OCOS Meeting
April 15

2 Hours CE
6-7 Cocktails 7-9 Dinner

Emery Huber, OD:
“VEP for the Office - How New Technology Improves Patient Care & Practice Revenue”

$40 members
$55 non-members
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Charlie Palmer
@ Bloomingdale's, South Coast Plaza
On the eve of my departure, I stop to think of all the changes headed our way.

It’s a changing time in optometry. With healthcare on the verge of massive overhauls and with more patients coming into the system it is certain optometry will play a strong role in administering preventative and frontline care.

The society itself is still a force to be reckoned with as our presence in Sacramento has shown. This is the best opportunity to continue to expand our scope of practice as well as redefine optometry. Senator Ed Hernandez has positioned himself superbly to engineer the care of the more than 4 million people into the healthcare system and with it the cause of the COA. COA’s main cause continues to be to advance optometrists and their scope, to increase membership, and to insure the future of optometry in healthcare. I personally have seen benefit in COA membership and will continue to champion the cause especially now that we are all entering a new phase in 2014 with the Affordable Care Act.

This year has been good to me. At first I felt overwhelmed by the workload and the emailing but as the year progressed the relationships I forged reminded me of why we do this job. Through these relationships OCOS has managed to recruit promising new board members, and given industry representatives a better knowledge of what optometrists do. Last but not least, the relationships I made in Sacramento with Assembly members will keep optometry strong when it comes time for new legislation. If you think about it, life is really just a series of relationships; hopefully more good than bad.

So I’d like to thank the board who has helped me lead and who by far has done much of the heavy lifting this year. I’d also like to thank the membership who we tirelessly strive to keep informed and who we live to serve. It’s been great to know the speakers who have donated their time and effort to provide the utmost cutting edge research and technology. And finally many thanks to the sponsors without whom none of this would be possible. It has been fun and stressful but most of all rewarding. I look forward to seeing you all soon.

Christopher Vargas O.D.
Immediate Past President

Perceptions
Orange County Optometric Society

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APRIL OCOS MEETING @ Charlie Palmers

Installation of 2013-2014 OCOS Board

Speaker Emery Huber, O.D.

LEGISLATIVE NEWS

SB 492 has cleared its first hurdle by passing out of the Senate Business and Professions Committee on an 8-0 vote.

Next up is the Senate Appropriations Committee which needs to hear the bill prior to May 24th. It should be noted that our own member and COA past president Harue Marsden spoke in support of our bill in Sacramento.

While this is an important first step, this bill is in the earliest stages. Due to the myriad changes occurring in 2014, COA is working hard to make it law by the end of the year.

Please read all communication from the COA this year as they may include links to email your legislators. These emails take 2 minutes and can really aid in getting this bill passed. Thank you!

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With the burgeoning senior population, shared management in the care of the surgical cataract patient will become increasingly important to better meet the needs of our patients. Whether you are a seasoned comanaging optometric physician or thinking about it, there are a few very important pointers to keep in mind.

First, the patient's care plan for success begins as soon as the patient is identified as a cataract surgical candidate. The fact that the patient has a cataract and the best corrected visual acuity (BCVA) should be documented. It is also very helpful to test the patient's BCVA with lights shining in his/her eyes (glare testing) especially if their vision is 20/40 or better but they have subjective complaints of decreased vision or increased photophobia (for instance, driving at night with the headlights shining in their eyes). Finally, the subjective complaints of the patient must be sought and clearly stated—the most common complaints being unable to see things clearly, difficulty driving at night or in bright sunlight, difficulty seeing signs, or unhappiness with their glasses.

Since the source for most postoperative infections is the eyelid flora, **it is imperative to look specifically for blepharitis**—anterior blepharitis (scurf and collarettes around the lashes) and/or posterior blepharitis (inspissated meibomian glands). I routinely prescribe a topical antibiotic such as Azasite or Erythromycin ointment every night for at least two to four weeks prior to the surgery whether they have blepharitis or not. If they have blepharitis, then I will treat them additionally with lid scrubs (for anterior blepharitis) and/or warm compresses to the lid margins (for posterior blepharitis) daily.

