Pediatric Eye Health: A School Nurse’s Perspective

Sandi Delack, RN, MEd, NCNS
President, National Association of School Nurses

National Association of School Nurses
• Professional non-profit 501(c)3
• Approximately 15,000 members
• 51 Affiliates in US and abroad

NASN supports the health and educational success of children and youth by developing and providing leadership to advance the school nursing practice by specialized registered nurses

Pediatric Eye Health: A School Nurse’s Perspective

• Screening
• Common Eye Injuries
• Eye Pathology
• Barriers to care
• Collaboration

Screening
• The Needs
  – Importance of vision screening to academic success
  – Conducted by trained and qualified screener
  – Lack of health insurance/primary health care provider
  – Lack of screenings by primary health care providers

Screening
• The Myths
  – Screening vs exam
  – Referral vs diagnosis
  – My Child goes to the doctor!

Screening
• The Challenges
  – Staffing
  – To conduct screenings
  – To provide referrals
  – To conduct follow-ups
  – Time
  – Full academic days
  – Busy nurse’s offices with many interruptions
  – Equipment
  – What is appropriate equipment
  – Training vs equipment

Screening
• More Challenges
  – Lack of Standards
  – Training
  – Referral criteria
  – Which visual functions assessed?
  – Vary from state to state and sometimes within states!
  – Cultural and Socioeconomic Barriers
  – Need for coordination with philanthropic groups
  – Lost/broken/scratched glasses
  – Cultural barriers to treatment

Common Eye Problems
• Conjunctivitis
  – Bacterial, viral, allergic

Common Eye Problems
• Traumatic eye injuries
  – Contact lens injuries

Common Eye Problems
• Chemical eye injuries
• Infections, styes

Common Eye Problems
• Sudden loss of vision or a field of vision
• Eye pathology as it relates to other medical/neurological conditions

• Screening
• Common Eye Injuries
• Eye Pathology
• Barriers to care
• Collaboration
Collaboration is key!

Thank you!
Reading, Dyslexia, and Vision

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Financial Disclosure

• The author acknowledges no financial interest

Reading

• Oral language is the foundation for reading
• Oral language is broken up into phonemes
  – Sounds signaling differences of meaning
  – English is a phonemically complex language
  – 44 phonemes (sounds) in 70 letter combinations
• English has many inconsistencies & exceptions

Reading

• Reading is the complex process of extracting meaning from abstract written symbols
• English uses the alphabetic system where each symbol represents an abstract building block of that language's phonemes

Reading

• Reading is more difficult than speaking because children must be aware of the sound structure in spoken language
• Then utilize the corresponding alphabetic code to acquire the sound/symbol connection

Reading

• Comprised of
  – Decoding
  – Fluency
  – Comprehension
• Requires
  – Adequate memory
  – Ability to sustain attention

The Complexity of the Mind

Believe it or not, you can read this...

Learning Disabilities

• Are common problems
• 5 – 17.5% of the U.S. population has a learning disability
• In 2007 2.7 million (5.5%) of public school students were eligible to receive educational assistance under IDEA

The Complexity of the Mind

I cdnuolt blveiee taht I cluod aulaclty uesdnatnrd waht I was rdgnieg. The phaonmneal pweor of the hmuan mnid. Aoccdrnig to rscheearch at Cmabrigde Uinervtisy, it deosn't mttaer in waht oredr the ltteers in a wrod are, teh olny iprmoatnt tihng is that the frist and lsat ltteer be in the rghit pclae. Yaeh and I awlyas thought spleling was ipmorantt!
Learning Disabilities

- Arise from neurological differences in brain structure and function
- Affect the brain’s ability to store, process or communicate information

Learning Disabilities

- Teachers & nurses may suspect a L.D. when a child has difficulty in learning to:
  - Read
  - Listen
  - Speak
  - Spell
  - Write
  - Reason
  - Solve mathematical calculations
  - Organize information

Dyslexia (Reading Disability)

- A type of learning disability
- 80% of all learning disabilities
- Family history
  - 40% affected sibling
  - 40% affected parent

Dyslexia – Epidemiology

- Boys minimally more frequent than girls
- But schools identify four times as many boys as girls

Dyslexia – Epidemiology

- Reading disability represents the lower tail of a normal distribution of reading ability
- Dyslexia is persistent & does not represent a transient “developmental lag”

Dyslexia – Primary Reading Disability

- Should be separated from secondary causes of difficulties in learning to read
  - Intellectual disability
  - Environmental deprivation
  - Educational deprivation
  - Physical (organic) disease
  - Including visual or hearing disorders
  - (complete eye exam is important)

Dyslexia – A Language-Based Reading Disorder

- Dyslexia typically results from a deficit in the phonological processing of language
- That is often unexpected in relation to other cognitive abilities given the provision of effective classroom instruction

