1-800 Contacts is ramping up its fight against organized optometry at the state and federal levels over legislation that would change important aspects of contact lens pre-prescriptions and dispensing. Among the company's goals: longer expiration dates, elimination of contact lens brand on the Rx, and enacting a contact lens patient bill of rights.

1-800 Contacts began by taking aim at contact lens prescribers by backing bills around the country that would have blocked unilateral pricing policies (UPP) on contact lenses. The company is now working to extend contact lens prescriptions to up to five years and possibly prevent ODs from selling contact lenses.

American Optometric Association (AOA) President Steve Loomis, OD, says he suspected that 1-800 Contacts' attack on UPP was just the beginning and that the company and other...
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**By Bryan Rogoff, OD, MBA, CPHM**

Two bills making their way through Congress—one on patient access and another on online contact lens sellers—will have a major impact on how optometrists practice.

The first, the Dental and Optometric Care Access Act, also known as the DOC Access Act, is a combined effort with the American Dental Association which aims to protect patient’s access to care. The company is now working to extend contact lens prescriptions to up to five years and possibly prevent ODs from selling contact lenses.

**By Colleen McCarthy | Content Specialist**

1-800 Contacts began by taking aim at contact lens prescribers by backing bills around the country that would have blocked unilateral pricing policies (UPP) on contact lenses. The company is now working to extend contact lens prescriptions to up to five years and possibly prevent ODs from selling contact lenses.

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**By Mile Brujic, OD, FAAO**

As optometry’s scope of practice has increased, optometrists have embraced the treatment of allergic eye disease. Ocular allergies have multiple effects to patients in our practice. But, if allergies are unidentified because symptoms may not be present during office visits, patients may treat themselves. This leads patients to taking advice from friends and family members on what they think they should be using to treat their symptoms or looking to over-the-counter (OTC) products.

Some topical OTC agents contain vasoconstrictors which have the potential for abuse and rebound hyperemia. Plus, overusing these products can cause keratitis. Contact lens-wearing allergy sufferers present an additional logistical challenge to appropriate treatment. Often these individuals are using products that are not approved to be used with contact lens wear. This can even further exacerbate their symptoms.

With all of the potential sequelaes with those who treat themselves with topical OTC products, it is critical to identify these individuals when they are in the office and guide them to appropriate treatment options. If they come into their appointments asymptomatic, it is relatively easy to identify them as allergy sufferers. But, if they come in to see you in the winter and their allergy symptoms are present in the spring and fall, they may not seek your advice on appropriate treatment options when symptomatic.

**Probe deeper for allergy symptoms**

Identifying individuals who may be symptomatic for allergic eye disease requires uncovering symptoms that patients may have at other times throughout the year. Make sure that the medication list that you have for your patients is current. Probe for more details about medications that patients may take as needed. We ask patients if they take any medications throughout the year, even if they are non-prescription products.

Additionally, if no medications are recorded in the chart, I will often ask, “Do you ever use allergy medications at any time throughout the year?” Frequently, this question will elicit a positive response for OTC allergy medication.

**Why what happens in Washington, DC, affects optometry**

Two bills making their way through Congress—one on patient access and another on online contact lens sellers—will have a major impact on how optometrists practice.

The first, the Dental and Optometric Care Access Act, also known as the DOC Access Act, is a combined effort with the American Dental Association which aims to protect patient’s access to care.

**See DC and optometry on page 9**
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strengths, weaknesses, opportunities, and threats (SWOT) to optometry

By Ernie Bowling, OD, FAAO
Chief Optometric Editor

A recent meeting I attended one of the discussions included a quick and brief outline of what is termed SWOT. SWOT stands for Strength, Weaknesses, Opportunities, and Threats. The idea here is that a scan of the internal and external environment is an important part of a strategic planning process for any business. A SWOT analysis helps to identify your organization’s strengths and weaknesses (S-W), as well as broader opportunities and threats (O-T). The SWOT analysis provides helpful information in matching an entity’s resources and capabilities to the competitive environment in which it operates. The SWOT method was originally developed for business and industry, but it is equally useful for personal growth.1

I left that meeting thinking about my own practice’s SWOT, but my thoughts turned to the strengths and weaknesses, opportunities and threats to optometry in general. I came up with a quick list:

- Strengths: Patient care. I have always felt that we do an outstanding job of caring for our patients, and this is the one mainstay that will carry our profession forward.
- Weaknesses: A lack of self-confidence. We tend to defer to other professionals much too quickly and at times don’t appear to have the confidence in our own abilities.
- Opportunities: There are an abundance of opportunities in our profession. Two come to mind rather quickly: clinical point-of-care testing and dry eye. Optometry should own the ocular surface!
- Threats: Just as there are an abundance of opportunities, there are an equal number of threats. Opternative is the first that comes to mind. The continual erosion of profit margins due to vision care plans is another. I’m certain some would say an over-abundance of providers.

The purpose of performing a SWOT is to reveal positive forces that work together and potential problems that need to be recognized and possibly addressed. This is my shortlist. What do you think are the strengths, weaknesses, opportunities, and threats to our profession? I would enjoy hearing your list.

REFERENCE

If you have millennial staff or patients, see page 27 for more.
MISSION STATEMENT

In partnership with our readers, we will achieve mutual success by:

- Addressing political and socioeconomic issues that may either assist or hinder the optometric community.
- Providing management information that allows optometrists to enhance and expand their practices.
- Being a forum for optometrists to communicate their clinical knowledge, insights, and discoveries.

TOP HEADLINES

1. States where ODs make bank in 2016
   OptometryTimes.com/odsmakebank16

2. 10 tips for reducing staff time on MVC plans
   OptometryTimes.com/mvcmadecasy

3. 5 ways to fire a patient
   OptometryTimes.com/firingapatient
online contact lens retailers had bigger plans in mind.

**Going big in Arizona**

As evidence of 1-800 Contacts’ bigger plans, Dr. Loomis points to Arizona’s HB 2523—legislation that would have extended a contact lens prescription to beyond one year. While at least 14 states across the country have faced 1-800 Contacts-backed legislation, the company was particularly aggressive in Arizona.

Annette Hanian, OD, Arizona Optometric Association (AZOA) legislative chair, says that after the company tried—and failed—to stop UPP in Arizona in 2015, it came back with bigger demands. During the latest legislative session, Dr. Hanian says 1-800 Contacts worked on a number of bills, although HB 2523 was the only one that made it as far as a committee hearing.

See **1-800 Contacts** on page 6

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**AOA’s proposed updates to the Contact Lens Rule**

**In its comments on the Contact Lens Rule submitted in October 2015, the AOA asked the FTC to:**

- Fix the broken passive verification system
- Ensure retailers can’t sell contact lenses based on an expired prescription
- Stop “robocalls” that the AOA says are often difficult to understand or are incomplete
- Shut down online retailers that allow patients to purchase contact lenses without a prescription
- Ensure consumers are well informed about patient agency (retailers acting on behalf of the patient to contact the prescriber for the Rx), and prevent practices to assert patient agency that it calls deceptive
- Stop retailers from encouraging patients to stockpile contact lenses that far exceed the prescription length
- Stop retailers’ business practices that misguide patients on the requirements of the Rule
- Shut down retailers that do not follow the requirements of the Rule and target patients through social media and e-commerce sites
- Ensure retailers provide a reliably accessible live-contact person for doctors to discuss prescription problems, as outlined in the Rule

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1-800 Contacts
Continued from page 5

“1-800 Contacts talked about everything from no brands and no prescription expiration dates at all—that was their ultimate goal,” she says.

She says that the company also originally wanted the bill to specify that optometrists could not sell the contact lenses they prescribed.

Over the course of the legislative session, Dr. Hanian says the bill was whittled down to a five-year Rx expiration date, then finally to a three-year expiration date. However, that three–year date had strings attached.

“The bill that was finally introduced was [an expiration of] three years, plus if a patient had failed to release prescriptions to the state board. It was just a publicity stunt.”

The Arizona Board of Optometry did not respond to Optometry Times’ request for comment on the number or nature of the complaints.

Ultimately, the bill was defeated in the Commerce Committee with a 6-2 vote in February 2016.

What happened in Arizona can happen in your state
Dr. Hanian speculates that 1-800 Contacts saw Arizona as an ideal environment with a conservative government that is often anti-regulation.

She says what happened in Arizona should open the eyes of ODs across the country to what 1-800 Contacts is trying to do legislatively. According to the AOA, 1-800 Contacts tried to refill within the last two months of the prescription—so two years and 10 months—then a contact lens dispenser could fill the prescription for the shelf life expiration date of the lenses,” she says. “So, if the dispenser had contact lenses that didn’t expire for another three years, the patient could order an additional three years.”

1-800 Contacts general counsel Cindy Williams says that the bill was about giving consumers a choice. While the optometric community argues that prescriptions longer than one year are dangerous to patients’ ocular health, Williams maintains that denying patients access to an affordable way to purchase their lenses is a bigger danger.

“If patients don’t have an affordable option, they tend to stretch their lenses beyond the recommended wearing schedule,” she says.

Both sides put up an intense fight.

Dr. Hanian says 1-800 Contacts brought in nine lobbying firms and a public relations company throughout the course of the session, and the aggressive approach was gaining the company support.

“1-800 Contacts held a press conference and called us ‘economic monsters,’” says Dr. Hanian. “The most egregious thing 1-800 Contacts did was—the day before our Senate government hearing—lob off more than 3,200 complaints against optometrists who backed bills sit in various stages in Oregon, New York, Rhode Island, and more

Proposed federal contact lens regulations
At the federal level, a new bill would amend the Fairness to Contact Lens Consumers Act of 2004 (FCLCA) to require contact lens retailers to provide a toll-free telephone number and email address that prescribers can use to ask questions about a seller’s prescription verification request.

The bill, SB 2777, is sponsored by Sen. Bill Cassidy, MD (R-LA).

“It’s a bill that brings common-sense practices to this business of prescribing contact lenses,” says Dr. Loomis. “SB 2777 provides for more communication between the seller and the prescriber of the contact lens.”

Under FCLCA, a prescription is considered verified if the prescriber fails to communicate with the retailer within eight business hours after receiving the seller-provided verification information. This passive verification process is one of the biggest complaints from optometrists.

Optometry Times Editorial Advisory Board member Crystal Brimer, OD, FAAO, says that although she’s seen a decrease in the number of patients who choose to buy lenses online, she is familiar with the flaws in the verification process.