Dry eye disease can also significantly impact the patient’s overall outcome and satisfaction since about 85% of the eye’s refractive power lies at the air-tear film interface. **Even after the most perfect surgery, the patient will see poorly and possibly perceive the surgery to be a failure if they have dry eyes.** Adequate treatment of this condition before and after surgery with artificial tears several times a day (preservative free if more than four times a day) and possibly Restasis can significantly improve their outcomes and overall satisfaction with the surgery (and your care!).

Once the patient has surgery, the surgeon will typically (but not always) see the patient at least once to make sure everything is ok. What kind of things is the surgeon (or the optometrist) looking for? The first thing to check is the uncorrected visual acuity. Of course, if the eye is aimed for near vision, check the near visual acuity. With the Restor or Tecnis multifocal, you can check distance and near vision. For the CrystaLens, typically the distance vision is the only one checked until the patient is at least one week out from the surgery; after that, the intermediate and near vision can also be checked.

**Typically, if vision is not very good on the first day or during the first week (about 20/80 or worse), it is due to corneal edema.** Ask yourself if this amount of corneal edema can explain their vision—if not, look at the lens and make sure it is in place and not tilted or decentered (if so, call the surgeon). Also, check the chart to make sure the patient does not have another preexisting condition that would explain this, such as macular degeneration or optic atrophy. If there is none, then you should dilate the eye to make sure the retina is flat and there are no tears.
or other problems such as a vitritis secondary to dislocated nuclear or cortical fragments (check to make sure the posterior capsule is intact).

**The pressure is also very important to check. If it is 30 mm Hg and higher, and if the patient is in pain or has glaucoma, then consider pressure lowering medications for a week.** I typically use brimonidine for pressures up to 40 mmHg or Combigan (make sure they have no asthma, heart problems, or lung problems such as emphysema or chronic obstructive lung disease) for pressures higher than this. If the pressure is above 50 mmHg, you should consider additionally prescribing acetazolamide or methazolamide orally for 3-5 days (check for allergies to sulfa medications, and make sure they do not have kidney problems) and talking to the surgeon. The most common reason for increased IOP after surgery is retained viscoelastic in the eye (used during surgery to maintain the anterior chamber), typically dispersing within 3-5 days. Depending on how high the pressure is, you should see them again within 1 to 7 days.

**Check the wounds with fluorescein and make sure there is no leak, especially if the IOP is below 10 mmHg.** If slowly leaking, consider a bandage contact lens and adding a pressure lowering medication (such as brimonidine) in order to lessen the amount of fluid traversing the wound, and then see them again in 1-2 days. If there is a bigger leak (you might notice anterior chamber shallowing), a suture might need to be placed, and you can contact your friendly neighborhood surgeon. Also, make sure there is no exposed lint coming out of the wound (which could act as a wick to invite bacteria in the eye)—if so, you can remove it by simply grasping it with non-toothed forceps if easy to reach (without applying pressure on the wound), or consult the surgeon. If you notice vitreous to the wound, a lens haptic coming out of the wound, hyphema, hypopion, an anterior chamber reaction that is +3 cells or more (or any posterior cellular reaction), or if you notice any nuclear fragments in the vitreous or in the anterior chamber, consult the surgeon.

**The dosing of the medications should be adjusted according to what is noted on the exam.** If the eye is relatively quiet, then the original medication schedule can be followed. If, however, there is a significant cellular reaction (more than +2) or if the patient is younger (60 years or below) or healthier, then you might need to increase the dosing of the steroid to every 2 hours and keep them on it for longer periods of time (up to two months or more with a tapering off of the steroid). The NSAID might also need to be continued for two months or more in this situation.

**So what should a perfect case and result look like?** Minimal injection of the conjunctiva and possibly a small subconjunctival hemorrhage, non-leaking healing incisions with minimal edema and no foreign objects, a cellular reaction of +1-2 cells, deep anterior chamber, well placed and centered IOL, a good red reflex, an IOP less than 25 mm Hg and vision that is improved depending on their preexisting conditions. If this is the case, the patient can be seen at the first week, 3-4 weeks postop and then again at 3 months postop. If the patient will do the other eye, refract the first eye within the first week if possible and send them to the surgeon. Glasses are typically prescribed 4-6 weeks after surgery.