Dyslexia – A Language-Based Reading Disorder

- Dyslexia is characterized by difficulties in:
  - Phonologic decoding
  - Accurate and/or fluent word recognition
  - Rapid Automatic Naming (RAN)
  - Verbal memory
  - Comprehension
Dyslexia – Early Detection
- Possible early indications of dyslexia:
  - Family history
  - Speech delay
  - Difficulty with rhymes
  - Confusing words that sound alike
  - Delay in learning letters
  - Delay in learning phonics

Dyslexia – Common Signs
Significance of signs is age dependent:
- Difficulty remembering the names of the letters
- Difficulty remembering the sounds of the letters
- Reading words incorrectly – guessing
- Reversing letters and words – (past 3rd grade)
- Skipping words & lines
- Slow reading in adolescents & adults

Dyslexia – A Language-Based Reading Disorder - Neurobiology
- Over 20 years of educational, psychological, and brain research show that:
  - Dyslexia is an abnormality in the word analysis pathways of the brain
  - Children with dyslexia use different areas of the brain when reading

Dyslexia – NOT a Vision Based Disorder
- Historically dyslexia was thought to be a vision-based disorder but research has shown:
  - There is no increased incidence of eye problems in children with dyslexia
  - Children with dyslexia have the same ocular health, ocular coordination, motility, and visual processing as children without dyslexia

Dyslexia – NOT a Vision Based Disorder
- Subtle eye or visual problems do not cause or increase decoding difficulties
- Individuals with known strabismus, eye movement defects, or nystagmus do not have an increase in dyslexia
- No specific eye-related defect causes dyslexia

Dyslexia – NOT a Vision Based Disorder
- Reversals
  - Of letters & words occur normally in early readers
  - Are a symptom, not a cause, of reading disorders
  - Reversals and skipping words and lines are due to linguistic, attention & memory deficiencies and not visual or perceptual disorders

Dyslexia – NOT a Vision Based Problem
- “Eye tracking”
  - Fluent reading is not due to “eye tracking”
  - Some people call word and line skipping an “eye tracking problem”
  - “Reading tracking” has nothing to do with either ocular smooth pursuit or horizontal saccades - it has to do with attention, memory & comprehension

Overcoming Dyslexia - Important Laws
- Individuals with Disabilities Education Act (IDEA)
- Section 504 of the Rehabilitation Act of 1973 (504)
- Americans with Disabilities Act (ADA)
- ADA Amendments of 2008
Multidisciplinary Approach

• The diagnosis and treatment depends on the collaboration of a team
• Making the correct diagnosis in children with reading weaknesses is important before a therapeutic regimen can be prescribed

Role of Education

• “Prevention”
• Early Detection – via educational screening
• Evaluation
• Treatment
• Vision screening – performed by school nurses or screeners

Role of Education – “Prevention”

• 2000 National Reading Panel
• Promotion of evidence-based programs
  – Early explicit instruction in phonemic awareness
  – Phonics-based reading programs
  – Guided oral reading – to improve fluency

Role of Education - Screening

• Screen yearly for early detection
• K – Alphabet recognition, phonemic awareness & rapid naming
• 1st – Add word identification fluency
• 2nd – Add oral reading fluency

Role of Education - Evaluation

• Formal assessment includes:
  – Cognition
  – Memory
  – Attention
  – Intellectual ability
  – Information processing
  – Psycholinguistic processing
  – Language function – expressive & receptive
  – Academic skills
  – Social-emotional development
  – Adaptive behavioral functioning

Role of Education – 2 Approaches

• Persistently poor achievement for 2 years prior to referral and assessment
• Response to Intervention
  – Screening allows earlier identification of LDs than the “wait to fail” approach
  – Child is quickly placed directly in an educational intervention program when early difficulties arise
  – Only children who do not show significant improvement with small group intervention & targeted intensive individual intervention will undergo a full educational assessment

Role of Education – Early Detection, Evaluation & Treatment is Critical

• If dyslexic children receive effective phonological training in K & 1st grade then only 10 – 25% will continue to show reading difficulties
• If intervention is delayed until 3rd grade then 74% will continue to show reading difficulties

What works? Education - Remediation

• Educational treatment to improve the ability to read
• Intensive treatment of sufficient duration
• Individual or small group instruction
• Individualized multi-sensory (visual, auditory, tactile) reading and language program by a high quality instructor

What works? Education – Remediation

• Decoding training - explicitly teaching:
  – Phonemic awareness
  – The application of phonics
• Fluency practice
  – Guided oral reading
• Comprehension
  – Vocabulary instruction
  – Active reading comprehension
What works?

Education

Accommodations & Modifications
- Extra time
- Separate quiet room
- Preferential seating
- Testing alternatives – oral instead of written tests
- Computers
- Spell checkers
- Lecture notes
- Recorded books

What works?

Parental Involvement
- Read to their children
- Children should read to their parents as soon as they are able
- Monitor children for language difficulties
- Collaborate with teachers & educators
- Educate themselves on LDs, available services, and state rules & regulations
- Advocate for the child

What doesn’t work?

