymetry For Everyone!



08/07/06 @ 07:26



[2 comments](#)

07/27/06

📅 06:17:04 am, Categories: [General](#), 285 words 

Contact Lens Links of Interest (Scott Jens)

I have made notes in the past about the usefulness of a website that is being maintained by some bright individuals at the University of Waterloo, which is entirely about the science of silicone hydrogel contact lenses. SiliconeHydrogels.org has a number of interesting articles published on a monthly basis that allow practicing optometrists to gain knowledge about developments in this expansive area. A recent editorial on the site located at <http://www.siliconehydrogels.org/editorials/index.asp> gives a nice summary of the debate about oxygen flux. I recommend that you subscribe to this newsletter to ensure that you are well-read about this technology.

On another front, optometrists Dr. Todd Zarwell and Dr. Brian Chou have taken on an endeavor that is noteworthy to practicing optometrists. Their website, www.eyedock.com is a comprehensive source for the latest contact lens parameters, pharmaceutical options, and online calculators that help on everything from toric rotation over-refractions to vertex distance calculations. I have bookmarked this site and used it for a couple of years and the innovation that these doctors have brought to the profession for absolutely no costs amazes me every time I visit.

Viewpoint: Numerous online resources exist for optometrists to stay current with contact lens technology. In the day when printed resources and monthly journals were the primary source for contact lens information, it felt like there was a significant delay between product launches and practitioner awareness. Today, these websites plus a few really good e-news options allow ODs to be up-to-the-day aware of the latest... do you have sites that you can offer that would help all of us know more? Send them in a reply when time permits.

Until next time,
Scott

No comment yet...



[Leave a comment](#)

07/05/06

📅 09:11:02 am, Categories: [General](#), 178 words 

Academy Meeting in December (Scott Jens)

The American Academy of Optometry meeting is in Denver in December, the dates being December 7-10. The link to the website for the meeting is: <http://www.aaopt.org/meetings/meeting6/>

As a Fellow of the Academy, I have made efforts to go to the meetings over the years although it is held at a difficult time of year for my practice and family. There have been some very nice locations and this year will be no exception, however the sunny/warm locations can be somewhat more inviting.

The leadership of the Academy has worked to increase the number of Fellows in the last few years and the best method to do this is peer-to-peer encouragement. So, I challenge those of you who have never pursued Fellowship to consider it. The process is a fulfilling one, and you will never regret challenging yourself to achieve the Academy's standards.

Whether you are a Fellow or not, consider attending the meeting in Denver. The continuing education offerings are some of the most appealing in the entire world!

Until next time,
Scott

No comment yet...



[Leave a comment](#)

06/19/06

📅 10:30:05 pm, Categories: [General](#), 338 words 

One More AOA Reminder (Scott Jens)

With as many posts as John Warren and I have made about the AOA national meeting, "Optometry's Meeting", one might think that we think that every OD will be in Las Vegas this week. While most will, we have an offering for those who will attend as well as those who will not.

First, on the ECR Community Center, <http://eyecoderight.com/community/index.php>, we will be posting the first-of-its-kind InfantSEE Online Assessment Form. This document is an editable PDF that can be pulled up on any computer that has internet access, and can be completed by doctor and staff while the assessment proceeds. At the end of the visit, one copy should be printed for the record and one copy without the patient name should be printed for faxing the data to AOA for collection.

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The second is another InfantSEE form, a Letter to the Primary Care Provider that will summarize the assessment's findings. Since education of allies in health care is a key to future success of InfantSEE, this unique tool will allow more InfantSEE participating optometrists to easily convey their results to the infant's PCP. A copy can be printed and sent to the PCP for a professional looking documentation of care.

EyeCodeRight is proud to be a member of the InfantSEE Family Tree, a group of industry supporters that believe in the public health ideology of InfantSEE. While anyone will be able to access these forms after Optometry's Meeting later this week, those in attendance should stop by the EyeCodeRight booth at 6 pm on Thursday to see the unveiling of these documents. I will be giving a brief presentation of their functionality and you can get a demo of the new ECR 4.0 system as well!

And if you miss it all, make sure to put the June 28 ECR webinar on your calendar to see the latest from ECR's attendance at the AOA meeting. Just email Steve Elfrink at selfrink@eyecoderight.com to register for the webinar -- it's free!

See you in Vegas!
Scott

06/12/06

📅 08:34:43 pm, Categories: [General](#), 284 words 

An Optometry Day... (Scott Jens)

Today I had an "optometry day." That's my term, not one that I've heard elsewhere. It's a day when I feel wiped out because I was really busy, and upon reflection there were so many patients that benefitted from my abilities as a primary care optometrist.

An optometry day includes a bit of everything. Any OD can tell you about the days that really make them feel most proud to be an optometrist. For me today, it was the diversity of the patients that made it an optometry day.

Retinal detachment with split of fixation requiring immediate retinology consult and buckle (and some emotional counseling for understandable reasons.) New diagnosis of POAG with initial medical treatment. Referral of a chronic POAG for SLT. Helping a patient get a corneal transplant consult for post-HZ ophthalmicus. Ordering a new rigid/soft blended lens for a KC patient who cannot tolerate any RGP KC design anymore. A teen who had one eye increase by 0.75D of myopia in four months. A elementary school child who benefits from only +1.25 because of her accommodative status. Putting a PAL into my friend's sunglasses despite her reluctance to "put bifocals into that pair of glasses, too!"

Viewpoint: An optometry day is a day that feels a little different than the others because of the way that we help our patients. We want them to be well, and we expect ourselves to be up to almost any task or case presentation.

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I knew I had one of those days when the RD patient said, "I'm really glad that if I had to have this bad news broken to me by someone like you... you made it seem so positive." That's optometry!

Scott

In response to: [An Optometry Day...](#)

Elliot M. Kirstein, OD [Visitor]

Scott:

It looks like this (optometry days) is something that one could get addicted to and that early retirement probably isn't in your future.

It's like having the joy of being very good at playing a musical instrument. Why would one want to stop playing?

Thank you!

Elliot



06/20/06 @ 03:49



[1 comment](#)

05/25/06

🕒 03:02:32 pm, Categories: [General](#), 339 words 

Vision Therapy in Practice (Scott Jens)

The EyeCodeRight Community Center has been designed to give optometrists a varied number of viewpoints, and the Blog forum validates the intention of sharing intelligence amongst colleagues. In fact, there is a blog that is specifically targeted toward vision therapy (amongst other similarly excellent offerings.)

I am not a vision therapy expert. But as a primary care OD, I do a fair amount of consultation on straightforward training. Today, I was referred a young patient by an OD colleague who wanted the child to be assessed for CI and given a treatment protocol. I was given a full rundown of the last exam and asked to initiate the proper program.

Optometry doesn't do intraprofessional referrals enough. Often times, it's because we don't feel comfortable with our own case management and the peer review of our management. That's a shame. So here's my fully naked view of my vision therapy practice, for critique by you, my colleagues:

I do not do in office therapy.

I do training advice with patient and parent, including demonstrations of home activities.

I recommend training for basic accommodative and convergence problems.

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I use prism and bifocals more often than I suspect vision therapy-specializing ODs do, especially for minor accommodative and postural problems.

I refer to optometrists for strabismus evaluations and possible vision therapy any time that I am considering a referral for strabismus surgery.

My follow-ups are done about every one to two months.

Now, I do more evaluations for amblyopia, so that's not part of this equation. I use standard drops and/or patching protocols and refractive protocols for that condition.

Viewpoint: I think that a majority of ODs do VT limitedly, as I do. I think they believe they do a good job for patients. But I think we underrefer and we need to have those that are involved with VT to be better advocates of their services to us. Without many options, our patients are often left to the best that we feel we can do.

What do you think?

Regards,
Scott

In response to: [Vision Therapy in Practice](#)

Moshe Roth [Visitor]

Dear Scott: I agree with you that we tend not to do refer intraprofessionally. I think that many within our own ranks feel that we play second fiddle. I have come across a significant enough number of patients that had been referred by OD's to OMD's, and inadvertently arrive in our office...and it is not for lack of reaching out to OD's. Like you, I have a full scope practice, treat patients for glaucoma, eyeglasses, contact lenses, and PRESCRIBE in-office VT. I find that as a stand-alone, home based VT does not work. Patching regimens for amblyopia do not work. More on this below. In our hectic lives, where is the control and direction that we give in overseeing home based VT ? Essentially you are asking the parent to become a therapist. Would you imagine sending someone home to do speech therapy or occupational therapy or physical therapy at home, on their own, without appropriate direction? Vision is the primary way that we bring in information from the world around us. I know that you know that, but when we send someone home without the appropriate direction of what to do, as well as overseeing a program, you are, in fact telling that person that he is a magic bullet and we hope that all will be well. If they had not developed their skill on their own, it is not likely that sending them home with some 'exercises' or a computer program alone, will resolve the problem. I think that we need to accord vision the respect that it deserves, and vision therapy the recognition that it is often a life altering. Patching: the thinking is that patching the "good eye" will enable the "bad" eye to improve, and once that happens, then miraculously the two will work together. 1- kids hate to wear the patch because of other kids make fun of them, and besides, the patch feels uncomfortable. 2- patching REMOVES the information from the side of the body that is patched. I lose information of what it going on, on that side of my body. 3- it doesn't promote the use of the two together as a team. Vision therapy is a natural adjunct to InfantSEE and young children's examinations because those doctors that feel comfortable with children, (likely the largest population in most VT practices),

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feel comfortable with infants and young children. The point is that it stands to reason that doctors that see that you promote InfantSEE assume that you offer VT services as well. Vision therapy is not only for strabismus and amblyopia, although clearly that is integral within VT. Doctors that provide VT have the potential for helping patients to make huge improvements. I agree with some of the points that you made in your viewpoint. I think, however, that it is optimistic at best, to think that a majority of ODs do VT, even on a limited basis, as you do. I agree that most OD's believe that they do a good job for patients, and I agree that we, as a profession tend to under-refer to our fellow OD's. I think that doctors that provide VT make an effort to refer patients back to the referring doctor for eyeglasses, contact lenses, etc as well as send all family members back to the referring doctor. It is the responsibility of doctors that offer VT to let primary care OD's be aware that they offer these services.