At the Orange County Eye Institute, we are happy to comanage in the postoperative care of the cataract patient. Please feel free to contact me at gsalibmd@yahoo.com should you have any questions.
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ICL Surgery to Improve Our Troops' Vision

The Staar Intraocular Collamer Lens (ICL) continues to be an excellent surgical option for patients with high myopia. There have been over 400,000 ICL surgeries done worldwide. Several recent studies have reaffirmed the level of safety and clarity that the ICL provides for our patients.

The Army Warfighter Refractive Eye Surgery Program (WRESP) recently compared the ICL vs LASIK for their troops and tested specifically for scotopic vision using a night vision goggle (NVG) simulation. This prospective study found that the contrast sensitivity with NVG was significantly better with ICL surgery, as compared with wavefront-guided LASIK. Igarashi et al reported that when compared to wavefront-guided LASIK, the ICL induced significantly fewer higher order aberrations and showed improved contrast sensitivity from pre-op measurements.

Follow up studies from the original FDA study have shown that the rate of complication from ICL surgery remains very low over time. The ICL is also an excellent alternative for myopes who have thin corneas, dry eyes or small eyelid fissures.

Drs. Diana Kersten and John Hovanesian, of Harvard Eye, are pleased to offer ICL surgery as an option for our patients.
Let’s face it, we live in a drive thru society. Everyone wants everything all the time and they want it now. This concept is no different when patients are coming to you expressing interest in having laser eye surgery. Have you ever had the patient come into your office and ask to have their laser eye surgery NOW! A patient’s initial perception about any type of procedure is THEIR reality. If they think that a surgery is no big deal AND that it takes 15 minutes AND they can return to their normal life right away, well that is their perception and it is their reality. It may not be true but it is their reality. Our job is to give that patient exceptional care, properly manage their expectations and tell them the truth about the procedure and the typical expected results. The best way to do this is to have a full discussion about the benefits and risks of that procedure so the patient can make the best informed decision for themselves.

As our screening equipment inevitably gets technologically more advanced and as we continually learn who is a proper LASIK candidate, we find patients that will be better suited for PRK than for LASIK. So let’s say this is a real patient that is sitting in your chair and they are motivated to have LASIK. Their friends, mother and cousins all had LASIK. They woke up the next morning and had vision good enough to drive. There was minimal discomfort and almost no concerns after the procedure. Your patient wants the same exact experience but you notice that they have a −5.50 Rx and a cornea that is 482 microns at its thinnest point. After a proper corneal evaluation, there is no evidence of keratoconus. So your patient is a great candidate for PRK and not LASIK, how do you deliver the message?

**Always discuss the 4 main points about PRK:**

1. **Safety**—PRK is just as safe as LASIK, it just has different risks, not more risks. You can’t have a flap complication without a flap. Proper prescreening, follow-up and medical management may even make it safe than LASIK. There is a tremendous amount of new information regarding the biomechanical strength of the cornea that shows the post PRK cornea is more biomechanically strong than the post LASIK cornea.

2. **Vision**—The long term visual outcome is the same as LASIK. As we all know the initial recovery is longer but this is a procedure that is meant to last for the rest of the patient’s life, not the first 4 weeks. The slower visual recovery is a short term issue.

3. **Trauma**—For patients that are in a position (military, police, martial arts) where trauma to the eyes and head can be a more common occurrence, the incidence of complication is lower.

4. **Laser**—The same exact information goes into the laser for PRK and LASIK. The laser has no idea if we are doing a PRK or LASIK procedure. The actual ablation of the cornea (wavefront
Don’t be a Debbie Downer.

Patients read your body language better than you think they do. If a patient is a candidate for refractive surgery, congratulate them. This is a huge lifestyle change improvement! The worst thing you can do is say something like, “Sorry, you can’t have LASIK. The only surgery that would work for you is PRK, you may remember that PRK was the old laser surgery from the 1990’s. Oh yeah it hurts more than LASIK and you can’t see for a month.” I wouldn’t have the procedure either with that presentation.