Tinted Lenses & Filters
- The scientific evidence does not support the use of tinted lenses & filters as a direct or indirect treatment in patients with learning disabilities

What doesn’t work?

Vision Therapy
- No evidence that children who participate in vision therapy are more responsive to educational instruction
- No evidence that vision training is a necessary primary or adjunctive therapy in learning disabilities
- No evidence of benefit from “training glasses”

What doesn’t work?

Vision Therapy
- Parents should be informed that the scientific evidence shows vision therapy does not benefit children with learning disabilities, saving their valuable time and resources

Role of the Ophthalmologist
- Perform comprehensive eye examination
- Identify & treat any significant ocular or visual disorder
  - As children may have a treatable vision problem as well as a L.D.
- Ophthalmologists do not diagnose learning disabilities
  - But may be suspicious
- Examine for treatable ocular conditions that could impact visual performance:
  - Refractive errors
  - Hyperopia
  - Myopia
  - Astigmatism
  - Amblyopia
  - Strabismus
  - Convergence and/or focusing deficiencies
- Institute treatments that might include:
  - Glasses
  - Eye patching
  - Eye drops
  - Prisms
  - Eye muscle surgery
  - Convergence training
Role of the Ophthalmologist

• Assist with referral to appropriate educational evaluation, medical, psychological, and other services
• Distribute information on learning disabilities

Role of the Ophthalmologist

• Discuss & advise against diagnostic & treatment approaches for dyslexia that lack scientific evidence of efficacy:
  – Behavioral vision therapy
  – Eye muscle exercises
  – Colored filters & lenses

Final Recommendations

• Primary care physicians should perform eye & vision screening
• Children who fail vision screening or those with suspected visual problems should be referred to an ophthalmologist experienced in children’s care

Final Recommendations

• Children who exhibit signs of LDs should be referred as early in the process for educational, psychological, neuropsychological, and medical diagnostic assessment
• Children with LDs should receive individualized evidence-based educational interventions combined with psychological and medical treatments as needed

Final Recommendations

• Primary care physicians should only recommend evidence-based treatments & accommodations to school districts
• Families of children with suspected LDs should receive information about state & local parent support programs

Resources:

• The Learning Disabilities, Dyslexia & Vision Policy Statement is available at:
• More information about vision therapy for learning disabilities is available at:

Resources:

• International Dyslexia Association: www.interdys.org
• National Center for Learning Disabilities: www.ncld.org
• Learning Disabilities On Line: http://www.ldonline.org
• Interdisciplinary Council on Developmental and Learning Disorders: www.icdl.com
• Great Schools Inc/Schwab Learning: www.schwablearning.org
• All Kinds of Minds: www.allkindsofminds.org
Vision Screening and Vision Screening Devices

Daniel E. Neely, MD
Indiana University School of Medicine
AAPOS Vision Screening Committee

AAPOS Vision Screening Guidelines*
- Anisometropia (spherical or cylindrical) >1.5 D
- Any manifest strabismus
- Hyperopia >3.5 D
- Myopia >3.00 D
- Any media opacity >1 mm
- Astigmatism >1.5 D at 90° or 180° >1.0 in oblique axis (>10° eccentric to 90° or 180°)
- Ptosis ≤1 mm margin reflex distance


Eye Examination in Infants and Children by Pediatricians (revised by AAPOS 2009)*

<table>
<thead>
<tr>
<th>Age</th>
<th>Tests</th>
<th>Referral Criteria</th>
</tr>
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<tbody>
<tr>
<td>Newborn to 6 months</td>
<td>• Ocular history&lt;br&gt;• Vision assessment&lt;br&gt;• External inspection of the eyes and lids&lt;br&gt;• Ocular motility assessment&lt;br&gt;• Pupil examination&lt;br&gt;• Red reflex examination</td>
<td>Refer infants who do not track well after 3 months of age.&lt;br&gt;Refer infants with an abnormal red reflex or history of retinoblastoma in a parent or sibling.</td>
</tr>
<tr>
<td>6 to 42 months</td>
<td>• Items listed above, plus:&lt;br&gt;• Visual acuity testing&lt;br&gt;• Objective screening device “photoscreening”&lt;br&gt;• Ophthalmoscopy</td>
<td>Refer infants with strabismus&lt;br&gt;Refer infants with chronic tearing or discharge.&lt;br&gt;Refer children who fail photoscreening.</td>
</tr>
<tr>
<td>42 months to 5 years</td>
<td>• Items listed above, plus:&lt;br&gt;• Visual acuity testing (preferred) or photoscreening&lt;br&gt;• Ophthalmoscopy</td>
<td>Refer children with a two-line difference between eyes&lt;br&gt;Refer children who cannot read at least 20/40 with either eye.</td>
</tr>
</tbody>
</table>

Photoscreening
- Does not replace acuity screening.
- Now recognized by AAPOS and others to be of significant value in younger children. Particularly those less than 5 years of age.
- Devices generally fall into one of two categories:
  - Photoscreeners
  - Autorefractors

Photoscreeners
- An instrument that utilizes optical images of the eye’s red reflex to estimate refractive error, ocular alignment and other conditions degrading or blocking line of sight.