05/29/06 @ 10:43



[1 comment](#)

05/09/06

📅 10:07:29 pm, Categories: [General](#), 317 words 

Optometry's Meeting -- You've Got to Go! (Scott Jens)

From June 20 to 25 in Las Vegas, AOA will be holding the newest edition of "Optometry's Meeting." This annual conference, previously called the "congress," has become one of optometry's crown jewel meetings.

While I realize that some of our subscribers might not be AOA members, I am a shameless promoter of the AOA. It is obvious to me that our membership in the national association and state affiliates has driven optometry to a level of professionalism and commitment that would not have occurred without the association.

There is no better example of AOA's existence than Optometry's Meeting. This meeting represents the confluence of academics, research, politics, and professional relations. Optometry has other incredibly important meetings, including the American Academy of Optometry's meeting each December and the many regional meetings that optometrists love.

When you look at this year's CE schedule at Optometry's Meeting, the courses are top-notch. Furthermore, there are plenty of options for no-fee education sponsored by our friends in industry. Vegas is one person's paradise and another's trash, but it does give one plenty of options for fun as well. If you are interested in reviewing the courses or even registering for attendance, visit www.optometrismeeing.org

EyeCodeRight is going to give a sneak peek at its product at Optometry's Meeting, in the exhibit hall in a booth on the far left side of the hall, #134. It's going to be the time and place to meet the creators, offer your "open development" input, and get a look at the forthcoming product.

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Viewpoint: EyeCodeRight is going to be a novel product for optometry. It's going to show the revolution in web-based applications, it will be an EHRcentric practice management system, that promotes wellness-based eye care and peer-to-peer relationships in the optometric community. AOA's meeting in June is the right time and the right place to give you a peek under the hood. Join us there!

Regards,
Scott

No comment yet...



[Leave a comment](#)

05/02/06

📅 06:33:09 am, Categories: [General](#), 214 words 

Online InfantSEE CE (Scott Jens)

EyeCodeRight is committed to a new frontier of online CE. The future may hold that optometrists take CE because it is good for their patients. While that has been true, many CE courses are taken with the primary purpose of meeting a state license requirement. With access to new types of CE such as online courses, perhaps we will all look at a broader range of courses to enhance our primary care skills.

At EyeCodeRight, we continue to deal with the nuances of COPE approval. Currently, a school of optometry must grade the test given with online CE and you can imagine that they are not responsive to outside agencies since many schools themselves offer online CE. In due time, we hope this will become something that will allow for CE credit. For now, it's just about professional betterment.

As a follow up to last week's blog about InfantSEE, I am posting a link to the first-ever online CE program for optometrists to learn some pearls about primary eye and vision care of the infant.

So take a peek at this 40 minute Breeze presentation... from a primary care perspective, it might give you a few ideas on assessing infants without needing to be a sub-specialist.

<http://breeze44695586.breezecentral.com/infantcare/>

Until next time,
Scott

No comment yet...



[Leave a comment](#)

04/24/06

100,000 Infants (Scott Jens)

If you've read this blog before, you know that I've been involved with an AOA Committee that has helped create the InfantSEE(TM) program. After a weekend in St. Louis working with some brilliant people in optometry, a plan has been created that will ensure that this public health program becomes an engrained part of the profession.

It is very apparent that InfantSEE(TM) is taking hold. Over 7,300 ODs are offering this service. It will never be 100% of the ODs nationally, yet I am amazed at survey statistics that show that 85% of doctors have seen at least one infant in the last nine months. ODs did not routinely see infants before InfantSEE(TM) so this is a movement of the needle.

AOA has set out for a goal of 100,000 infant assessments in 2006. Unfortunately, the only tracking mechanism to measure numbers is the doctors using the official AOA form and submitting the carbon copy/second page of the form. It was hoped that this would allow an accurate head count as well as allow for an effective data collection process to get a great research program started.

There have been only 8,000 report forms submitted. The survey of doctors who participate showed an average of 5 assessments per doctor (about 1 infant visit every 2 months) and therefore it might be that AOA members have provided as many as 40,000 assessments.

That number may be a bit high, but 8,000 is a bit low. The reality is that 100,000 in 2006 is a realistic goal.

Viewpoint: For those of you who are participating in the AOA InfantSEE(TM) program, please use the AOA form. The forms are free by emailing Debra Fox at AOA. Her email address is DFox@AOA.org. Mail (don't fax) the yellow second copy after every assessment you do. If you did assessments and didn't turn in forms, have your staff pull the charts and fill in the results retrospectively.

If 100,000 infants are seen, InfantSEE(TM) will have met its first goal. Next year: 250,000. Not many when you consider 4 million births a year in America. Public health means caring cradle to grave for all patients, and educating them about how risk can be managed. It's optometry's role, so let's get it done!

Scott

In response to: [100,000 Infants](#)

Landon Liska, OD [Visitor]

Scott,

I am an InfantSee Doc, and have seen 5 infants for examination in the last year. I usually see Infants after one of the other family members have entered my office for examination. At this time, I let the mother know that I am affiliated with the national InfantSee program and will perform a free screening on her infant. Most of

the larger populated areas in the US is where our Optometrists locate themselves. If they were to advertise themselves as Infantsee Docs they would not make any profits, and would become a full time non-profit Pediatric Optometrist, and probably put every other Optometrist out of business. Who wants to spend money advertising, and work for free. I know that it may work to bring in referrals, but I see it working better the way I do it. It adds comfort and caring to my practice with the knowing of my patient's mothers always returning with the rest of the family and not expecting anything for free. By the way, they refer plenty also, and those patients do not enter expecting anything for free.



04/25/06 @ 07:21

04/18/06

📅 08:29:34 pm, Categories: [General](#), 611 words 

Ultraviolet Protection Knowledge Gap (Scott Jens)

The dermatology world has done an excellent job of informing the public about the harm of ultraviolet (UV) radiation on our skin. When I was a kid, my parents applied Coppertone to try to get MORE tan and they never put sunscreen on us despite the fact that we were outdoors every minute possible. Due to some French Canadian bloodlines, my slightly dark complexion would turn to a very dark shade of brown. Of course, we burned a few times and shed like a snake before we cooked our skin to that brownish color.

Today, I wouldn't think of putting my kids into heavy amounts of sunshine without sunscreen. We make every effort to get sunscreen on them and we try to reapply it after they've been in a pool. I cannot remember one time that my twelve year old has had a sunburn!

Why is it that we continue to let our children into the sun without UV protection over their eyes? What is it about the skin protection advice that the public has received that makes the lay public take action for skin?

In my estimation, it's one word: cancer. Skin cancer just doesn't sound good, and anyone who has had to deal with squamous cell or basal cell carcinoma will tell you that it is something you should try to avoid.

Like many things about the eyes that the public doesn't comprehend, UV protection is not perceived as directly affecting a person's visual future. Unless one suffers a fairly uncommon exposure photokeratitis, UV exposure is not painful and doesn't knowingly cause any form of cancer! The public has a knowledge gap about how damaging UV radiation can be to the eye tissues, and it's our job to educate them.

I think about the UV exposure that professional golfers undergo, watching guys like Lefty and Tiger walk around without protective eyewear. It seems avoidable by wearing sunglasses like Annika does, but I would assume those that don't wear sunwear would argue that the frames obstruct their vision in a way that is very

bothersome. And casual golfers mimic their idols on TV, so they go without sunglasses too.

About the time that I get concerned about adult patients, I read UV advice pieces that say that we get 90% of all of the UV radiation exposure in our lives by age 12. It makes me realize that Lefty might be out there for hours a day but it probably compares minimally to the amount of exposure he had as a child.

Viewpoint: So UV protection for children's eyes is something we must more strongly recommend to parents. I know my kids resist putting on their sunglasses. We try to get them to wear them, but we aren't perfect with enforcement. So as optometrists we have to give compelling recommendations and hope for moderate compliance in families who don't have an OD as a parent!

My son has taken a great love of the game of golf, and at nearly thirteen years old, he thinks he's the next Phil Mickelson. He dresses like him, walks like him, twirls his putter like him, and frighteningly hits a flop wedge like him. And he bailed out of his Transitions Poly spectacle lenses this spring to full time contact lenses. I didn't hesitate to use Acuvue Oasys for the UV protection; he might just be outdoors an average of 14 hours per day this spring and summer!

