Adopting a Medical Model in Optometric Practice

How doctors are making the transition to providing the highest level of care

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Based on a live event held during SECO 2014
Adopting a Medical Model in Optometric Practice

FACULTY

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Lyn Walsh (Allergan): The mission of the Allergan Access Eye Care Business Advisor Team is to support eye care professionals on the business side of their practices: strategic planning, financials, staff management, marketing, and so on. An aspect of this that generates a high level of engagement and excitement is the concept of expanding the optometric practice beyond the traditional model by incorporating medical service lines and treating disease states that are traditionally covered by medical insurance. Our team has been fielding an increasing number of questions on this topic. Doctors want to know what this type of practice model looks like and how to make it a success.

Why did you decide to take your practice in the direction of a medical model, and how did you begin?

Jason Miller, OD, MBA, FAAO: The optometric business model needs to transition away from solely providing vision services, i.e., regular refractions and the ensuing sale of eyeglasses and contact lenses. We should be transforming into a medical profession, providing reimbursable services that reflect our knowledge and the care we provide.

To be a medical practice, we must first understand the difference between a vision patient and a medical patient. Some are both, but we need to identify the true reason(s) for each visit, how to properly bill and where to submit the claims. In our practice, we’ve taken a proactive approach to this. We have a brochure that explains the differences between medical and vision benefits. At the front desk, we ask for each patient’s vision and medical insurance information.

Ms. Walsh: What conditions and diseases do you treat in your practice?

Dr. Miller: The biggest ones are dry eye, ocular allergy and glaucoma. We also coordinate care with retina specialists. The goal is to be the primary entry point for all eye care.

Gina Wesley, OD, MS, FAAO: I started out in a group practice but shortly thereafter opened my own practice. I began practicing medical optometry right away. Growing that segment is a grassroots effort in that you have to tell every patient, at every exam, that you treat all conditions. To this day, I do that. It’s an ongoing education effort. I treat a great deal of dry eye as well as glaucoma, allergies and any red-eye type of condition. We see all patients who present to us, regardless of their issues or problems. We triage them and figure out what we can do to help, even if that ultimately requires some sort of outside specialty care. I’ve learned that no one is going to hand us a magic recipe for how to incorporate medical optometry into the practice. We have to be our own advocates in finding information, learning how to bill, how to code, and so on. I use electronic health records software, which makes the information very accessible for me and helps ensure I’m coding properly. I also keep up on the related literature.

Dr. Miller: The “red-eye” patient is a great starting point for developing a medical practice. I realized early that I wasn’t educating my patients well enough about the care I provide, when people, including friends, were telling me their son or daughter had pink eye so they took them to their primary care doctor.

Ryan Corte, OD: I fell in love with the treatment and management of ocular disease during my first half of rotations in optometry school, and I completed a residency in Ocular Disease and Primary Care. In my opinion, if I’m not providing full-scope care, binocular vision, low vision, specialty contact lenses, ocular disease management and so on, then I’m not fully serving my patients. Now, I treat a great deal of allergy and dry eye and I perform a number of glaucoma workups. I frequently see neurological cases as well, such as papilledema and MS, which I co-manage with neurologists. Being involved in the community and building relationships with primary care doctors, neurologists and endocrinologists has been a practice builder for me.

Ian Benjamin Gaddie, OD, FAAO: I had the benefit of coming into my father’s practice, which he started in 1968. At the time, optometrists weren’t permitted to perform diagnostics or use therapeutics. I watched much of the evolution of the practice and the scope-of-practice legislative battles, which gave me a nice perspective on where we’ve been and where we are today and what it took to get here. When I arrived, the practice already had a pretty solid culture
of managing eye disease. However, as Dr. Corte said, concentrating on ocular disease is important, but we must be able to handle every condition that comes through the door. If we don’t do a good job of taking care of the basic things, we’ll never be able to elevate our practices to take care of disease.

Also, changing a practice culture to be more medically oriented requires leadership. Going beyond the comfort level and introducing new services isn’t easy. It takes some courage. Staff and even other doctors in the practice aren’t necessarily going to push you to a new level, so it’s incumbent on the practice owner to prompt change. In addition, as has been mentioned, patients have to realize what services you provide. That is a one-on-one conversation that I still have every day with patients. It includes talking to them about what I’m doing and what I’m evaluating throughout the exam. When that is articulated, it changes their perception. They think “Wow, there’s a lot to my eye and this doctor really knows about it; that’s impressive because no other doctor has given me this much detail.” We’ve done some public service-type marketing in our practice, as well. We display posters around the office that illustrate glaucoma as “the silent thief of sight” and diabetes as “diabetes affects more than just your waistline.”

