The technician is usually the patient’s first contact in the clinic. He or she frequently will perform the initial history to include both medical and ocular conditions and may perform the initial stages of the exam, including dilating the patient. As the first contact, the technician has an important role in obtaining a good medical history and a detailed medication and allergy list. In addition, the technician needs to understand the significance of this information in preparing the patient for surgery.

Anesthesia in eye care
Anesthesia is defined as a temporary state involving a lack of pain, loss of memory, muscle relaxation, and/or unconsciousness. In ophthalmology, anesthesia is very broad, ranging from the anesthetic eye drops used in clinic to the sedation and analgesia of cataract surgery and finally to the general anesthesia that may be used for strabismus or retinal surgery. Achieving this wide range of goals may require multiple classes of medications for anxiolytic (anti-anxiety), muscle relaxation, analgesia, and loss of awareness.

Except for a few minor office procedures which may require only eye drops, most patients for cataract, retina, and many plastic procedures will undergo conscious sedation anesthesia either in the hospital or ambulatory surgery center (ASC) setting. Moderate sedation/analgesia (conscious sedation) is defined as the use of medication which allows patients to tolerate unpleasant procedures while maintaining adequate cardiorespiratory function, protective reflexes, and the ability to respond purposefully to verbal and/or tactile stimulation.

This is usually achieved through a combination of medications, first to relieve anxiety followed by an anesthetic agent which may be topical, locally injected, or systemic. The goal is to provide a safe and controlled environment for the surgeon while at the same time allow the patient to have a relaxed, pain-free experience with rapid return to normal activity.

Preparing for surgery
In preparation for surgery, all patients undergoing procedures in Medicare-approved facilities are required to have a comprehensive history and physical prior to the surgery. In 2010, CMS provided guidelines to clarify when this needs to be done and what it should include.

The history and physical needs to be:
- Performed by qualified personnel
- Comprehensive
- Placed in the record prior to surgery
- May be combined with the pre-surgical assessment

1. If the patient has a well-documented procaine (Novocain) allergy, can you instill topical anesthetic to check intraocular pressure?
2. Why is it so important to have a complete medication list not only for the name of the medication but also the dosage?
3. Why is it important to let the doctor know if the patient has been on medications for prostate such as tamsulosin (Flomax)?

For answers, see page 4
Uncover a potential systemic cause of dry eye **before it takes hold**

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The purpose of the history and physical is to establish the patient’s chief complaint, record pertinent findings, and, when appropriate, record laboratory testing. The surgeon ultimately determines the need for the procedure, but much of the initial assessment starts with the technician. It is valuable to the surgeon not only to know the patient’s ocular complaint but also the patient’s perception of his problem as well as the patient’s ability to understand and communicate. Is the patient extremely anxious? Is the patient hard of hearing? What other ongoing medical problems and what medications, both prescribed and over the counter, are present? In addition, baseline vital signs, including height and weight, are essential to calculate dosages for anesthesia.

When the patient is scheduled to undergo a procedure requiring more than local anesthesia, he is usually given a medication first to relieve anxiety, followed by a medication to prevent pain. The medications that are given intravenously must have dosages adjusted for both age and physical condition. This is particularly true for our geriatric patients. Geriatrics is arbitrarily defined as age 65 or older, but aging is associated with a one percent to 1.5 percent decrease in major organ function after age 30.

The anesthesia provider will review the information in the history and physical to make a decision for what medications can be used. Many times with geriatrics, the anesthesia provider may need to reduce the doses by 30 percent to 50 percent and wait longer before being able to fully assess the full pharmacologic effect. This can be particularly true in the patient with multiple medical problems involving the heart, lungs, and kidneys in which the functional age may be much more than the chronological age. These observations of how a patient looks and acts when recorded in clinic will help the anesthesia provider develop a plan for the procedure.

The success of the patient’s clinical and surgical experience depends greatly on the success of the anesthesia. The technician’s role as the first contact with the patient is critical in collecting key data to ensure a safe experience for the patient.