If UV protection is right for my child, it's right for my patients. You might think about enhancing your youngest patients' future by recommending UV protection more often. Tell them it's "sunscreen for the eyes."

Until next time,
Scott

In response to: [Ultraviolet Protection Knowledge Gap](#)

Scott Jens [Visitor]

I am very happy for the comments from Dr. Davis and Dr. Liska.

First, Michael is wise to point out that my son's eyelids aren't going to get any protection from a UV protective contact lens. He is being fit for sunglasses as well, for that very reason, and it's an excellent point to bring forward. Thanks, Michael!

Next, I appreciate Landon's comments about the practice benefits of recommending second pair sales of UV protective eyewear. I've always been a believer that if you recommend products that enhance a patient's wellness, the practice will do fine. I am amazed by the 55% second pair ratio; that might be a record! Congrats.

Finally, I do not have any pre-printed pieces that I can recommend about sunwear for children. Perhaps someone has a relationship with industry that is involved in this market that can provide an option?

Thanks for the insights, Scott



04/19/06 @ 19:39

In response to: [Ultraviolet Protection Knowledge Gap](#)

Michael I. Davis, O.D. [Visitor]

The UV protection from Acuvue is good, but remember, this does not protect the lids, and this is where the basal cell lives.



04/19/06 @ 14:17

In response to: [Ultraviolet Protection Knowledge Gap](#)

Landon Liska, OD [Visitor]

Very good point Scott. By the way selling a second pair helps the bank deposits. I recommend this to all my patients and have educated all my employees of the need for sunglasses. We have a 55% rate of second pair sells. It isn't difficult. Have you ran across, or happen to know where you can find brochures on the importance of sunwear protection for children?



04/19/06 @ 11:39



[3 comments](#)

04/11/06

10:58:08 am, Categories: [General](#), 126 words

Fusarium and Renu? (Scott Jens)

<http://www.foodconsumer.org/777/8/>

[Contact lens solution linked to serious fungal eye infection.shtml](#)

As you may have already heard, B&L is suspending distribution of Renu and private label Renu off the market due to suspicion that its South Carolina plant is part of the fungal infection issue. There is an investigation into the production of the solution Renu with Moisture Loc.

In my estimation, the approach we should take with patients is "innocent until proven guilty" but offering our patients who might call the office a sample of alternative solution to retain their confidence.

I would recommend halting distribution all Renu products at this time to allow the reps to explain their situation and to advise when this situation has cleared.

FWIW,
Scott

No comment yet...



[Leave a comment](#)

04/07/06

03:02:27 pm, Categories: [General](#), 177 words

Contact Lens Infections (Scott Jens)

OcularCommons.com

Contact lens wearers were warned this week about eye infections of fungal etiology. There are few primary eye care providers who have seen fungal keratitis. Such infections are typically related to abrasions from organic matter, such as fingernails or shrub branches.

So when reports started to outline corneal infections that were resistant to antibiotic therapy or worsened under the use of steroid drops, cultures confirmed fusarium fungus. It is very uncommon for contact lens wearers to show fungal keratitis.

The warnings to eye care providers have been nicely distributed with reminders that feathery-edged corneal infiltrates should be carefully scrutinized and that steroid drops be reserved for confirmed cases that have a well-controlled infection.

For more information from the American Optometric Association, visit: <http://www.aoa.org/x5137.xml>

To see an interview with Dr. Art Epstein on Good Morning America, visit: <http://www.abcnews.go.com/GMA/Health/story?id=1807992&page=2>

Keep a clear mind with corneal infiltrates in the next few months, and remember this information prior to applying any treatments.

Until next time,
Scott

No comment yet...



[Leave a comment](#)

04/04/06

07:31:32 pm, Categories: [General](#), 809 words

Technician Benefits (Scott Jens)

I learned recently that there has been a history of optometry looking down on allowing technicians to discuss their benefits, particularly pay, with their cohorts. Evidently, the fear has been that too many technicians in the same room will result in mass mutiny when they go back to their doctors and ask for the same pay that others are getting.

It was explained that many doctors have disallowed staff from attending large meetings where they might rub shoulders with technicians that would spill the beans and give them a reality check about how little they are being paid! Can someone explain to me the concern that these doctors have?

Don't get me wrong. We don't pay untrained technicians \$20 per hour or give three weeks vacation after the first month of employment. I'm entirely serious with this edition of the Eye Dream blog... I am truly interested in having a discussion about how optometrists pay their staff.

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There have not been a lot of replies to my previous blogs. I assume that most of you just skim the content, and a few of you have chimed in with thoughts. Let's get some discussion on this matter; I'll go first:

When I started my practice 15 years ago, I inherited a staff from the previous doctor. I didn't have a chance of keeping them around; I represented too much change to them. In the first six months of my career, I took some small business administration classes from the university's extension program. In the portion of the class about at-will employment, I learned a lot about benefits and the importance of a good handbook. I have modified the original handbook many times, but its basic layout has gone unchanged for all 15 years.

Our employees receive an hourly wage and full time is considered 30 hours per week or more. After a ninety day review, the employee is granted permanent full time status. At that time, there is accumulated personal/sick/emergency leave that collects at a rate of 4 hours/month, so after six months there are three days of PSE time available for use in an approved manner.

Vacation is hard to grant in a small business environment. We offer one full week after the one year anniversary review, and we add one day for each additional year. After six years of employment, the employee has two full weeks of paid vacation to utilize, plus their accumulated PSE time. We are very flexible with unpaid time off for family issues, personal time, etc.

Today, our wages are directly linked to the cost of health insurance benefits. Our three doctor/two clinic group spends over \$80,000 on health insurance for the 10+ employees. Virtually every employee feels that their primary benefit is health coverage for them and their dependents. We pay roughly 80% of the employee's premium, 70% of employee/spouse coverage, and 50% of the family rate. The remainder is deducted from their pay as their contribution.

We trump the employee's contribution to their SIMPLE retirement plan (a small business equivalent of a 401K) by matching their first 3% contribution. That is not a small amount of "take home" pay, but since they don't take it home, they don't feel like they have it.

The hourly wage is what new employees use to gauge your offer, and it's what current employees look at when they are thinking about their options in other places. It's what they evidently talk about at the meetings that some doctors forbid their staff to attend! Why? I assume that we have done a fairly rotten job of telling them what their entire benefits package constitutes. We pay pretty darn well, certainly as well as most of the big clinics in the area, but we have the added value of a much more relaxed environment, plus the opportunity to control one's own destiny with extra effort.

Newly graduated technicians from the local technical college average \$10 to \$11 per hour. That's not bad for an education that involves one year of intense study. But it's hardly enough to afford a one bedroom apartment and car payment. We have tried to pay another dollar an hour above that at start-up and we add about another dollar for significant experience. We regret that we have had to keep to

cost of living wage increases at annual reviews the last couple of years because of escalating health care costs. In cases where exceptional contributions have been noted, we have added a percentage point or two "merit" increases annually.

Viewpoint: It will help independent optometrists greatly if they share the best policies that they have for employee benefits. Rather than scrutinize my comments, use them as a gauge. Share your thoughts; tell us about unique employee benefits programs; contribute a policy about how to pay for continuing education programs for technicians.

I look forward to seeing some thoughts on this!
Scott

No comment yet...



[Leave a comment](#)

03/23/06

📅 07:22:11 pm, Categories: [General](#), 372 words 

Contact Lens Wearers Wear You Out? (Scott Jens)

Don't get me wrong, I thoroughly enjoy fitting contact lenses...

But contact lens fitting is increasingly related to the marketplace pressures of pricing. There is the camp that says "fit more RGPs" to give your patients the advantages of these great lenses and to avoid the disposable prescription issues.

The reality is that soft disposable lenses are the apple of the patients' eyes, and there is an increasing number of manufacturers who offer practitioners private-labeled lenses so the doctors can provide their patients a unique, practice-specific product to differentiate them from the mass retailers.

The stringent rules of the federal contact lens prescription legislation are good for patients and doctors. They ensure that the doctor provides valid lens prescriptions including the manufacturer so the patient can know what they have been provided. And they ensure that the patients receive proper fitting and regular follow-up care to continue to have the privilege of a current prescription.

But soft disposable lenses are more of a commodity today than ever. Manufacturers have increased the value of a patient purchasing a full year supply from their eye care provider because there is evidence that the patients are more compliant with replacement and examination schedules. Yet we continue to get regular calls for Rx's from internet sites.

We don't fight the trend. Our clinic isn't significantly impacted by the internet sales because we price our products competitively and we properly value our professional services. It helps patients by decreasing the sense that they need to shop around.

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It does become tiring to debate contact lens wearers about replacement schedules, though. We do fight that fight, because too many eye care providers take the easy path and ignore their patients' noncompliance. It becomes our little battle to attempt to educate every patient about their proper replacement schedule.

Viewpoint: It is an eye care professional's responsibility to work toward maximum compliance with our prescribed treatments. Most glaucoma patients get much more advice about compliance than contact lens patients. Optometrists would be wise to take a more aggressive education stance with their contact lens patients.

They can wear you down, but don't let them wear you out!

Until next time,
Scott

Scott A. Jens, O.D., F.A.A.O.