Remember, pain control is much better than it used to be and even though there are times that a patient needs to take off work after the procedure, the typical PRK patient is back to work and on the road driving by themselves in 4-5 days. Try to phrase it like this: “Congratulations, you are a candidate for refractive surgery. Based on your results, the procedure that I would recommend for you that would give you the best visual outcome combined with the greatest level of safety is PRK. Everyone’s eyes are different, just like the color of everyone’s eyes. It is my job to take all of this information that is unique to you and figure out your best and safest option. I’m sure you will have questions, please let me know what they are.” PRK is a fantastic procedure that produces a tremendously high number of very happy patients. PRK does have its risks like infection and corneal haze. These risks are very minimal and in almost all cases can be resolved using eye drops and other medications. Don’t be afraid to talk about PRK. It has worked incredibly well for over 20 years in hundreds of thousands of patients.

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.
Dry eye disease is one of the common topics patients discuss with their eye doctor. Dr. Tom Tooma, Founder of NVISION, is one of the first ophthalmologists in Southern California to utilize this new treatment for patients who suffer from Evaporative Dry Eye disease.

This new, advanced in-office treatment, called LipiFlow®, is intended to treat patients with meibomian gland dysfunction by unblocking the glands and allowing them to resume the secretion of oily lipids needed for a healthy tear film. This disease stems from a deficiency in the oily lipid layer of the eye’s natural tear film. The oily lipids serve as a protective layer so that the aqueous layer of the eye’s tear film does not evaporate.

Dry eye disease affects more than 23 million Americans. Of those, 86 percent suffer from evaporative dry eye. Common symptoms of dry eye include dryness, grittiness, soreness, irritation, burning and eye fatigue. "Dry eye disease is one of the most common topics patients discuss when visiting their eye care professional," said Dr. Tom Tooma. "We want to make sure our 1400 referring ODs know that this treatment is now currently available at our Newport Beach location."

"Eighty-five percent of dry eye patients have meibomian gland dysfunction," continues Dr. Tooma. "Many of our patients are disappointed and ultimately non-compliant with warm compresses, lid scrubs, and long-term topical and oral medications. If meibomian gland dysfunction is not treated aggressively, the meibomian glands will atrophy and lead to permanent damage to the ocular surface.

"Lipiview and Tear Osmolarity are excellent diagnostic devices that allow an objective measure of the meibomian gland function and evaporative dry eye disease. Lipiflow is an excellent treatment modality that helps our patients by stopping the disease cascade and preventing permanent damage to the ocular surface. Most patients are happy that their life is no longer disrupted by the constant use of drops and medications and the cost associated with them," concludes Dr. Tooma.

In controlled clinical studies of patients who received a single LipiFlow treatment, the average meibomian gland score at four weeks increased by two to three times over baseline, which reflects improvement in the number of glands secreting and secretion quality. Additionally, at four weeks after the LipiFlow treatment, 79% of patients reported improvement in dry eye symptoms.
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Financial Planning: Helping You See the Big Picture

Do you picture yourself owning a new home, starting a business, or retiring comfortably? These are a few of the financial goals that may be important to you, and each comes with a price tag attached. That’s where financial planning comes in. Financial planning is a process that can help you reach your goals by evaluating your whole financial picture, then outlining strategies that are tailored to your individual needs and available resources.

**Why is financial planning important?**

A comprehensive financial plan serves as a framework for organizing the pieces of your financial picture. With a financial plan in place, you’ll be better able to focus on your goals and understand what it will take to reach them.

![Pie chart showing various financial planning categories]

One of the main benefits of having a financial plan is that it can help you balance competing financial priorities. A financial plan will clearly show you how your financial goals are related—for example, how saving for your children’s college education might impact your ability to save for retirement. Then you can use the information you’ve gleaned to decide how to prioritize your goals, implement specific strategies, and choose suitable products or services. Best of all, you’ll have the peace of mind that comes from knowing that your financial life is on track.