“We used to get faxes after hours and on weekends asking for prescription verification—mainly expired prescriptions—knowing we couldn’t respond in time, and [retailers] would be allowed to fill the prescription based on patients’ existing boxes,” she says. “I think that’s the biggest danger: it seems that my patients who resorted to online sales did so because their prescriptions had expired, and they didn’t think they needed another exam.”

When a prescriber has questions about the accuracy or verification of the Rx, SB 2777 requires that the prescription be considered unverified until the seller obtains affirmative confirmation of its accuracy from the prescriber. The prescriber must call or email questions before the end of that eight-hour period. The bill also removes the Federal Trade Commission’s (FTC) authority to adjust the eight-hour period.

According to the bill, if a prescriber asks a question before the deadline, the seller shall not fill the prescription, and the prescriber shall provide the seller with an accurate prescription. The bill would alleviate some of the problems Optometry Times Editorial Advisory Board member David Geffen, OD, FAAO, has experienced, just like many of his fellow ODs.

“We have received verification requests on Friday evenings and are asked to respond within a short time frame,” he says. “We are not open Saturday and have found that patients may have requested contact lenses which we did not prescribe. By the time we respond on Monday, the order has shipped out.”

1-800 Contacts strongly opposes SB 2777 and formed a coalition to fight it.

In April 2016, 1-800 Contacts formed a coalition with Costco Wholesale and Lens.com, calling themselves the Coalition for Contact Lens Consumer Choice.

In a statement, the companies say the coalition will work to:

- Protect contact lens consumers by educating the public about the benefits of the FCLCA

See 1-800 Contacts on page 8
**DUREZOL® (difluprednate ophthalmic emulsion) 0.05%, A Potent Steroid**

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*3x more patients achieved zero inflammation at days 8 and 15*1

- 22%* versus 7% on day 8*
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- 45%* versus 25% on day 3*
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*Pooled data from placebo-controlled studies of DUREZOL® Emulsion (n=107) versus placebo (n=220) in patients undergoing cataract surgery (N=527; P<0.01).*1

*This offer is not valid for patients who are enrolled in Medicare Part D, Medicaid, Medigap, VA, DOD, Tricare, or any other government-run or government-sponsored healthcare program with a pharmacy benefit. Additional terms and conditions apply. See co-pay materials for details.

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**INDICATIONS AND USAGE:**

DUREZOL® Emulsion is a topical corticosteroid that is indicated for:

- The treatment of inflammation and pain associated with ocular surgery.
- The treatment of endogenous anterior uveitis.

**Dosage and Administration**

- For the treatment of inflammation and pain associated with ocular surgery instill one drop into the conjunctival sac of the affected eye 4 times daily beginning 24 hours after surgery and continuing throughout the first 2 weeks of the postoperative period, followed by 2 times daily for a week and then a taper based on the response.

**For the treatment of endogenous anterior uveitis, instill one drop into the conjunctival sac of the affected eye 4 times daily for 14 days followed by tapering as clinically indicated.**

**IMPORTANT SAFETY INFORMATION**

**Contraindications:** DUREZOL® Emulsion, as with other topical corticosteroids, is contraindicated in most active viral diseases of the cornea and conjunctiva including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, and varicella, and also in mycobacterial infection of the eye and fungal diseases of ocular structures.

**Warnings and Precautions**

- **Intraocular pressure (IOP) increase** — Prolonged use of corticosteroids may result in glaucoma with damage to the optic nerve, defects in visual acuity and fields of vision. If this product is used for 10 days or longer, IOP should be monitored.

- **Cataracts** — Use of corticosteroids may result in posterior subcapsular cataract formation.

- **Delayed healing** — The use of steroids after cataract surgery may delay healing and increase the incidence of bleb formation. In those diseases causing thinning of the cornea or sclera, perforations have been known to occur with the use of topical steroids. The initial prescription and renewal of the medication order beyond 28 days should be made by a physician only after examination of the patient with the aid of magnification such as slit lamp biomicroscopy and, where appropriate, fluorescein staining.

- **Bacterial infections** — Prolonged use of corticosteroids may suppress the host response and thus increase the hazard of secondary ocular infections. In acute purulent conditions, steroids may mask infection or enhance existing infection. If signs and symptoms fail to improve after 2 days, the patient should be re-evaluated.

- **Viral infections** — Employment of a corticosteroid medication in the treatment of patients with a history of herpes simplex requires great caution. Use of ocular steroids may prolong the course and may exacerbate the severity of many viral infections of the eye (including herpes simplex).

- **Fungal infections** — Fungal infections of the cornea are particularly prone to develop coincidentally with long-term local steroid application. Fungus invasion must be considered in any persistent corneal ulceration where a steroid has been used or is in use.

- **Contact lens wear** — DUREZOL® Emulsion should not be instilled while wearing contact lenses. Remove contact lenses prior to instillation of DUREZOL® Emulsion. The preservative in DUREZOL® Emulsion may be absorbed by soft contact lenses. Lenses may be reinserted after 10 minutes following administration of DUREZOL® Emulsion.

**Most Common Adverse Reactions**

- **Post Operative Ocular Inflammation and Pain** — Ocular adverse reactions occurring in 5–15% of subjects included corneal edema, ciliary and conjunctival hyperemia, eye pain, photophobia, posterior capsule opacification, anterior chamber cells, anterior chamber flare, conjunctival edema, and blepharitis.

- **In the endogenous anterior uveitis studies, the most common adverse reactions occurring in 5–10% of subjects included blurred vision, eye irritation, eye pain, headache, increased IOP, iritis, limbal and conjunctival hyperemia, punctate keratitis, and uveitis.**

For additional information about DUREZOL® Emulsion, please refer to the brief summary of Prescribing Information on adjacent page.

**References:**

1. Durezol [package insert]. Fort Worth, TX: Alcon Laboratories, Inc; May 2013. 2. Data on file. 3. Fingertip Formulary, October 2015 (estimate derived from information used under license from Fingertip Formulary, LLC, which expressly reserves all rights, including rights of copying, distribution and republication).
The coalition started a petition in April 2016 at keepcontactlenschoice.org, urging Congress to reject legislation that would restrict where patients could buy their contact lenses. 1-800 Contacts told Optometry Times that to date, 71,000 people have signed it.

Updating the Contact Lens Rule

The FTC is planning to update its Contact Lens Rule, which requires contact lens prescribers to provide patients with a copy of their contact lens prescription after fitting is complete and prohibits sellers from providing contact lenses without a verified contact lens Rx.

1-800 Contacts would like eyecare providers to require patients to sign what the company is referring to as a “patient bill of rights,” informing patients they have the right to their prescription and to purchase contact lenses anywhere they wish.

According to Williams, enforcing the Contact Lens Rule is difficult. She says that the patient bill of rights would ensure that ODs are following the FCLA and would be able to provide proof of such in case of a reported violation.

“Our main goal at the federal level is to be an advocate for the 41 million Americans who use contact lenses in an industry that is fraught with anti-competitive behavior,” Williams says.

See “AOA’s proposed updates to the Contact Lens Rule” on page 5 for the AOA’s list of proposed modifications.

Dr. Loomis says the AOA is expecting the FTC to release its findings for comment this summer.

The AOA is part of the Coalition for Patient Vision Care Safety, which supports policies that promote patient health and safety. Also part of the Coalition are AdvaMed, Alcon, Bausch + Lomb, The Contact Lens Institute, CooperVision, and Johnson & Johnson. The Coalition supplied comments similar to those of the AOA to the FTC in support of amendment of the Contact Lens Rule.

“We strongly believe that the safe and appropriate use of contact lenses must be firmly

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8 JUNE 2016 | OptometryTimes.com

A new bill would amend FCLA to require retailers to provide a phone number and email address for prescribers to ask questions about verification of a contact lens prescription. 

Pediatric Use

DUREZOL® Emulsion was evaluated in a 3-month, open-label trial in pediatric patients (19 DUREZOL® Emulsion; 40 prednisolone sodium phosphate) for up to 3 years of age for the treatment of inflammation following cataract surgery. A similar percentage of DUREZOL® Emulsion treated patients were found to be comparing DUREZOL® Emulsion to prednisolone acetate ophthalmic suspension, 1%.

DUREZOL® Emulsion was also negative. Treatment of male and female rats with subcutaneous difluprednate up to 10 mcg/kg/day prior to and during mating did not impair fertility in either gender. Long term studies have not been conducted to evaluate the carcinogenic potential of difluprednate.

Animal Toxicology and/or Pharmacology

In multiple studies performed in rodents and non-rodents, subchronic and chronic toxicity tests of difluprednate showed systemic effects such as suppression of body weight gain; a decrease in lymphocyte count, atrophy of the lymphoid glands and adrenal gland; and for local effects, thinning of the skin; all of which were due to the pharmacologic action of the molecule and are well known glucocorticosteroid effects. Most, if not all of these effects were reversible after drug withdrawal. The NOEL for the subchronic and chronic tests was consistent between different species and ranged from 1-1.25 mcg/kg/day.

PATIENT COUNSELING INFORMATION

Risk of Contamination

This product is sterile when packaged. Patients should be advised not to allow the dropper tip to touch any surface, as this may contaminate the emulsion. Use of the same bottle for both eyes is not recommended with topical eye drops that are used in association with surgery.

Risk of Secondary Infection

If pain, redness, itching, or irritation becomes aggravated, the patient should be advised to consult a physician.

Contact Lens Wear

DUREZOL® Emulsion was not intended while wearing contact lenses. Patients should be advised to remove contact lenses prior to instillation of DUREZOL® Emulsion. On the preservation in DUREZOL® Emulsion may be absorbed by soft contact lenses. Lenses may be damaged after 10 minutes following administration of DUREZOL® Emulsion.

Released: May 2013
U.S. Patent 8,114,319

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See 1-800 Contacts on page 31
to high-quality care and “preserve and protect” the doctor-patient relationship. Furthermore, it focuses on discount plans that limit coverage for preventative care and materials for patients. Currently, 40 states have passed similar legislation, some only with vision or dental, and HB 3233 currently has 23 co-sponsors in Congress.

Certain managed vision care plans may force ODs to choose between continuing as providers or keeping the practice financially viable. Individual ODs are usually not able to negotiate with these plans that set prices for provider services and materials such as contact lenses or eyeglasses. The DOC Access Act will protect ODs from these types of plans by targeting anti-patient and anti-competitive provisions, such as forcing discounts on noncovered services, forcing doctors to participate in a vision or dental plan as a condition for participation in a medical plan, and restricting a doctor’s choice of lab.