Rob Grim (Allergan): Speaking of marketing, as an Allergan Eye Care Business Advisor, I’ve worked with many practices who thought they had a sufficient medical model marketing plan, but they weren’t effectively communicating the scope of their services. Having brochures on the services is important, as is a website that explains those services and therefore registers with search engines. The marketing plan must be comprehensive.

Key Building Blocks for the Medical Model
Ms. Walsh: When a doctor wants to be the primary entry point for comprehensive eye care, what are the key components that need to be put into place to make the medical model work?

Dr. Gaddie: Having mentors who have made this kind of change and can explain how they succeeded is crucial. If you’re stuck on a case, it’s important to be able to ask others how they would handle it. Even for established practitioners, it’s not too late to find someone in the community or someone in the state association to learn from. Don’t expect to jump in and be able to do it all on your own.

Dr. Miller: Infrastructure, such as an electronic health records system with e-prescribing, is important, too.

Dr. Wesley: You have to be able to get paid for what you’re doing, so coding and billing knowledge is important. Also, even though we can manage medical conditions with the equipment most ODs already have in their offices, we also need to plan ahead for how to build on that. I know my practice and patient population aren’t perfect for the medical model, but I’m laying the groundwork so they can be down the road. It’s a work in progress.

Dr. Corte: You don’t necessarily have to invest in every possible piece of equipment right away. In one of the practices where I work, we send patients to other offices (one optometry and one ophthalmology) for visual field testing and OCT. They send the results back to us and we interpret and bill.

Dr. Wesley: That’s how I started, but I sent patients to the optometry practice where I previously worked. I paid them a fee to utilize their equipment. I slowly built up to having all the capabilities in house.

Dr. Gaddie: Ancillary help in the lane is a critical stepping stone to managing medical cases. It took time to implement my current process and train personnel, but now I have people that truly are extensions of me, including a scribe. I no longer have to spend time explaining the side effects of every drug, or how to instill drops or perform lid scrubs, or whatever the case may be. My staff members tell patients exactly what I would tell them. They also help perform tests and document details of exams. This type of staff support allows me to be more efficient and readily able to tackle the medical caseload. Otherwise, managing the medical side of an eye care practice could be a drain of my time or could create a situation in which bottlenecks are created as patients wait to see me.

Also, don’t try to incorporate treatment for every disease state at once. Start with something that’s obtainable and doesn’t require a significant investment in equipment, such as dry eye. Get comfortable with it, gain confidence, then move on to the next disease or condition.

Mr. Grim: I agree. If you go out and buy every piece of equipment trying to be everything to every patient, you could end up struggling. It’s better to do some strategic planning and break-even analyses to decide what the core services will be and plan to make the next move only when you’re ready.

Ms. Walsh: What have you found to be your key pieces of equipment in a medical model optometric practice?
Dr. Wesley: I waited 6 months before I got a retinal camera, but I wish I’d have had that right away. I obtained an OCT unit within the past year, and I wish I’d had that a long time ago as well. Those are the two items that have really elevated the level of care at my office because they allow me to fully comprehend what exactly is going on with retinal health, screening for glaucoma, and so on.

Dr. Miller: I think the visual field machine is absolutely of baseline importance. Also, I like my anterior segment camera and the ability to take videos and pictures and turn that screen around to show the patient what I’m seeing.

Dr. Gaddie: Yes, a picture is worth a thousand words. The anterior segment camera is very helpful for discussing conditions such as giant papillary conjunctivitis. If a patient thinks I’m just trying to stop him from over-wearing his contact lenses or selling him a more expensive option, an image can make all the difference in turning that perception around. Anterior segment pictures are also good for illustrating corneal staining, tear break-up time and superficial punctate keratitis, or showing the patient — and me — how a corneal ulcer is responding to treatment. It builds confidence for me and the patient, and it’s financially viable because it’s often billable.

Putting Together an Effective Team

Ms. Walsh: In regard to staffing, what are the key roles that need to be filled in a medical optometry practice?