Anesthesia and medication
Medication history is important not only for allergies but also the increased risk of bleeding. I’ve found that over-the-counter medications and herbas such as ginkgo biloba, ginseng, garlic, and ginger as well as high levels of Vitamin E have been associated with increased risk of bleeding. Again, it gets back to that initial assessment, making sure that all medications, including over-the-counter products, are recorded.

In the past, many doctors would have standing orders to discontinue blood thinners prior to surgery. “The issue of the medical-legal aspects is a very critical one… The older literature indicates that anticoagulation should be modified or discontinued prior to embarking on ocular surgery. But a more recent appraisal of the literature shows that certainly cataract surgery can be done safely despite anticoagulation.”

The trend now is not to stop most anticoagulants prior to surgery, recognizing that the risk of discontinuing the medication may outweigh the risk associated with the procedure. It is acceptable to continue anticoagulants such as aspirin, clopidogrel (Plavix, Bristol-Myers Squibb), and warfarin (Coumadin, Bristol-Myers Squibb) for both cataract and retinal surgery, although many plastic and strabismus cases will still require some adjustment in blood thinners. If the ophthalmologist feels that blood thinners need to be limited or discontinued prior to the procedure, he may wish to seek evaluation from the patient’s internist prior to the procedure. This is especially true if the patient has a drug-eluting heart stent in which there is a risk of occlusion during the first year after placement of the stent.
Anesthesia, as discussed earlier, uses a wide range of topical, local, and systemic medications. For most cases within the ASC setting, this would involve an IV medication for analgesia or pain relief, amnesia, and relaxation. This is usually followed with a local anesthetic. Local anesthesia is the mainstay for ophthalmology, both in the office and ASC setting. This would include eye drops for topical anesthesia and local injection into the skin or around the globe with retrobulbar or peribulbar block not only to provide pain relief but limit motion of the globe.

There are two general classes of local anesthetics: esters and amides. Esters which include procaine (Novocain, Hospira) are no longer routinely used systemically; but most of our commercially available eye drops such as benoxinate (Fluress, Akorn), proparacaine, and tetracaine are esters. The amides are the injectable class of anesthetics. They include lidocaine, mepivacaine, and bupivacaine and may have additives such as epinephrine to prolong the effect. The ester class of anesthetics has been associated with an increased risk of allergic reaction which may include rash, redness, hives, and asthma; but the amides rarely have been reported to have significant allergic reaction. Because most topical anesthetics such as Fluress are esters, in the presence of a well-documented history of Novocain allergy or in the patient who has a documented reaction to the commercially available anesthetic drops, the use of preservative-free lidocaine can be substituted in the presence of a Novocain allergy.7

The amide anesthetics such as lidocaine have traditionally been used for injection into the skin or for peribulbar and retrobulbar anesthesia, both to numb the tissue and limit the movement. In recent years, lidocaine, either as a drop or gel form, has been used commonly in cataract surgery topically on the conjunctiva and in the preservative-free form of lidocaine within the eye. The addition of epinephrine to the intraocular lidocaine may reduce the risk of a tamsulosin-related complication called intraoperative floppy iris syndrome (IFIS).8

The success of the patient’s clinical and surgical experience depends greatly on the success of the anesthesia. The technician’s role as the first contact with the patient is critical in collecting key data to ensure a safe experience for the patient. Every member of the ophthalmic team has an important role in the ultimate success of the clinical and surgical experience. It starts with the technician’s initial contact with the patient. The technician must gain the confidence of the patient, spend the time necessary to identify medications and potential risks, record these findings, and convey key information to the doctor and nurses or ASC staff.

References

Check out this great video resource for cataract surgery anesthesia.
http://www.thedoctorschannel.com/view/topical-or-regional-anesthesia-for-cataract-surgery/
5 things that make a great technician

Some skills can be learned, some just can’t be taught

By Dianna E. Graves, COMT

I don’t want good technicians working in our clinic. There—now that I have your attention, let me continue.