The DOC Access Act also specifically targets vision plans, such as those organized under the Employment Retirement Income Security Act (ERISA), that are regulated on a federal level and often are beyond the reach of state law. These vision plans impede consumer-driven health care and have left providers and patients frustrated about increasing costs, which have led to diminished access in areas where patients have been delayed diagnosis and treatment opportunities.

The second bill, SB 2777, the Contact Lens Consumer Health Protection Act, attempts to modernize the Fairness to Contact Lens Consumers Act (FCLCA) passed in 2003. The current FCLCA lacks oversight; SB 2777 aims to hold Internet contact lens sellers accountable for illegal sales without verifying Rxs, filling expired Rxs, and other tactics used to fill Rxs. Lawmakers need to understand that contact lenses are regulated FDA Class II medical devices and need to be properly fitted before an Rx is written and improper use of contact lenses can lead to serious infections and sometimes sight-threatening conditions.

This bill will ban “robo” Rx verification calls from Internet contact lens sellers to eyecare practitioners (ECP) offices and allow ECPs to choose “live” calls or emails to verify Rxs. Also, holding Internet sellers accountable for illegal sales without verifying Rxs, filling expired Rxs, and other tactics used to fill Rxs. Lawmakers need to understand that contact lenses are regulated FDA Class II medical devices and need to be properly fitted before an Rx is written and improper use of contact lenses can lead to serious infections and sometimes sight-threatening conditions.

“Sen. John Boozman, OD, (R-AR) spoke to the AOA at the Congressional Advocacy Congress. “The AOA is a respected and effective advocate on the issues impacting optometrists,” he says. “I see firsthand the great work of the AOA team on Capitol Hill and the difference that individual optometrists can make by educating and informing members of Congress about our profession’s expanding role in the healthcare system. Every member can be proud of AOA’s advocacy.”

AOA at work in DC

Each year the American Optometric Association (AOA) holds a Congressional Advocacy Conference (CAC) where your fellow optometric colleagues and optometric students educate lawmakers about optometry’s pressing concerns. More than 600 students and ODs attended CAC in April 2016. AOA officers and executive staff coached us how to give a 20-second elevator speech to lawmakers about the current challenges. Optometry is not the only profession that has a constant, proactive agenda, and we had to be quick, concise, and focused about how it affects our patients. I was able to see firsthand how lawmakers and their aides allow only about 10 minutes to explain optometry’s concerns.

The AOA gets its strength from ODs around the country willing to develop and maintain relationships with their members of Congress. Bills that advance our scope of practice, protect access to our patients, and advocate for payment parity for ODs sometimes take years to get sponsors to bring to the floors of the House and Senate. This can be frustrating to the average OD who may not understand the process while practicing through dynamic changes of the profession. As a quick reminder of how a bill becomes a law, I revert to my childhood of Saturday morning cartoons of “I’m Just a Bill” from Schoolhouse Rock. It can be hard to understand what is happening in Washington, DC, on a daily basis when ODs spend their days focusing on patient care. Remember that the AOA executive board is comprised of dedicated caregivers like yourself, who volunteer and have as much stake in this as you.

Sen. Andrea P. Thom, OD, AOA president-elect: “AOA has been recognized as a political force on Capitol Hill and as a respected voice in Congress and at federal agencies throughout Washington, DC. We can attribute some of our successes to a strong AOA-PAC and unmatched shoe-leather lobbying abilities, but the real source of our strength comes from the thousands of AOA doctors and students—including AOA Federal Keypersons—willing to fight for fairer treatment for our patients, practices, and profession.”

Optometry and legislative battles

Optometry is one of the few health professions facing challenges with a retail presence from corporate and private entities, both vision and medical insurance, 50 difference state regulatory bodies along with federal legislation, challenges with ophthalmology, while still figuring out how to earn a living.

If optometry did not have representation in Washington, DC, optometry would be excluded from programs like Medicare, Veterans Affairs, and Affordable Care Act (ACA).

The AOA must be aware of all bills regarding physicians and insurance that are introduced to Congress. It has to educate—and sometimes re-educate—lawmakers every year that ODs are considered physicians. I was astonished to learn that no matter how far optometry has evolved, we still have to defend our place as physicians.

An example of this is the Harkin Law, which is a specific section of the ACA, Section 2706, which defines the meaning of non-discrimination of health care. Former Sen. Tom Harkin (D-IA), who sponsored this section, was approached by the AOA, along with the Integrative Health-Care Policy Consortium and the American Chiropractic Association, which were red-line out of ACA from the insurance coverage section. Optometry’s inclusion was strongly opposed by our counterparts in medicine and the insurance industry because without this section, it would allow discrimination in reimbursement rates based on broad “market considerations” rather than the more limited exception cited in the law for “performance and quality measures.”

The AOA provides a service to every OD. We need to be reminded that optometry’s standing today came from the profession joining together for a common goal. What happens in Washington, DC, does matter more, than we may think.

REFERENCES

There were no contributory elements to her medical, family, or social histories. Best-corrected visual acuity was 20/20 in each eye. The anterior segments of each eye were unremarkable. Specifically, there was no evidence of corneal, iris, or lens damage, and intraocular pressure (IOP) was in the statistically normal range. Dilated fundus evaluation of the right eye was unremarkable but revealed the picture shown in Figure 1 for the left eye. This was consistent with a diagnosis of choroidal rupture.

On further questioning alone, the patient admitted that the left-eye trauma was secondary to being punched in the eye. This appeared to be more congruent with the fundus damage that was observed.

Optical coherence tomography (OCT) was ordered to better characterize the nature of the choroidal rupture. See Figures 2–4. Additional findings included gonioscopy, which ruled out so-called angle recession. This finding was consistent with the normal IOP finding and lack of optic disc damage.

The patient was advised of the findings and the guarded prognosis following blunt trauma with resulting choroidal rupture. She was advised of the symptoms and risks that can be consequences of choroidal rupture and will be monitored annually unless vision changes intervene.

A 31-year-old female attended to UAB Eye Care for refractive care accompanied by her opposite-sex partner. Her current spectacle lens prescription had been obtained elsewhere; however, her glasses were broken. She reported blurred vision without them. Significant in her history was blunt trauma to the left eye approximately six years earlier. The nature of this was described as, “...getting a finger poked in my eye.”
There is a recent review in *International Ophthalmology Clinics* on the topic of choroidal rupture. Symptoms of choroidal neovascularization would consist of reduced or distorted vision; risks for choroidal neovascularization include older age and macular involvement, which was not present in this case.

Because of the significant disruption of the outer and inner retina, the patient was asked to return for visual field testing. The purpose of this would be to document the status of retinal sensitivity and follow for any functional changes as well as to make the patient aware of any potential nonseeing areas. The patient refused further testing. Annual surveillance for changes was recommended. In the absence of choroidal neovascularization, primary-care monitoring is appropriate.

**Symptoms of choroidal neovascularization would consist of reduced or distorted vision**

**REFERENCES**


7 techniques to boost your annual supply sales

Help your contact lens patients and your practice with these tips

Let's talk about an elephant in the room. Some practices are incredibly effective at selling annual supplies of contact lenses, and some practices are not. Just like daily disposables, low sales numbers are blamed on “the demographics of my practice.” There are certainly times when the patient just can’t afford to buy all of their contact lenses at once, but perhaps we could be more convincing.

But selling is nothing more than conveying the value of something to someone. It’s no different than trying to convince someone where to go for dinner, for example. The key is being passionate and believing that what you want for them has value—and then, of course, being able to effectively communicate that value.

Here are seven techniques we use to close the sale.

1. Create the culture
   This starts with initial phone call with the patient. However, in order to be convincing, your staff must truly believe that buying an annual supply is the best option. Do this by asking your staff to write out all the benefits to patient and practice.

   Begin with why contact lens patients get eye exams. Then there are the patients who typically don’t call for an appointment until they are on their last pair of lenses. Even before then, once they realize they are running low, they may be tempted to overextend the life of the lenses. So, if your patient decides to buy a three- or six-month supply, this process can happen more than once. This means that his annual exam could end up being delayed by months. For some, this may not have severe consequences, but for others it may compromise their outcome due to delayed diagnosis. This is in addition to the risk they take in abusing the lenses. The reality is that patients are more likely to change their lenses regularly when they have a handy supply. Talk through examples of patients who have experienced complications due to overwear of their lenses.

   Of course, the patient also sacrifices significant savings when she forgoes the annual supply. This forfeiture may include a reduced price per box or free shipping in addition to her rebate. An annual supply purchase also adds convenience, eliminating her need to remember to reorder or return for a pick up.

   We know that having to process multiple orders per year means increased administration time in placing the orders, checking them in, and calling the patients, but it also creates more opportunity for order errors. Furthermore, it reduces practice profit margin due to decreased exam frequency and increased cost. And by allowing the patient time to shop around for the cheapest price, we could potentially lose the sale altogether.

   Getting back to the phone call, your staff member should set the stage by telling the patient what to expect. “You will have your exam and contact lens fitting on the day of your appointment. You may also need a follow-up visit, but once the prescription is finalized, we will order your annual supply.” This message should be reiterated in the office. Be sure to record when the patient had his last exam. If he was overdue and resists buying an annual supply, “This message should be reiterated in the office. Be sure to record when the patient had his last exam. If he was overdue and resists buying an annual supply, discuss that as well as the risks involved.

2. Seal it with a red-letter stamp
   After printing the contact lens prescription, make it official with a red

More useful tips

- Have staff members wear two different colors of lenses. It reminds patients about contact lens wear in general (including the fashion potential) and also sets a fun tone for the office.
- When presenting an annual supply, create value by highlighting a positive and eliminating a negative. For example, a staff member could say: “By purchasing your annual supply, you’ll receive the highest value rebate on the market, and you won’t have to worry about coming in for more contacts until this time next year.”
- If you stock contact lenses, have the annual supply bagged and ready for the patient at check out after his exam or follow up.
- If you don’t stock them, but are nearly certain of the final prescription, order the annual supply so it will be ready at the follow up visit (but leave the boxes unmarked).
- Add a color lens trial (or brochure) to the bag. This could lead to an additional sale later in the year.
- When shipping the annual supply, ask if you can send it to the patient’s workplace. It’s an opportunity for interoffice interest and referrals.
- Never assume a patient will not buy an annual supply, or allow your presentation to differ according to the patient’s personality. It demonstrates a lack of conviction and belief. Every patient deserves the added value and convenience.
- Add six months, interest-free, before payment is due, by offering Care Credit to patients with financial obstacles. The small increase in your service fee (versus a typical credit card fee) is likely much less than the cost of multiple orders, a delay in the annual exam, or a lost sale.
stamp that reads, “Approved for Annual Supply.” This reiterates the message to the patient with added emphasis that he should purchase an annual supply sooner rather than later.