Autorefractors
- An instrument that utilizes automated optical methods to determine the refractive error of an eye, detecting errors likely to cause strabismus and/or amblyopia. Other conditions degrading or distorting the unit’s imaging pathway, such as media opacities, may also cause a screening failure.

Performance Data of Commercially Available Instruments for Pediatric Photoscreening and Autorefraction

Complete list is available to public at:
- AAPOS website under: Health Care Provider Resources
- Or as a direct link to Kurt Simons webpage: https://jshare.johnshopkins.edu/ksimons1/ps10b.htm

Acuity Testing
- Still the gold standard for children > 5 yrs old.
- Crowded optotypes:
  - Multiple on single line
  - Isolated with crowded bars
- Matching card for younger children
- Monocular test with fellow eye patched or carefully occluded

Recommended tests:
- Lea Test
- HOTV

Photoscreener
- Example: Hyperopic crescents of the MTI Photoscreener

Autorefractor
- Plusoptix SO9
- Welch Allyn SureSight

By Kurt Simons, Ph.D. and the Vision Screening Committee, American Association for Pediatric Ophthalmology and Strabismus (AAPOS) 2009 (Last updated 01/27/2010)
Acuity Test: Age 6+

Recommended tests:
- Avoid traditional Snellen charts
- Prefer Sloan optotypes
  - Blocked font, without serifs of Snellen letters
  - CDEFLNOPTZ
- ETDRS style spacing
  - Five letters every line
  - Inverted pyramid

Acuity Testing

Acuity Test Failure Criteria
- Two line difference between eyes.
- Unable to read at least 20/40 with either eye.

Stereopsis Testing?

- Optional and controversial!
- Has been removed from recently revised AAPOS Vision Screening by Pediatricians Guidelines.

Stereopsis Testing

- Vision in Preschoolers Study Group (VIPS)
  - Combining a stereo acuity test with a visual acuity test or photoscreener did not result in improved sensitivities for detecting amblyogenic conditions.

Pros and Cons of Stereo Testing

Pros
- Probably the easiest way for nurses or lay screeners to detect strabismus if using an acuity test or monocular autorefractor for testing.
- Easier than cover test

Cons
- May not help detect amblyogenic conditions.
- Time consuming:
  - Add 2 more minutes to the vision screening process:
    - Visual acuity test 4 minutes
    - Photoscreening 2 minutes
- Higher referral rate for false positives and children unable to perform test.
The ABC’s of Children’s Eye Health - Educating School Nurses
Mary Louise Z. Collins, MD
Baltimore, MD

SYMPOSIUM
- NASN
- VISION SCREENING PROGRAMS
- INSTRUMENTS

WHY ME?
- Preaching to the choir
- Time out of your practice
- Work to prepare

WHY PEDIATRIC OPHTHALMOLOGISTS?
- Good for the kids
  - Want to provide the best information to the health care providers who will be caring for the children
  - Ophthalmologists are best qualified to teach from a medical perspective

WHY PEDIATRIC OPHTHALMOLOGISTS?
- Best public health approach
  - Referral to most appropriate provider for specific condition
  - Best use of health care dollars

WHY PEDIATRIC OPHTHALMOLOGISTS?
- Teach “our message”
  - Vision screenings vs. comprehensive eye exams
  - Methods of vision screening
  - Learning disabilities/Vision therapy

IF WE DON’T PROVIDE THE MESSAGE…
WHO WILL??

AND WHAT WILL THE MESSAGE BE???
NASN
- Receptive to educational opportunities
- Ophthalmology needs to have a presence
- Develop relationships locally so our opinion will be solicited
- If we aren’t “at the table”, we won’t be asked to participate

Developing Relationships
Maryland Story
- Vision screening law
- Interested in improving the screening regulations

Maryland Law
- Vision screening required “upon entry to school, grade 3, 4, or 5, and grade 8 or 9”
- No requirement for how the screenings are done
- No requirement for follow-up care

Collaboration
- Ophthalmology
- Optometry
- School nurses
- Maryland State Department of Education
- Maryland Department of Health and Mental Hygiene

Ophthalmology and Optometry Collaboration
- Rare
- Ophthalmology should collaborate on issues where we can find agreement with optometry
- Not without precedent - MA

Maryland
- New Law - 2008
- Screening requirements in schools
  - Entry to school (pre-k or Kindergarten)
  - Grade 1
  - Grade 8

COLLABORATION
- Building coalitions
- Engage potential “partners”
- Agreement to continue collaborative efforts to properly implement the new law

