AMERICAN ACADEMY OF OPHTHALMOLOGY®

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AMERICAN ACADEMY OF OPHTHALMOLOGY®

Mid-Year Forum 2019

Reining in Drug Spending

Highlights from a Mid-Year Forum 2019 session on drug policy changes from the Trump administration, moderated by American Academy of Ophthalmology President George Williams, MD.

Abstract

As American consumers call for lower cost pharmaceutical drugs, federal policymakers are committed to identifying solutions to slow rising drug spending. The administration and Congress are considering new policies that could have substantial impacts for ophthalmology, with expensive Medicare Part B drugs a top target.

The session at Mid-Year Forum 2019 focused on the administration's drug policy changes, as well as congressional initiatives to address challenges in this arena. Important perspectives were shared, by the Department of Health and Human Services, Centers for Medicare & Medicaid Services, ophthalmology and the broader stakeholder community, on how to ensure patient access to critical treatments while also controlling costs and maintaining incentives to promote pharmaceutical innovations.

Background Information

As American consumers call for lower-cost pharmaceutical drugs, federal policymakers are committed to identifying policy solutions to slow rising drug spending. The Administration and Congress are considering new policies that could have substantial impacts for ophthalmology, with expensive Medicare Part B drugs a top target. As these policies are implemented and considered, the Academy is working to educate the membership on the potential impact while simultaneously advocating against federal policy that is not in the best interest of ophthalmology patients.

Summary of Comments from Guest Speakers

George Williams, MD, president, American Academy of Ophthalmology Moderator

Dr. Williams opened the session by outlining the purpose of Mid-Year Forum for attendees and thanking participants for their willingness to discuss important challenges and issues related to drug spending. Dr. Williams introduced Rep. Kurt Schrader (D-Ore.) to provide his perspective on congressional efforts to address drug prices.

Rep. Kurt Schrader, Energy & Commerce Committee, United States House of Representatives

Rep. Schrader pointed out that while the media is focused on hot political topics, he and his colleagues in Congress are working on solutions to important issues, including drug pricing. He discussed his own efforts to promote bills to increase

competition, end gaming by drug manufacturers, and to make drugs more affordable. He highlighted that the Energy & Commerce Committee, which he is a member of, recently passed six bills out of the committee on the issue of drug pricing. Rep. Schrader also mentioned his work to address issues impacting ophthalmology, including drug shortages. He closed his remarks taking questions from the audience on global budgeting, addressing high deductibles and pharmacy benefit managers.

Perspective on Trump Administration Drug Spending Proposals

Joel White, president and CEO of Council for Affordable Health Coverage

Mr. White highlighted various actions by the administration on drug spending, including new proposed rules and regulations. He informed attendees that both political parties were invested in addressing drug prices and that a major legislative package could happen this year. He highlighted actions that have occurred that impact ophthalmology, including Medicare Advantage step therapy authority in Part B, Food and Drug Administration clearing the generic backlog and eliminating pharmacy gag-clauses. Mr. White also highlighted potential actions related to Average-Sale Price (ASP) and linking drug pricing to costs internationally.

Drug Spending and Perspective of Retina Specialists

Sunil Gupta, MD, CEO, USRetina

Dr. Gupta opened by highlighting need and ongoing efforts to improve quality, affordability and access. He discussed efforts within ophthalmology to advance all three, including new treatments for macular degeneration, the IRIS registry and prevention of blindness. Ophthalmology has shown clear efforts to address affordability without government mandates and has also focused on improved outcomes. Dr. Gupta also discussed step therapy and how it is counter-productive to providing quality care to Medicare beneficiaries. He encouraged attendees to continue advocating for the profession of ophthalmology and against proposals that would negatively impact our patients.

Industry Perspectives on Drug Development and Pricing

Mark Blumenkranz, MD, MMS, chairman and professor emeritus, Byers Eye Institute, Stanford University

Dr. Blumenkranz opened his talk by discussing several headwinds and tailwinds that are impacting drug pricing and drug spending in 2020 and beyond. This included discussion of public and media perception of drug makers and market, as well as ophthalmology drugs coming off patent and new biologics coming to market. He discussed the evolving landscape of anti-VEGF therapies, including biosimilars attempting to come to market. He also discussed that many companies who sought to bring a new ophthalmology therapy to market have failed, despite heavy investments in development.

AAO Advocacy and Perspectives on Drug Spending

David Glasser, MD, Academy Secretary for Federal Affairs

Dr. Glasser highlighted the challenge of drug spending under Medicare, informing attendees that prescription drug spending was expected to grow 6.3% annually through 2026. He stated that ophthalmology has multiple drugs at the top for costs within Medicare Part B, which is why regulatory and legislative action on Part B is impacting ophthalmology. He outlined various solutions that have been proposed that impact ophthalmology, including prior authorization, step therapy, moving Part B drugs to Part D and reviving the competitive acquisition program.

Dr. Glasser told attendees that these efforts are top priorities for the Academy's advocacy efforts. Dr. Glasser closed with a brief discussion of generic drug shortages and how pricing is linked to those issues.

High Priority Objectives

- Continue to educate the Academy membership about new drug pricing policies that impact ophthalmologists and their patients.
- Continue the Academy's engagement with Congress and the administration on challenges and new proposals related to drug spending.

Leadership, Engagement, Advocacy and Practice Management (L.E.A.P.) Forward Report

Abstract

Advocacy Ambassadors will be inspired and engaged to be successful leaders in their practice setting, community, state and subspecialty society as well as national and international organizations. This session provides members in training an opportunity to network and interact with active leaders in ophthalmology with panel discussions covering four major areas: Leadership, Engagement, Advocacy and Practice Management (LEAP).

Background Information

The Academy's Advocacy Ambassador Program is a partnership with state, subspecialty/specialized interest societies and training programs. The goals of the Advocacy Ambassador Program are to:

1. Engage and educate members-in-training (residents and those undergoing fellowship training) early on as to the importance of advocating for their profession (training future advocates for patients and for the profession)
2. Help members-in-training understand the importance of membership and active involvement in their respective state ophthalmology and subspecialty societies
3. Expose members-in-training to some of the critical issues in medicine being discussed by leaders in ophthalmology during the Mid-Year Forum and council sessions

The LEAP Forward concept was first introduced at Mid-Year Forum 2015 and continues to incorporate suggestions for improvement each year. Session organizers, the Academy's Young Ophthalmologist (YO) Committee and Secretariat for State

Affairs, have recommended enhancements to the session at Mid-Year Forum 2019 that included:

- Assignment of "table leaders" moderated Q&A sessions with Advocacy Ambassadors during designated networking times. Twenty table leaders were assigned and included Academy and state and subspecialty society leaders in different phases of their careers.
- Rotation of table leaders which Advocacy Ambassadors an opportunity to interact with different leaders and hear different perspectives.
- A preview of issues related to private equity buyouts of ophthalmology practices in addition to other practice management concepts during the Practice Management panel.