3 Celebrate!
When you tell the patient she is “approved for an annual supply,” celebrate. Help the patient understand that not all prescriptions and eyes are as stable as hers, and that this is a great privilege. Now, she can take advantage of all the savings associated with an annual supply. You don’t need to go overboard, but try to seem genuinely happy for her.

4 Wait for it
This one is sometimes tough but quite effective. When walking the patient to the front desk for the handoff, announce that he is approved for an annual supply. But instead of walking away, wait 10 seconds to hear the patient’s response. Patients are often more accountable to the doctor and may be more hesitant to deny the doctor’s recommendation face to face. Furthermore, if he does object, you are likely better suited to diffuse the objection.

5 Know your totals and rebates
Have simple tools accessible to demonstrate the annual supply cost for the patient, especially when insurance is involved. When you fumble around for the numbers, not only does the patient lose confidence in you, it gives her time to second-guess her purchase. You should be so prepared that your only question is, “How would you like to pay for that?” If possible, enter the sale at full price and apply an annual supply package discount to the total. At the end of the transaction, be sure to write on the receipt, “You saved $____.” Sometimes that’s more important to the patient than the amount paid!

6 Never talk “boxes”
Many prefer to present contact lenses as an annual supply, but you have to take it one step further. Resist ever discussing a box price with the patient, even when asked. If he pushes you for a box price, tell him the price per box after all rebates and discounts. This is how most online dealers quote their box prices, yet when a patient asks us, we typically quote the highest price we have and then mention the rebates afterwards. Don’t put yourself at a disadvantage against your competition; instead speak their language.

7 Incur a penalty vs. reward
If your expectation is that patients will buy an annual supply of lenses, follow through. Always quote the discounted annual supply price. Now it’s time to get the calculator out and ask the patient: “You don’t want your full supply? That will change the price; let me see how much it will be now. You will no longer get to use the rebate, receive the discounted price per box, or the free shipping because you’re buying only a portion of your lenses.” This is usually effective in changing the patient’s perception because she already had her mind set on a cheaper price and now it’s been taken away.

Dr. Brimer has special interests in contact lenses and dry eye. She has received study or sponsor support from Alcon, Alden, Allergan, Bio-Tissue, BlephEx, iCare, and PRN. drbrimer@crystalvisionservices.com

Marco has redefined slit lamp imaging by combining a new intra-optics beam-splitter, adapter and camera mount, with the tremendous computing and imaging power of Apple Technology. The result is ion – a highly sophisticated ‘mainstream’ imaging system that emphasizes image quality, simplicity and efficiency. Finally, an imaging solution like no other. The Difference is Marco.
Three steps to staff empowerment

By Michael Rothschild, OD
Director of What's Next-Leadership OD.

It is not uncommon to hear a doctor or office manager lament that they are so busy, they can’t get anything done. It is all the daily tasks that keep them from planning, looking ahead, or improving. “It just seems like I am always putting out fires,” is a common way to express this frustration.

Another complaint is that the staff “doesn’t care,” “won’t accept responsibilities,” or has “bad attitudes.” Low staff morale is consistently at the top of the list of management problems in most industries, including ours.

The solution to these two complaints is the same: staff empowerment. If the team can adequately take care of the “fires,” then there will be more quality time for you to work on other areas of the practice—and staff morale will dramatically increase if they are entrusted with some real responsibility. (Just trust me on this.)

Which to fix first?

Now the real challenge is next: turning over some of the most important pieces of the practice to a team of people who, at the moment, are not performing well.

This difficult task can be overcome with a strategic staff empowerment plan that has three steps. It is important to note that while this can be done, it is not easy, and the steps are not simple. But by being dedicated to the final outcome and sticking with it, your team will be putting out all of the fires and you can spend your time working on that stack of papers that won’t go away.

1. Talk
2. Listen
3. Be the example

STEP 1 Talk. It is important that a leader clearly define the direction the team is going. The leader typically has a very good mental image of what she is working toward in the practice. She knows how big she wants the practice to be, how busy, and the type of care she wants to deliver. However, the mental image is only in her brain.

Everyone on the team has their own mental image of the practice, too. Everyone has something they are building within the practice. If the visions of the entire team are not aligned, then stalemate ensues. Only by being very clear of what we are working to accomplish as a team can you begin to empower the individuals on that team. Expectations must be set, guidelines and limitations put in place and metrics defined that will be used to monitor progress.

STEP 2 Listen. After the vision is shared with the team along with any associated guidelines, it is critical that a system is created so the team can share their perspectives. The culture must exist so that everyone feels safe to tell the truth.

How you do this depends largely on the history of these conversations. Let me give you a quick tip: If nobody in your office disagrees with you, then they don’t feel safe to share their opinions.

If you have a recent history of asking questions, engaging conversation, and inviting feedback, then you are ready to listen and act on the feedback your team gives you. If you have made every decision for the last few years and haven’t heard any good ideas from your team in a while, you have some work to do before you will get any meaningful feedback.

Surveys are fine, but they will be guarded if it is the only way to communicate. Conversations are better. No matter how you elicit this feedback, start with easy questions that won’t offend anyone. Here’s an example of an easy question: “In your mind, what is the most important aspect of the practice: optical, clinic or administrative?” Let your staff know that there is no right answer to the question so that they feel safe to share.

STEP 3 Be an example. To have a team that really cares and is willing to do the extra work, they have to see you doing it, too. A leader who comes to work 15 minutes after the first patient arrives cannot effectively motivate a team to arrive early, ready to work. A leader who complains about a patient can’t expect her team to have respect for every single patient.

If detailed work is important from your team, they have to see that same level of detail in the work that you do. Lines of communication need to remain open, and revisiting the initial vision of the practice is important. Remember, benchmarks need to be defined to measure success.

It is far too common in today’s practices to feel a sense of stress and fear. The stress comes from a number of factors, but mostly it is just the fear of not knowing what is going to happen next. We worry about healthcare reform, insurance companies, and public perception of us as people. Two no-shows in one day makes us panic that we won’t be able to pay the bills. So, we react (often badly) when someone on our team makes a mistake.

These reactions lead to a tendency to cover future mistakes and an overall lack of trust, leading to more fear. You get it.

This culture of stress and fear is natural and, if left alone, will get worse—not better. Steps must be taken to get on the right track and the longer it’s been stressful, the longer this plan is going to take. Either way, the best time to start is now. Empower your staff today to give you an easier tomorrow.

Dr. Rothschild is also a consultant for Alcon, Optos, and Vision Source; a member of the speakers’ bureau for VSP; and a clinical researcher for CIBA Vision.
PATIENT AND PRACTICE SUCCESS
OFFERING ONE-OF-A-KIND TECHNOLOGY

Steven I. Bennett, OD, FAAO
Bennett Optometry, Ann Arbor, MI

As an avid cyclist, I know that there are several factors that make all the difference in the quality of my ride. A high-quality bike is important for a safe and smooth journey, but equally critical are the fittings I make to the bike to adjust for my body. When the fittings are right, I feel completely comfortable in the seat and can focus on the joy of cycling. I have the same goal for my patients who wear contact lenses. The lenses should first address their unique ocular needs, but at the end of the day I want their contact lens experience to be effortless, as if they weren’t even wearing contact lenses. I’ve found the perfect fit for my patients, and for my practice, with DAILIES TOTAL1® contact lenses.

A successful practice starts with superior patient outcomes, which is what DAILIES TOTAL1® contact lenses provide for my patients. DAILIES TOTAL1® are the first and only water gradient contact lens on the market today.1 These high-performance lenses have a unique structure that incorporates different levels of water content from the core to the surface. In a truly remarkable technological development, the water content at the surface of the lens approaches 100%, providing an extraordinary level of comfort from the beginning to the end of the day.2 The science behind these contact lenses is complex. However, I find that most of my patients today are technologically savvy and eager to learn how DAILIES TOTAL1® provide this level of comfort and to experience the lenses on their eyes.

DAILIES TOTAL1® contact lenses feature water gradient technology to optimize comfort for the full lens-wearing period.1 The silicone hydrogel core provides high breathability,3 while the chemistry change from core to late into the evening for dinner and attending his kids’ sporting events. The effect was, as he put it, “life changing.” He was able to keep wearing his lenses later into the evening for dinner and attending his kids’ sporting events.

I am pleased to report that studies of DAILIES TOTAL1® contact lenses have confirmed what my patients have been telling me about the outstanding moisture and comfort of these lenses and how these lenses have improved their lives. For example, one study found that the lubricity of DAILIES TOTAL1® lenses is the same at insertion as it is 16 hours later, at the end of a typical lens-wearing day.3 The value of DAILIES TOTAL1® to patients is also reflected in an Alcon survey of contact lens wearers, in which nearly 90% of respondents said that DAILIES TOTAL1® contacts lenses were so comfortable they sometimes forgot they were wearing them.4 In addition, almost 80% of contact lens wearers who tried DAILIES TOTAL1® preferred them to their previous lenses.4

The highest testimonial I can provide for DAILIES TOTAL1® contact lenses is that nearly all of my patients comment on their unique level of comfort, which I describe to them as a “cushion of moisture.” Not everyone who tries DAILIES TOTAL1® lenses in our office purchases them, but they leave knowing that we can provide them with the newest technology should they later decide to upgrade to a more advanced vision care option. DAILIES TOTAL1® contact lenses represent Alcon’s commitment to innovation and science that produces one-of-a-kind lens technology. These research advances not only improve patients’ quality of life and outcomes, but also practice outcomes; a win-win situation for everyone.

References

See product instructions for complete wear, care, and safety information. © 2016 Novartis

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Why patients are choosing eyecare apps over you

5 ways you can get your patients to start choosing you over the apps

It’s raining eyecare apps. Just for a second, I’m going to embrace the hate because we can use it to help lead us to a better understanding of the situation and ultimately to a solution. In our technologically enhanced world there seems to be an app for everything—including for eye care. Let’s assume that people will embrace vision care apps and online programs and that they will perceive you—as their eye doctor—with significantly less value.

Why would anyone want to get a prescription for the same contact lenses with which they are doing fine? Or why would anyone think that an online refraction would be as good as your care?

The answer is simple: Patients don’t value your care or the experience they have in your office more than they value online programs and apps. In fact, they are telling you that they would rather do business with them than you. You can say, “Well, they just want the prescription, and they don’t care about their eye health.” Yes—that is exactly what they are saying.

Why are you OK with this?

