Happy New Year from OCOS
Dear OCOS colleagues,

On behalf of myself and the OCOS board, we would like to wish everyone a very happy holiday season! The OCOS hosted its annual holiday party on the evening of December 9th at the Marconi Auto Museum. We enjoyed good food and good company with staff, family, and friends as we celebrated your membership this year. Check out photos from the event in this issue!

I had the privilege of attending President’s Council at the Monterey Symposium last month. For 4 hours, local society leaders from all across the state convened to discuss the future of our profession and to hear updates on our changing health care system. Knowledge is key! If you have downtime between patients, go to coveredca.com and read about the health plans in your area. Also our weekly GA emails provide links and information about Accountable Care Organizations (ACOs), the future implementation of ICD-10s, and much more. COA and OCOS are here to help ease this transition for you.

Looking forward to 2014, the future of optometry looks bright. We are still working on Senator Ed Hernandez’s bill SB 492 (our scope expansion bill). It will be Dr. Ed Hernandez’s election year and we ask that you support his campaign. Here is the link to donate: https://secure.netolhost.com/www.edhernandez4senate.com/contribute.html His pro-optometry work has done great things for our profession and we need his presence in Sacramento to keep optometry at the forefront of healthcare.

All business aside, the holiday season is upon us. I am truly grateful for the blessings in my life and for being a part of OCOS. Thank you for your support this year and I look forward to a productive 2014! Again, happy holidays and I wish you and your family the best of the season! Cheers!

Isabell Choi-Srirata, O.D.
OCOS President
OCOS General Meeting
2 Hours of CE
February 10th * 6-9 pm

Sally Dang, OD
Low Vision Rehabilitation in the Primary Care Setting

Azadeh Khatibi, MD, MS, MPH
The New Frontier of the Retinal-Vitreous Interface: Update on Evaluation & Treatment of Vitreomacular Traction Syndrome and other Related Retinal Diseases

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“It has been my pleasure to work in cooperation with family eye doctors for over 15 years” - Tom Tooma, MD, Founder
Thanks to all of our sponsors and guests for making the 2013 OCOS Holiday Mixer such a fun event... And even more thanks to Dr. Rebecca Ng and Dr. Eunice Myung-Lee for planning and pulling it off!
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Preoperative Evaluation of the Ocular Surface

Prior to proceeding with refractive surgery or cataract surgery, it is important to properly evaluate the ocular surface. Ocular surface disease is quite prevalent and can have a profound effect on the results of an otherwise successful surgery.

A healthy ocular surface is vital preoperatively, since biometry, topography, Wavescan imaging and refractions can all be adversely affected by a suboptimal ocular surface. Patients have high expectations with refractive surgery and premium IOL implantation, so it’s essential to listen to your patient’s preoperative symptoms and concerns.

A preoperative dry-eye condition should be treated vigorously. Preservative-free artificial tears, gel-based lubricants and topical cyclosporine drops are all employed to treat dry eyes. Punctal plugs, soft steroids and omega 3 supplementation can also be added to the regimen.

Meibomian gland dysfunction (MGD) is often a causative factor with dry-eye patients. Careful observation of the eyelid margins and glands are important. We often recommend aggressive treatment of MGD with lid hygiene, topical antibiotics and oral doxycycline.

Allergic conjunctivitis can also affect the ocular surface, particularly if patients are taking systemic antihistamines. Contact lens wearers often have problems with ocular allergies. Antihistamine drops and mast cell stabilizers can be employed to treat these allergies preoperatively.

Thorough screening of all surgical patients for dry eyes, MGD and allergic conjunctivitis is vital to ensuring a good outcome for refractive and cataract surgery. Aggressive treatment of ocular surface disease is needed prior to initiation of preoperative measurements. Patients should be fully counseled about their best surgical options, given their pre-existing ocular surface disease. An educated patient, who is fully treated for ocular surface disease, will have a much more successful surgical outcome.
NVISION Laser Eye Centers Acquires Another Eye Center in Sacramento

This is NVISION's third acquisition in Northern California this year.

NVISION Laser Eye Centers has expanded again in Northern California with its acquisition of another Sacramento-based eye center – this time Capital Eye Medical Group in Carmichael, California.

“We are thrilled that Dr. Mitra Ayazifar, with Capital Eye Medical Group, will be joining the NVISION family,” says Todd Cooper, CEO of NVISION. “Dr. 'Mitra', as she is known by her patients, will be joining Dr. Richard Meister, Chief Surgeon, at our newest NVISION Laser Eye Center location in Sacramento.”