Vision Screening Law-Implementation
- Phase I
  - Education of school nurses and trained vision screeners
  - MSDE, Ophthalmologists, Optometrists, MD Society for Sight collaborative effort
  - Education sessions
  - 30 attendees per session
  - Options session
  - Workshop - hands-on vision screening
Vision Screening Law-
Implementation

• Phase II
  – Regulations
  – Manual for screeners
  – We are the consultants - provide the “HOW TO” answers

MESSAGE

• Developing working relationships on the local level by offering education
• Relationships spread
• Encourages pediatric ophthalmologists to be considered the primary eye care providers for children

AAPOS - AAO - NASN
National Level Activities

• AAPOS Booth to NASN annual meeting
• Meeting in DC between ophthalmology representatives and NASN Executive Director
• NASN President speaking at AAPOS Annual Meeting 2010
• Education of NASN members
  – Website links
  – Articles for scientific journal and newsletter
  – Lectures for pediatric ophthalmologists to give to school nurses

AAPOS - AAO - NASN
National Level Activities

• Instructional DVD on vision screening of school-age child
  – LDP Project - Kathy Lee
  – Planned link to DVD on AAPLOS website
  – In development

AAPOS - AAO - NASN
National Level Activities

• FUNDING
  – Need to provide school nurses with the tools to do their job
  – Variety of “tools” in each school - not standardized
  – Concerns of school nurses on local level

AAPOS - NASN
Local Level

• EDUCATION
  – Contact NASN representative in your state/local affiliate
    – www.nasn.org (click on Affiliates on side bar)
• LEGISLATION
  – Work to improve vision screening law
  – Implement the regulations

SUMMARY

• It’s all about RELATIONSHIPS
  – COMMUNICATION
  – EDUCATION
  – JUST DO IT!

JUST DO IT!

FOR OUR PATIENTS...
FOR OUR PROFESSION
Financial Benchmarks

• One should know the numbers cold to be economically successful in today’s healthcare environment
• Once you have developed a system for tracking pertinent information, it can be generated in a monthly or quarterly report without a great deal of effort
• Overall trends within an individual practice are more important than comparison to the “norm” and should correlate with practice changes

Financials Graphed Monthly

• A/R
• Total charges
• Deposits
• Expenses before MD compensation and depreciation/amortization
• Average charges per visit
• Average collections per visit

Gross Collection Ratio

• Gross collection ratio = collections / total charges
• 50-85%; varies depending on both fee schedule and accounts management efficiency
• What you are looking for is stability within a historic range with not a lot of volatility unless associated with MD absence from practice

Profit Margin

• Profit margin = profits / total collections
• Target > 35%
• Wide range, depending upon the nature of the practice; 15% in an HMO-driven practice and as much as 60% in a high-volume LASIK, retinal, or cataract referral center practice
Practice Revenue Growth Rate

- Practice revenue growth rate = \( \frac{\text{collections for this year} - \text{collections for prior year}}{\text{collections for prior year}} \)
- 3-5% should be the baseline goal
- Young and aggressive practices should aim for 10% growth rate
- Mature practices can do well with zero net growth

New Patient Ratio

- New patient ratio = \( \frac{\text{new patients}}{\text{total patient visits}} \)
- Goal is 10-20%
- Younger offices will have a higher ratio of new patients
- Higher percentages than this baseline for an established practice may indicate poor continuity of care and recall protocols

Cost Per Patient Visit

- Cost per patient visit = \( \frac{\text{total annual practice costs before MD and optical costs}}{\text{number of patient visits per year}} \)
- Should be $70-90

Collections Per Average Patient Encounter

- Collections per average patient encounter = \( \frac{\text{monthly total collections}}{\text{monthly total patient visits, inclusive of post-ops}} \)
- Also referred to as the “average ticket”
- Should be $125-$175

No-Show Rates

- The percentage of a day’s scheduled appointments, after prior reminder calls have been placed, who do not show up that day for their appointment
- Rates generally 10-15% in pediatric offices or settings with a higher percentage of Medicaid patients
- Lower rates possible but may be linked to the availability of health care coverage in that area

Lay Staff Efficiency

- Number of “man-hours” per patient visit
- Lay staff efficiency = \( \frac{\text{average monthly lay staff payroll hours}}{\text{average monthly patient visits}} \)
- Ranges from 1.5 to 3.0, typically averaging 2.0 or lower in an efficient practice
Practice Market Share

- Practice market share = 
  \[
  \frac{\text{annual collections}}{\$100 \times \text{total population of your service area}}
  \]
- The figure you get, expressed as a percent, is your approximate market share
- This should be pro rata or better to your share of the service area’s provider base

Marketing Cost Ratio

- Marketing cost ratio = 
  \[
  \frac{\text{creative, production, media printing, etc. costs}}{\text{collections}}
  \]
  (Do not include internal marketing staff costs)
- 3-12%
- Higher when launching new services
- An old-line, established practice with no further growth aspirations can get by on 1-2%
Reducing Denied Claims and Write-offs