In response to: [Contact Lens Wearers Wear You Out?](#)

sjens [Member]

Keep in mind that the FDA does not mandate nor even determine replacement schedules. In fact, the FDA only determines risk rates for lenses relative to their indicated wear, either daytime or continuous wear. Having been part of a number of FDA trials for continuous wear, I can tell you that there are instances where we have been part of protocols that tested lenses for one wearing cycle and a different length of time was ultimately approved by the FDA or promoted by the manufacturer. Compliance is directly related to the replacement cycle and there is rationale for monthly (1st of the month replacement) and also biweekly (1st/15th replacement.) The key is to communicate your recommendation to your patients!



04/04/06 @ 18:54

In response to: [Contact Lens Wearers Wear You Out?](#)

Michael I. Davis, O.D. [Visitor]

About replacement schedules; have you noticed that some of the lenses with two week replacement schedules, are monthly replacement in Europe (Oasis, most of the Cooper line, and a few others that I would have to look up) I would prefer to set my own replacement schedule for the patient, based on their rate of deposits rather than the manufacture/FDA mandates



04/03/06 @ 16:52

03/13/06

📅 07:52:51 pm, Categories: [General](#), 503 words 

Computerized Practice Management Systems: History and Future (Scott Jens)

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In our practices, we have been using a computerized practice management system (PMS) for twelve years. When the use of personal computers became more prominent in the American workplace in the early 1990's, optometric practices had many offerings in the PMS arena from which to choose. Perhaps it's with a less-than-full knowledge of all of the options that I say that most of them were pretty much the same. We looked at most systems, and as I try to remember the final decision today, they were mostly copycats.

Most of the systems were databases that allowed the practice to manage recall and track account balances. Later, lens ordering and scheduling became focal points, and then some programs were inclusive of inventory management.

In the late 1990's, electronic claims submission tracked along with the increasing width of the world wide web. Optometric business staff had been printing HCFA forms and mailing them, followed by the common practice of faxing submissions. Most recognized optometric PMSs offered electronic claims with the value that Medicare and other insurance companies would pay the electronic claims faster.

In the last five years, there has been a proliferation of computerized electronic medical records (EMRs) that often accompany a PMS. Within eye care, a few dozen reasonable options have been created. However, there is mounting evidence that optometry is not proceeding down the path toward EMR. Partly, this is due to lack of a clear industry standard as well as an acknowledged industry leader. In equal part, it is about cost, constant upgrades, cost, lackluster support, cost, and finally, cost.

In a recent survey of optometrists, EyeCodeRight found that over 90% had access to high-speed internet connections in their offices. Yet only 1/3 was using an EMR. What are they using their internet access for? Insurance claims, email, literature research, and... is that it?

As the world has become flattened by instant access to information and each other via the internet, it would seem obvious that optometric practices are ready for a very novel approach to PMS/EMR. At EyeCodeRight, we have been creating a PMS/EMR that is web-based. This will be the future of this industry.

In our March Newsletter, Steve Elfrink spent some time comparing the advantages and disadvantages of this 21st century "online intrusion" into our practices. The good news: most ODs are ready for internet-based PMS/EMR. The bad news: most ODs who have invested in traditional hard-drive based systems will be reluctant to give up their comfort systems despite the significant advantages that web-based systems will deliver.

Viewpoint: It's not our intention to tease. I am truly trying to elicit some thoughts about what you WANT from your future PMS/EMR. EyeCodeRight will be hosting a webinar on March 28 because we truly believe in our statement, "tapping into the collective intelligence of optometry." Before we can deliver our solution in its first iteration, we need your collaborative input. To register, email selfrink@eyecoderight.com

Moving optometric practices into web-based practice management... what a great challenge!

Regards,
Scott

No comment yet...



[Leave a comment](#)

03/05/06

📅 07:18:45 am, Categories: [General](#), 620 words 

Opticians in Optometry (Scott Jens)

Following up on the recent blog about staffing, I am happy to report that our clinic has found a hire for our optical dispensary. We actually had two very qualified candidates and sided with a person with over two decades experience. Although this is his first foray into truly private optometric practice, we believe he will give us a much more solid basis for the optical dispensary.

Which makes me think... how much do you depend on an optician? In my fifteen years, I have never employed a certified optician. I know that some ODs in private practice have, but my unscientific sense is that most work for corporate outfits or ophthalmology opticals. That is the particular background of our new hire.

Just this morning I was reading an archived article that I found on the internet that included commentary by the likes of the respected Irving Borish about optometry forgetting its roots to an extent. Comments were standard for the post-TPA environment: refractive care had been the core of the profession, then ODs became too focused on prescribing drugs, and now everyone has lost the ability to refract much less recognize the value of VT, etc. Nothing inflammatory intended here, just the standard-fare of discussion that optometry has had with itself over the last fifteen years.

In response, ODs from AOA and the educational world commented that we should be cautious with such generalizations. There were reminders that optometry is as involved in refractive care as ever, and education includes many experiences with vision treatment aside from medical eye care.

Maybe I've digressed, but it seems to me that this perspective gets each of us to think about our own involvement with optical work. Except for a few ODs who are specialized, every OD is intimately involved with optical correction of our patients. Even ODs who don't own a dispensary deal with giving Rx's and dealing with the 10% of patients who feel that their script is not visually correct after the fact.

When I took over my first practice from a doctor who had been trained in the 50's, his OD daughter who had been trained in the 70's was following in his footsteps by providing most of the optical dispensing work. They had a trained staff but strongly felt that the optical work fell on the optometrist. I had seen that in other OD

practices, including a very successful one that I worked at while in optometry school.

It seems that while optometrists have less hands-on time in their optical dispensaries, they still have a responsibility to their optical practice. It is virtually impossible to expect that my new optician will eliminate my role with my patients in determining their best optical options and in solving their optical problems.

However, opticians lend optometrists a pretty powerful benefit at a time when optometrists do spend more time than ever in the medical care of their patients. ODs tend to delegate technical steps of their examination and a number of ophthalmic procedures to their staff who have paraoptometric or ophthalmic backgrounds. I suspect that equal numbers of doctors delegate a good share of their optical duties as well.

Viewpoint: As I enter my first experience with an optician who has significant experience, I relish the opportunity to learn some things and to partner in our mutual goal of visual satisfaction of our patients. Frankly, ODs still have the primary objective of maximum visual benefit of our patients and cooperative efforts with trained personnel help ensure our patients get the greatest effect of our care of their eyes.

Do you have a viewpoint on how optometrist might best work with their opticians?

Until next time,
Scott

Scott A. Jens, O.D.

No comment yet...



[Leave a comment](#)

02/21/06

🕒 07:20:57 pm, Categories: [General](#), 439 words 

Recall (Scott Jens)

Do you have an effective recall system? In my 15 years of practice, I have tried them all. In the last couple of years, our group has tried a variation of a recall program that we learned at a practice management seminar.

We use pre-appointment cards, printed on one side with text that tells the patient the day and time of their appointment next year. The other side is printed with our return address and four blank address lines for the patient to self-address their recall card.

Research shows that we tend to avoid mail that looks like junk mail, but people will pay attention to mail that has handwritten addressing. It can be argued that they will pay even more attention to mail that is addressed in their OWN handwriting!

OcularCommons.com

At the end of the examination, the doctor recommends the next examination and asks the patient to self-address the recall card. The post-examination technician works with the front desk staff to ensure that the patient gets a "tentative exam date and time" for next year. The patient gets a card for their calendar, and the postcard is sent next year about six weeks in advance of the appointment date.

The staff calls one month and again two days in advance of the appointment day to ensure that the patients keep their appointments. The patients are clearly told at the time the appointment is made that they must reply to at least one of our communications or the appointment will be removed from our schedule two days before the appointment so we can fill the time with a patient who may be on a waiting list.

We operate with roughly 90% of our appointment times booked and the system results in an incredibly low no-show or cancellation rate. It flat-out works.

Viewpoint: I keep thinking that this system works pretty well, and that we probably have it figured out. Then I realize that I never leave these systems alone, that we are always changing and "improving" our systems. And it leads me to believe that the systems that are available that do recall electronically will probably be the way of the future. I have talked to ODs who use automated phone call systems with computerized voices, and I know some who have tried email communications.

I look forward to the open development that EyeCodeRight will use to create its recall system. I have a hand in creating the initial template for recall and will be applying aspects of our current system into the new system. If you have ideas that work for you, drop me a line.

Until next time,
Scott

No comment yet...



[Leave a comment](#)

02/11/06

🕒 01:09:14 pm, Categories: [General](#), 430 words

The Never-Ending Staff Challenge (Scott Jens)

Seems to me that the most challenging part of being in practice is staffing. It is very difficult to isolate any one part of managing a practice to make such a statement, since managing finances, ensuring good communications with other health care providers, and other issues could be considered THE biggest challenges in practice.

Staffing is one of the issues that runs across every optometrist's day, regardless of place of practice or mode of practice. Some ODs have more control over staffing than others, but staff issues have a direct impact on quality of care.

OcularCommons.com

I am in private practice and with two partners, we have split the responsibilities of management. I have been primarily been working on human resources, which is my technical term for staffing. In private practice, the doctor must also deal with health insurance renewals, benefit packages, requests for time off, staff reviews, and of course hiring and firing.

We are looking for an optical specialist right now. So are many other practices in our area. As a result, we are not exactly finding the magical person for the job because we can't find any interviews! So we continue to have our own internal discussion about staffing choices: find a "good person" and train him/her, versus finding an experienced person who might not be the right fit.