Why are you not seeking solutions and actively making changes in your approach and practice? Most likely what you have been doing for years will still continue to work, and you will continue to do well. However, unless we create a desire in people to value our services and support us with their business, then we will be in trouble. We know specialty care is a great way to go, but what about the majority of the patients who are in need of primary care?

It starts with what we can control—the level of care we provide and the experience we give them. I’m tired of hearing, “Well, at this office, they don’t dilate. Well, at this office, because we don’t take medical insurance, we tell them to go to a local ophthalmologist for their dry eye care. Well, at this office, patients won’t pay for an Optomap.” Etcetera, etcetera, ad nauseum. Those are not reasons; those are excuses. Stop with the excuses and start with the solutions.

It’s you

Sometimes it’s helpful to envision a worst-case scenario in order to find solutions to those scenarios that aren’t as bad. Let’s try it out.

Assume stand-alone refractions can easily and accurately be conducted online or via an app. Would people still seek routine comprehensive eye exams from an OD? Why would they? We can answer the why, but can the general public? Probably not.

So, the issue becomes one of awareness and image. How do we make the visit something patients look forward to and have a pleasant experience at your office? How did it get to the point where our essential services are seemingly essential only to us?

The answer is simple: It’s you. Staff asks patients, “Are you here today for an exam for glasses or contact lenses?” Put a stop to that immediately. It is detrimental to your reputation as a trusted eyecare expert because right from the start you are making it seem that glasses or contact lenses is all you do. Consider breaking it down and explaining the parts of the visit. Use terms like a “comprehensive eye exam,” “refraction,” and “contact lens exam.”

In the exam room, prove you are not a “prescription robot” by educating the patient on what you’re doing and why it’s helpful to him. The visit is often seen as an inconvenience, overpriced, and unnecessary when compared to the final outcome of getting the prescription. You are going to lose out if you continue to think that you can still be successful doing the same things you have always done.

Get patients to choose you over an app

So, how do we get more people to choose us over an app? More people would want to go to their doctor if more doctors created patient experiences in which the value of the service was made apparent and the experience was enjoyable.

5 ways to increase your value

1. Ask how you can help the patient today, and address that chief complaint first.
2. Educate patients about ocular health—and why it’s important.
3. Demonstrate components of ocular health—wow the patient.
4. Ask about the patient’s children or spouse if you haven’t examined them at all or not in a long time. Show you care.
5. Give your patient a small item to emphasize you care about her eyes. It could be a contact lens care solution kit or the sunglasses off your head, like I do.
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Continued from page 16

 Patients don’t value your care or the experience they have in your office more than they value online programs and apps

loyalty as well as the perceived value of your services. You can make this an opportunity to create loyal patients who want to come in for their scheduled (word intentionally used) eye care.

Consider the following ideas to enhance your patients’ experience and to prove your worth by helping them.

1 After a friendly greeting, ask how you are helping the patient today. Address that first and foremost. Often it is related to refractive error.

2 Always let patients know that their visit is not just about a new prescription. Tell them that you are doing both a vision exam and an eye health exam—and don’t forget to tell them why! People will learn better if you throw a “because” in there.

Consider: “First, I am going to check your vision because I know you want to see your best. That is the vision part of the exam. After that, I am going to perform the ocular health exam because we both want to prove your eyes are in as good as shape as we both think they are. This is the most important part because often you can be seeing great but still have something wrong with your eyes.”

I bet if you think about it, you will find a way to improve your delivery or consistency.

3 Do the work. Don’t just give commands and shine some lights. Prove your worth and help the patient understand the importance of the ocular health exam. For example, show a patient a retinal scan and

educate him about his eye using his own eye. You show your value when you find something that probably has been missed, often because previous doctors didn’t look at his peripheral retina in the past—or didn’t tell him they did.

4 Look for opportunities to set things straight. For example, ask about the kids. How many times have you seen the parents but never their kids? Find out why. Kids need more than a vision test ad-
in which change is not only accepted, but embraced. It is up to you to set the example and refine the standard. It becomes very easy to just see the patient, get the prescription, and move on to the next one. Sure the patient knows you did something with that light to check his eyes, but the opportunity to wow and educate him was lost. I propose that a new standard of your success should be judged by how good you are at creating a desire for patients to come back when you want to see them. So, how good are you?

Dr. Bazar is a 2004 SUNY grad.
Reach him on his Facebook page.

IN BRIEF

Presbyopia treatment shows positive results

FORT WORTH, TX—The primary efficacy and safety endpoints have been met in Encore Vision’s Phase I-II proof of concept study of EV06 ophthalmic solution 1.5%. EV06 is the first topical medical treatment directed at softening the gradual stiffening of the crystalline lens, according to the company.

The Phase I-II randomized, double-masked, multicenter study examined the safety and efficacy of EV06 compared to placebo for the treatment of presbyopia. A total of 75 subjects between the ages of 45 and 55 with distance corrected near visual acuity (DCNVA) worse than 20/40 and best corrected distance visual acuity (BCDVA) of 20/20 or better in each eye were randomized 2:1 to receive one drop of EV06 (n=50) or placebo (n=25) twice daily over 90 days.

The mean change in DCNVA and BCDVA was evaluated throughout the study, along with secondary efficacy outcomes and safety parameters.

The study met both primary safety and efficacy outcomes. A significant improvement of DCNVA from baseline was observed in the EV06 group compared to placebo, with onset of DCNVA improvement beginning at Day 15 (p=0.017) and continuing throughout the 90-day study period (p=0.005).

EV06 outperformed placebo in objective and subjective measures throughout the study duration, according to the company.

From a historic perspective, one can see the decline of the perceived worth because now it is much more common for your patients to shop elsewhere—that is, options are up and loyalty is down. Maybe we should call it “perceived” loyalty.

I’ve been in optometry since 2000 and before that, a decade as a patient. I’ve watched society change into one in which the trait of loyalty is often fleeting and

Focus On TECHNOLOGY

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Indication

LOTEMAX® GEL (loteprednol etabonate ophthalmic gel) 0.5% is indicated for the treatment of post-operative inflammation and pain following ocular surgery.

Important Safety Information about LOTEMAX® GEL

- LOTEMAX® GEL is contraindicated in most viral diseases of the cornea and conjunctiva including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, and varicella, and also in mycobacterial infection of the eye and fungal diseases of ocular structures.
- Prolonged use of corticosteroids may result in glaucoma with damage to the optic nerve, defects in visual acuity and fields of vision. If this product is used for 10 days or longer, IOP should be monitored.
- Use of corticosteroids may result in posterior subcapsular cataract formation.
- Use of steroids after cataract surgery may delay healing and increase the incidence of bleb formation and occurrence of perforations in those with diseases causing corneal and scleral thinning. The initial prescription and renewal of the medication order should be made by a physician only after examination of the patient with the aid of magnification, and where appropriate, fluorescein staining.
- Prolonged use of corticosteroids may suppress the host response and thus increase the hazard of secondary ocular infection. In acute purulent conditions, steroids may mask infection or enhance existing infection.
- Use of a corticosteroid medication in the treatment of patients with a history of herpes simplex requires great caution. Use of ocular steroids may prolong the course and exacerbate the severity of many viral infections of the eye (including herpes simplex).
- Fungal infections of the cornea are particularly prone to develop coincidentally with long-term local steroid application. Fungus invasion must be considered in any persistent corneal ulceration where a steroid has been used or is in use.
- Patients should not wear contact lenses when using LOTEMAX® GEL.
- The most common ocular adverse drug reactions reported were anterior chamber inflammation (5%), eye pain (2%) and foreign body sensation (2%).

Please see brief summary of Prescribing Information on adjacent page.
Lotemprednol etabonate has been shown to be embryotoxic (delayed teratogenic effects). Pregnancy Category C.

**INDICATIONS AND USAGE**

LOTEMAX is a corticosteroid indicated for the treatment of post-operative inflammation and pain following ocular surgery.

**DOSEAGE AND ADMINISTRATION**

Invert closed bottle and shake once to fill tip before instilling drops. Apply one to two drops of LOTEMAX into the conjunctival sac of the affected eye four times daily beginning the day after surgery and continuing throughout the first 2 weeks of the post-operative period.

**CONTRAINDICATIONS**

LOTEMAX, as with other ophthalmic corticosteroids, is contraindicated in most viral diseases of the cornea and conjunctiva including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, and varicella, and also in mycobacterial infection of the eye and fungal diseases of ocular structures.

**WARNINGS AND PRECAUTIONS**

**Intraocular Pressure (IOP) Increase**

Prolonged use of corticosteroids may result in glaucoma with damage to the optic nerve, defects in visual acuity and fields of vision. Steroids should be used with caution in the presence of glaucoma. If this product is used for 10 days or longer, intraocular pressure should be monitored.

**Cataracts**

Use of corticosteroids may result in posterior subcapsular cataract formation.

**Delayed Healing**

The use of steroids after cataract surgery may delay healing and increase the incidence of bleb formation. In those diseases causing thinning of the cornea or sclera, perforations have been known to occur with the use of topical steroids. The initial prescription and renewal of the medication order should be made by a physician only after examination of the patient with the aid of magnification such as slit lamp biomicroscopy and, where appropriate, fluorescein staining.

**Bacterial Infections**

Prolonged use of corticosteroids may suppress the host response and thus increase the hazard of secondary ocular infections. In acute purulent conditions of the eye, steroids may mask infection or enhance existing infection.

**Viral Infections**

Employment of a corticosteroid medication in the treatment of patients with a history of herpes simplex requires great caution. Use of ocular steroids may prolong the course and may exacerbate the severity of many viral infections of the eye (including herpes simplex).

**Fungal Infections**

Fungal infections of the cornea are particularly prone to develop coincidentally with long-term local steroid application. Fungus invasion must be considered in any persistent corneal ulceration where a steroid has been used or is in use. Fungal cultures should be taken when appropriate.

**Contact Lens Wear**

Patients should not wear contact lenses during their course of therapy with LOTEMAX.

**ADVERSE REACTIONS**

Adverse reactions associated with ophthalmic steroids include elevated intraocular pressure, which may be associated with infrequent optic nerve damage, visual acuity and field defects, posterior subcapsular cataract formation, delayed wound healing and secondary ocular infection from pathogens including herpes simplex, and perforation of the globe where there is thinning of the cornea or sclera.

The most common adverse drug reactions reported were anterior chamber inflammation (5%), eye pain (2%), and foreign body sensation (2%).

**USE IN SPECIFIC POPULATIONS**

**Pregnancy**

Teratogenic Effects: Pregnancy Category C.