“Dr. Mitra will continue to offer her current and new patients comprehensive ophthalmology services, and oculoplastic surgery (cosmetic and functional eye lid procedures) as well as cataract surgery at the NVISION Sacramento location,” said James Pereyra, Vice President of Business Development at NVISION.

“I am thrilled to join the NVISION family,” says Dr. Mitra. “It is truly an honor to be part of a company that is an innovative leader in the lifestyle surgical eye care with its exceptional team of surgeons who provide superior outcomes.”

Dr. Mitra received a bachelor’s degree in Molecular and Cellular Biology from Berkeley; a medical degree from George Washington University School of Medicine and Health Sciences in DC; and her Ophthalmology Residency took place at Rhode Island Hospital/Brown Medical School.

For more information about LASIK in Sacramento, go to www.nvisioncenters.com.
“Don’t forget the Binoculars”  
Andrew Morgenstern, O.D.

Performing a comprehensive eye examination as part of the LASIK evaluation process is critical. It is easy to remember the refraction, slit lamp exam and the fundus exam, but one component that you must remember to complete on every refractive candidate is a good old-fashioned binocular evaluation. The cover test tells us a tremendous amount of information. There are many reasons why we need to know the ocular posture of the eyes prior to the procedure. Remember, we are altering the refractive state of the eyes. There are many involuntary linked sensory and motor mechanisms in place that will affect the post-operative ocular posture. There have been rare cases of a patient having a decompensating phoria or tropia that is masked prior to the procedure but becomes a constant issue that causes diplopia after the procedure.

As we all know, taking a great and detailed patient history is one of the most important parts of the exam. Make sure to ask if there is any history of amblyopia, strabismus and most importantly prior strabismus surgery. These patients may posture at ortho but may function atypically because of the off-set extra-ocular muscles. For any patient that has had prior strabismus surgery, it is advised to get a consultation with a Pediatric and Adult Strabismus specialist. In a nutshell, you want to be able to predict what the final binocular status will be as best as possible. Also, do not forget to have a complete discussion with the patient about the lower predictability of outcome based on the previous surgery.

Remember, your patient may be 20/20 but if they see 2 of everything they will most likely not be happy and potentially need a strabismic surgery to correct the problem. Don’t forget the binoculars!

FOCM: Physician Spotlight  
with Dr. Eric Donnenfeld, M.D.

At TLC Laser Eye Centers, we are proud to highlight our outstanding surgeons. This month we would like to introduce you to Eric Donnenfeld, MD. Among many other professional accomplishments, we are so proud that Dr. Donnenfeld is the current President of ASCRS (American Society of Cataract and Refractive Surgery) the premier international organization for refractive surgeons. He is also the Medical Director of the Garden City, Long Island and Fairfield Connecticut TLC Laser Eye Center locations.

As the President of ASCRS, you have many responsibilities and a very high standard to uphold. I would like to conduct this interview from the perspective of your ASCRS Presidency since they have in the past, present and future been the primary authoritative figure in LASIK education.

AM: What does ASCRS do and why is it important to us managing doctors?
ED: ASCRS is an organization of ophthalmologists dedicated to anterior segment surgery. Part of the main mission of ASCRS is education. Recently, ASCRS developed the IOFD Committee, (Integrated Ophthalmic Managed EyeCare Delivery) a task force integrating optometrists and optometric education into the ASCRS organization to help deliver education.

AM: How safe is LASIK?
ED: LASIK is the safest procedure that has ever been developed and also one of the most researched and studied. In 2013, the quality of the LASIK procedure is unparalleled in its safety and accuracy. A substantial number of patients actually see better after the procedure without glasses than prior to surgery with their best refraction. Of all different groups, Ophthalmologists and Optometrists are the most likely to have undergone LASIK, which is a testimonial to the safety and accuracy of the procedure.

AM: What is the ASCRS opinion on femtosecond laser flap creation?
ED: Again, ASCRS is an educational organization, we strongly believe in new technology which improves patient care. Femtosecond lasers are very, very safe and effective. Ultimately, it is up to the individual surgeon to make the best decision regarding surgical equipment for her/his patients.

AM: Does ASCRS make surgical recommendations?
ED: ASCRS makes recommendations on best surgical procedures especially if a problem is identified in the community. Via the education mission, there is a formal committee on refractive surgery. When the refractive committee recognizes a problem, it can create a position paper to educate and evaluate the problem in question and make a best practice recommendation. We recently saw this regarding ophthalmic medications used in refractive procedures.