Summary of Comments from Guest Speakers

The 2019 session was moderated by Academy YO Committee members Steven M. Christiansen, MD, and Grace Sun, MD, with a lead-off introduction by YO Committee Chair Janice C. Law, MD. Drs. Christiansen and Sun moderated the four panel discussions on **L**eadership, **E**ngagement, **A**dvocacy and **P**ractice Management. Dr. Law guided Advocacy Ambassadors in networking with assigned table leaders.

Each of the four topic themes began with a keynote speaker* followed by an interactive panel discussion. Keynote speakers and panelists each shared pearls and inspirational personal stories as examples on ways to become *engaged* and *involved* at the community, state society and national levels. The four panels included leaders in ophthalmology at varying points in their ophthalmology careers, as well as previous Advocacy Ambassadors.

Keynote Speakers

Leadership: **Tamara R. Fountain, MD,** immediate past president, American Society of Ophthalmic Plastic & Reconstructive Surgery and Graduate, LDP 1, Class of 1999, American Academy of Ophthalmology

Engagement: **Aaron M. Miller, MD,** secretary for member services and graduate, Leadership Development Program XI, Class of 2009, American Academy of Ophthalmology

Advocacy: **Paul Sternberg Jr., MD**, past president and cofounder Leadership Development Program, American Academy of Ophthalmology / G.W. Hale professor and chair, Vanderbilt Eye Institute

Practice Management: **Ruth D. Williams, MD,** chief medical editor for *EyeNet*® Magazine, member, Committee of Secretaries and past president, American Academy of Ophthalmology / consultant and partner, Wheaton Eye Clinic

Summary of Audience Comments

Residents and fellows participating as Advocacy Ambassadors appreciate this unique opportunity to interact and network with Academy and society leaders. This included a presentation by the Academy's CEO David W. Parke II, MD. Follow-up to the LEAP Forward session included many positive statements by the participating Advocacy Ambassadors. When asked what they liked most about the session, ambassadors responded:

- The session provided a wonderful opportunity to network and learn from AAO and society leaders as well as from fellow ambassadors. Understanding the paths many of our leaders took to gain leadership roles and become advocates was very insightful and helped me think of new ways to become more engaged. The realities of practice management are also very important to young ophthalmologists transitioning into practice and this was very helpful to hear as well. Overall great speakers. Truly inspiring for residents in-training.
- The time taken to discuss future practice concerns such as raising awareness about Private Equity groups.
- The whole thing was great! I really liked the portion where we talked about private practice and private equity. It was helpful as I'm currently trying to plan for my career and the YO leaders had really great insights.
- Best part is meeting amazing leaders in the field and roundtable opportunities.
- The group discussions were great, and it was really good to have an experienced advocate at each table to discuss the issues with and answers questions. The panel discussions were also informative.

High Priority Objectives

- Motivate Advocacy Ambassadors to engage in future state scope issues.
- Continue to engage and inspire Advocacy Ambassadors to be involved not only in the Academy, but also back at home within their respective state ophthalmology societies as well as subspecialty/specialized interest societies.
- Encourage state and subspecialty/specialized interest societies to be inclusive and offer YOs an opportunity to be involved.
- Continue to educate Advocacy Ambassadors on the differences and the importance of contributing to three critical funds: OPHTHPAC® Fund, the Surgical Scope Fund and State Eye PACs.
- Ensure that Advocacy Ambassadors fulfill the requirement to present their Mid-Year Forum experiences to their colleagues during grand rounds or other presentation opportunities (the Academy's Ophthalmic Society Relations department distributed a template PowerPoint to all Advocacy Ambassadors immediately after the Mid-Year Forum on April 15, 2019 and encouraged them to personalize it based on their own experiences).
- Inspire Advocacy Ambassadors to return to Mid-Year Forum and Congressional Advocacy Day as part of a committed community of advocates.

Social Media Training: Why You Need it and How It's Done

Social media is everywhere, and it's being used for work and play. At a session during Mid-Year Forum 2019, ophthalmologists discussed how to harness the power of social media to benefit their medical practices and their patients.

Abstract

Social media is comprised of various forms of electronic communication through which users create online communities to share information, ideas, personal messages and digital content. Originally created as tools to facilitate personal relationships, they have advanced to become as ubiquitous within a business context

as the telephone and email, enhanced by their ability to extend the reach of communication like never before.

The power of social media is increasingly being deployed within medicine to market physician services to the public as well as to provide a platform for physicians and medical organizations to advance their educational objectives. This session is a social media grand rounds, providing an overview of the major platforms and practical hands-on experience that will prepare participants to immediately enhance their ability to effectively engage with patients, the public and their fellow ophthalmologists.

Background Information

Social media is ubiquitous and should be part of physicians' lives by now. The dominant social platforms in terms of user adoption are Facebook and YouTube. The fastest-growing platform from 2016 to 2018: Instagram. The typical American uses three of the eight major platforms (YouTube, Facebook, Instagram, Pinterest, Snapchat, LinkedIn, Twitter, WhatsApp).

The Academy operates both member-focused channels (Facebook, YouTube, Twitter, LinkedIn) and public-focused channels (Facebook, YouTube, Twitter, Instagram).

Summary of Comments from Guest Speakers

SOCIAL MEDIA FOR OPHTHALMOLOGISTS (INTRO)
Andrea A. Tooley, MD, assistant professor of ophthalmology, Mayo Clinic, Rochester, Minn.

Dr. Tooley started a blog to document her time in medical school, and it morphed into a broader social media offering with thousands of followers.

Purpose of social media: Find your "why" and post with consistency. Learn to avoid pitfalls.

Your why:

- Educate
- Inspire and mentor
- Establish yourself as a leader in the field
- Market your practice

Post with consistency

- Use a service for posting, like Hootsuite or Buffer

Avoid pitfalls

- Safeguard patient privacy and protect your patients above all else.
- Obtain consent for ALL patient-related posts.
- If "de-identified," remove any identifiers of PERSON, PLACE and TIME.
- Avoid posts containing negativity, controversy, anger, etc.

WHY YOU SHOULD 'LIKE' FACEBOOK, GOOGLE REVIEWS AND HEALTHGRADES FOR YOUR PRACTICE

Ravi D. Goel, MD, Wills Eye Hospital, Philadelphia and Regional Eye Associates, Cherry Hill, N.J.