I don’t want good technicians working in our clinic; I want the best technicians working in the clinic. Many people make the assumption that if they pass the JCAHPO, COA, COT, or COMT tests that they are good technicians. That might mean it would also be safe to say that the higher the certification, the better the technician.

I do not believe that your certificate, or lack of certificate, is the true indication of what type of technician you actually are. There are so many intangibles involved in the mix. These skills are very hard to cultivate in a person, and it is very hard to evaluate whether someone might possess them during an interview.

There are five things you must know to be a quality technician:

1. Histories and vision
2. Refractometry
3. Pupils
4. Anterior chamber depth assessment
5. People skills

A. Histories

By nature, a history should be a series of specific questions linked together in an orderly sequence that builds on the patient’s response. The history is designed to paint a picture of the patient and his eye health.

These are the important parts of the history (in order):

- History of the chief complaint
- Medications and allergies
- Eye history
- General medical history (review of systems)
- Family history

The doctor’s exam builds off your history. Your exam and test planning (Does the patient need a brightness acuity test? Does she need a refraction? Does she need a visual field?) build off your history. And billing is also largely based off your history. It is one of the most crucial parts of a technician’s job—but most technicians will tell you they hate taking histories and race through this process to get to the more interesting parts of the exam (refractometry and slit lamp).

Why do we dislike it so? Because patient’s ramble during their histories. We want them to give us their story in a small, Reader’s Digest-condensed version; the patient wants to share with us War and Peace.

Here are some tips:

- Keeping in mind patients want to tell their story, try to ask yes-or-no questions. If you ask, “So, tell me what happened with your eye,”
he will begin the story at birth and continue until present day—often with information not pertinent to the problem.

- Put the chief complaint in their words. I have never had patient come in and state, “I am having episodes of metamorphopsia x three days.” They say, “I am seeing floating mosquitoes this week.”
- When asking about allergies or medications, never carry that information forward in the patient’s record. Allergies need to be discussed at every visit. If a patient states he does not have an allergy, write: “Patient denies allergies.” The word “denies” implies that you asked the patient, and he said, “no.” Do not use the “universal no” symbol (circle with a slash).

1B. VISION TESTING

If you are conducting an exam on a new patient, always check her vision with and without correction. Some techs might think this is a waste of time, especially if the patient is seeing 20/20 with her current correction. Here's a hint: not everyone wears their glasses. It is not uncommon for spouses sharing a pair of glasses. While the patient may see 20/20, it is not really her correction.

If she is a returning patient, always look back at the last correction that was listed, as well as the last refraction the doctor ordered. We often wrongly assume that because the doctor gave her an Rx, she ran right out and got the new glasses. Be triply alert when working with nursing home patients. They might be wearing someone else’s glasses.

Some of the most important skills technicians must have to be a great technician are:

- Empathy
- Sympathy
- Listening skills
- Ability to work in a team
- Ability to share and help others in the office grow in their fields
- Wanna

Here are some tips:

- Most of us use projected visual acuity charts. If a patient cannot see the “big E,” often a tech will then perform counting fingers (CF) testing at 10 feet or five feet. This is not the best measurement, and in insurance worlds, as well as sometimes the medical-legal world, CF is a lot different than 10/200.
- If you use projectors, get a handheld block E to use if patients can’t see the big E.
- If a patient does not see 20/40 or better, always use a pinhole. Pinhole is a great cheat. If the patient’s vision improves, it gives you an idea that you might be able to improve her vision with a refraction. If she does not improve, the problem may be an ocular condition (macular degeneration, cataract, etc.).
- When testing children, always note if you, or a parent, is pointing at a letter on the chart. This is called semi blocking. Children will often see up to two lines better when someone is blocking or isolating letters for them to follow. Your doctor will want to know if this is occurring.

2 REFRACTOMETRY

When I was learning refractometry, I was told the number-one sin was over-minusing a patient. Through the years, I have learned that actually the number-one sin is under-plussing a patient, followed closely by over-minusing. In both cases, these two sins occur for this main reason: you are listening too much to what patients want and not giving them what they need.