AM: How does TLC stand in regard to the ASCRS best practice guidelines?
ED: From my personal perspective, I am proud to say that TLC's best in care guidelines provides an extraordinary high quality of care to our patients. In terms of refractive surgery, TLC is a national leader in refractive surgery due to its commitment to working with leading ophthalmologists and optometrists while providing the latest and best in technology.
We are excited to announce that **TLC Laser Eye Centers** has launched a joint venture partnership with **Harvard Eye Associates** at our Laguna Hills location.

**TLC brings your patients the very best** in technology, surgical outcomes and a personal approach for both LASIK and refractive IOL’s. TLC was founded on the philosophy of co-managing patients with Optometry, working with some of the most experienced surgeons while maintaining our strong commitment to our affiliate optometrists.

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**Addressing the Visual Experience of Hyperopic and Myopic Presbyopes**

Shamir’s R&D team focused on the fact that although their lens design is the same, each patient’s perceived viewing field is significantly different, based on their prescription. A minus power lens increases the field of view, while a plus power lens has the effect of reducing the field of view. This results in hyperopic patients experiencing a narrower viewing field than that experienced by their myopic counterparts.
Just in case you were worried about having enough patients, I have some good news for you. With the aging of the US population, we are all going to have to deal with more patients needing cataract surgery. Currently, there are about 20.5 million people in the country age 40 years and above who have cataracts. In 2010, there were 24.4 million cataract surgeries performed in the USA, which is an approximately 19% increase compared with the year 2000. By the year 2030, it is estimated that there will be approximately 38.7 million cataract surgeries performed in the United States.

The need for comanagement of cataract surgery is ever-increasing. Despite the projected increase in cataract surgeries, the number of ophthalmologists is expected to remain the same over the next decade. This will result in growing demands on the time of the operating surgeon as well as the need for the cooperative management of these patients pre-and postoperatively.

So now you are in your office and a postoperative cataract patient comes to see you. What are the top 10 things that you should look for in these patients to ensure that they have successful outcomes?

1. **Find out what kind of surgery, IOL, and focus (near, far, multifocal) the patient received, and whether any complications occurred.** It is vital to find out as much as you can about the surgery in order to manage it effectively postoperatively. For instance, was laser assisted cataract surgery performed, or were limbal relaxing incisions (LRI) performed for astigmatism management? If monovision or a multifocal IOL was employed, be sure to check the near vision using good lighting. Also, do not forget to aggressively manage dry eye disease, as this can make a huge difference in their final outcomes, comfort and quality of vision.

2. **Always make sure that the incisions are not leaking, especially during the first week postoperatively.** Do this by checking the wound after having placed fluorescein in the eye and gently applying pressure on the eyelid in a location opposite the wound. If it's a slow leak, you can place a bandage contact lens and prescribe pressure lowering eye drops and see them back in a couple of days. If it's a larger leak, contact the surgeon for possible suture placement.

3. **Check for cells in the anterior chamber.** This vital step is often overlooked. This is especially important part of the exam, and these are best noted in a darkened room with a thin, shorter slit beam. Typically, within the first week, you might find up to +2 cells in the anterior chamber. If this is the case, have them continue their steroid and NSAID drops as indicated. However, if you see more cells, consider increasing the frequency of the steroid eyedrops and seeing them back sooner. Of course, if you have any questions, you should contact the operating surgeon.

4. **Check the intraocular pressure.** A very important part of the examination, applanation tonometry should be used on every postoperative visit. The most common reason for increased intraocular pressure after cataract surgery is the retention of viscoelastic, the thick
fluid we used during surgery in order to maintain the anterior chamber. If the pressure is less than 30 mmHg, have them continue their current drops and see them back in a week—unless they have a history of glaucoma, in which case have them restart their preoperative glaucoma drops. If the pressure is between 30 and 39, consider using brimonidine and see them back in a week. If the pressure is between 40 and 49 consider using a combination drug such as Combigan (check for asthma, heart/lung problems or stroke before using a beta blocker) and Azopt while increasing the use of the steroids to Q2 hours and see them back in 1 to 2 days. If the pressure is 50 or above, consider adding an oral medication such as Diamox or Neptazane for five days (check for sulfa allergy and kidney problems), increase the steroid to Q1 hour, add Lumigan in addition to the Combigan and Azopt, and see them the next day. Alternatively, the pressure can be low, in which case you should rule out a wound leak as above. Again, consult the surgeon with any questions.

5. **Check for corneal edema.** This is most common in the first week after surgery. Patients with Fuchs dystrophy tend to have more corneal edema and can heal more slowly than others. Muro eye drops can be used if there is persistent edema after one week. Slightly higher intraocular pressures (20 to 30 mmHg range) can actually help decrease corneal edema.