Warren Buffett said, "It takes 20 years to build a reputation, five minutes to ruin it."

Dr. Goel said he was afraid of his social media presence until 2012. That year, he Googled himself, looked at his results and ranked them. He saw that review sites like Healthgrades were prominent in search results. In 2014, 60% of his results were physician review sites.

He asked people to review him but did not offer incentives. This was his optimization strategy.

He offers this Monday morning action plan to claim your Google and Healthgrades profiles:

1. Google yourself and manage your Google profile or Google places page.
2. Use Google's tools to build and manage your profile. Google will start giving you powerful data that can help.
3. Go to Healthgrades and do the same.
4. Got to Facebook and do the same.

Continue to manage your social and web presence in other ways: For instance, during the 2017 solar eclipse, Dr. Goel created a blog post about eye safety. He spent $200 on a Facebook ad to promote that post, targeting men and women ages 60 to 65 in specific zip codes. That post received 7,000 engagements on Facebook and brought media interview opportunities.

INSTAGRAM IN OPHTHALMOLOGY: A PIC (OR VIDEO) IS WORTH A THOUSAND WORDS

Sidney K. Gicheru, MD, LaserCare Eye Center, Dallas

Dr. Gicheru talked about his practice's Instagram account, launched in a competitive Dallas market for laser correction. The goal was to engage millennials as prospective patients through social networks.

Patients like to actively talk about LASIK, sharing their experience and talking about who did the surgery.

At their practice, Dr. Gicheru said, they learned to make engaging videos to bolster their Instagram profile. They now have 24,000-plus followers.

Benefits include excellent return on investment and "social proof," he said. A strong social presence also helps reach out-of-town patients. He said his practice's market is now broadened to Houston, Austin and even reaches internationally.

To do Instagram well, have an infrastructure in place, post regularly, vary your posts, monitor your performance. Experiment to understand the platform's algorithm for promoting posts. Embrace influencers.

Understand the barriers to entry: Make it a team effort, empower young staff to help you and share their tricks and tactics. Expenses are minimal, but you must understand the legal and aesthetic issues.

Immediate action with patients: Take a picture right after you see them, use a phone if you must. The immediacy pays dividends.

Videos: Music will help, pay attention to who reaches out to you, find your voice (don't try to copy someone else) and have fun with it. It will grow.

PROFESSOR OR STUDENT? YOU CAN BE BOTH AT 'YOUTUBE UNIVERSITY'
Andrea A. Tooley, MD, assistant professor of ophthalmology, Mayo Clinic, Rochester, Minn.

Dr. Tooley started creating YouTube videos during medical school and has published 70 to 80 videos. She said she kept the bar low and didn't try to do anything special, but was able to be successful with some videos drawing hundreds of thousands of views. Her approach has been to post "day in the life" or lifestyle types of content.

Reasons to publish on YouTube include:

- Patient education
- Mentoring
- Teaching

Your video content can be repurposed on other platforms.

To be successful:

- Pay attention to the thumbnail, the static image that displays before the video play button is clicked. Opt for images that appeal to the layperson, rather than physician. Free photo editing apps, like PicMonkey, helps you do this.
- Text should have keywords in the caption and description box. This text makes the video more discoverable. Include a link to your other platforms, like Instagram.
- Create an attractive landing page using a customizable banner. Include an introductory video.

Music: Videos pop when you add music. Match the vibe of what you're trying to portray. You can also add narration. Embrace YouTube's free services.

BIG ON IDEAS, SHORT ON TIME? TWEET IT IN 280 CHARACTERS
Usiwoma E. Abugo, MD, oculoplastic surgeon, Carolina Eye Associates, Greensboro, N.C.

Why tweet? Ophthalmologists can have an incredible reach. Twitter has 335 million users. Interact directly with your audience and identify your brand. Embrace the community of professionals with whom Twitter helps you engage.

Tips

- Consider your username. What are you there for? Make it succinct and easy to remember.

- Pay attention to character count, add hashtags to increase your visibility on the network. Identify three or four hashtags on which you rely regularly. Hashtags for meetings and events are very important to see who you can interact with (a social media party!).
- Tagging other accounts: Maximizes photos and content and engages and brings key people into the fold.
- Generate content, relying on trusted resources. Academy material is vetted, reviewed and easy for patients to understand. Content from the World Health Organization also can be useful.
- Pay attention to timing. People on Twitter are usually online in the afternoon or midday. Also Saturday at 3 p.m.

Engage: Like others' posts, comment on their tweets, and retweet to share with your followers.

CASE STUDY 1: GROWING A PRACTICE THROUGH SOCIAL MEDIA

Drs. Gicheru and Goel

Dr. Gicheru said data shows two-thirds of small businesses use social media to generate leads or drive people to their websites and listings. "Social media is the new Yellow Pages!"

It's important because of its impact on search engine rankings. Better rankings show your relevance. 75 percent of patients look at online reviews prior to choosing a physician.

Social media helps establish your brand. Your brand isn't just your logo. It's your knowledge, breadth, patient experiences. Don't be afraid to ask patents how they heard about you.

Leverage Facebook's capacity for engagement, but know what you're doing. For example, most people expect a direct message response within an hour.

Establish a broad marketing plan, which includes owned media, earned media and paid media.

Dr. Goel said that in 2010, he stopped handing out video CDs to patients and instead posted them to YouTube. He started tracking YouTube views using link shortener bit.ly and grew annual views from 66,000 to 151,000 in four years. Bit.ly helps you track who pays attention, where they are and what actions they took.

CASE STUDY 2: PROMOTING OPHTHALMIC KNOWLEDGE AND PROFESSIONAL NETWORKING

Drs. Abugo and Tooley

Three strong platforms for education are Instagram, YouTube and Vimeo (another video-hosting platform).

Twitter and Facebook are strong platforms for networking. They help you find job openings, gather career advice, discuss interesting cases and showcase the latest technology. They also help you seek collectives of like-minded individuals, which exposes you to the greater ophthalmology community on key issues, events and education. Check out the hashtag engagement on Twitter around #whyIadvocate.

Using YouTube for education and mentoring can be low-budget and personal. The latter lends authenticity to your message. It helps establish you as a provider and expert in your field.

Instagram can be "ophthalmology in real time." It reaches med students and fellows directly to allow them to understand what they're doing or could aspire to do.