Common complaints with hyperopes:

- “I used to love to read, but now I am so tired at the end of the day it’s no fun.”
- “I used to wear glasses when I was younger, but I outgrew it.”
- Hyperopic eyes are what I call “martyr” eyes. These patients need glasses, but their brain doesn’t want the help. So, the brain works and works to keep things in focus. They get tired, and some people

See Great technician on Page 8
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Continued from page 6

even complain of headaches or upset stomach.
Be careful of listening too much to what he likes. He may need +3.50 D to correct his hyperopia, but his brain tells him he needs -1.00 D. My personal best example of this: 34-year-old man came to our office five times in a year with the same complaints. He liked being a -3.00 D in the office, but he needed to be a +4.50 D.

Refractometry tips:
- Pay attention to your auto refractor (or retinoscopy). If a patient’s auto refractor is -1.50 + 0.75 x 145, why are you giving him -3.50 +1.25 x 145? The answer is usually, “Because he liked it!”
- If it ain’t broke, don’t fix it. Pay attention to the patient’s vision. When the patient comes to clinic and states, “My vision is fine; I just want to get a new pair of glasses. These ones are a little scratched,” don’t make broad changes. She has no complaints, and her vision is good. All she needs is a quick refinement.
- For every 0.25D you give a patient, he should improve a line (however, this doesn’t necessarily work with hyperopes).

Pupils should be checked every time on all patients who are being dilated.

Pupil evaluation tips:
- Use a battery-operated transilluminator when you are checking pupils, not a disposable penlight. Penlights are variable, depending on the age of the penlight.
- Have someone in the office show you an afferent pupillary defect (APD) on the next patient who has one. Once you see it, you will never forget it.
- I tell my technicians to always assume that any patient with 20/100 vision or worse has an APD until proven otherwise. It doesn’t mean he actually does, but it will make you double-check his pupils because his vision is poor. Regardless of vision, always check those pupils well.

ANTERIOR CHAMBER ASSESSMENT
Checking the anterior chamber depth prior to dilation ensures that the anterior chamber is deep enough that you will hopefully avoid an angle closure complication. Once again, technicians will tell me they just saw the patient two weeks ago and the angle was wide open, so they don’t need to check it again this week. This goes right along with pupils—a lot can change with a patient in two weeks.

We check every time because the pupil acts like an accordion. When you dilate the patient, her pupil will enlarge to allow more light in. The iris then gets pushed into the anterior chamber. If the anterior chamber depth is narrow to begin with, you may potentially cause a narrow-angle attack. This can also happen when the patient walks into a dark room.

Anterior chamber evaluation tips:
- Do not use a penlight to check the anterior chamber. Have someone show you how to use the slit lamp to check the depth.
- Have someone show you what a narrow angle looks like. Again, once you see it you won’t forget it.

PEOPLE
Some of the most important skills technicians must have to be a great technician are empathy, sympathy, listening skills, ability to work in a team, ability to share and help others in the office grow in their fields, and finally, “wanna.” Wanna is the drive, the fire, the technician’s goal to want to be great, not just good. Some might call it passion or drive—I call it “wanna.”

These are the people skills that make a good technician great. Unfortunately, those skills can’t be taught. You either have them, or you don’t. In our office, I look for people who have good clinical skills, and then I look deeper to see where they will fit. Fit is everything to running a healthy clinic. You need the quality technical skills as well as the “fit” in your process of developing a great technician.

I challenge you now to read this article again, and pay attention to what it is saying. Then go look in the mirror and ask yourself the following question: Am I a good technician or a great technician? If you say “good,” what will you need to do to become great? You can do this!!
The pros & cons of clear lens exchange

Patient selection and realistic expectations are key to success

By Katherine M. Mastrota, MS, OD, FAAO

With evolving cataract surgical techniques and advanced-technology intraocular lenses (IOLs), we now have the facility to offer patients spectacle-independent vision akin to their youth. Under normal circumstances, the discussion of natural lens extraction and replacement comes at the heels of the diagnosis of cataracts. More and more, however, well-informed individuals are requesting lens extraction for refractive purposes even though their natural lenses are clear.