6. **Check the anterior chamber to make sure it is well formed.** If the anterior chamber is shallow, make sure to look for a wound leak. If the pressure is low, a wound leak is more likely, but choroidal detachments can also do this (do a dilated exam if you suspect this). If the pressure is normal to high, this could either be acute angle closure from a pupillary block or even aqueous misdirection (the latter being more common in hyperopes). Again, consult the surgeon.

7. **Make sure there are no pieces of residual nuclear/cortical lens material in the anterior chamber.** Always look at the bottom half of the anterior chamber to look for wayward pieces of the cataract that might have hidden during surgery. If small and cortical (more white and fluffy is cortical, more yellow/green and defined is nuclear), then these pieces might dissolve on their own with time and increased use of the steroid eye drops. Monitor the situation closely (every 3-7 days depending on the severity of the cellular reaction. If there is significant (+3 cells) iritis or if the cornea remains edematous as a result of endothelial damage due to the cataract pieces, refer this patient back to the surgeon for possible surgical removal.

8. **Always be on the lookout for endophthalmitis.** This is a potentially devastating complication which is quite rare. Usually, this presents in days five through seven postoperatively with pain, photophobia, injection, dense anterior cellular reaction, vitritis and hypopyon. Consult the surgeon immediately if you suspect this.

9. **Dilate the patient at 1 month and 3 months postoperatively.** It is especially important to have a good look at the fundus in diabetics and those with preexisting retinal pathology such as epiretinal membranes, which can worsen postoperatively. Cystoid macular edema (CME) tends to occur most commonly 4-6 weeks after surgery, so also be on the lookout for decreased vision and macular cystic changes (best seen on OCT). CME is treated with NSAIDS and possibly steroids.
once it occurs, but it is best to prevent it by keeping the patient on NSAIDS for at least 4-6 weeks postoperatively. Also, it is important to check for proper axis orientation of the IOL if it is a toric IOL (such as the Acrysof Toric or the new Trulign Toric, which is an astigmatism correcting accommodative IOL) and also to check for proper positioning of the IOL. Make sure that the optic of an accommodative IOL (Crystalens, Trulign Toric) is vaulted posteriorly, and also check behind all IOL types to see if posterior capsular opacification is visually significant or causing anterior displacement of the IOL optic (requiring a YAG capsulotomy).

10. **Be encouraging and positive, and never criticize the surgeon or surgery.** This may seem trite, but what a difference it makes! Let the patient know how good their eye looks to you, how nice their IOL is, and how pleased you are with their outcome. Congratulate them on their success, show unwavering support for their decision to undergo surgery and for which IOL and method of surgery (laser assisted cataract surgery or standard surgery) they chose. Lavish praise on the surgeon (I like this one) and give yourself kudos for guiding and caring for the patient throughout. Show them you care with a simple touch on their shoulder or a shake of the hand, always with a warm smile. These simple things make a world of difference to the patient, who will then turn around and tell all of their family and friends what a wonderful doctor you are!
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Staying on Track with Your Retirement Investments

Investing for your retirement isn't about getting rich quick. More often, it's about having a game plan that you can live with over a long time. You wouldn't expect to be able to play the piano without learning the basics and practicing. Investing for your retirement over the long term also takes a little knowledge and discipline. Though there can be no guarantee that any investment strategy will be successful and all investing involves risk, including the possible loss of principal, there are ways to help yourself build your retirement nest egg.

Compounding is your best friend

It's the "rolling snowball" effect. Put simply, compounding pays you earnings on your reinvested earnings. Here's how it works: Let's say you invest $100, and that money earns a 7% annual return. At the end of a year, the $7 you earned is added to your $100; that would give you $107 in your account. If you earn 7% again the next year, you're earning 7% of $107 rather than $100, as you did in the first year. That adds $7.49 to your account instead of $7. In the third year with a 7% return, you'd earn $8 and have a total of $122. Like a snowball rolling downhill, the value of compounding grows the longer you leave your money in the account. In effect, compounding can do some of the work of building a nest egg for you.

The longer you leave your money at work for you, the more exciting the numbers get. For example, imagine an investment of $10,000 at an annual rate of return of 8%. In 20 years, assuming no withdrawals, your $10,000 investment would grow to $46,610. In 25 years, it would grow to $68,485, a 47% gain over the 20-year figure. After 30 years, your account would total $100,627. (Of course, these are hypothetical examples that do not reflect the performance of any specific investment and assume that no taxes are paid or withdrawals are made during that time.)

