How To Build A Dry Eye Practice That Generates New Revenue

Dry eye disease is a topic we as eye care professionals are all somewhat familiar with. Yet, many practitioners avoid actively treating it for a variety of reasons. With new commercials and marketing campaigns bringing the dry eye conversation to the general public, it is more important than ever for optometrists to be comfortable and well-versed in the management of this disease. At Vision Expo West, Drs. Josh Johnston, Dan Epshtein, and Patricia Fulmer sat down to discuss dry eye and how you can build a dry eye practice.

Below is a recap of their best tips.

Why do docs, particularly new graduates, avoid

actively treating dry eye?

In the beginning of most optometrists careers, they are floating…just getting through the day navigating patient care without an attending and trying to learn "real world optometry". They aren't looking for the dry eye patients when often they're right under their noses. Depending upon the type of practice setting, up to 80% of patients have dry eye, while only maybe 20% are treated.

In addition, dry eye can be downplayed in school, leaving new graduates thinking it's unimportant and can be managed with artificial tears and yearly visits alone. However, after embracing the condition as a disease and actively looking for these patients, care becomes rewarding.

Why should optometrists want to begin treating dry eye and build a dry eye practice?

Optometry is a medical profession, and as such, we should be actively looking for diseases ailing our patients and ways we can improve their quality of life. Treatment of dry eye is one such way. As previously stated, there are a plethora of patients suffering from dry eye daily, but this condition doesn't have to be something your patients just deal with. One specific commonly overlooked area in which ODs can make a difference is with perioperative patients. Treatment of their dry eye prior to surgery can mean improved measurements prior to surgery and improved outcomes post-surgery. Dryness is often worse after surgery and can lead a patient to believing he or she had poor results of surgery. Treatment of the post-surgical dry eye can restore patient comfort as well as improve vision to the level the patient was initially expecting.

Additionally, medical optometry is becoming more and more important as the refractive side of our profession is swiftly changing. There is more awareness of dry eye in the optometric community and general population

now than ever before, and many in ophthalmology don’t want to take on treating the condition, either due to patient load or speciality. These facts leave the door wide open for optometrists to become the go-to practitioners for dry eye care and give us a very easy way to incorporate the medical model into our practices.

Remember: Dry eye is the easiest way to introduce the medical model into your practice.

Why does dry eye have a bad rep?

Unfortunately, many practitioners believe treating dry eye is a nuisance, something tedious and time consuming that won't pay off much in the end. This is simply not true. Dry eye is extremely common within our patient base, and when treated early, can be easy and somewhat straightforward. In the past, though, many have waited until the condition became severe to actively treat. This made for a much larger challenge and raised the chances of patient and doctor frustration resulting from inadequate results.

Remember: Treating earlier = better success = happier patients and doctors

Why is it important for us to treat dry eye NOW?

There is no better profession in the world to treat dry eye than optometry and no better time to do so than now. Baby boomers are here. They are developing worsening dry eye symptoms daily, and beyond that, many of them need surgery- outcomes of which depend highly upon their ocular surface integrity. We have the time and compassion to treat these, and we are well equipped to do so. Recent studies have shown that roughly 63% of cataract surgery patients had level 2 dry eye (meaning they needed a cyclosporine or other prescription therapy), and 50% had central staining (which should be prompting punctal occlusion, amniotic membrane treatments, etc). Instead, these patients are having surgery and coming out

with poor outcomes. Their untreated dry eye can lead to poor measurements on the front end of surgery, decreased vision afterwards, and increased dryness symptoms post surgery. It is integral that we, as primary care providers, catch this condition and treat on both the front and back end of surgery. ***You should always strive to treat the dry eye on the front end*.**

Have you seen a shift in demographics of DES patients?

100% yes.

In addition to our baby boomers, we also have 20-30 year olds with significant dry eye. This can be contributed to digital device use as well as environmental factors (for example, working in big office buildings with the A/C blowing all day). Just like in older patients, we don't have to wait for severe DES to treat this demographic with Restasis and other prescription therapies. In fact, when treated early, these patients typically respond very well as they have fewer comorbidities working against them than the baby boomers do.