Summary of Audience Comments and responses to Q&A

- How do you block time for social media? Use the free time between patients to edit a photo, craft a post, etc.
- Gicheru, who has an online office manager at his practice, was asked how much of that person's time was spent online. He said, 80 percent, all day long.
- How do you deal with haters and trolls? You don't have to be in social media if you don't want to be. Take those people with a grain of salt. Handling bad reviews depends on the platform, so the best thing to do is address it directly. Start with "I'm sorry you had that experience/feel that way. Someone from our office will contact you to resolve this issue." And combat bad reviews with good reviews. Ask your staff to help you find people who will post honest, positive reviews of how you care for patients. Positive feedback outweighs the negative. Dr. Gicheru's electronic health records (EHR) automatically reaches out to patient to solicit a review.
- When do you find time to replay to social comments/questions? Take five minutes during lunchtime and with your response be honest about your availability ("I'm really busy, but I can answer you later"). Dr. Tooley did an Instagram Live to go through questions from patients and followers, which she then saved and shared on YouTube.
- What about SnapChat? It could be big, but not Instagram-big. But you need to respect and embrace all social platforms. User engagement on SnapChat is actually declining.

Private Equity – Round Two

Private-equity acquisition of ophthalmic and other medical practices has grown significantly in recent years. Mid-Year Forum 2019 once again examined this trend during a session on what it means for the profession.

Abstract

There has been recent publicity regarding the purchase of ophthalmology practices by private equity firms. Physicians did not fare well in an earlier round of practice purchases by physician practice management companies in the 1990s. Is this time different? Hear from physicians who have explored or sold their practices to private equity firms and gain insights from their experience, whether you are considering selling your practice or joining one owned by a private equity firm.

Background Information

The business models of healthcare delivery are rapidly changing. There is increasing consolidation of practices within ophthalmology and health care in general. The Physician Practice Management Company buyouts of the 1990s did not fare well for

physicians. Today, private equity (PE) companies have a more prominent presence in ophthalmology than in past years.

Practices considering a move to PE have potentially seen high valuations in recent years, making a sale more attractive to senior partners. Although selling may be attractive to some ophthalmologists, weighing the financial impact against the loss of practice management control and impact on the younger physicians and future recruiting opportunities must be considered.

Larger health systems traditionally have had a limited interest in ophthalmology, but the landscape is changing. Mergers and affiliations with other ophthalmology practices or organizations represent other opportunities for practices that wish to maintain some level of autonomy but have the benefit of a larger network for patient access. Efficiencies using common practice management systems and financial savings through group purchasing are positive outcomes with these models.

Summary of Comments from Guest Speakers

Robert E. Wiggins Jr., MD, MHA, senior secretary of ophthalmic practice, American Academy of Ophthalmology
Partner, Asheville Eye Associates (co-moderator)

PRIVATE EQUITY ROUND-ONE: THE 1990S

Physician Practice Management Companies (PPMCs) of the 1990s served as the forerunner of today's private equity (PE) companies which are purchasing physician practices. The promise of PPMCs to consolidate physician practices was a means for physicians to increase their leverage in contracting with managed care organizations and maintain access to patients. In addition, PPMCs promoted management expertise which could streamline practice operations and reduce costs. Money from venture capitalists and stock sales was used to fund practice purchases and payments from acquired practices were also used to fund further acquisitions.

Thousands of physician practices were purchased in the early-mid 1990s. The two largest PPMCs were Phycor and MedPartners, which combined had nearly 10,000 physicians in acquired practices by the mid-1990s. Revenues grew rapidly initially, but by the late 1990s, most PPMCs were reporting losses, and stock prices of those companies that had gone public had fallen precipitously. By the end of the decade, this business model had run its course.

Physicians during this time had great concerns about their ability to compete without being part of a large network of physicians. The reality was that PPMCs did not provide these physicians with either significant contracting benefits or operational efficiencies.

Physicians contemplating the sale of their practice to PE firms would do well to familiarize themselves with lessons learned from the experience with PPMCs of the 1990s. Is it different this time around? For the current private equity business model to be successful, PE firms need to:

1. provide a true value proposition to physicians in terms of income prospects and reduced administrative burdens
2. develop a model with effective governance that aligns incentives and engages physicians, and
3. tailor the new company to allow it to thrive in the local market.

PRIVATE EQUITY – ROUND TWO

Gary Markowitz, MD, consultant, Medical Practice Private Equity, founder and medical director emeritus, Delaware Eye Care Center, Blue Hen Ambulatory Surgical Center

PRIVATE EQUITY – IS THIS TIME DIFFERENT?

The larger question is how sustainable is private equity (PE) when compared to the Physician Practice Management Companies (PPMCs) of the 1990s. Unlike the PPMCs of the '90s, PE companies are well-funded and do not depend on going to the public market to turn a profit. In most practice buy-out models, the private equity company gains full practice control.

Practice valuation is a critical first step when considering a sale and involves a multiple of earnings before interest, taxes, depreciation and amortization (EBITDA). EBITDA measures the practice's operation performance, or net profit.

Adjusted EBITDA (AjEBITDA) = EBITDA **minus** all doctors' wages. PE companies use Adjusted EBITDA to value a practice. PE practice valuations have increased over the last five years (2014 to 2019).

- **Platform Practices (larger practices): Adjusted EBITDA > $2 million**
- **Satellite (smaller practices): Adjusted EBITDA < $2 million**

Platform Practice Value: 2014 = 6 x AjEBITDA 2019 = 8-14 x AjEBITDA
Satellite Practice Value: 2014 = 2-4 x AjEBITDA 2019 = 5-8 x AjEBITDA

PE Companies buy with possible intent to:

1. sell to larger PE Companies
2. take the corporation public or
3. find alternate institutional investors

Their goal is to sell the practice five to seven years after purchase with a growth in the value of the stock to three to five times the initial value. Practices are acquired for higher prices now leading to less profit initially and long term if multiple sales occur.

Private equity sales may create different classes of stock and practice owners should be aware and research the implications. "PARI PASSU" – creating an equal class of stock for all investors.

Has private equity interest peaked? In 2019, valuations have not risen. Healthcare reform could put a cap on consolidations profits. Downturns in the market could also result from a recession and a lack of attractive practices to buy. Private equity will likely continue to be a factor in ophthalmology, but not a driving force. It is critical to be conservative and do your due diligence before deciding to sell.

ADMINISTRATOR PERSPECTIVE

Dustin Carter, director of clinics, M&M Eye Institute - A division of American Vision Partners, a portfolio company of H.I.G. Capital

M&M Eye Institute partnered with American Vision Partners (AVP) an eye care physician services organization. H.I.G. Capital is the private equity sponsor for AVP.

Know what your motivations to sell are, as these will define your future.

- Early preparations include investment bankers and finding the best legal team.
- Review examples of contracting.
- Identify potential buyers and create one due diligence period to review multiple offers to purchase.
- Know which PE companies are entering your area.