Dr. Gaddie: We have 53 employees, including an administrator, operations manager, office manager, head technician and head optician. Obviously, the administrator or top manager in a practice has to understand that you’re trying to build a medical eye care practice. Beyond that, one of the most important parts of a medical optometric practice is the front desk — the receptionist. Ours differentiates between medical eye problems and eyeglass-type problems as soon as a patient calls. Technicians need to be detail-oriented, so they can back up the doctor on things that can be overlooked such as getting the patient scheduled for follow-up. And, as I mentioned previously, if you don’t have the right help in the exam room with you, it’s an obstacle to expanding the medical portion of the practice.

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— Jason Miller, OD, MBA, FAAO

Dr. Wesley: I have seven staff members working with me, and any one of them might answer the phone. So they all need to know how to triage and understand what we’re trying to accomplish. We have training all the time, even if it’s just a discussion during our weekly office meeting.

Dr. Miller: I agree; staff education is a critical component, especially at the front desk. We remind employees every year that we have a budget for them to pursue education, whether it’s online or at a local or national meeting. We also have staff come into the exam room to observe what we’re doing, what ocular structures and disease states we’re looking at, which raises their interest in the care we’re providing.

Dr. Corte: We’ve worked with a consulting group to profile staff members’ personalities to determine who fits best in what role.

Ms. Walsh: How important is an external support network? How do you handle your relationships with ophthalmologists in the area, especially if they feel anxious that you’re stepping into their territory?

Dr. Corte: I don’t hesitate to refer when I need to. If I think I see a retinal hole or tear, for instance, I play it cautiously and send the patient out for further evaluation.

Dr. Miller: If you’re still thinking about a case when you’re in bed at night, you may want to get another opinion on that situation.

Dr. Wesley: I think it’s best to be candid with neighboring ophthalmologists and take advantage of the potential relationship. We’re a valuable referral source for them, and they likely have cases they prefer not to manage that we would want to manage. It makes sense to meet with them, maybe shadow them for half a day, and let them know the direction in which you want to take your practice.

Breaking into the Medical Insurance Arena

Ms. Walsh: What has been your experience with the medical insurance companies and getting onto plan panels?

Dr. Miller: Many medical panels are open to optometry. The state associations have information about that. Usually, it just comes down to making the effort to fill out the paperwork.

Dr. Gaddie: In Kentucky, we’re fortunate to have an Any Willing Provider law, which means if an optometrist wants to be on a panel, they can’t be excluded by provider type. We also have a pay parity law, which
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It can be a long and daunting task to get credentialed for a provider panel. I’ve done it in two states, and it helps to find someone who can help you with the process. From a broader perspective, if we continue to get the word out about the level of training we receive and that our goals are to help patients prevent disease and decrease healthcare costs by detecting chronic illnesses earlier, we can make a significant impact.

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**Drilling Down to the Numbers and Logistics**

**Ms. Walsh:** How do you schedule medical visits versus healthy patient eye exams?

**Dr. Wesley:** For the most part, we incorporate them into the regular mix. I suspect other practices have a more specific protocol.

**Dr. Gaddie:** In an hour’s time, we schedule three vision exams and three medical visits. Of the three medical slots, two may be for an IOP check, a red eye, a diabetic exam or an AMD exam, and the third slot is for special testing. The patients are staggered in such a way that the patient who needs the work-up equipment for a red eye or a pressure check can be scheduled at the same time as someone who’s getting a comprehensive eye exam, which enables me to allocate my resources.

We’ve also spent a great deal of money and time with consultants — videotaping our flow, recording visit times, and determining how all of that affects our optical sales, how it affects patient satisfaction, and so on. We really dissected everything, which wasn’t easy. However, we cut patient time in the office by 30%, which results in more conversions in the optical and other positive outcomes. But you have to recognize that it’s a process. You can’t just say, OK, today I’m going to go from seeing three patients an hour to six.

**Dr. Miller:** It really does need to be an evolution. Perhaps you go from two exams an hour to two exams and a medical check. Then maybe you move to two exams and two medical checks, and so on. Adopting the medical model is one step at a time.

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— Ryan Corte, OD

**Mr. Grim:** Do you monitor what percentage of your revenue comes from the medical side versus the refractive side?

**Dr. Wesley:** Yes. At first, the medical percentage was very low. It’s up to 15% today, and I’d like to see it increase in the future.

**Dr. Miller:** I bought into a practice as a partner where the senior doctor is very successful with medical eye care. Her percentage is typically 35-40%, and mine is 20-25%. That’s flipped for contact lenses, where my percentage is usually higher than hers. We watch that regularly and almost make a game out of it — discussing who is higher in each category each month. We need to look at those monthly numbers to identify areas in which we’re doing well and identify areas for improvement.