Lotemprednol etabonate has been shown to be embryotoxic (delayed ossification) and teratogenic (increased incidence of meningocele, abnormal left common carotid artery, and limb flexures) when administered orally to rabbits during organogenesis at a dose of 3 mg/kg/day (35 times the maximum daily clinical dose), a dose which caused no maternal toxicity. The no-observed-effect-level (NOEL) for these effects was 0.5 mg/kg/day (6 times the maximum daily clinical dose). Oral treatment of rats during organogenesis resulted in teratogenesis (absent innominate artery at ≥5 mg/kg/day doses, and cleft palate and umbilical hernia at ≥50 mg/kg/day) and embryotoxicity (increased post-implantation losses at 100 mg/kg/day and decreased fetal body weight and skeletal ossification with ≥50 mg/kg/day). Treatment of rats with 0.5 mg/kg/day (6 times the maximum clinical dose) during organogenesis did not result in any reproductive toxicity. Lotemprednol etabonate was maternally toxic (significantly reduced body weight gain during treatment) when administered to pregnant rats during organogenesis at doses of ≥5 mg/kg/day.

**Nursing Mothers**

It is not known whether topical ophthalmic administration of corticosteroids could result in sufficient systemic absorption to produce detectable quantities in human milk. Systemic steroids appear in human milk and could suppress growth, interfere with endogenous corticosteroid production, or cause other untoward effects. Caution should be exercised when LOTEMAX is administered to a nursing woman.

**Pediatric Use**

Safety and effectiveness in pediatric patients have not been established.

**Geriatric Use**

No overall differences in safety and effectiveness have been observed between elderly and younger patients.

**NONCLINICAL TOXICOLOGY**

**Carcinogenesis, Mutagenesis, Impairment Of Fertility**

Long-term animal studies have not been conducted to evaluate the carcinogenic potential of loteprednol etabonate. Loteprednol etabonate was not genotoxic in vitro in the Ames test, the mouse lymphoma tk assay, or in a chromosome aberration test in human lymphocytes, or in vivo in the single dose mouse micronucleus assay. Treatment of male and female rats with up to 50 mg/kg/day and 25 mg/kg/day of loteprednol etabonate, respectively, (600 and 300 times the maximum clinical dose, respectively) prior to and during mating did not impair fertility in either gender.

**PATIENT COUNSELING INFORMATION**

**Administration**

Invert closed bottle and shake once to fill tip before instilling drops.

**Risk of Contamination**

Patients should be advised not to allow the dropper tip to touch any surface, as this may contaminate the gel.

**Contact Lens Wear**

Patients should be advised not to wear contact lenses when using LOTEMAX.

**Risk of Secondary Infection**

If pain develops, redness, itching or inflammation becomes aggravated, the patient should be advised to consult a physician.

**Bausch & Lomb Incorporated**

Tampa, Florida 33637 USA

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Diabetes cases and rates of “prediabetes” are rising rapidly in the United States, and these patients will be showing up even more frequently in optometry offices. Physicians should be monitoring ocular surface health as well as signs of diabetic retinopathy, given the strong correlation between dry eye disease and diabetes.

TAKE-HOME MESSAGE

Diabetes cases and rates of “prediabetes” are rising rapidly in the United States, and these patients will be showing up even more frequently in optometry offices. Physicians should be monitoring ocular surface health as well as signs of diabetic retinopathy, given the strong correlation between dry eye disease and diabetes.

How diabetes affects contact lens wear

Keep A1C in mind and watch for corneal erosions

By Nancy Groves

Mass media and medical publications have been warning for years that the incidence of diabetes is rising rapidly and predicting a “health catastrophe” in which more than 10 percent of the U.S. population would be living with this disease. The future looks even worse with statistics showing that the rate of prediabetes has been climbing even faster than predicted and that without significant lifestyle changes, most people with prediabetes condition will develop type 2 diabetes within 10 years.

If diabetes-related problems are soon to become the reason for nearly 90 percent of patient visits to U.S. physicians, as has been suggested, then optometrists will be seeing many more of these cases. But optometrists should be expanding their management beyond checking patients for signs of diabetic retinopathy.

**Diabetes and dry eye**

“There are distinct evidence-based reasons why we should be looking at the ocular surface,” said Milton M. Hom, OD, FAAO, who is in private practice in Azusa, CA, and a member of Optometry Times Editorial Advisory Board. He spoke at the SECO 2016 meeting in Atlanta.

According to Dr. Hom, studies have shown that half of patients with type 2 diabetes also have dry eye symptoms and that the higher the hemoglobin A1C (HBA1C) values, the higher the rate of dry eye syndrome.

The association may be linked to automatic neuropathy, which decreases corneal sensitivity and affects feedback mechanisms and lacrimal gland secretion. In addition, hyperglycemia impairs inflammatory cell function and raises the risk of corneal infection.

Patients with diabetes are also at risk of endothelial cell loss, impaired sensitivity, and recurrent corneal abrasions. “The diabetic endothelium is morphologically abnormal,” Dr. Hom said.

To better address the host of eye-related risks associated with diabetes, Dr. Hom divides his management of these patients into two categories addressed in separate visits: one for the standard diabetic exam and one for ocular surface problems. During the ocular surface exam, measurement of HBA1C is standard. These readings can offer a more accurate picture of the disease status than glucometer readings because they provide a snapshot of the amount of glucose in the blood over the past two to three months.

Currently, an A1C level of 6.5 percent or higher indicates diabetes. This is lower than the value used in the past, and it’s likely to be reduced again in a few years, according to Dr. Hom. The rationale for adjusting the numbers is early intervention and better treatment outcomes.

“That’s going to increase the number of patients with diabetes that you’re seeing,” he said.

**Contact lenses and diabetes**

Patients who have diabetes and wear contact lenses are particularly challenging for optometrists. The susceptibility of patients with diabetes to corneal erosions, occurring at multiple places on the cornea, must be a factor in recommending a lens and ongoing patient management, Dr. Hom said.

Not every patient with diabetes is a good candidate for contact lenses, based on A1C levels and ocular surface health. But if contact lenses seem to be appropriate, the best option may be daily disposable contact lenses.

While there is no absolute upper limit of A1C levels that prohibits fitting for contact lenses, a value in the 7 percent to 8 percent range warrants caution, and a patient with an A1C level of 10% ordinarily would not be a good candidate.

“I will fit patients with high A1C levels with daily disposable lenses, but I watch them very, very closely, and I tell them that if they start experiencing abrasions, they will need to make some changes,” Dr. Hom said.

Every case must be considered individually rather than solely on the basis of a test result. He has seen patients with high A1C values but no evidence of ocular surface disease.

Every optometrist has patients who refuse to wear disposable lenses, even against the doctor’s recommendation. In these instances, tell diabetic patients they can wear reusable lenses but should use a hydrogen peroxide-based care system to reduce the risk of ocular surface problems, Dr. Hom said.

**Keep a mindful eye**

Vigilance with patients who have diabetes requires not only monitoring for retinopathy, corneal abrasions, and contact lens-related complications but corneal ulcerations. Dr. Hom said. Standard treatment for corneal ulcers relies on initial treatment with an antibiotic, followed by an added steroid. But this could be counterproductive in patients with diabetes.

“Steroids is increase the amount of glucose, See Diabetes and contact lenses on page 22
Diabetes and contact lenses
Continued from page 21

especially in the liver. If the patient already has diabetes, you can increase blood sugar by putting him on steroids,” Dr. Hom said.

Nutritional support is another avenue for advising patients with diabetes, which to a great extent is a lifestyle disease.

“The evidence is pointing toward using omega-3 fatty acids to help control both dry eye and diabetes,” Dr. Hom said.

However, using omega-3s may also cause complications such as a higher risk of prostate cancer or a decrease in clotting factor. They are not a miracle product that will benefit all patients.

Today, many nutritional supplements contain both omega-3 and omega-6 fatty acids, which have opposite effects, with the goal of stimulating an anti-inflammatory pathway. But there is little evidence on the ideal ratio of omega-6 to omega-3 or the best way to modify the pathway, despite the opinions presented in some papers, Dr. Hom said.

Most optometrists who recommend omega-3s or combination products know that they help some patients but not others.

“The reasons why omegas fail is because we have absolutely no idea what the omega-3 and omega-6 count is in our patients,” he said. “The only way to know is to take blood samples and measure the fatty acid content.”

When doctors blindly recommend a supplement without baseline information, the patient may end up with too much or too little omega-3 or omega 6, producing little or no benefit and potentially some harm.

Answers about omega-3s may come from the ongoing DREAM (Dry Eye Assessment and Management Study) study, the first study on dry eye sponsored by the National Institutes of Health (NIH). In this multisite study, patients are assigned to either omega-3 supplements (2,000 mg EPA and 1,000 mg DHA per day) or placebo; the primary outcome measure is mean change in Ocular Surface Disease Index score from baseline at 6 and 12 months in the primary trial and from 12 months to 18 and 24 months in the extension study. Blood samples will be taken at the beginning and end of the study. The estimated study completion date is April 2017, according to data at clinicaltrials.gov.

Help for diabetic patients may also come from an unorthodox source. Google announced in 2014 that it is developing a smart contact lens that could measure glucose levels in tears using a miniature wireless chip and glucose sensor. Google is partnering with Alcon to bring the project to the market in the next few years.●

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We call it our fundamental business truth: Your success is essential to our success. When your practice grows and flourishes, so does ours.

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Allergic eye disease

Continued from page 1

Then I will engage the patient to discuss ocular symptoms. Asking the question to prompt a discussion will allow you to appropriately educate the patient on how to proceed with managing his allergies by providing a therapeutic agent or advising a return visit to assess ocular tissues and symptoms during an allergy flare.

Allergy mechanism of action

Acute allergic eye disease that is caused by a type 1 hypersensitivity response usually manifests with significant signs and symptoms when the allergen is encountered. It is often referred to as the immediate hypersensitivity response and is a mast cell-driven response—mast cells in the susceptible individual are coated with IgE antibodies specific for a certain allergen. When the patient comes in contact with the allergen and the allergen binds to the IgE molecules on the mast cell, the cell creates a crosslinking of these molecules on its surface, forming a massive release of histamine. The histamine release and then binding to various tissues is what manifests in the typical signs and symptoms our patients experience: ocular hyperemia, itching, tissue swelling, and tearing.

This mechanism is involved in both seasonal and perennial allergic conjunctivitis. Perennial allergic conjunctivitis has a chronic, prolonged exposure to allergens, which can also cause more chronic inflammation. Together, these comprise over 95 percent of allergic eye disease that we encounter in our practices. A number of topical medications will provide symptomatic relief by having both anti-histamine and mast cell stabilizing properties.