Refractive lens exchange—also referred to as clear lens exchange or, more recently, refractive lensectomy—is now a viable option for patients who are not candidates for other refractive procedures (such as LASIK, PRK, ICL) or who simply wish to avoid the visual consequences of presbyopia with multifocal or accommodating IOLs. There is significant debate among cataract surgeons regarding the ethics of clear lens exchange. The crux of the issue, of course, is the risk, albeit small, of loss of vision (infection, retinal detachment, etc.). The polar opinion is that refractive lensectomy is no different from any other refractive procedure.

Another consideration is the potential for a dissatisfied self-pay patient for whom surgical results are underwhelming: the limitations of presbyopia-correcting IOLs are no different for refractive lensectomy patients than they are for cataract patients. Additionally, IOL calculation is less accurate in the patients who would benefit the most from the procedure, that is, those of higher ametropia, resulting in a post-operative refractive miss.

The importance of patient selection

Derek Cunningham, OD, is director of optometry at Dell Laser Consultants in Austin, TX. Dr. Cunningham is integrally involved in patient selection and IOL planning for clear lens exchange patients that, at Dell Laser Consultants, are 50 percent of their lens surgical volume. Dell Laser estimates that 85 percent of its patients achieve the goal of full-time spectacle independence; the majority of these patients are 40 years of age and older. Half of Dell Laser’s refractive lensectomy patients come to the practice referred from patients who are satisfied with their own procedures, or those interested in LASIK, Dr. Cunningham says.

Patient selection and realistic expectations are essential to success with refractive lens exchange, Dr. Cunningham explains. Often IOLs and refractive endpoints are blended to maximize clear vision at all distances. For example, a diffractive multifocal IOL will be placed in the patient’s dominant eye, and a -0.50 D aimed accommodating IOL in the non-dominant eye. The multifocal IOL functions best for distance-near, and the -0.50 D accommodating IOL would give better intermediate vision. The availability of a toric accommodating IOL broadens the scope of patients for whom clear lens exchange can now become an option.

Cost of clear lens exchange

Clear lens exchange is not covered by insurance and the IOL, facility, and surgical fees are not inexpensive. Many practices that offer refractive lens exchange will bundle surface laser touch-up and astigmatic correction in their fees. Remember also that multifocal and accommodating IOL patients require early YAG laser treatment of posterior lens capsule opacities/contraction for optimum performance of the IOL, adding to the cost of the process.

Notwithstanding the aforementioned, clear lens exchange can be the best refractive option for patients with high myopia or hyperopia, the contact lens intolerant, or those who wish to avoid the inconvenience and aesthetic compromise of presbyopia. Be prepared to guide your patients through the non-surgical and surgical options available for their visual concerns.

Dr. Mastrota is center director of Omni Eye Surgery in New York City.
Cultivating happy patients before, during, and after a visit to your clinic or practice is key to maintaining a profitable and credible practice.

“The most powerful thing today is what other people say about your practice,” said Mark N. King, practice administrator in Cape Coral, FL. “If a patient is really, really happy, she is going to go out and tell one or two people about her experience. If she is unhappy, she is going to go out and tell eight or 10 people. Unhappy patients turn potential patients away, which is bad for your practice’s perception and bottom line.

“As soon as they’re out your door, they’re going to be on Google or on their cell phones,” King said.

To make sure your patients have the best experience possible with your practice, King said there are several essential steps to follow that will ensure memorable customer service:

■ Hire the right people
■ Train your employees with what you want them to accomplish
■ Inspect what you expect
■ Reward positive behavior and counsel underperformers
■ Give unhappy patients a forum to express their displeasure
■ If concerns come up, deal with them head on; do not hide from them

Getting started
In order to get started with a customer service plan, you need to find out what your patients already expect from your practice.