Our practice reviewed eight offers and narrowed down to three before making a final decision. It is critical to document every step of the process in writing and not just verbal discussions/agreements. It is important to identify what is the driving force behind the PE Company's interests in buying the practice.

Integration of business processes is important to the decision to sell. Human resources, IT, optical, revenue cycle management, accounts payable, credentialing of providers and surgery processes are critical. These changes can impact overall revenue. What type of support will the PE company be providing? Decisions about facilities, how purchases are made, who provides the training to staff and providers, and communications that are consistent and timely must be a part of the integration process.

The process of selling your practice is stressful. The greatest success is achieved with a team approach. It is critical to establish a command center with good communications flow. There is a great deal of actions to track; it is important to separate the emotions from fact.

Successes of PE sale for M&M Eye: Greater Benefits, Better Training and Guidance, Contract Negotiation Power, Expanded Services to patients, Capital for Development. The sale did create new bureaucracies, but with new benefits as well. Cons do exist with the sale, but are within reason.

PRIVATE EQUITY: EXPECTATIONS AND PREPARATIONS FOR CHANGE

K David Epley, MD, physician, Children's Eye Care Pediatrics Medical

When considering a sale to a private equity firm or other company, you must consider the purchase price which is complex because of taxes, opportunity costs, the compounding effect of interests, retirement timelines, equity/stock in the company, company plans and stability. PE Firms won't assume any liabilities – any debt the practice has will need to be paid off. Do your due diligence: Know the company, have frank discussions with partners and staff.

Know the effect on partners in different stages of life and practice. PE firms typically offer employment contracts and pay physicians a base rate with bonus, often based on wRVU productivity. A restrictive covenant is common practice. Know the impact on your staff. Benefit structures, professional development allowances, PTO and human resource policies are just some areas that will change.

It is important to hire a good attorney experienced in PE negotiations, BUT you still need to carefully read the contracts. Get financial advice from your practice administrator and/or accountant

Plan for the optical if you have one. You must plan for the real estate if you own the building/land. Take time to list all the Pros and Cons of selling your practice. Know

that the sale will have a global effect on your staff and physicians. The transition will require many meetings to address changes/questions. Pay attention to post-sale details: insurance contracting, IT considerations, support for office staff, patient flow, etc. Expect the unexpected and give the transition a year plus to stabilize.

HOW A PRACTICE SHOULD MANAGE DUE DILIGENCE

Kimberly Drenser, MD, PhD, physician at Associated Retinal Consultants, director at Pediatric Retinal Disease Molecular Genetics Laboratory

The decision to engage a PE deal is the biggest decision of your career; physicians are uniquely inexperienced in this arena. A sale is not "easy money." The entire process requires careful due diligence by the practice. Post deal outcome should be "thrive" not just "survive."

Exploring the option is a full-time job and requires a carefully assembled team of professionals for the practice including: selling group members, bankers, accountants, and legal team (attorneys). The buyers' team includes: buyers, accountants and attorneys. Expect the total time invested to be one plus years.

The greatest amount of time is spent with the bankers and it is important to have good rapport. There must be a willingness to understand your practice's unique culture. Bankers help determine valuation, structure and deal process. You should interview multiple bankers before identifying the best for the transaction. Negotiate the banker's compensation knowing the full details of expected costs.

The bankers and legal team work together to evaluate the proposals from prospective investors and help negotiate and consummate any proposed transactions. The legal team provides direction with purchase agreement, legal/tax impacts, asset distribution and compliance issues found with buyer's due diligence. You will spend the most money on having the best legal team, but they are essential to the process and help achieve the best possible outcome for the seller.

The extra time you spend developing the best financial and legal team will pay off in the end. The dollars and time invested will be well spent when a deal to sell is made.

PRACTICE IMPACT FOR THE YOUNG OPHTHALMOLOGIST

Arvind Saini, MD, MBA, physician practice owner, Hidden Valley Eye Associates; Graduate AAO LPD (co-moderator)

There are compelling reasons for the senior ophthalmologist to sell a practice. Higher technology costs, burdensome administrative regulations and an ever-changing payment structure are all concerns. Incentives to sell include a large cash payout with continued employment and retirement planning.

Young ophthalmologists (YOs) are naïve relative to their college peers, as they have never had to seek a professional job. They are also naïve relative to practice management and employment contract negotiations. These decisions are made during their last years of residency and/or fellowship and can cost them hundreds of thousands of dollars in lost opportunities. In the first two to three years the financial and professional benefits may be better with PE. After the traditional associate period in PE-owned practices, the potential equity and max salary as well as physician control are all different and can be less satisfying as private practice with an option for partnership.

There are YOs who are entrepreneurial and motivated to run a practice. The involvement of private equity in ophthalmology does not have a clear benefit to YOs, especially those that are interested in partnership with traditional private group models.

The impacts of leaving a PE practice are also a concern to the YOs. If you leave a PE practice and you have equity, how do you get your cash back? Is there a difference in the "class" of your stock? How long do you have to stay if you don't like the changes? If you leave, how will your non-compete impact you since many PE ophthalmology companies extend across state lines. If you stay and the PE is sold again, what will the next owner be like?

Transparency in discussing potential PE transactions to prospective YO employees is critically important to allow them to make informed decisions about their career choices.

Summary of Audience Comments

Questions addressed by YOs when interviewing for new junior positions have changed with the growth of Private Equity. Questions that commonly raise discussion include:

1. Do you own the practice?
2. Do you plan to continue owning?
3. Are you considering a sale to private equity?
4. Do practices owned by PE really have better contract negotiation with payers?

The panel suggests that often PE does get better contract pricing, but much depends on the penetration of the market. Markets with lower PE penetration would not have as much influence. Physician compensation is often based on wRVUs with a conversion factor so contract pricing for the physician compensation isn't as relevant. Pricing is relevant to the PE company.

Medical corporations continue to exist and impact the PE sales. Corporate Practice of Medicine Laws vary across the country and state to state. Most PE companies have their own team of attorneys that review and insure the new practice models meet the terms of the laws.

Physician owners have a stewardship responsibility to the younger physicians. It is important to be honest and direct with all impacted and to know what the PE companies' stance is on current junior physicians as well as hiring new junior physicians.

Ophthalmologists also have a stewardship responsibility to their patients. A PE sale can significantly impact the culture of the practice and impact patient care standards. The Academy's mission, "Protecting Sight, Empowering Lives," must be kept at the front of decisions.

High Priority Objectives

Private Equity firms are a more prominent presence in ophthalmology than past years. Although selling may be attractive to some, weighing the financial impact against the loss of control and impact on the younger physicians and future recruits should be carefully considered. Due diligence and understanding the valuation

methodologies are critical. Involving those impacted by a sale and open communication is key.