Table 1 lists current medications that have both mast cell stabilizing and anti-histaminic properties, including their active molecule, brand name, whether they are prescription or over the counter, and their dosing regimen.

All of these medications work well, but realize that some patients may respond better to certain agents then others. Keep in mind that topical corticosteroids may be concurrently used in these individuals to help reduce the inflammation more quickly. Alrex (lotevrednol 0.2%, Bausch + Lomb) is the only corticosteroid approved for use for allergies. Although it works remarkably well and is favored because of its low concentration and thus lower side effect profile, consider higher concentration topical corticosteroids for more severe inflammatory cases, such as lotevrednol 0.5% (Lotemax and Lotemax gel, Bausch + Lomb).

Do not discount non-medical therapies for allergic conjunctivitis, including removing the patient from the allergen or attempting to remove the allergen from the patient with topical lubricants. Cold compresses for ocular manifestations also work wonders. Additionally, for those patients who are most symptomatic in the morning, suggest the patient wash her hair in the evening instead of in the morning because allergens reside in hair—washing her hair in the evening can help to remove them. For those patients who are most symptomatic in the afternoon, suggest the patient attempt to refit these patients into a daily disposable lens. Until the presence of GPC has subsided, we don’t think to talk about allergic eye disease, especially if they present when they are not symptomatic. Be sure to ask your patients if they take medication for allergies at any time throughout the year. Probing questions can bring more information to help you better diagnose and treat patients with ocular allergies.

Giant papillary conjunctivitis

With the increasing utilization of more frequent replacement contact lenses, we aren’t seeing giant papillary conjunctivitis (GPC) as much as we used to with soft lenses that were kept for a year. But, there will still be instances, often associated with contact lens abuse, that we will see GPC. Early GPC identification is critical because it can cause significant irritation and visual blurring. Additionally, it can cause excessive movement of the contact lens on the eye because of the large papillae that will cause movement of the lens with the blink.

GPC is caused by an ensuing irritation to the upper tarsal plate. Although a number of things can cause this, it is usually secondary to a contact lens deposit. Because of the chronic inflammation that is visible in patients exhibiting GPC, in addition to mast cell stabilizer/antihistamine combinations, these patients will often require temporary discontinuation of contact lens wear along with treatment with a topical corticosteroid.

Contact lens wear is typically not resumed until the presence of GPC has subsided. We attempt to refit these patients into a daily disposable lens. Because a fresh, clean lens is placed on the eye every day, there isn’t the opportunity for deposits to accumulate on the lens, and there is less of a likelihood of reactivation of GPC.

If daily disposables aren’t an option, consider prescribing a hydrogen peroxide solution to clean and care for the lenses. This seems to provide those individuals comfort and the cleaning mechanism provides a clean surface that mitigates the superior tarsal plate interaction with chemicals typically found in multipurpose solutions. Table 2 shows three one-step peroxide systems.

Other chronic allergic disease

Other forms of chronic ocular allergic disease include atopic keratoconjunctivitis (AKC) and vernal keratoconjunctivitis (VKC).

AKC is typically seen in adults with an associated atopic dermatitis. Although itching and redness are seen in this condition, it can involve the cornea because of the inflammatory cells that invade it. These patients will

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**TABLE 1** Available medications with mast cell stabilizing and anti-histaminic properties

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand name</th>
<th>Manufacturer</th>
<th>Rx or OTC?</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcaftadine</td>
<td>Lastacaft</td>
<td>Allergan</td>
<td>Rx</td>
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<tr>
<td>Azelastine</td>
<td>Optivar</td>
<td>Meda</td>
<td>Rx</td>
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<tr>
<td>Bepotastine</td>
<td>Bepreve</td>
<td>Bausch + Lomb</td>
<td>Rx</td>
<td>bid</td>
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<tr>
<td>Epinastine</td>
<td>Elestat</td>
<td>Allergan</td>
<td>Rx</td>
<td>bid</td>
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<tr>
<td>Ketotifen</td>
<td>Zaditor, Alaway</td>
<td>Alcon, Bausch + Lomb</td>
<td>OTC</td>
<td>bid</td>
</tr>
<tr>
<td>Olopatadine 0.1%</td>
<td>Patanol</td>
<td>Alcon</td>
<td>Rx</td>
<td>bid</td>
</tr>
<tr>
<td>Olopatadine 0.2%</td>
<td>Pataday</td>
<td>Alcon</td>
<td>Rx</td>
<td>qd</td>
</tr>
<tr>
<td>Olopatadine 0.7%</td>
<td>Pazeo</td>
<td>Alcon</td>
<td>Rx</td>
<td>qd</td>
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have significant mucous discharge. Additionally, they may have a blepharitis concurrently seen in atopic disease.

VKC will often be seen in younger males, usually below age 20, although not exclusive to this patient type. These patients will have a classic cobblestone papillae which can cause ptosis due to the size of the papillae. These patients will also have significant mucous discharge. Additionally, the limbal corneal region can manifest trantas dot—small, white elevations in the limbal region of the cornea that represent inflammatory cell infiltration into the region. They may be very obvious or very subtle.

For both AKC and VKC, in addition to the mast cell stabilizer/anti-histamine agents, these conditions frequently require a short-term pulse therapy of a topical corticosteroid to subside the underlying inflammatory response. Whenever utilizing topical corticosteroids, be sure to rule out infectious etiology and monitor intraocular pressures (IOPs).

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Expressor Pro Features
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• Ergonomic design & malleable
• Silver (.925) anti-microbial

TABLE 2 One-step peroxide systems

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<thead>
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<tr>
<td><strong>Alcon Clear Care</strong></td>
<td>6-hour neutralization soak</td>
</tr>
<tr>
<td><strong>Alcon Clear Care Plus</strong></td>
<td>6-hour neutralization soak (Note: contains HydraGlyde)</td>
</tr>
<tr>
<td><strong>Bausch + Lomb Peroxiclear</strong></td>
<td>4-hour neutralization soak</td>
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to make sure they do not become elevated. Immnomodulator therapy, such as topical cyclosporine A 0.05% (Restasis, Allergan), has shown effectiveness in each of these disease states and has the benefit of not having the side effect profile of corticosteroids.12,13

Be sure to accurately identify and appropriately treat this highly symptomatic condition in your patients. Considering these strategies can optimize both the identification and treatment strategies.

REFERENCES

Dr. Brujic received honoraria in the past two years for speaking, writing, participating in an advisory capacity or research from: Alcon, Allergan, Bausch + Lomb, Beaver Visitec, Bio-Tissue, Optovue, Paragon, RPS, Shire, Specialtyeyes, TelScreen, Topcon, Valley Contax, VMax Vision, VSP and ZeaVision.
Understanding millennial patients and staff

This generation wants to engage more, and preferably digitally

By Whitney Hauser, OD

Millennials, also known as Generation Y, can drive Generation Xers and baby boomers crazy. Many Gen Xers and Boomers don’t embrace those young, fresh faces because their approach to life is so foreign. Whether your practice wants to market to millennials or you need to hire them to be part of your eyecare team, understanding these up-and-comers is the key to a successful relationship.

Millennials, Americans born between 1980 and 1994, are the largest generation in world history. They exceed the large baby boomer generation and are poised to be the largest generation in the United States. They will be spending billions of dollars, cumulatively, over their lifetimes in the United States. Buying power means that by 2017, millennials are projected to spend $10 trillion, annually and $1 trillion, cumulatively, over their lifetimes in the United States. Buying power means that advertising will be tailored to them in both content and delivery.

Appealing to millennials

While they will be spending billions of dollars annually, getting millennials to value your product and invest in it is a little tricky. The mean income for this generation has dropped by five percent over the last 10 years, and its student loan debt has more than doubled. With less disposable income, they’re driven to make purchases out of necessity.

The question is, how do you make your practice and products a necessity? Brands aren’t as critical for this generation. They look for value and quality over the name on the label. Stacking a boutique optical with the likes of Tom Ford, Jimmy Choo, and Oliver Peoples may not draw crowds of this generation like it would Xers and boomers. Only nine percent of millennials strongly agree that they always try to by a branded product.

Rather than brand names, millennials seek brand love. They want to build a relationship with companies based on helping a greater good. Some 50 percent of millennials would be more willing to make a purchase from a company if their purchase supports a cause. Toms, a forward-thinking company founded in 2006, was one of the first to welcome the “one for one” concept. For every pair of Toms shoes purchased, the company promised to deliver a pair of new shoes to a child in need in one of many countries around the world. In the first six months, the company received nine times the available stock, and 10,000 pairs were sold.

Toms was one of the first companies to embrace the kind of corporate responsibility that appeal to millennials in a big and public way. It is joined by other companies like Fetch Eyewear who donate 100 percent of profits to animal rescue and Warby Parker’s “buy-a-pair, give-a-pair program.”

Reaching out to millennials

These young consumers are considered digital natives. Most of them don’t remember a time when the Internet didn’t exist. Not surprisingly, they utilize technology to connect socially, determine goods worthy of purchase, and execute those purchases.

Thirty-seven percent of millennials say they regularly enjoy social media for fun and entertainment. (Generation Xers are not far off that number with 35 percent, and boomers lag behind at 23 percent.) About 46 percent of millennials have 200+ Facebook friends compared to only 19 percent of non-millennials. While a retiree might be on Facebook, odds are she isn’t connected with many people, and her “likes” and “shares” won’t necessarily carry much weight.

While it’s debatable which social media outlet appeals to the most people and translates into tangible profit for a practice, few can argue that raising a practice’s brand awareness won’t pay off over time. Alan Glazier, OD, and ODs on Facebook founder, says, “The older generation used traditional media like radio and television, the younger generation uses social media. The channels most popular are Instagram and, surprisingly, YouTube.”

A social media outreach to millennials, connect socially, determine goods worthy of purchase, and execute those purchases.

Take-home message

Millennials, also known as Generation Y, can drive generation Xers and baby boomers crazy. Many gen Xers and boomers don’t embrace those young, fresh faces because their approach to life is so foreign. Whether your practice wants to market to millennials or you need to hire them to be part of your eyecare team, understanding these up-and-comers is the key to a successful relationship.

Millennials have a higher expectation that employers will invest in their training and education

Millennial facts

- First generation to have had internet in their formative years
- Racially diverse, 42 percent identify with a race other than non-Hispanic, white
- Highly educated, 61 percent attended college
- 23 percent are married and living on their own
- Average age of marriage 30 years old
- Chamber
- 2.5Xs more likely to be early adopters of new technology
who are often classified visual learners, may require an unconventional approach to be impactful.