I tend to employ educated paraoptometric technicians. It's harder to find quality opticians because they are more likely to enjoy spiff-related retail jobs even though they work many evenings and weekends. When I look for technicians or opticians, it always seems like we find fewer quality candidates than we'd like to have. And it's not because we are too picky with giving interviews.

More often than not, we spend a good chunk of each year slightly understaffed as we wait for the right candidate. Add that to the existing staff's personal time and vacations, and it can be estimated that we are understaffed as many as 20% of the days of the year. And I don't think that is an uncommon situation for many doctors.

Viewpoint: The never-ending staff challenge requires a strong fortitude. Staff expense tends to run 20% of a practice's gross, and I've always assumed that this takes into consideration the occasional understaffing that practices like ours experience. I am seriously considering a more aggressive staffing attitude, including finding more experienced staff that might cost a couple of extra percentage points, but which might pay off in practice growth in the long run.

Do you have a view on staffing? Send it along as time permits.

Scott

In response to: [The Never-Ending Staff Challenge](#)

Dan DeWinter [Visitor]

Hi scott and all, I'm currently looking for "a good person" also.....have spent \$500.00 on ads and have interviewed 2 people out of 5-6 responses. One person wreaked of alcohol.....literally smelled like she just was doing shots out in the parking lot.....could not believe it. I have no thoughts on how to find anyone. Feel spending more money on help wanted ads that bring no prospects is a waste...but what other options are there????? Dan



02/13/06 @ 16:01



[1 comment](#)

01/31/06

Infant Eye and Vision Care (Scott Jens)

Sorry for the delay between entries... had the wonderful opportunity to travel to Maui for the Island Eyes Conference hosted by the Pacific University's College of Optometry and Southern California College of Optometry. Since I'm digressing already, let me strongly encourage you to consider this conference in the future, as the location and the program are both top notch.

The purpose of my visit to the conference was to lecture on primary eye and vision care of the infant. I am not one of the ODs on the "lecture circuit" but I do enjoy opportunities to speak. And with my involvement with a brilliant team of ODs and staff at AOA in creating InfantSEE, I have picked up a few engagements that allow me to share my primary care viewpoint with my colleagues.

In the two years that I've been addressing ODs on this subject, it's amazing to me how many have already integrated infant eye and vision care into their daily practice. They typically report that they see an infant every few weeks, although I've met some that are now examining infants daily. Some doctors tell me that they have seen only one or two infants in their career, somewhat like the number of corneal foreign bodies they remove in a year's time, but for some reason they are much more comfortable with their base knowledge with such minor procedures than they do with the objective assessment of an infant's visual system.

In our practice, the number of babies seen is quite variable. Sometimes we see one a day for a week, and then we see none for a week. In a full scope primary care practice, it's a lot like the streaks of patients with AMD, diabetes, continuous wear contact lenses... you see a bunch and then it seems to cycle back at another time.

Infant eye and vision care is part of optometry's responsibility. Not every practicing OD can or will see infants, just as they don't all see glaucoma patients or do low vision. I do hear from some optometrists and ophthalmologists that optometry is not generally prepared to see infants, and also that most babies seen will not have problems so, "what's the point?"

Wellness of our patients of all ages is our profession's mission. Of course, cardiologists and oncologists and dentists all have wellness as the basis of their mission, too. But optometry's commitment is to provide periodic professional care, even to those who are symptomless and without obvious risk, and in most cases those terms describe an infant patient. Most health care professions talk the talk about wellness, but only dentistry makes a commitment equal to optometry in regard to planned rescheduling of wellness visits. Not even my primary care physician tells me when to return or has a recall system.

If optometry via InfantSEE is willing to provide the first eye assessment of life at no cost to the family and no cost to the health care system, the community's wellness will elevate in due time. And not just because optometrists will find many babies will unwell eyes. The values of such a broad-based public health initiative include:

- 1) Detecting infants with at-risk status for amblyopia development, primarily significant ametropia or anisometropia, subtle strabismus, or an ocular health

threat;

2) Informing parents about the need for periodic professional eye examinations in addition to wellness screenings provided by general health care providers, community clinics, and later schools, thereby...

3) Increasing the number of young children who receive optometric or ophthalmologic eye examinations prior to the critical period, even if they are not found at-risk as infants

Viewpoint: Optometric "cradle-to-grave" eye care services are at the core of our existence. The public does not understand the need for health care for their eyes. By participating in InfantSEE, optometrists can improve the wellness status of developing young children AND improve public appreciation for the importance of eye and vision care by an eye care professional.

To learn more about InfantSEE's national exposure online, visit www.infantsee.org

AOA members may register to provide InfantSEE assessments by emailing Debra Fox at AOA: Fox@aoa.org">DFox@aoa.org

Until next time,
Scott

In response to: [Infant Eye and Vision Care](#)

Bert Happel [Visitor]

I found a great external marketing for promotion of InfantSEE this week - the local Head Start program's nurse. I've done the annual vision screening for my local Head Start for several years. Consequently, I'm a (default) member of the Health Advisory Committee. The HAC is comprised of representatives from all local social services that deal with children's health. During the committee meeting I made a 2 minute presentation about InfantSEE - what it is and that it exists - and handed out the AOA supplied promotional flyer with a business card attached. It generated a lot of interest and I expect to see more infants because of this brief talk. I plan on putting together a posterboard presentation of InfantSEE to take to the Head Start Health Fair in April.



02/01/06 @ 19:56

01/17/06

📅 06:34:29 pm, Categories: [General](#), 583 words

It All Starts With The Infant (Scott Jens)

I have a soft spot in my heart for babies. Like most anyone who has become a parent, once you have a child in the world, you cannot help but be drawn to any baby that you see or meet.

I'm not an optometrist who espouses a specialty in pediatrics, functional vision, or vision therapy. My ICO training led me to have an appreciation for the various

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aspects of managing children's vision. I refer cases that require special attention to my few optometric colleagues who focus on the special visual functions of children.

Early in my career, it became apparent that few optometrists and ophthalmologists were interested in promoting early eye and vision examinations. More amazingly, the public did not have any idea of the need for periodic professional eye examinations. I couldn't believe the lack of understanding, the dependence on school screenings, and the sense that organized optometry wasn't doing anything to help the public's awareness.

Like many of you, I spent my time away from the office in volunteer mode for the state optometric association. I gained a lot of insight about how challenging optometry's history had been. I learned to be patient with the public.

About four years ago, AOA initiated an ideology called "Healthy Eyes, Healthy People" (TM) that was intended to demonstrate optometry's wellness mindset. As providers of primary eye care services, we truly affect the overall health of our patients.

The AOA leadership asked us to think about the wellness of our patients following years of fighting for the right to diagnose and treat diseases. They knew that we had more aspects of care of our patients that we had to explore, but optometry also needed to think about how to keep patients well.

With the AOA Clinical Practice Guidelines as our beacon, the leaders explored the idea of caring for our patients from cradle to grave, rather than when the patients seemed to realize that they might need to come in, if ever. The Pediatric Eye Examination CPG states that the first examination should be at six months of age, with the next at three years of age, and then by the start of first grade.

Optometry has often been chastised by organized medicine as being financially interested in selling glasses to patients who don't really need them. This serious misrepresentation of the facts should not distract anyone from the fact that optometry is much more interested in preventive care than ophthalmology and is willing to state that a professional eye and vision examination is an important part of a child's wellness care.

One small problem existed: few optometrists made a concerted effort to recommend eye examinations for infants and young children consistent with the AOA CPG. The public's lack of awareness that was so evident to me in the early 1990's was directly related to the profession's lack of consistent education of the parents that were sitting in the chair every day!

The solution? InfantSEE (TM) -- a flagship AOA program of the Healthy Eyes, Healthy People mindset.

Are you on board? Do you understand the program? Do you have the same biases that many optometrists have had, and use those biases to avoid the largest potential program that optometry has ever created?

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Viewpoint: I'll let you think about those questions and give you my view of InfantSEE (TM) in the next installment. Just think... getting to see those beautiful babies, educating their parents, and finding risk factors that may challenge a patient's wellness.

Regards,
Scott

No comment yet...



[Leave a comment](#)

01/11/06

📅 08:04:36 pm, Categories: [General](#), 585 words 

Managing Contact Lens Compliance (Scott Jens)

Most of the time we talk about managing contact lens compliance, we are really talking about non-compliance. The contact lens wearers in my practice behave just like those in yours...

They tend to want to stretch their contact lens replacement cycles because "my lenses feel fine." They don't digitally clean their lenses nor do they rinse each side for five seconds with no-rub multipurpose solution because they don't listen to or read directions. They sleep in lenses that are not approved for overnight wear because "I've done it many times and I've never had a problem before."

An effective contact lens practice must provide compelling education to patients to reduce or even eliminate non-compliance trends. But since I've never met a doctor who thinks that his/her technicians give patients rotten advice about how to properly wear and care for lenses, there's got to be more to it than good education.

In the seventeen years since the launch of Acuvue, patients have had to modify their contact lens wear and care practices. ODs have also changed their practices, but too many times we are not willing to be strong enough with our patients' compliance. In our practice, we had to take actions to demonstrate our commitment to patient compliance.