A good question to ask yourself: What are our patients’ basic expectations? For example, most patients expect good outcomes from their clinic visits, courtesy from staff members during all stages of their appointments, and timely service.

The key to exceeding those expectations, according to King, is hiring knowledgeable and friendly staff for your practice. “They’re what makes things tick,” he said.

An important but overlooked step in the interview process, King explained, is involving the clinic manager because she will be working closely with the new hires and will need to get along. Other suggestions include instituting a multi-step interview process, perform interviews face-to-face, and bring the potential employee to the practice so he can get a real sense of the environment and you can see if he actually fits.

Asking the right questions is also highly important, King said, as well as being prepared and using behavior and competency-based questions.

Train to expectations
Clinic staff can excel with a customer service plan only if they know what you expect. Staff need to be trained with specifics and shown how to interact with patients. If this step is missed, then the practice will not operate to its fullest potential or meet expectations. Both possibilities run the risk of creating a bad customer service atmosphere for patients.

Inspect what you expect
Inspecting how your clinic is run, and most importantly, how you expect it to be run, is key to maintaining good customer service for your patients, King said.

There are various methods—such as utilizing an outside company, various programs, hiring someone to come into your clinic, or inspecting yourself—that all clinics can and should take advantage of to keep tabs on the practice’s functionality and how staff members are performing, he said.

“It’s amazing what you can find out,” said King.

Conducting a survey to find out how long staffers take to answer phones or how long patients are put on hold, for example, is an easy way to generate data on the practice to analyze and find problem areas on which to focus attention.

“You can use these to enhance train-
Reward and counsel

Using performance reviews to pinpoint the clinic’s overachievers, as well as the underperformers, can help the practice’s customer service in several key areas, King explained. “Underperformers affect other employees, the practice, and themselves,” he said.

Once underperformers have been identified, King said one action any practice should not make—but almost always does—is to load that staff member’s duties onto an overachiever because the perception is she can handle it.

“Is it really fair for the high performers to have to do all the work?” King asked.

Doing so, he said, can cause those overachievers to burn out quickly due to an increased workload—as well as low office morale—and eventually leave the practice.

Instead, he suggested, approach the underperformers in a more positive way.

King said three important non-financial motivators may outscore offering monetary inspirations: praise, attention from leadership, opportunity to lead products or tasks.

“Those methods engage them and turn their motivation around,” he said.

When staff members do excel, King suggested implementing a monthly customer service reward voted on by staff.

“It’s easy to look for the bad things, but can you actually document something every day that was positive? That’s a little more difficult to do,” King said. Such a move is vital to ensuring staff is giving the best customer service they can to patients.

Giving the unhappy a voice

Dealing with unhappy patients is unavoidable, but the most important action the clinic’s staff can take is to tackle it head-on.

Said King: “Ask patients about their complaints, not just in a survey, but in person, such as during the check-out process. Ask them details, which helps to get them talking.”

Logging the patient’s complaints—instead of saying, “Thanks for the comment,” and moving on—is an important tool that all staff members should use to show patients their complaints matter to the practice, King said.

Staff should know how to handle these situations due to proper customer service training. Part of addressing a complaint is the ability to apologize to patients for their bad experiences, sympathize with them so the patients know they are being heard, accept responsibility for the negative experiences, and be prepared to help the patient solve the problem.

In most situations, unhappy patients simply want to know the clinic is actually listening to them.

“People just want to know that they’ve been heard,” King said.

While staff will most likely hear the same collection of complaints on a regular basis, and thus can be taught exactly what to say or do during those times, he said it is vital to train the staff to know how to handle the “crazy situations.”

“Those are a little tougher, but you’ve got to be prepared for the unexpected,” he said.

Surveys, whether paper or digital, are another way to add a touchpoint in order to find how patients felt their experiences went while visiting your practice.

Paper surveys are helpful tools, King said, because they are easily mailed or given out by the front desk staff members at the end of the patient’s appointment.

However, digital surveys tend to have better luck in receiving more patients’ comments, he said. Paper surveys also tend to be more costly.