**Dr. Gaddie:** The bottom line is if you’re not watching the numbers, you can’t set goals.

It’s important to mention also that in this discussion we’re not assuming that most optometrists are out there doing nothing medical. Many are treating medically, but perhaps aren’t billing and being paid medically. My advice for getting to that point is to start slow. You can’t build a medical practice overnight. You may have a week where you treat 15 patients medically, and the next week you don’t treat any. Work at identifying disease processes, learn the difference between services defined by vision insurance versus services defined by medical insurance, and understand the codes.

**Vision Patient, Medical Patient, or Both?**

**Ms. Walsh:** Give us a sense of how a medically oriented practice actually functions on a daily basis. If a patient is in the chair for a vision appointment and...
you discover a medical issue, how do you proceed?

**Dr. Corte:** It depends on the scenario. For example, if during a routine comprehensive vision examination I see signs of dry eye and/or the patient tells me his eye has been burning, we talk about trying different contact lenses, artificial tears, and medical/prescription options to treat the disease. We can start him on a medical treatment plan that day and have him back for follow-up.

**Dr. Miller:** I wish we could take the word “routine” out of describing what we do every day. No patient encounter is routine; each is unique. “Routine” isn’t fair to our practices or our profession. Patients need to be educated on vision issues versus medical issues, and the co-pay should not be a deciding factor on how a visit is billed. There are times when the benefits can be coordinated between the medical and the vision, and that should be explained to the patient. “This is the situation. We’re going to submit this to your medical insurance first. If the medical doesn’t cover it, we’ll submit to your vision plan.”

One example is finding a choroidal nevus, which we all do. Overall, the eye is normal, and a nevus doesn’t affect the refraction, but the finding should be explained to the patient along with the need for a medical level retina image, which we submit to the medical insurance.

**Dr. Gaddie:** Another example is the patient who presents with his vision insurance plan and has no complaints other than needing new glasses and contact lenses. In the middle of the refraction, he’s reading 20/30 until I make a quarter-diopter change in the sphere. All of a sudden, he can barely see at all. If you pull the phoropter back and look at it, often you see condensation on the lenses, which is coming from the tear film. In a case like this, when the patient can’t even complete a refraction because of tear film evaporation, I tend to stop and explain the reason he’s struggling with his answers and that if I prescribe glasses based on this exam, he’s not going to be happy and it may be a waste of time and money. Instead, I recommend we treat the dry eye first. We run the appropriate tests and prescribe the appropriate medications and “save” the vision insurance for when the condition stabilizes. The prescription will be accurate, and, in the meantime, we’ve kept a progressive problem from getting worse.

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— Ian Benjamin Gaddie OD, FAAO

The flip side is a patient with medical insurance but no vision coverage who comes in expecting to get a vision exam. An honest, difficult, discussion must take place. Here, I explain that it would be fraudulent to bill the medical insurance if no medical issue exists. Furthermore, the patient needs to sign an Advance Beneficiary Notice for the refraction because it isn’t covered. In my practice, I see equal numbers of patients with medical insurance who present with vision complaints and patients with vision insurance who have medical complaints. The majority of medical issues I encounter are incidental findings and were not the patient’s chief complaint. For most of these patients, we can complete the vision services and bring them back later for a comprehensive medically oriented exam that leads to prescribing the appropriate medications and controlling the condition longer-term.

What absolutely should not be done is to attempt to switch every vision visit to a medical visit. Don’t be aggressive for the sake of being aggressive.

**Dr. Miller:** Diabetic patients are a prime example of when to coordinate between medical and vision insurance. We’re coordinating their care with their primary care physician; they’re sent to us for the ocular aspect of their care; and we’re educating them about diabetic retinopathy and the importance of controlling their blood sugar. In fact, we get letters from our diabetic patients’ medical insurers asking us to bill them for what we do because they’re now being evaluated on the number of enrollees with diabetes that have undergone an eye exam.

**Embracing Change and Moving Forward**

**Dr. Miller:** The face of optometry is definitely changing. Moving forward, we shouldn’t be “giving away” exam services with the hope that somebody will buy glasses from us. As a profession, we have to be dedicated to the medical model and dedicated to adapting to the changes in our field.

**Dr. Corte:** The medical model is very rewarding. We’re treating and managing disease and fostering preventive care while building trust and a special rapport with our patients. We’re taking care of their problems and removing pain or discomfort from their lives. All of this can help the practice grow financially, and it allows us to develop professionally as well.
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