About ten years ago, we took advantage of the "free shipping on a one year supply" policies to encourage a cupboard effect. Just like that bag of Oreos in the pantry that goes quickly until the last three cookies are left, a full supply of lenses tends to result in proper replacement until the patient gets to the end of the lot.

The next step we took was to pre-appoint a one year comprehensive medical eye and vision examination for all contact lens wearers. Slowly, many patients were ordering a year supply of lenses and were increasing their compliance.

It wasn't until a few years ago that our practice developed a more significant action plan to ensure maximum compliance. We took the federal contact lens legislation and saw an opportunity: we created a contact lens prescription pad that looked just

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like a medication prescription pad and we treat them the same. We write the lens, manufacturer, and all lens parameters, along with the recommended lens replacement cycle, number of lenses allowed for the life of the prescription, and an expiration date.

At the end of every examination or at the end of a fitting, we give the patient the prescription and offer the following statement: YOUR PRESCRIPTION IS VALID FOR A ONE YEAR SUPPLY OF LENSES WITH REEXAMINATION REQUIRED IN ONE YEAR. PLEASE SEE THE STAFF TO FILL YOUR PRESCRIPTION.

The staff then reinforces that "the doctor has authorized your chart for a full year supply of lenses." They announce the fee and reach for a rebate form. They DO NOT ask the patient how many boxes they want to buy, because we all know they'd buy lenses one at a time if they could!

Viewpoint: It's critical that we create policies that improve contact lens compliance. I thought we had done everything possible, and then we started saying "I've authorized your chart for a one year supply" and we have approached 70% filling annual supplies.

Clearly, industry trends like continuous wear and rebates have helped our battle with non-compliance. But the best action you can take is treating a prescription like a meaningful medical document. Go ahead and RECOMMEND a one year supply and enjoy better compliance.

Until next time,
Scott

Scott A. Jens, O.D.

No comment yet...



[Leave a comment](#)

01/06/06

🕒 09:34:48 pm, Categories: [General](#), 314 words

Waiting for EMR: Answering the Mailbag (Scott Jens)

Had a couple of good comments come in on my blog about my wait for EMR (see below.) Some thoughts in reply...

REPLY to prozanec:

In general, we will work with you to try to import as much information as possible from IFILE to our new system. However, it depends on how "standard the database format is or whether the data can be exported in some standard format. If it is standard, we can import data fairly easily. If not, it's less easy.

You can certainly continue to use IFILE along side the EMR in our new system if IFILE can support that. However, integration between the two systems is unlikely,

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unless IFILE wants to rewrite their software to integrate with our web services interface :-)

For what it's worth, after reviewing the features list on the IFILE web site, we will be supporting most of those features listed. What features of IFILE do you like (and why)?

The bottom line, however, is that we will work with you to determine the best solution for your practice, whether that includes our new system or not. We want to be a partner with the community and not just a software vendor.

REPLY to Larry Wilkinson:

Yes, I am one of those ODs who loves to take on multifocal RGP fits and all of those painstaking cases that drive others nuts. Life without EMR is not ideal, but it's my sense that I've done right for myself.

My \$150K total included the buildout... wiring, networking, servers, stations, VPN for two offices to link, and the EMR software (which was a big chunk up front, although not all are as high.)

I'm sure I could have done it cheaper. But web-based solutions are the jewels of the internet. I am glad I've waited with what I am privileged to see on the horizon.

Thanks for the comments!
Scott

In response to: [Waiting for EMR: Answering the Mailbag](#)

Scott Jens [Visitor]

Michael,

A user of the current ECR system will be able to push all of their data over to the new system. Since the development team is utilizing similar databases, that will be the easiest transfer of all. There will also be an opportunity for doctors who have had other practice management systems (PMSs) to discuss with our developers transferring some of their core data (e.g. patient demographics) into the new ECR system when they switch over.

Thanks for the question!
Scott



01/18/06 @ 05:58

In response to: [Waiting for EMR: Answering the Mailbag](#)

Michael I. Davis, O.D. [Visitor]

Scott; Do you know if the current eyecoderight data will transfer over to the web based system. In other words, if I were to get eyecoderight now, could I upload all the demographics etc., to the new system or would I have to start from scratch?

Thanks.



01/18/06 @ 05:31

In response to: [Waiting for EMR: Answering the Mailbag](#)

Peter Rozanec [Visitor]

IFILE is the most popular optometric practice management system used in Canada. I don't know much about databases, but IFILE is written in Clarion which is not the most common database developing tool. IFILE is very stable and not too fancy. The EMR portion is quite functional, but from the sounds of it, Eyecoderight's product will be much more sophisticated.



01/07/06 @ 06:40

In response to: [Waiting for EMR: Answering the Mailbag](#)

Michael I. Davis, O.D. [Visitor]

I realize you can not have an exact roll out date at this point of development, but, any estimates? This year next year (2007) or? I want to try to plan around this.

Thanks



01/07/06 @ 04:46



[4 comments](#)

01/04/06

📅 02:46:48 pm, Categories: [General](#), 470 words 

Waiting for EMR (Scott Jens)

I don't think I'm alone when I admit that I'm still not on an electronic medical record (EMR) system. We do use computers in the practice as our practice management system (PMS) handles our electronic schedule, accounting system, billing processing, and optical/CL ordering.

There is quite a sea of options for EMR. While the optometric press has attempted to summarize and compare the programs that are available, I have been attacked by "paralysis by analysis." Walking the halls of various optometry meetings, I have overheard the many conversations about what system X does well and what system Y does better. But I didn't spend the time necessary to make a very difficult (and potentially expensive) decision.

One national program was in my sights for a while. I felt that they had a strong product and a commitment to making the product better via customer feedback. My partners and I were looking at this EMR when we were building a new office that was going to cost a few multiples of a hundred thousand, and we were absolutely astounded by the infrastructure costs and software fees.

We never jumped on that boat... could have easily cost us \$150,000 for the program software, support, and the necessary computers and wiring. I've seen the templates that show the efficiency of EMR and the cost savings can come back in due time, but we just weren't convinced that the timing was right.

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Now in January 2006, we are starving for the move into an integrated PMS/EMR. We have 10 staff for three doctors at two locations, and we need efficiency. We need centralized and automated billing, we need a system that better communicates with the health care community about the care we deliver, and we need more effective communications with our patients before and after their examinations.

Rather than look at the systems out there as less than meets my needs, I decided to join the fray. I'm thrilled to have joined forces with the team at EyeCodeRight to develop the strongest, most unique system that optometry will ever see. When it's ready, optometrists like me will have an extremely thorough PMS with an EMR that helps me take care of my patients the way that I do with my paper charts.

Viewpoint: I'm willing to say that EyeCodeRight will make an optometrist's decision about going into EMR much easier than it has been. It may be bordering on a pitch, but I think that anyone looking to move into EMR in 2006 should wait and watch for the EyeCodeRight system to evolve. I know it will cost me less than many of the systems that are out there now and I know it will serve optometry's needs in a very special way.

All OD's waiting for excellence in EMR: just wait!

Until next time,
Scott

In response to: [Waiting for EMR](#)

prozanec [Member]

If Eyecoderight is something I want to use in the future, how would I take existing data in my current EMR and convert it to Eyecoderight?

My current EMR (IFILE -- see www.msfc.com) is integrated tightly to the practice management module. It's as integrated as Internet Explorer and Windows! That might pose a problem if I want to use Eyecoderight with IFILE.



01/04/06 @ 15:35

In response to: [Waiting for EMR](#)

Larry Wilkinson [Visitor]

Scott, I sure am glad that you are the patient type. All my patients who want to wait for later or better yet catch you later wuth a payment I will surely send your way. II have been using EMR for 8 years and am sure glad I did not wait or I would have never got started. Just curious how many work stations you plan on having if the cost is going to be 150,000 Gs. I could replace my 15 station system, buy new software, and pay for the instalation for 50,000 K. Not much less by some. If you have multiple offices then I stand corrected.

Lots of luck.

Larry



01/04/06 @ 15:20



[2 comments](#)

12/26/05

📅 03:03:43 pm, Categories: [General](#), 204 words 

Year End (Scott Jens)

Well, it's the year end and I've been at this blogging thing for a couple of months. No public feedback means either that the subjects aren't compelling or no one is reading. Either way, I'm going to resolve to provide more compelling commentary in 2006 and try to engage you in a dialogue about the wellness model for primary eye care.

There are many issues near and dear to me that I haven't even begun to talk about: InfantSEE (TM), primary eye and vision care of young school-age children, finding greater access to optometrists practicing functional vision, calling out organized ophthalmology in its ridiculous incrimination of optometry, addressing terrible public awareness of optometry directly related to ODs not defining themselves to their patients, and the list could go on....

I don't have all the answers. I like to think that you might have something that trips your trigger. Email me if you wish, or reply to this blog if you have a subject you'd like to see addressed. And if you are just reading and nodding or shaking your head, that's cool too.

2006 is going to be phenomenal for this community. Stay tuned, stay informed, and hang on for the ride! Happy New Year!

Scott

In response to: [Year End](#)

Paul Farkas [Visitor]

Scott...

We are discussing the need to add a Blog Forum on to www.seniordc.org.

I don't see the advantage over our current forum and topic system. Perhaps you can visit the Student and Recent Grad forum on www.seniordc.org and help enlighten those of us who do not understand the advantages.