If choosing paper surveys, King suggested sending the survey to the patient directly after she leaves your clinic because you want her to remember her experience so she can provide the most detailed comments.

“You’re most invested in the survey at the time directly after the appointment,” he said.

However, while digital may receive more responses than paper surveys due to convenience, King said patients tend to give better, more honest feedback with the paper surveys.

“They’re more likely to send the survey back without their name on it and give you their true comments, while with digital they may not because you’ve got their e-mail addresses,” he said.

Keeping an eye on what people are posting online, such as on user review sites such as Yelp or Facebook, is another helpful outlet to understand how patients feel about your practice. Reading these reviews may offer insight on areas that need attention.

“You’re looking for trends, so then you can figure out why bad service is happening and then how to fix it,” King said.

Overall points

Nevertheless, King said it is ideal to remember that maintaining excellent customer service is not just about maintaining profits and growing the practice.

“It’s not all about the money,” King said. “Take care of your customers and employees first, and growth and profits will follow.”
How visual field loss impacts driving

Researchers aim to develop evidence based on visual field location and performance

By Cheryl Guttman Krader

Visual field loss can affect driving performance, but the extent of impairment varies depending on the location of the defect, according to the results of a study reported by Fiona C. Glen, PhD and colleagues.

“Binocular visual field loss has been linked to subject-reported driving difficulties and risk of motor vehicle accidents,” said Dr. Glen, postdoctoral research assistant, Department of Optometry and Visual Science, School of Health Sciences, City University London. “The results of our study suggest that driving performance and potentially rates of vehicular accidents does not depend simply on the presence of binocular loss, but rather on the location of the defect.”

To test their hypothesis, the investigators conducted a trial in which 30 participants with visual field loss took part.

Example screenshots taken from the three versions of the Hazard Perception Test. The visual field defects used for each test situation are shown beneath each image. (Images courtesy of Fiona C. Glen, PhD)
Understanding circadian patterns, drug efficacy could improve care

Why eyecare practitioners need to consider factors as guide for management of glaucoma

By Cheryl Guttmann Krader

Knowledge about the circadian pattern of IOP and the 24-hour efficacy of glaucoma medications is increasing and is expected to contribute to better medical management of glaucoma in the future, said Sunita Radhakrishnan, MD.

“IOP is not a static parameter and glaucoma is not a 9-to-5 disease,” said Dr. Radhakrishnan, private practice, Glaucoma Center of San Francisco. “However, we typically assess IOP in our patients by measuring it only in the daytime and at best during a handful of visits throughout the year.

“This approach seems to be adequate for many patients, since glaucoma progression is typically very slow,” Dr. Radhakrishnan explained. “However, more often than not, clinicians are confronted with cases that bring to light how little data we actually have to guide our management decisions. In the future, technology for self-tonometry and 24-hour IOP-monitoring may be used to obtain information on individual IOP circadian patterns and response to intervention in order to guide our decisions on patient care.”

Body position as factor

Research conducted at specialized sleep laboratories has provided information demonstrating that IOP varies depending on time of day and body position. The results of these studies show that IOP is higher during the night than during the day and when subjects are in a supine versus upright (lying down versus sitting) position.

Though the change in body position is an important contributor to the nocturnal rise in IOP, it does not explain the entire increase, Dr. Radhakrishnan said.

24-hour efficacy of IOP drugs

Research has also generated information about the 24-hour efficacy of IOP-lowering medications. Results from multiple studies show prostaglandin analogues are effective in reducing IOP during the day and at night, and a study comparing bimatoprost, latanoprost, and travoprost found no statistically significant differences among the three agents in their 24-hour efficacy.

In contrast, studies investigating beta-blockers found they were effective in lowering IOP during the day, but not at night. The finding is consistent with the fact that aqueous humor production, which is inhibited by beta-blockers, is already decreased during the night.

Like the beta-blockers, the alpha-agonist brimonidine was also shown to reduce IOP during the daytime only, whereas the carbonic anhydrase inhibitors dorzolamide and brinzolamide demonstrated efficacy for lowering IOP during the day and at night.