If your workplace savings plan contributions are made pretax, as most people's are, compounding really becomes a powerful force. Not having to pay taxes from year to year on either your contributions or the compounded earnings helps your savings grow even faster (though you'll owe taxes on that money when you start withdrawing from your account). The value of compounded tax-deferred dollars is the main reason you may want to fully fund all tax-advantaged retirement accounts and plans available to you, and start as early as you can. Money invested over time offers the greatest potential for compounding to help produce a significant return. With time on your side, you don't necessarily have to aim for investment "home runs" in order to be successful.

Diversify your investments

Asset allocation is the process of spreading your dollars over several categories of investments, usually referred to as asset classes. A basic asset allocation would likely include at least stocks, bonds, and cash or cash alternatives such as a money market fund. The term "asset classes" also may refer to subcategories, such as aggressive growth stocks, international stocks, investment-grade corporate bonds, and high-yield or "junk" bonds.

Asset allocation is important for two reasons. First, the mix of asset classes you own is a large factor--some say the biggest factor by far--in determining your overall investment portfolio performance. How you divide your money between stocks, bonds, and cash can be more important than your choice of specific investments. Second, by dividing your portfolio among asset classes that don't respond to
market forces in the same way at the same time, you can help minimize the effects of market volatility while maximizing your chances of long-term return. Ideally, if your investments in one class are performing poorly, assets in another class may be doing better and may help stabilize your portfolio.

Remember that during any given period of market or economic turmoil, some asset categories and some individual investments historically have been less volatile than others. Bond price swings, for example, have generally been less dramatic than stock prices. You can manage your risk to some extent by diversifying your holdings among various classes of assets, as well as different types of assets within each class. Taking steps that can help manage the amount of volatility you experience can help you stay with your game plan over the long term.

**Take advantage of dollar cost averaging**

One of the benefits of having a systematic investment plan is that you’re automatically using an investment strategy called dollar cost averaging. With dollar cost averaging, you acquire shares of an investment by investing a fixed dollar amount at regularly scheduled intervals over time. When the price is high, your investment buys less; when prices are low, the same dollar investment will buy more shares. A regular, fixed-dollar investment should result in a lower average price per share than you would get buying a fixed number of shares at each investment interval.

The accompanying graph illustrates how share price fluctuations can yield a lower average cost per share through dollar cost averaging. In this hypothetical example, ABC Company’s stock price is $30 a share in January, $10 a share in February, $20 a share in March, $15 a share in April, and $25 a share in May. If you invest $300 a month for 5 months, the number of shares you would buy each month would range from 10 shares when the price is at $30, to 30 shares when the price is $10. The average market price is $20 a share ($30+$10+$20+$15+$25 = $100 divided by 5 = $20). However, because your $300 bought more shares at the lower prices, the average purchase price is $17.24 ($300 x 5 months = $1,500 invested divided by 87 shares purchased = $17.24).

In addition to potentially lowering the average cost per share, investing the same amount regularly automates your decision-making, and can help take emotion out of investment decisions.

**Stick to your strategy**

Try to resist the impulse to change your investment strategy with every news headline or investing tip from a relative or coworker. Timing the market correctly is very difficult; even professionals find it a
challenge. Most people fare better by having an investment game plan that can weather good times and bad, and then sticking to it.

That doesn't mean you should simply forget about your investments altogether. At least once a year, you should review your portfolio to see if your choices are still appropriate. Even if your circumstances haven't changed, market movements can affect how your money is divided among various types of investments. For example, if one type of asset has been very successful, it may now represent too large a share of your holdings. To rebalance your portfolio, you could sell some of an asset that's now larger than you intended and buy more of a type that is lower than desired. Or you could keep your existing allocation but shift future investments into an asset class you want to increase. But if you don't review your holdings periodically, you won't know whether a change is needed.

Disclosure: All investing involves risk, including the possible loss of principal, and there can be no assurance that any investment strategy will be successful. And diversification alone cannot guarantee a profit or eliminate the possibility of loss, including the loss of principal. Broadridge Investor Communication Solutions, Inc. does not provide investment, tax, or legal advice. The information presented here is not specific to any individual's personal circumstances. To the extent that this material concerns tax matters, it is not intended or written to be used, and cannot be used, by a taxpayer for the purpose of avoiding penalties that may be imposed by law. Each taxpayer should seek independent advice from a tax professional based on his or her individual circumstances. These materials are provided for general information and educational purposes based upon publicly available information from sources believed to be reliable—we cannot assure the accuracy or completeness of these materials. The information in these materials may change at any time and without notice. Prepared by Broadridge Investor Communication Solutions, Inc. Copyright 2013.

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When LA Magazine asked 31,000 doctors "Who would you choose as your doctor?" only two vitreo-retinal specialists in Long Beach and Orange County were named by their peers from 2010 through 2012
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