Thanks.

Paul



12/26/05 @ 15:37

12/20/05

📅 08:50:15 am, Categories: [General](#), 585 words 

The Numbers Game (Scott Jens)

As our practice approaches the year-end, we get into our annual discussion of "the numbers." Admittedly, I was not much of a numbers person early in my career. Like most new ODs, I had not received a lot of business training in my undergrad classes and there wasn't much of the business of eye care within optometry school.

When I joined my practice with two other independent ODs in a group corporation, I was fortunate to learn their business principles that had been refined over longer careers than mine. One of the interesting exercises we went through was comparing our practice statistics against those that were considered the standards.

Of course, the standards were often published in the various optometric publications. To this day, the practice management gurus continue to write annual articles about how a private practice's numbers should look. Recently, I saw another discussion about the numbers game and it made me think that you might want to share your insight about the practice ratios that are most critical to practice success.

In our two location, three doctor practice, we use the following breakdown:

1. Cost of Goods Sold: Frames, ophthalmic lenses, contact lenses -- should constitute roughly 27 to 30% of revenue
2. Staff Payroll -- roughly 20% of revenue
3. Occupancy -- roughly 5 to 8% of revenue
4. Marketing -- 2 to 4% of revenue

Assuming that this is roughly 60% of the expense of doing business, the next breakdown is of the remaining 40% which is what we call the "gross contribution." I think too often this number is referred to as the "net income" and in my experience few doctors take home 40 cents on every dollar.

We enjoy the benefit of being a corporation rather than being an entity in and of ourselves. We can then factor in expenses like depreciation, professional dues, and accounting/legal fees. These are costs that will have to come out of the "net income" of many sole proprietors which ultimately affects their true income.

Assume that those "business overhead expenses" take another chunk of the practice revenue. They include the items listed in the last paragraph, plus telephone, office supplies, business insurance, new instrumentation, etc. This adds another line item for the list above:

5. Total overhead expenses -- 10 to 20% of revenue

Viewpoint: Ultimately, the private practicing optometrist is going to realistically take home 20 cents on the dollar. This is a significantly lower number than is usually quoted by the practice management gurus. To me, it's a numbers game that misses the real issues of optometric income.

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The practice's net (read: your take-home pay) can be ratcheted upward to 25 or 30% with very cautious practice oversight. Like most optometrists, we look for every possible advantage to increase our bottom line. Some of the factors cannot be easily addressed, such as occupancy.

We work carefully with our staff to address these directly influenceable factors:

1. Effective control of frame purchasing
2. Improved patient education programs to stress the improved quality of vision and life from the newest visionware technologies
3. Pre-appointed recall for annual or biannual exams
4. Referral appreciation programs
5. Efficient staffing levels via use of computerized practice management systems/ electronic medical records

In 2006, spend some time on the numbers game. Don't expect to take home 40% of every dollar collected. But do aim toward increasing your bottom line by enhancing the wellness of your business. Concentrate on the five items listed above, and you should have a very prosperous year!

If you have a different viewpoint, or other ideas for managing a practice, please drop me a line or submit a comment.

Until next time...

Scott

No comment yet...




[Leave a comment](#)

12/14/05

🕒 02:58:17 pm, Categories: [General](#), 483 words 
Optometry Giving Sight (Scott Jens)

Do you believe in the right to sight? Not just for all Americans, but for mankind? Optometry Giving Sight is a unique initiative that is seeking to ensure that our primary care profession takes a stake in elimination of uncorrected refractive error worldwide.

According to the OGS brochure, "Optometry Giving Sight is a global campaign in support of the goal of VISION 2020: THE RIGHT TO SIGHT through mobilization of funds directed towards the elimination of uncorrected refractive error and helping those with permanent low vision. It is a joint initiative of the World Optometry Foundation (WOF), the International Agency for the Prevention of Blindness (IAP ) and the International Centre for Eyecare Education (ICEE)."

To listen to Brien Holden describe OGS's mission at the 2005 House of Delegates at AOA's meeting in Dallas last June, you had to have been moved by his stirring

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presentation about the impact of uncorrected refractive error and low vision in the underdeveloped countries of our "global community."

I don't know about your practice or clinic, but our Mission Statement includes a directive that we serve our community. We have asked our staff to do this in a number of ways. One of those was to create an implementation plan for OGS. This would set an example to our employees and patients that we are involved in wellness of those beyond the borders of our local communities.

Our plan is simple: provide each patient a compelling explanation of the fact that 37 million people worldwide are clinically blind and 124 million suffer from low vision (statistics: World Health Organization, 2004.) To know that refractive error affects 25% of the world population by age 15 (statistic: Helen Keller International) is to know that there are millions of people who are practically, functionally blind where they have no access to primary vision care.

Action Items:

- 1) We posted a placard in the waiting room that one of our staff members made to announce our program.
- 2) We offer an Optometry Giving Sight explanation form upon patient check-in. (for a copy, see the Contest section of the ECR Community Center)
- 3) The doctors talk to the patients about the recommendation: Give \$1 or \$3 at the end of your examination, and our clinic group will match the donation.

We have had a very positive result, with most patients offering some investment. It makes the staff and patients create a connection on another level, and allows the patients to understand their role in the worldwide community as well.

Viewpoint: If all practicing optometrists in the US would participate in OGS, millions of dollars would be collected to help provide infrastructure for clinics, and to provide examinations and optical devices to those in underprivileged countries. While we have many needs here in the US, our participation in a global community is a necessary part of giving back to mankind.

For more information about OGS, visit their website at:

www.givingsight.org

Until next time,
Scott

No comment yet...



[Leave a comment](#)

12/07/05

🕒 03:37:07 pm, Categories: [General](#), 370 words 

Microbial Keratitis and You (Scott Jens)

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Sorry for the extended break from the blog world. If you've read any of the other postings, you might recall that I spent a couple of weeks at the MK... that is, the Magic Kingdom. It went as any trip to DisneyWorld goes: get up, deal with the crowds, get a few thrills that are unlike any other, then pour the kids into bed to get ready for the next day. I like watching the family dynamics that bubble to the surface at DisneyWorld... makes my family seem pretty normal!

There's another MK in our lives: Microbial Keratitis. Fact is that most optometrists and ophthalmologists won't see but a few MKs in their entire careers, if any. Corneal infiltrates that are outside of the central 6 mm corneal zone, that are less than 1 mm in diameter, and that are not associated with an anterior chamber reaction tend to be sterile. This is so practically true that few eye care providers have ever cultured a corneal infiltrate. And in today's world of potent topical antibiotics, treatment has become quite routine and uncomplicated.

Perhaps eye care providers have become too complacent with their treatment regimens, but most patients have exceptional outcomes. For those of you who have had the opportunity to have a pseudomonas or acanthamoeba keratitis land in your chair, you probably have a thing or two to say about how cautious we should be with all of our corneal ulcer patients.

Late today, I had one of those questionable peripheral infiltrates. It was about 1.5 mm from the limbus, it was just over 1 mm in size, and had no apparent ulceration on the surface. The patient was not photophobic and the eye was white, and the AC was entirely clear. I didn't culture. I trust these things to not be MK... do you?

Viewpoint: This month, researchers look into MK more closely on the Silicone Hydrogels website: www.siliconehydrogels.org. It's an incredible place to learn about subjects related to the latest contact lens material revolution. For the wellness of our patients, it's my recommendation that you take a look at MK closer by visiting that site.

As for the Magic Kingdom, I've had enough of that MK for now!

Later,
Scott

In response to: [Microbial Keratitis and You](#)

sjens [Member]

Kent,

No I was not treating central ulcers... did something I write make it sound that way? The only case that I specifically referenced as an infiltrate that was 1.5 mm from the limbus. If you have any thoughts, please share them.

Scott



03/05/06 @ 11:56

In response to: [Microbial Keratitis and You](#)

Kent Juffer, O.D. [Visitor]

Were you treating central corneal ulcers?



03/05/06 @ 10:05

In response to: [Microbial Keratitis and You](#)

jwarrenod [Member]

Scott,

In 13 years of clinical practice (close to five spent in an OMD practice) I have never cultured a corneal lesion.

John Warren, OD



12/08/05 @ 08:50



[3 comments](#)

11/17/05

📅 02:00:32 pm, Categories: [General](#), 645 words 

Be Our Guest (Scott Jens)

In just seven short days, I'll be hiking up a pair of swim shorts much bigger than a Speedo to enjoy the sand-bottomed pools at Disney's Beach Club Resort in Orlando. For a lifelong Wisconsinite who is already sick of the snow since we saw a couple of inches this week, I cannot wait for the cabin doors to shut and all portable electronic devices to be turned off prior to our flight to sunny Florida.

Installment one of this series included a description of my interest in the business principles of Walt Disney. Here's a guy who built an amusement park in southern California for his kids to have a place to visit just like he had when he was a kid. He put a 1/8 scale train set in his backyard because he loved the idea of riding his own train. He dreamed big, and he made his biggest dreams come true.

When I was a ten year old obnoxious big brother, my parents took my little brother and I in a Pontiac station wagon (yeah, pine green with faux wood laminate siding) to a conference in South Carolina. We took a two day side trip to Orlando to see the big mouse, and the rain seemed to dampen our enjoyment of the brand new (actually 5 year old) Magic Kingdom park. But I did remember the way that the people who worked in the park treated us... they made us feel like we were special.