IRIS® Registry – What's New!

The Academy's IRIS® Registry has recorded more than 230 million patient visits, and its value to practicing ophthalmologists and researchers is growing. During Mid-Year Forum 2019, the registry was the focus of a session moderated by Michael Chiang, MD, Academy trustee-at-large and chair of the IRIS Registry Analytics Committee.

Abstract

The IRIS Registry is the largest specialty clinical database in medicine, featuring over 230 million patient encounters and 50 million unique patients. The value of the IRIS Registry to the profession is over $186 million collectively in avoided penalties in 2019 and bonuses on top of this for the vast majority of participants. Now, there are technology solutions to benefit Academy members and to bring value to their practice in other ways, including tools for more efficient clinical trial recruitment, and for looking at different patient populations and their outcomes.

Background Information

The Academy initiated the IRIS Registry on March 24, 2014 for the purposes of quality improvement and providing a method for ophthalmologists to benchmark their performance and to track patient outcomes. Over the years, the IRIS Registry has documented increases in performance over time, with improved patient outcomes and better adherence to standard processes of care, as well as helping ophthalmologists to meet federal government quality reporting requirements.

Summary of Comments From Guest Speakers

Michael F. Chiang, MD, trustee-at-large, Academy Board of Trustees
Associate Director, Department of Ophthalmology, Oregon Health and Sciences University

Dr. Chiang discussed the cycle of continuous quality improvement, starting from biomedical research to standards to creation of guidelines to information decision support. This is actually coming to fruition because of the incorporation of real-world data from sources like the IRIS Registry.

The IRIS Registry is the nation's first comprehensive eye disease clinical database. It was designed to improve care delivery and patient outcomes, to provide individual feedback on performance and comparison to benchmarks, and to help practices meet Merit-based Incentive Payment System. As of April 1, 2019, there are 234 million patient visits, representing 53 million patients. There are 14,793 physicians from 2,937 practices contracted for EHR integration, which includes other eligible clinicians practicing with the ophthalmologists.

Anne L. Coleman, MD, PhD, president-elect, Academy Board of Trustees

Fran and Ray Stark Professor of Ophthalmology at the Jules Stein Institute, David Geffen School of Medicine and professor of epidemiology at the Fielding School of Public Health

Dr. Coleman discussed the definition of big data, which can be characterized by the following features: high volume, a variety of sources, high velocity in terms of accessing or acquiring data quickly and accuracy of the data, or veracity. It is important to assure that the data is accurate.

There are different types of big data, including traditional medical data such as electronic health record data, OMICs or large-scale datasets in the biological field like genomics and microbiomics. Data sets also come from social media, including the internet, mobile applications, sensor devices and other technology like wearables that hold patient-generated data.

Wearable computing device information could potentially be uploaded to the electronic health record to see the level of physical activity of patients. With this patient-generated information, we as physicians can better understand diseases, risk factors and how to prevent poor outcomes.

Over the past decade, we started with big data through the analysis of large claims databases. Claims data can be used to assess our own practices and performance, compare to peers, understand risk factors, estimate adherence to therapy and evaluate utilization.

One of my early studies was to evaluate the rate of gonioscopy through claims data and because the rate was lower than expected, it was critical to understand the reasons in the real world setting for the lack of documentation. The benefits of claims data are that the potential sample sizes are much larger, patients can be followed up for outcomes and costs, modeling can be performed to account for potential confounding factors, data on nonocular conditions can be added to the ocular information, and studies can be much less costly than traditional clinical trials.

Dr. Coleman explained why big data is necessary with an example of endophthalmitis occurring after cataract surgery because the rate is so low with a background rate of 0.14%. To detect a 50% increase in the rate of endophthalmitis, the sample size would need to be 58,786 patients in each group. To detect a 25% increase in the rate of endophthalmitis, the sample size would need to be 207,182 patients in each group. To detect a 10% increase in the rate of endophthalmitis, the sample size would need to be 1,175,948 in each group.

The seminal claims data analysis article in ophthalmology was published in 1991 on a 50% sample of Medicare patients. The study reported on 338,141 cataract surgeries, with a rate of 58% of extracapsular extractions and 30% intracapsular cataract extractions.

Regarding the rate of endophthalmitis following cataract surgery, patients who had intracapsular cataract extractions had a 0.17% rate compared with a 0.12% rate in patients with extracapsular cataract extractions or phacoemulsification, a finding that was statistically significant. This finding, along with other factors, ultimately led to the predominance of extracapsular cataract surgery over intracapsular cataract surgery. However, if the number of patients were lower in the sample, it would not have been possible for the study authors to detect this rate of difference.

In a recent study of glaucoma surgery in patients receiving corneal transplants, based on a 2010-2013 5% random Medicare claims dataset, the total sample size was 3,098 patients, including 1919 EK, 1012 PK, 46 ALK, 32 Kpro and 89 both PK and EK.

The rates of glaucoma surgery ranged from 6.1–9.4%. But a few of the different transplant procedure groups were few in number, underscoring the fact that the 5% Medicare claims database is too small for some analyses.

The limitations of claims and EHR data are that there are potential misclassifications, with inaccurate coding, missing data and incomplete data. Claims data lack clinical information such as visual acuity, intraocular pressures and medications. Confounding by clinical indication is another limitation of both claims and EHR data because this is the art of medicine, and this could create a bias. This bias is addressed through randomization in a prospective clinical study.

Dr. Coleman described the David E. I. Pyott Glaucoma Education Center on the Academy's Ophthalmic Network for Education. Based on the IRIS Registry database for 2017, there were 3.92 million individuals with glaucoma, with the largest group at 2.45 million patients with the diagnosis of glaucoma suspect. There were 145,600 total glaucoma surgeries, with laser trabeculoplasty comprising about 55% of the total surgeries performed.

Dr. Coleman concluded that claims data ushered the era of big data. EHR data advantages include the presence of clinical observations and measurements such as visual acuity and intraocular pressure. We are in the midst of an information wave, with the amount of digital data in the world being more than 40 zettabytes. Big data brings with it the capacity to continuously improve outcomes and the quality of care we provide.

Aaron Y. Lee, MD, assistant professor of ophthalmology, University of Washington

Drs. Chiang and Lee demonstrated the member value tools that Verana Health has created now. These tools include a outcomes tracker module and a treatment tracker module that help practices to look at their patient populations in different ways to review patient outcomes, and a clinical study module to help practices that are interested to learn about ongoing clinical studies and to identify patients that might meet the inclusion criteria for the study.