**The financial planning process**

Creating and implementing a comprehensive financial plan generally involves working with financial professionals to:

- Develop a clear picture of your current financial situation by reviewing your income, assets, and liabilities, and evaluating your insurance coverage, your investment portfolio, your tax exposure, and your estate plan
- Establish and prioritize financial goals and time frames for achieving these goals
- Implement strategies that address your current financial weaknesses and build on your financial strengths
- Choose specific products and services that are tailored to meet your financial objectives
- Monitor your plan, making adjustments as your goals, time frames, or circumstances change

**Some members of the team**

The financial planning process can involve a number of professionals. Certified Financial Planners™ typically play a central role in the process, focusing on your overall financial plan, and often coordinating the activities of other professionals who have expertise in specific areas.

Accountants or tax attorneys provide advice on federal and state tax issues.

Estate planning attorneys help you plan your estate and give advice on transferring and managing your assets before and after your death.

Insurance professionals evaluate insurance needs and recommend appropriate products and strategies.
Investment advisors provide advice about investment options and asset allocation, and can help you plan a strategy to manage your investment portfolio.

The most important member of the team, however, is you. Your needs and objectives drive the team, and once you've carefully considered any recommendations, all decisions lie in your hands.

**Why can't I do it myself?**

You can, if you have enough time and knowledge, but developing a comprehensive financial plan may require expertise in several areas. A financial professional can give you objective information and help you weigh your alternatives, saving you time and ensuring that all angles of your financial picture are covered.

**Common questions about financial planning**

**What if I'm too busy?**

Don't wait until you're in the midst of a financial crisis before beginning the planning process. The sooner you start, the more options you may have.

**Is the financial planning process complicated?**

Each financial plan is tailored to the needs of the individual, so how complicated the process will be depends on your individual circumstances. But no matter what type of help you need, a financial professional will work hard to make the process as easy as possible, and will gladly answer all of your questions.

**Can I still control my own finances?**

Financial planning professionals make recommendations, not decisions. You retain control over your finances. Recommendations will be based on your needs, values, goals, and time frames. You decide which recommendations to follow, then work with a financial professional to implement them.

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Partnerships offer a variety of benefits for owners. They help divide the work load, improve efficiency, allow more time off which can help balance work and play and should increase revenue through added doctor hours. Bottom line is that all partners need to make a good wage, share duties in an equitable manner and be able to work together in a compromising way. Like any investment a partner should enjoy the equity of their investment that grows over time.

For the partnership to be successful the owners should separate their "employee" hat with their owner hat. As an employee, each should be paid a salary for work as a producing doctor. This salary can be a combination of a base plus a percentage of personal production; the total profit of the practice must be sufficient to support everyone’s compensation. Non-revenue producing duties can be paid as well, if there is enough profit; whatever is left over is divided among the owners (which might be the same people).

The goal of any partnership is to have a large enough practice (profit) to support the income needs for each owner/doctor. If every owner needs a full time wage then the practice must produce more revenue.

A great method of attracting employed doctors is by offering them an opportunity of becoming a partner after a certain honeymoon period. Traditionally there have been 2 methods: (a) "sweat" equity where they earn a lower salary in exchange for stock; or (b) purchasing the stock with cash or a loan. Either way the buyer still needs to make enough money to live and feed their family. In both cases there are tax consequences for the buyer that could make the buy-in less attractive or unaffordable.

A revised structure has been developed that allows the majority of the buy-in to be depreciated by the buyer. This saves the buyer substantial dollars offering a greater incentive for them to buy-in. In turn it allows the seller to maintain their practice value without artificially lowering its price.

The process works using 2 methods and one must be careful to structure it correctly to avoid the anti-churning tax rules. The purchase must be carefully planned including a proper appraisal and may require the creation of an additional corporation.

The amount of the buy-in should be at least $300,000 to justify the added structuring and costs involved preparing the documents needed to do this properly. As always it is best to review all plans with your CPA. For more information about how to save money with your partner buy-in, contact Scott Daniels at 877-778-2020 or via email at Scott@PracticeConcepts.com
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