Fast forward to June 1991, when my wife and I tied the knot and took a trip to the Walt Disney World complex as a honeymoon. The reintroduction to the Disney spirit was amazing. Customer service was what it was all about. They had us hooked. As we prepare to revisit the World again next week, my count of Disney vacations since 1991 is over a dozen.

Before you tell me to get a life and spend some cash on a trip to Arizona, SoCal, Cape Cod, or St. Thomas, let me explain what keeps us coming back.

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The workers at the parks and hotels of Walt Disney World are referred to as "cast members," and the customers are "guests." No exceptions allowed... treat the customer like a guest!

Viewpoint: We all like to be treated like a guest. In particular, our patients like to be treated like they really mean something to the doctor, the technicians, the front desk staff.

In all too many situations in the American health care machine, patients are not directly spending their own money on their decisions and they begin to act as though they are entitled to your best service. The health care entities then treat them like they are entitled to the most basic service, nothing more. That polarity results in unhappy health care providers and unhappy patients.

I go back to Disney World as much as I do because I like to watch the new employees try to grasp the "be our guest" philosophy. I enjoy seeing a cast member trying to keep guests happy as they wait for a parade in the rain. It is a treat to have a business actually attempt to raise the bar on the service they provide.

Then I bring those observations back to the office, and try to reenact them. I work to give my best to every patient, no matter what kind of a day it is away from the office. And I compel my staff to believe that they should be having fun with their patients and they should be trying to get to the point where the patient walks out the door and says, "That was a very enjoyable appointment."

I know that I will leave Orlando in a couple of weeks saying, "That was a very enjoyable vacation."

Until next time,
Scott

Scott A. Jens, O.D., F.A.A.O.

No comment yet...



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11/10/05

🕒 03:42:57 pm, Categories: [General](#), 435 words 

Talking Diabetes (Scott Jens)

Do you talk diabetes? I mean, do you actually TALK diabetes. Eye care providers should spend as much time educating their patients as examining their patients. Most patients' understanding of diabetes is as good as their understanding of astigmatism, glaucoma, and presbyopia: they don't get it.

Every optometric practice management journal has had annual issues about diabetes management. They focus on clinical issues, new technology in diabetic

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management, and new surgical techniques. The discussion of patient education is always at the forefront, and we all have a commitment to teaching our patients about their diabetic eyes.

But what if you surveyed your last 100 diabetic patients about their understanding of their condition or their risk for diabetic retinopathy? Do you do a good job in explaining how diabetes affects the eyes? Do you give your patient a sense of empowerment over their condition? Do you give a the patient a sound reason to return annually?

The standard talking points that you use with your diabetic patients probably feel very comfortable. You know how much time you have, and you know what seems to work to get your patients to nod their heads with an appreciation of understanding.

Patient education on all matters of eye health and vision must be a core of your practice. Many ODs use printed handouts to educate, and others have gone toward software programs and practice websites. The central function of an excellent EMR is an education module.

VIEWPOINT: To explain how I view patient education about eye health, I use a phrase that I saw in an Acuvue(TM) Eye Health Advisor video:

*It's not that patients don't CARE

*It's that they don't KNOW

*It's our responsibility to EDUCATE them

To rephrase in terms of the diabetic, it's not that the diabetic patient doesn't care about diabetic retinopathy, it's that he doesn't know anything about diabetic retinopathy... so how do we educate him?

Recently, I found this interactive tutorial that runs on a Macromedia Flash Player. It is within the Medline Plus website of the National Library of Medicine and the National Institutes of Health:

http://www.nlm.nih.gov/medlineplus/tutorials/diabeteseyecomplications/html/_no_50_no_0.htm

It is a well done presentation of the details about diabetic retina disorders and associated ocular problems. As a patient education tool, it's as good as many that would cost a fair amount of money. Can you use a tool like this to "talk diabetes" with your patients?

I think so. Tell me if you have other ideas for excellence in patient education.

Regards,
Scott

Scott A. Jens, O.D., F.A.A.O.

📅 12:30:22 pm, Categories: [General](#), 473 words 

Eye Care in the 21st Century (Scott Jens)

Installment #2 of the Eye Dream blog. Hopefully, we can get some practice management ideology out on the table via this forum. I know that as readership escalates, there will be many experts in eye care that will pick up on this trail and offer their insights.

I want to encourage you to read a book called "The World is Flat: A Brief History of the 21st Century" by Thomas Friedman. You should be engaged in a trend that the author refers to as "Globalization 3.0," the globalization of the individual.

Many times during my practice day, I get thoughtful advice from my patients. Often, they are trying to be helpful with insight about how to raise children, how to take the best vacation you've ever imagined, etc.

When one patient noted our clinic's interest in patient wellness via use of technology, he strongly recommended that I get this book. Since so many patients offer these kinds of recommendations, I have learned to filter them. But this time, this guy seemed to be giving a stronger-than-usual recommendation. So I sought out "The World is Flat."

Friedman suggests that there have been stages of globalization that have occurred since the Berlin Wall fell. The first phase was globalization of countries, followed by globalization of corporations, and now globalization of the individual. There are parallels in eye care.

Optometry in particular was a private practice profession with few employed doctors. They lived in their own little worlds, had little need for relationships with other health care providers. Slowly optometrists in a greater percentage moved toward employed status, working for corporate entities with store-front locations, working for ophthalmology groups, and working for HMOs.

The resulting environment is one where ODs are as likely to be found in private practices as group practices and multi-disciplinary medical groups. Optometrists provide a critical health care service that is better understood by primary physicians. Optometrists work in concert with ophthalmologic sub-specialists and must communicate clearly with them for the patient's wellness to be maximized.

All of the communication tools available to an optometrist must be utilized for a patient to receive coordinated care. Pharmacy prescriptions must be filled accurately and timely; primary physicians must know about exam findings that are pertinent to the patient's medical care; nurse educators must know how to help a diabetic manage her Hb a1c measurements better.

Viewpoint: If you are reading this blog, you get the technology thing. Do yourself a favor, read "The World is Flat." You will nod your head about many of the amazing technology arguments that the author makes. And perhaps you will see the

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parallels to today's optometrist being a "global" practitioner. IF he or she chooses to use technology, the future is very bright for patient and doctor.

Until next time,
Scott

Scott Jens, O.D., F.A.A.O.

No comment yet...



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10/26/05

🕒 11:52:22 am, Categories: [General](#), 549 words 

Eye Dream, Eye Believe: The Jens Viewpoint (Jim Schneider)

Welcome to "Eye Dream, Eye Believe: The Jens Viewpoint."

In what I hope is the first Blog of many, I will give you a brief summary of who I am and what it will be about.

Mostly, I'm an average optometrist who sees kids, adults, seniors, who loves to provide eye and vision care services to the greatest extent my license allows, and who when the day is done enjoys the finer pleasures of family and free time like coaching youth sports, taking a run, or going to a comedy film with my wife.

Optometry has an opportunity in the next three decades to affect the wellness of its patients more uniquely than any other health care profession. People want good eyesight, and the independence that is associated with it. We practice within a "wellness" framework that helps our patients manage their vision and eye health conditions for maximum quality of life.

I am a new member of the EyeCodeRight team, and will ultimately serve as the director of professional affairs as projects move forward. The hope is that this blog will stimulate your thoughts about practicing eye care within the framework that I have just mentioned. As for more about me...

Vital stats:

- *University of Wisconsin - Madison
- *Illinois College of Optometry (1991)
- *Primary Care Optometry with full Therapeutic privileges
- *Private group practice, Madison and Middleton, WI
- *Past President, Wisconsin Optometric Association
- *Volunteer, American Optometric Association

Viewpoint: It is increasingly evident that optometry has taken its proper place within the conventional health care model. ODs practice on Native American reservations and in multidisciplinary clinics, they have secured hospital privileges and work with school OTs, and they use Brock strings and excimer lasers.

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To varying degrees, of course, optometrists have taken their clinical competence to levels that were not dreamed of in the mid-20th century. Oklahoma ODs perform some laser therapeutic procedures, Kentucky ODs provide mandated professional eye examinations for every entering kindergartner, nationally one-third of AOA members provide InfantSEE assessments in the first year of life...

It's a great time to be an optometrist. But all is not rosy. Doctors are struggling with their clinic employers on RVU-based pay scales, private practice ODs are struggling with reimbursement rates from vision plans that have been grabbed by local employers, and retiring doctors are having a hard time finding new grads to take interest in breathing life into their aging practices as a career choice.

I tell optometrists to apply the principle of a scrawny kid born in Chicago, who grew up for a while in small town in Missouri, who grew into one of the most pivotal visionaries in American history: DREAM, BELIEVE, DARE, DO. For Walter Elias Disney, this principle founded an empire that was based on the foundation of enjoying life while expanding one's horizon beyond the current view.

Eye Dream, Eye Believe: In this forum, I will work the Disney philosophy into the eye care model that is evolving. Every day, we dare to take on new initiatives that will help our patients, and we do what is best for our practices. Dream of the greatest, and believe you can make it happen.

Welcome, and I hope you will write back as time permits.

Scott

Scott A. Jens, O.D., F.A.A.O.