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I have no financial relationships to disclose

• Why is it important?
  – Every dollar you don’t collect is one less dollar of income
  – Work smarter, not harder

• Most consultants and billing companies accept a write-off of 5-10% per year as average
  – With the exception of charity care, physicians should not

Reduce Insurance Denials

• Meticulous data entry
  – Billing dept. communicates with front desk daily
• Check insurance eligibility
• Pre-certify procedures
• Letters to the medical director
  – Tips can be found on the AAPOS website
• Send claims to the state insurance commissioner

Insure proper payment

• Verify that codes are not bundled
• Spreadsheet of contract fees
• MD must audit their EOBs periodically

Reduce Patient Bad Accounts

• All patients must sign office policy stating that all accounts are due in 30 days
• Collect co-payments and all deductibles prior to service
• Send bill to both parents if separated
• Send to collections at 90 days with MD approval
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**Visits Per Month**

- New patients
- Consults
- Established patients
- Total patients
- Total new patients, including consults

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Insurance Contract Negotiations

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I have no financial relationships to disclose

Negotiation: Overview

- Where do fees come from?
- What do you want?
- Who are “they”?
- What do they want?
- Getting to yes

Negotiation: Where fees come from

- **Relative Value Unit (RVU)**
  - value assigned to each CPT code
  - work, expense, malpractice
    - (“resource-based”)
- **Conversion Factor (CF)**
  - Medicare budget = CF x global RVUs
  - CF = Medicare budget ÷ global RVUs
  - projected
- **RVU x CF = $ per service**
  - e.g.: CPT 67311
    - RVU 14, CF $36 (2009)   14 x $36 = $497

Negotiation: Who’s on the other end of the phone?

- ideal: knowledgeable/principled/fair
- +/- unequal power relationship
- unprincipled person
  - position is everything
- ignorant/ill-educated/obtuse
  - RVU, CF
  - scarcity of service
  - value of service (QALY)
  - difference between MD and OD

Negotiation: Who are you? What are your goals?

- fellowship trained
- 25 to 36yr
- < 1,000
- cost-effective
- more money for less work
  - higher fees × fewer patients
  = more time per patient, better life

Negotiation: Where to start?

- know what you want
- be careful what you wish for
- ask them what they want
- unequal power relationship level the field
- unprincipled negotiator stay principled
- ignorant/ill-educated/obtuse
  - educate and escalate
**Negotiation**

*Unequal relationship: Level the field*
- no other specialist with your qualifications
- liability to plan in not offering your services
- other insurers offer your services
- risk of subscriber migration
- you are cost-effective short-term, as well
- you are cheaper in-network

*Unprincipled: Stay principled*
- stick to your rationale
- show flexibility to reason, not threat
- be flexible or be prepared to walk
- do not enter negotiation otherwise

*Ignorant/obtuse: Educate and escalate*
- perstare et praestare
- be polite
- don’t condescend
- ask for help in reaching agreement
- insist on talking with someone who can make a contracting decision

**Negotiation**

*Possible Outcomes*
- Complete success
- Partial success
- Zip, nada, zero
Insurance Contract Negotiations

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I have no financial relationships to disclose
Negotiation: Overview

• Where do fees come from?
• What do you want?
• Who are “they”? 
• What do they want? 
• Getting to yes
Negotiation:

Where fees come from

- **Relative Value Unit (RVU)**
  - value assigned to each CPT code
  - work, expense, malpractice
  ("resource-based")

- **Conversion Factor (CF)**
  Medicare budget = CF x global RVUs
  CF = Medicare budget ÷ global RVUs
  projected

- **RVU x CF = $ per service**

  e.g.: CPT 67311
  RVU 14, CF $36 (2009)  14 x $36 = $497
Negotiation: Where fees come from

- Medicare (CMS) RVU scale based on needs of elderly population
- CMS CF based on Medicare B budget
- Medicare RVU scale and CF have nothing to do with pediatric population
- QALY – Quality Adjusted Life Years
Negotiation:

Who’s on the other end of the phone?

- ideal: knowledgeable/principled/fair
- +/- unequal power relationship
- unprincipled person
  - position is everything
- ignorant/ill-educated/obtuse
  - RVU, CF??
  - scarcity of service
  - value of service (QALY)
  - difference between MD and OD
Negotiation:  
Who are they?  What are their goals?  

- **Private plans:** maximize profit  
  cost-sensitive subscribers  
  - cut fees, deny services  
  - raise premiums, co-pays, deductibles  

- **CHIP plans:** avoid loss, social mission  
  cost-insensitive subscribers  
  - cut fees, deny services  
  - administrative barriers
Negotiation:

Who are you? What are your goals?

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- 25 to 30/yr
- < 1,000
- cost-effective

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Negotiation

What do you want?