Summary of Audience Comments

- How can patient-generated data be incorporated? To address patient-generated data, informed consent would be required for patients. Patients have been coming in and showing their wearable device data to physicians. This data is useful to provide meaningful advice for personalized care. For wearable data, patients could directly contribute and approve their data for use of research purposes.
- It would be good to address costs with big data and could be very informative. This would need to be carefully considered because of all the ramifications. People care a great deal about their vision, and vision always appears to be No. 1 or No. 2 in their valuation of their well-being and their future. If we move towards more a value-based purchasing mode, this would be an interesting approach.
- We would be interested in using these tools for our own clinic. These tools are going to be made available for Academy members participating in the IRIS Registry in the next few months.

- The sole quality metric in health care appears to be patient satisfaction. We should brand these as doing all these activities for the satisfaction of patients.
- Has the IRIS Registry been discussed with Food and Drug Administration (FDA) about usage for post-approval marketing studies and justification for new indications for treatment? Phase IV post-marketing approval studies could probably be easily performed using the IRIS Registry. There appears to be interest from the regulatory agencies in an independent registry for performing these studies. There is one post-approval study now planned using the IRIS Registry database. IRIS Registry could also be used as a platform for prospective, clinical trials. IRIS Registry could be a very good source for determining disease prevalence, particularly for rare diseases.
- The idea of incorporating best practices such as patients taking hydroxychloroquine and who haven't received a visual field test and reminding physicians of best practices could be considered. It could also be good for the PPP guidelines to be encoded in the future to help elevate how practitioners provide care.
- Topol recently tweeted that a great deal of medical innovation has been in the area of ophthalmology with artificial intelligence. Dr. Chiang asked the audience what else would be useful for practices in the member value tools. One member noted that feedback about how our practices are doing would be helpful. Another member noted that with respect to amblyopia, it would be good to see treatment outcomes and give us a concept of how we are doing.

Pediatric ophthalmologists do not have to participate in MIPS program but there is a significant volume of data in the IRIS Registry largely because pediatric ophthalmologists are part of participating group practices. There are newer quality measures for treatment outcomes, i.e., amblyopia, pediatric strabismus and adult strabismus. Another member noted that it might be helpful for physicians to note when they changed their practice patterns so that they can view differences for improving patient care.

- The IRIS Registry would be very interesting for ocular oncology and rare diseases. Patients are seen in children's hospital and oncology centers which are not integrated with the IRIS Registry but it would be helpful to capture the continuum of care for these patients. Currently, there is no way to capture this information outside of the ophthalmology practice.

High Priority Objectives

To enhance the member value tools by continuing to collate member input and feedback

Emergency Planning and Disaster Preparedness for Everyone

Ophthalmologists may not be able to predict the next calamity to strike, but they can be prepared for them. One of the sessions at Mid-Year Forum 2019 explored the resources available to physicians who want to prepare for the unexpected.

Abstract
Fires, hackers, hurricanes and shooters are in current events and ingrained in today's lexicon. Learn how to prepare and protect yourself, your family, and your practice from real and virtual threats by employing emergency preparedness strategies. At the end of this interactive, fast-paced session, you will receive access to a toolkit containing incident management resources, covering common natural disasters to man-made events such as cybersecurity and active shooter scenarios – real tools that you can put into practice when you return home.

Background Information
Moderator Daniel J. Briceland, MD, Senior Secretary for Advocacy, American Academy of Ophthalmology introduced the hearing with a bucolic slide focused on the scenery and fauna of his drive to work in Arizona and then transitioned to examples of possible threats that the speakers would cover that could affect attendees at home, including natural disasters, cybersecurity attacks, and active shooter events.

Summary of Comments from Guest Speakers

REAL-LIFE EXPERIENCES WITH DISASTER MANAGEMENT
Natalio J. Izquierdo, MD, past president, Puerto Rico Medical Association

Dr. Izquierdo led his session by stating that disasters can strike and mentioned examples (e.g., 9/11, earthquakes and hurricanes) and how these can they can impact patients from an ophthalmology perspective. He covered the following topics:

- Infrastructure
  - Examples of basic infrastructure components that were lost during Hurricane Maria included power, water, and communications.
- Personal loss
  - Effects included stress from dealing with family needs during a disaster.
- Professional loss
  - Without power or the internet, electronic health records (EHRs) didn't work, and hard copies of patient records weren't available. Medical supplies and samples were scarce.
  - Research and residency programs were affected by protocol interruption and the cancellation of lectures respectively.
  - At supra-tertiary hospitals, patients with retinopathy of prematurity (ROP) in the neonatal intensive care unit (NICU) were at highest risk of being adversely affected.
- Supranational organizations and local support
  - Various external organizations provided additional support to include the Academy and Pan-American Association of Ophthalmology (PAAO).
  - Local support to the residency program included fundraising events and the donation of equipment.

CYBERSECURITY: YOUR EXPOSURE RISKS, EXAMPLE SCENARIOS TO CONSIDER, AND BEST PRACTICES TO GUARD YOU AND YOUR PRACTICE
Susan Doucette, assistant vice president of underwriting, NAS Insurance Services

Ms. Doucette provided an overview of the importance and significance of cybersecurity to ophthalmology practices. The core areas she covered in her presentation included:

- Cyber Landscape – Understanding Your Exposure
  - In 2018, it was reported that 1,244 breaches affected over 446 million records, an increase of 126% over 2017.
- Cyber Claims Trends
  - Examples of the types of breaches mentioned before & after pictures, employee carelessness and/or negligence, employees & social media, ransomware, rogue employees, phishing schemes, and lost/stolen devices. Negligence was listed as the most the common cause.
- Claims Scenarios
  - Scenarios included the exposure of metadata in multimedia content, loss of a computer tablet with PII, effects of ransomware attacks, and a phishing attack resulting in a large financial loss.
- Best Practices
  - Best practices both for users and IT Departments were reviewed by Ms. Doucette.

ACTIVE SHOOTER PLANNING AND RESPONSE IN A HEALTHCARE SETTING: LEARN HOW TO SURVIVE A SHOOTING EVENT, WHILE DEALING WITH THE UNIQUE CHALLENGES ASSOCIATED WITH A HEALTHCARE FACILITY

Scott Cormier, vice president of Emergency Management, Environment of Care and Safety, Medxcel Facilities Management, Ascension Holdings

Mr. Cormier provided an overview of workplace violence and with a focus on active shooter events in a healthcare setting. The core concepts covered in his presentation included:

- Definition of healthcare workplace violence
  - Can be defined as violent acts including physical assaults and threats of assaults directed toward persons at work or on duty.
- Healthcare workplace violence statistics
  - Incidents of serious workplace violence were four times more common in healthcare than in private industry.
- Active shooter: definition and response
  - Misnomers and misunderstandings associated with the definitions of active shooters were addressed such as a differentiation between a person with a gun and an active shooter. Using this definition, the *actual* number of healthcare related active shooter incidents from 2000-2019 would be 8.
  - Definition of an Active Shooter: One who is actively engaged in killing or attempting to kill people in a populated area.
  - Common issues were discussed to include the concept of duty to attack vs. abandonment.
  - The tactic of run, hide, and fight was discussed. An emphasis was made to focus on moving (running) as its difficult to hit a moving target. During a Q&A session, a participant recommended running in a zig-zig pattern, Mr. Cormier disagreed as research indicated that a zig-zag

pattern would be riskier and expose the runner more (unless the runner was a world-class sprinter); essentially, a straight-line run to escape the line of fire would actually be the better (best) option.