**Millennials as employees**

Millennials are generally late to the party. Any party. They marry later, have children later, and often buy homes later. Similarly, they enter the workforce later, which means they have less “real world,” or work experience to offer your practice. Most baby boomers had covered a lot more ground by age 25 than their present-day counterparts.

Millennials prefer to communicate via text/instant message, email, social media, by phone, or in person. They can be valuable employees in your practice as staff or associates, but they have different expectations about an employer/employee relationship. Not quick to conform, they presume employers will search for a middle ground, not dictate. Millennials will leave a job quickly if they don’t perceive it as a good fit or if it affects their life balance. However, they will forgo a more lucrative job if they feel valued in their current position. Often they’re raring to go on their first day of employment and will challenge the status quo. Many practices don’t like nor look for change but have a stronger work ethic. Millennials also have a higher expectation that employers will invest in their training and education. Depending on their role in a practice, education can mean the yearly continuing education of an associate or formal technician training.

**Beyond millennials**

Who’s next in the lineup? iGen, or Gen Z, born between 1995 and 2009, will soon be nipping at the heels of the millennials. They’re predicted already to take on the jobs that millennials won’t, and they have a stronger work ethic. These youngsters are expected to be industrious and perhaps anxious about the future after spending their formative years during “the Great Recession.” Millennials have yet to solidify their place in the workforce and had better stay on their toes before the younger go-getters rock them on their heels.8,9

**REFERENCES**


Dr. Hauser graduated in 2001 from Southern College of Optometry, where she completed a residency in primary care optometry. She is the founder of Signal Ophthalmic Consulting.

whitneyhauser@sco.edu
Guess introduces tween Spring/Summer 2016 collection

The latest Guess tween eyewear collection for Spring/Summer 2016 is a colorful mix of optical frames for boys and girls in mature but fun variations. The collection features three new styles for girls and four new styles for boys. This collection capture the on-trend looks of the current fashion and accessory trends redesigned for the carefree lifestyle of today’s tween. Pops of color and retro-inspired silhouettes are combined into a youthful collection.

**GU9160** is a soft round acetate frame available in a vibrant color palette. The retro-inspired front features a keyhole bridge and temples that reveal a wire core beneath the Guess logo. This style is available in tortoise and red, seen here, and blue and black.

**GU9163** is described as a “geek chic” look with a pop of color revealed on the inner portion of the temples, while the outer portion and soft rectangular front are presented in a darker tone. It is available in blue and green, seen here, blue and black, and black and red.

**GU9168** is a flat metal design with a sporty rectangular profile in matte colorations, including black, brown, and blue. The frame’s temples feature temple tips crafted in acetate and delivered in pops of contrasting colors.

**GU1964** is also featured in a playful ombré effect in vibrant colors, like the style seen here.
DAYTONA BEACH, FL—Costa recently launched three new sunglasses styles, Hinano, Copra, and Trevally, each available in a variety of colors, finishes, and lenses. Like all Costa sunglasses styles, these new frames were inspired by life by the water. The name Hinano comes from the male flower of the pandanus tree that decorates French Polynesia. Copra is named for the dried, chopped coconut which is pressed for valuable oil. And finally, Trevally is named for the giant trevally, a large fish that is one of the hardest fighting fish a saltwater angler can choose to battle. All three styles are made of bio-based resin material sourced from the castor plant.

**Costa Sunglasses launches Hinano, Copra, and Trevally**

**Copra**, seen here in gray + cream + salmon, offers a durable, full coverage fit. Its integral hinge technology and soft nose pads create a comfortable fit.

**Copra**, seen here in matte coconut fade, is also available in retro tortoise with black temples, shiny black + amber, and shiny retro tortoise + cream + salmon.

**Trevally**, seen here in the matte tortuga fade, is also available in unisex frame colors, including tortoise, matte black, and matte orchid.

**Hinano**, seen here in driftwood + white + khaki, features a small fit, with cushioned high-grip temple tips, a low-wrap head curve and hypoallergenic rubberized soft nose pads, to help keep the frames comfortably in place all day. It is also available in blackout, shiny black, matte coconut fade, and shiny navy + red + gray.
1-800 Contacts

Continued from page 8

grounded in a legislative and regulatory environment that prioritizes and recognizes the vital role of eye care providers in supporting patients’ health and safety,” says Peter Menziuso, president of North America at Johnson & Johnson Vision Care, Inc.

1-800 Contacts says ODs often violate the FCLCA by not giving prescriptions to patients. The company has notified the FTC of nearly 28,000 violations of the FCLCA by ECPs. By not releasing the Rx, ODs are breaking the law

1-800 Contacts reports OD FCLCA violations
1-800 Contacts has notified the FTC of nearly 28,000 violations of the FCLCA by eyecare providers.

Among its chief complaints, the company says ODs often violate the FCLCA by not giving prescriptions to patients. 1-800 Contacts disagrees with ODs not releasing prescriptions to online retailers.

By not releasing the Rx—whether inadvertently or on purpose—the company says ODs are breaking the law and increasing the possibility of the sale of an expired prescription. This, 1-800 Contacts says, violates the trust of patients who believe their OD is looking out for their best interests.

Williams says 1-800 Contacts identified those violations using its own recorded phone records over a four-month period. When a patient called the company to place an order but didn’t have her prescription on hand, the company offers to contact her eyecare provider, acting as the patient’s agent. If the patient agrees—and Williams says patients agree 90 percent of the time on phone orders—the company has the right to contact the eyecare provider to obtain the patient’s prescription.

Williams says the company chose these orders to use to identify the violations because it wanted recorded proof that the patients understood what they were allowing the company to do.

The company faced problems in the past with the methods by which it asked patients for approval to act as their agent online after the eye-care community argued that patients were confused by the process. Williams says the company worked with the FTC to come up with a system in which the patient checks a box to opt in to having the company act as his agent—compared to the previous system in which the patient had to opt out.

The AOA agrees with consumer advocates who assert that the use of pre-selected boxes that force consumers to affirmatively opt out is deceptive and unfair to consumers and should be avoided.

Says Mike Stokes, AOA general counsel: “The AOA notified federal officials about this egregious overreach and violation of patient confidence, and we saw that 1-800 Contacts discontinued use of that particular form. The use of a pre-checked box on an order form for contact lenses is one more example of an industry that, we believe, at times downplays valid concerns about informed decision making and patient privacy in the interest of increasing sales and profits.”

While 1-800 Contacts is pointing fingers at optometrists, the FTC says online contact lens retailers have violated the FCLCA as well. In April 2016, the FTC issued warnings to 10 contact lens retailers and 45 prescribers for violating the law and reminding both that violations could include civil penalties up to $16,000 per violation. The FTC did not disclose which companies or eyecare providers received the letters.

View a sample of the FTC warning letter to retailers at http://1.usa.gov/1qETmjE and to prescribers at http://1.usa.gov/1TuFelb.

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William To  
2016 Doctor of Optometry Candidate, Western University of Health Sciences

**Opticianry, private practice, and playing Frogger on the freeway**

**Q** How did you start off as an optician? I was going the pre-dental route originally and then I graduated undergraduate and my brother, who had worked as an optician before, told me to try being an optician. He felt that type of profession suited me and my personality—more. I found a job down in San Diego for before going back up to the Bay Area. Everything just clicked. So, I’m glad I did look into opticianry, and that’s what pushed me into optometry.

**Q** Why should students get involved? Relative to health care, we’re a very small profession. It’s amazing how many people know people. If I talk to a doctor from Denver who will introduce me to his friend in Florida who will talk about an opportunity in New York, you’re literally talking about opposite sides of the country but that’s how small and how tight the profession is. Because there are so few of us, we care so much and so much about each other. So any relationship that you can develop, you never know where that can take you. So I do encourage students to get involved, get to know people. Try to get outside of your comfort zone just because the opportunities out there are endless.

**Q** What are your plans after graduation? I’m looking into buying a couple of practices in the Bay Area. For me, buying a practice uses the business skills I’ve developed over the past few years with the connections I’ve been able to make because of the leadership positions and opportunities that I’ve had. I’m in a position where I can take over two large practices relatively quickly after graduation. But just because I’ll be going for practice ownership right away doesn’t mean I’m still not developing my clinical skills. I figure this is a great opportunity, and if I have the ability to do it now, what’s the difference between purchasing practices now vs. a year or two years from now.

**Q** Why private practice? One of the reasons why I was drawn to optometry is the autonomy. I can be the type of clinician that I want to be. You hear enough doctors now talking about how insurances are controlling their ability to practice. I’m not saying that you don’t get that outside of private practice. To me, it’s the ultimate form of being able to do what you want to do vs. what other people want you to do.

**Q** What’s the craziest thing you’ve ever done? I was driving with a few of my buddies on the freeway in San Diego. This part of the freeway was only two lanes, and there was a car next to us. All of sudden, a red Porsche going 90+ mph comes up behind us in the left lane with high beams on. We keep driving because there’s nowhere for us to go. He jumps onto the left shoulder to get around us, which is dirt, rocks, and grass. He loses control and slams up against our car. Right when this happens, the freeway opens up into four lanes. He hit the car pretty hard—we pull over on the right and he pulls over on the left. Everyone’s fine, just a little shaken up. This is where the stupid part comes in. We think, “We don’t want this guy to get away. I don’t know what we were thinking—cars are coming at 80 mph—we did Frogger across the freeway. Cops come, take statements from everybody, then a cop looks at us and asks, “Where’s your car?” We point across the freeway. He looks at us and says, “You guys are idiots!” The cops had to stop the freeway for us to walk slowly across. Seemed like a great idea at the time. [Laughs]

—Vernon Trollinger

![William To](Photo courtesy William To)

To hear the full interview with William To, listen online: optometrytimes.com/WilliamTo

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**What one piece of advice would you offer fellow students?**

Whatever you want to do, it’s not too early. Establishing your name and your brand, building relationships, that should be started early, even in your first year. But on the opposite end, it’s never too late. I know some classmates who realized a few months from graduation, “Oh, I don’t actually know what I’m going to do a few months from now. Sure, I’ll have my license but I don’t really know anybody. I don’t really know where I’m going to practice.” You know what? Start now. [Laughs]. So if it just clicked in your mind that, “Oh, I need to do something,” then do it now. Put yourself out there—it’s never too late. You never know who knows who and what opportunities will open up from starting one relationship with one person and how that can quickly grow.
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