- higher CF
- refraction (92015)
- consult codes (99243, etc.)
  and visit codes (99214, 92004, etc.)
- bilateral surgery (e.g. - 67311 x 200%)
- *unlink* your fee schedule from Medicare
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Negotiation

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Pediatric Optical Dispensing

Daniel M. Laby, MD
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Pediatric Optical Dispensing

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I have no financial relationships to disclose

Why should a pediatric ophthalmologist sell glasses?

To Help Children See Better!!!

Keys to Successful Pediatric Optical Dispensing

- Carry over all of our advantages as Pediatric Ophthalmologists
- Child friendly atmosphere in optical
- Optician/staff “kid friendly”
- Special packages for children
- Bigger/better inventory for children
- What differentiates us from others …
- Kids are not a sideline, they are our business

Where do I start?

- Consider ...
- The Dispensing Ophthalmologist book available of AAO.Org website
- No financial interest in the text or the author

How to go about it

- Speak to colleagues to learn as much as possible (PedsOphths, ODs, local optical shops)
- Determine space needs and placement
- Visit VisionExpo (east or west) … LEARN!
- Space design and furniture (hire a carpenter)
- Frame manufacturers – make deals/discounts
- Types of lenses (TD2, Crizal, Transition)

Designing the Optical Space

- Fit theme of office
- Get help from whomever you can
- Other eye care providers
- Industry – “Fashion Optical/Eye Designs” design service
- Lead into Optical area from waiting room
- Fun, eye catching frames and items for kids/parents
- Security Concerns … touchy feely
- Space for optical lab
Don't forget space for a small optical lab

Small office layout

Large office layout

Tips for Success (recipes for disaster)
- Teamwork – hire the right staff!
- Maximize capture rate
- Discussion starts with Doc in chair
- Doc walks patient to Optical
- Doc begins process of frame selection (30-60 seconds)
- Doc hands off patient to Optical staff

Tips for Success (recipes for disaster)
- Dispensing Staff
  - Can hire an Optician, Optometrist, or Tech
  - Pros and Cons of each
  - Cost OD > Optician
  - Benefit OD can see kids, generate revenue outside of optical
  - The right person can make (or break) the success of the Optical
Take advantage of corporate and Optometric resources regarding optical business.

**Dispensary Management**

- **Who runs the shop?**
  - Self run
  - Follow progress of Optical
  - Make all decisions
  - Maximum profit
  - Maximum time commitment
  - 3rd party management
    - Several companies – differing levels of involvement
    - Less need for day to day management by MD
    - Less profit!

- **Essilor Program**
  - No charge if use an Essilor lab
  - Monthly in office meetings regarding all aspects of Optical management
  - Advice and Q & A
  - Frequently review capture rate and profit/loss
  - Frame & Lens Guarantees/Warrantees
  - Buy one – get one half price

**Learn from experience**

- Be willing to change labs – initially contract with several and later determine which works best
- One of each frame – order and drop ship to lab
- One example of each frame – patient can choose colors from catalog/web
- Be willing to call lab with any questions – get advice from prisms, fresnel placement, returns, contact lens help
- Be willing to return frames that don’t sell and negotiate prices all of the time

**Important Benefits**

- Team work is a must between office staff, technicians, doctors, and the opticians to maximize your Capture Ratio
- Opening an optical dispensary will make your practice complete and will increase patient satisfaction, cash flow and profits for the practice, and promote team building among your staff
- Most importantly – your patients will enjoy it and so will you!
Optometrist or Orthoptist ????

Merrill Stass-Isern, MD
Patrick Droste, MD
Lance Siegel, MD
Jorie Jackson, CO

All 3 presenters have no financial relationships to disclose

Who to Hire ?

Optometrist
- Failed vision screening
- Routine exams
- Sibling exams
- Older, stable strabismus
- Amblyopia follow-up
- Emergency exams
- Contact lenses
- Can see any pt per comfort zone of OD/MD

Orthoptist
- Expedite patient workup
- Adult strabismus workup
- Pre- and postop sensorimotor exams
- Amblyopia follow-up
- Non-surgical strabismus follow-up
- Contact lenses
- Coordinate clinical research

Employment Models for Optometrists
- Many different models - each comprised of several components
- Components:
  - How to choose an OD?
  - How are they educated?
  - What do they do?
  - How do they bill?
  - How are they paid?

How to Choose an OD
- Pediatric Optometric Residency Programs:
  - Children's Mercy Hospital/UMKC
  - New England College of Optometry
  - University of Houston
- Avoid the COVD - College of Optometrists in Vision Development - Behavioral VT
- Non-pediatric trained OD - possible but will require more training

Education for the OD
- If they are fellowship trained, little extra education will be necessary
- They should shadow you for a period of time until they understand the basics of how you treat amblyopia, strabismus etc.