- Implementation strategies
    - General concepts related to current knowledge were presented.
    - Planning strategies to include the need for an evacuation policy with procedures and the importance of knowing local emergency response agencies were emphasized to include an understanding as to what law enforcement would do upon arrival at the scene.
    - Though It's great to implement a plan to deal with an active shooter, it can be tougher to maintain it.

Summary of Audience Comments

- Thank you for developing the toolkit card. Very helpful and convenient.
- The presentation on Hurricane Maria in Puerto Rico was interesting and made me think.
- I thought I wouldn't enjoy the cybersecurity topic, but I really did.
- This is different from other sessions, but it was quite useful.
- I liked the active shooter presenter as he was a straight shooter and said it like it is.
- The active shooter training is great. Can I get a card?
- I'm going to take these (toolkit) cards back to my office.

High Priority Objective

- Attendees can download resource toolkit listed on the cards handed out during the session at aao.org/MYF19-EPDP.
- From there attendees can review relevant resources for themselves, their family, and their practices.

Cross-Cultural Challenges: Creating an Inclusive Practice

A physician treating patients will encounter diverse ages, health histories and conditions. One of the sessions at Mid-Year Forum 2019 explored what ophthalmologist can do to respond to a changing America.

Abstract

Today, and even more so in the future, our patients are from diverse backgrounds. How do we create real patient-centered care in which our patients and their families feel welcomed and at ease in our practices? This session will explore the cross-cultural challenges we all face in order to improve outcomes and maximize patient satisfaction.

Background Information

With an increasingly diverse U.S. population, it is critical that physicians ensure that their practice is prepared to provide a culturally-appropriate and positive experience to the patients it serves. This helps ensure that patients are comfortable and

forthcoming in communicating their health issues and concerns and to help ensure consistently high-quality eye care to all.

Summary of Comments from Guest Speakers
Moderators

Lynn K. Gordon, MD, PhD, council chair, American Academy of Ophthalmology
Keith D. Carter, MD, PACS, past president, American Academy of Ophthalmology

DELIVERING CULTURALLY COMPETENT CARE IN CLINICAL PRACTICES

Denice Cora-Bramble, MD, MBA, CMO & EVP Ambulatory & Community Health Services, Children's National Health System

Dr. Cora-Bramble stated that cultural competence definitions haven't changed much over time. It is the ability to establish an effective working relationship that supersedes cultural differences, the ability to communicate effectively with people from different backgrounds.

She offered practical ways to apply the theoretical tenets of cross-cultural competence, describing experiences reported by African Americans and Latinos which were perceived as inappropriate or culturally unaware.

Dr. Cora-Bramble related studies that have documented medical adverse effects that language barriers can have on health care encounters. She stressed the importance of using professional interpreter services for patients with limited English proficiency. Untrained interpreters make errors.

It is important to ask your patient whether they partake in any traditional practices for their health care.

In focus group studies with minority populations, they expressed a desire for patient-centered care.

WHY IS THIS IMPORTANT IN YOUR EVERYDAY PRACTICE?

Tamara R. Fountain, MD, professor, Rush University Medical Center

Dr. Fountain described interactions with patients with an assortment of impairments emphasizing the importance of communicating empathetically. Try to put yourself in the patient's shoes.

Separate the person from the disability. By this she meant to put the person first, not the disability. For example, think of him or her as a child with Down Syndrome and not a Down Syndrome child.

With visually impaired patients, identify yourself as the doctor. She noted that cognitive impairment among the elderly – ophthalmologists' largest patient group – is now at 6 million people and is expected to affect 15 million by 2060. Patients are usually aware of their impairment and are frightened by it.

Dr. Fountain recommended enlisting their care partner during encounters and to triangulate the conversation, having eye contact and communicating with both the care partner and the patient. Schedule shorter visits, simplify your message and slow down. Never forget the power of human touch.

HOW TO MAXIMIZE COMMUNICATIONS WITH MILLENNIALS AND BABY BOOMERS

Robert F. Melendez, MD, MBA, secretary for online education, American Academy of Ophthalmology

Dr. Melendez stated that the millennial generation (1981-1996) differs greatly from previous generations. They want digital access to you and will evaluate you through online reviews before making that first appointment, and they expect a great patient experience. This generation wants a strong connection with their physicians.

Millennials are the most educated generation and are twice as likely to search review sites. Sixty percent support the use of telehealth and 71% would like their physician to adopt a mobile health map.

Dr. Melendez encouraged ophthalmologists to know and use their patients' communication preferences as much as possible. Further, he recommended that you redesign your website every three years, create and use a professional Facebook presence and to check what reviews are being written about you.

Summary of Audience Comments

- Cultural humility is an even stronger way to connect with patients by asking them questions, learning about them first in order to provide the most appropriate care.
- How best to create an infrastructure that addresses unintended bias? Most of the time, it is best when senior leadership sets in motion an assessment of bias in the institution.
- There are lower cost ways to secure interpreter services than having someone in the practice, including telephone pay-by-the-minute services, video conference services and mobile apps.
    - The concern with mobile apps – what is your fallback position when the technology fails you?
    - Build "interpreter" time into the schedule.
    - Consider this extra time as equivalent to the extra time you would spend with someone with a complicated history or cognitive impairment.
- Use a risk-management technique of Parrot Talk to ask the patient to tell you what you just said. It will highlight and guide you to clarify areas that the patient missed or misunderstood.
- It is important to be aware of socioeconomic determinants of health.
- Remember that many patients come to the office with a fear that their eye condition will cause blindness. A lighthearted office can be discordant with that. Keep your office tone respectful of this fear.

High Priority Objectives

- Create a bubble of inclusion for everyone in your work environment, from the patient to the staff, referring doctors and so on. Treat all with respect.
- There was concern expressed about the additional time and money required when caring for those needing interpreter services, particularly for those in small practices. It is an unfunded mandate which will actually help the

physician provide more appropriate care to the patient and add to the patient-doctor relationship.