“The beta-blockers, carbonic anhydrase inhibitors, and alpha-agonists have all been shown to be effective for additional IOP lowering when added to a prostaglandin analogue,” Dr. Radhakrishnan said. “However, in most of the studies investigating adjunctive therapy, IOP was measured only during the day.

“In one 24-hour IOP study, evaluating the effect of adjunct treatment in patients receiving latanoprost, nocturnal IOP was lower in patients treated with brinzolamide three times a day compared with timolol every morning,” Dr. Radhakrishnan said. “In another study, both dorzolamide and brimonidine seemed to perform well when either was used twice daily in addition to a prostaglandin analogue.”

Translating to the real world

When trying to apply the findings from these studies to clinical practice, ophthalmologists need to consider that the circadian IOP studies are conducted under rigorous conditions, and so the results may not be applicable to the average patient. Furthermore, in some studies, the carbonic anhydrase inhibitors and brimonidine were administered three times daily rather than on the...
Field loss
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healthy vision completed the driving Hazard Perception Test (HPT). The computer-based test—a required component of the driving exam for new drivers in the United Kingdom—measures response times for detecting hazards appearing in real-life driving videos.

Participants performed the test three times in random order. One test served as a baseline and was performed without any modifications. In the two other test situations, novel software was used to simulate superior or inferior visual field defects that were linked to the user’s real-time gaze.

Study outcomes
The results showed that the participants’ mean HPT score exceeded the passing mark in the baseline-testing situation, but not when the testing was performed with either simulated field defect.

Compared with the baseline testing without visual field modification, HPT test scores fell 18 percent when the driving exam was done with the simulated superior defect and by 12 percent with the simulated inferior defect. Statistical analysis showed the effect of both visual field defects was statistically significant and also showed the impact of the superior visual field defect was significantly greater than the effect of the inferior visual field defect.

Motive for research
Interest in undertaking this study was motivated by the relative paucity of data on how different types and locations of visual field defect impact driving performance, Dr. Glen said.

“The lack of good scientific evidence in this area was particularly surprising, considering that driver’s license eligibility requirements in the United Kingdom include some complicated criteria relating to locations of visual field defects,” she said. “However, the existing standards, which are being used to make what is a life-altering decision, have never been documented to impair driving performance.”

Furthermore, the use of the binocular visual field test to assess fitness to drive is questionable, since it was never developed for that purpose and has many specifications that are not necessarily relevant to driving, according to Dr. Glen.

The study’s finding of significantly worse performance on the HPT when testing was done with the simulated superior visual field defect compared with the inferior visual field defect is not surprising considering the superior field of view is more relevant to the driving scene.

However, it is an important finding because the visual field test that is used for determining driving eligibility in the United Kingdom is weighted toward the inferior visual field,” she said. “Therefore, our study brings into question the appropriateness of using that test to determine fitness to drive.

“Our research is a first step toward understanding which visual field defect locations are most important for driving and, in turn, devising better tests for assessing fitness to drive in the future,” Dr. Glen said.

The research was sponsored by the International Glaucoma Association.

Glaucoma
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twice-daily schedule that is often prescribed for patients.

However, the most basic issue to consider is the lack of understanding about the clinical relevance of avoiding nocturnal IOP elevations.

“My makes intuitive sense to decrease IOP around the clock,” Dr. Radhakrishnan said. “However, it remains to be determined what role nocturnal IOP elevation has on the onset or progression of glaucoma.”

In addition, the goal of achieving 24-hour IOP control must be considered in the context of several other factors.

“Although it seems ideal to achieve diurnal and nocturnal IOP lowering for every patient, there is no ‘one-size-fits-all’ algorithm for managing glaucoma,” Dr. Radhakrishnan said. “Treatment decisions need to be individualized taking into account safety, tolerability, efficacy, and cost.”
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References:
2. Based on third party industry report 52 weeks ending 12/29/12; Alcon data on file.
4. SOFTWEAR™ Saline package insert.

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