What Should the OD See?
- Work independently - ODs can see
  - routine
  - failed vision screening
  - contacts
  - simple amblyopia
  - follow-up of stable, older strabismus
- Work with you - doing all or part of the exam with MD oversight - “Team Approach”

Other OD/Orthoptist Duties
- Some offices will have their OD or orthoptist:
  - manage HR
  - back office supervision
  - optical shop supervision
Billing for OD Services
- When they are working independently, they bill with their provider number - using either appropriate medical or eye codes.
- When they are working with you - you bill using your provider number.
- Their billings will need to be checked by you to make sure they are appropriate.

OD Salary Structure
- Salaries range with geographic location and level of expertise and experience.
- Average range is $75,000 - $150,000
  - Fixed salary with yearly raises and possible raises
  - OR - Base salary with production bonus

OD Issues
- “I consider myself a medical ophthalmologist”
- Refer patients to medical and surgical specialists autonomously.
- See patients outside of their scope of training.
- Hold on to patients before referring them for a second opinion.

Solutions
- Go over the charts together.
- Set guidelines on treatment patterns.
- Set guidelines on out of practice referral.
- Be transparent about revenue and production figures-monthly.
- Communication and Collaboration.

Billing for Orthoptists
- 92060 - Physician does NOT have to be present.
  - Can be used on its own or in addition to an eye code or E&M code.
  - May need to add modifier 59.
  - Can be used in the post op period.
- 99211 - Physician has to be in the building, but does not have to see the patient.
  - Can be billed along with 92060.

Orthoptist Reimbursement
- Varies by insurance company and region.
  - Negotiate for higher reimbursement.
  - Negotiate the actual code used.
- Provider code
  - Some orthoptists have their own (typically has to be negotiated).
  - Under clinic number.
  - Supervising ophthalmologist (most cases).
- Cash for services.

Can I Afford an Orthoptist?
- Average Salary is $60-65,000.
  - Increasing your patient visits by 25% will cover this and provide a profit.
  - Addition of one full-time CO to a practice can result in up to a 50% (avg. 30%) increase in patient volume and an average of 26% in surgical volume (2007 Manpower survey of AAPOMS members).
- Clinical Research Coordinators
  - PEDIG and most drug companies may provide money to cover the cost of a salary.

How to Best Utilize an Orthoptist
- Allow the CO to run an independent amblyopia and strabismus follow up clinic.
- Allow the CO to work up patients in your high volume clinic to help you move patients faster.
- Have the CO work up and manage the difficult and time consuming patients, such as your adult strabismus cases.
How to Reduce Your Percentage of No Show Appointments

Robert S. Gold, M.D.
Deborah Lenahan, M.D.
Nils Mungan, M.D.
& Jorie Jackson, M.D.

Financial Disclosures
- Alcon
- Bausch and Lomb
- Pediavision
- Quest Medical

No Show Appointments

• In 2000, the national no show rate was 5.5% according to MGMA.
• Pediatric ophthalmology typically is at 8-20% with sub-12% achievable in most settings.
• The AMA policy states a physician may charge a patient for a missed appointment or for one not cancelled 24 hours in advance, if the patient is fully advised the physician will make such a charge.
• No CPT code exists for missed appointments.

Improving Your No Show Percentage

• Confirm all appointments 24-48 hours in advance of appointment
  – Staff
  – Automated
• Contact a no-show immediately
  – Call within two to five five hours of the missed appointment, or
  – Send a remitter letter the same day
• Use waiting lists
  – Waiting lists can help fill more slots at the last minute

No Show Policy/Implementation

• Define a no show appointment (not calling within 24 hours to cancel or reschedule)
• Decide whether or not you want to charge a fee for no show appointments.
  – Very effective in some practices
  – Not practical in others- illegal for Medicaid in the state of Colorado

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No Show Appointments

• Missed appointments cost a practice in 3 ways:
  – Lost revenue (from the missed treatment)
  – Staff time (spent in making follow-up calls and rescheduling)
  – Empty time (which could have been filled with another patient)

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No Show Policy/Implementation

• Type a protocol for staff.
  – After 3 missed appointments patients will be dismissed from the practice, or
  – There will be a charge of $5 for no show appointments or cancellations less than 24 hours in advance.

Improving Your No Show Percentage

• Double-book appointments
  – By adding 2 extra appointments in the morning and afternoon, you can improve your productivity.
• Over-book by the same percentage as your no show rate
  – Log in to identify days that have the highest rates
• Send appointments reminders by staff
  – Reminders should be marked to patients two weeks prior to their appointments. This is especially helpful if you book appointments months or even a year in advance.
• Send a welcome package to new patients.
No Show Policy/Implementation

• Post a notice at the front desk where patients check-in (inform them of the charge, if any).
• Add a disclaimer to your financial form that new patients sign if you charge a fee.
• If you chose to charge a fee, have a protocol in place for your billing department and supervisors. Who can waive the fee?

No Show Policy/Implementation

• Develop a letter that will be sent to patients who no show for their appointment.
• Develop a form to be used when patients no show so you can communicate this to the doctor. Make sure your form includes how many no show appointments for this patient so the doctor can make an informed decision on whether or not to terminate the patient.