How do you get young patients to buy in when building a dry eye practice?

It can be difficult, but thankfully this is shifting as awareness of dryness, maintaining overall health, and the importance of preventative medicine is growing among young people.

One easy way to get through to these patients is to address their lifestyle. For example, helping them understand that while they are not currently too dry to wear contact lenses or work 8-10 hours a day, without treatment, they might but headed that way. You can use a discussion about digital eye strain as a segway into a digital dry eye discussion as many millennials understand and experience the strain associated with their device use.

Finally, always discuss the condition and recommend a treatment plan. Even if your patient does not comply at the moment, he or she will be much more likely to buy-in in the future as signs and symptoms inevitably increase. Planting the seed will go a long way down the road.

How do you start getting into dry eye?

Start with the why- understand why is it important to treat and why will it matter in your practice.

Then figure out how to implement it in your clinic- shadow a dry eye practice if you can and consider getting a mentor.

Once you have done these things, getting started is as easy as staining and talking to patients: do you have stinging, burning, decreased CL wear, fluctuating vision, etc. As you get busier, you will be able to invest in more tools and put in protocols for you and your staff to follow. Remember to make sure you're on medical insurance panels in your area before you begin.

What would be your #1 purchase for diagnostic equipment??

In order to **start a dry eye clinic**, the first things Dr. Johnston would recommend are the Speed questionnaire and NaFl strips. It's that simple. When you're ready to purchase true equipment, his recommendation would then be to buy an osmolarity unit such as TearLab. These days, the unit is usually supplied free and the cards are bought on a subscription basis.

Dr. Epshtein recommends the Non-invasive TBUT because it gives you natural information. The unit can run between $20-30,000 but it also provides you with topography and some external imaging capabilities.

What does the typical exam experience look like

for a DES patient in a DES clinic?

1. Check in: patients will fill out the Speed questionnaire first. It is fast and helps the doctor, patient, and staff get an idea of the situation.
2. Tech does the work-up: in a full-blown dry eye clinic, this will likely include interferometry (Lipiview by TearScience), **osmolarity (TearLab), and MMP-9 measurements (InflammaDry)**. Meibography (Lipiscan by TearScience) may also be performed as well.
3. Patient sees the doctor: prior to seeing a patient, the doctor will review all data. This will guide how to talk to the patient about his or her symptoms and treatment plans. The OD will also perform TBUT and stain with NaFl.
4. Treatment plan is given: based upon the data and patient symptoms gathered in the exam and work-up, the doctor will then give the patient a treatment plan. It is best to provide a written protocol as instructions can sometimes be overwhelming. Don't be afraid to start simple and add therapies at follow-up.

If your practice isn't at the point of being able to do all of these tests, that's okay! Keep in mind, you only need a good patient history and some NaFl strips to run a basic dry eye clinic. The protocol is still the same, though. Get a good patient history, perform objective testing, formulate a treatment plan, and prescribe.

No matter what you do, **DON'T OVER PROMISE!!!!!!** Set realistic goals for your patients and monitor their progress, adjusting those goals as needed. When you set the bar low and continually reach those individual goals, patients feel the progress they're making and are more motivated to keep going.

What does this work up look like financially for the patient?

Most of these tests can be billed to the patient's medical insurance, so the office visit copay will be their only out-of-pocket cost. Do keep in mind, however, that we are in the world of high deductibles, so if a patient's specific plan applies testing to a high deductible, the patient may be billed after their claim has processed. For tests that are not covered by insurance such as LipiView or LipiScan, Dr. Johnston recommends charging a low flat fee (his office charges $40) for those procedures, then applying that fee to the patient's cost for LipiFlow should that treatment be performed.

Tip: check with your insurance plans to see which codes are more beneficial for you to bill. If you are actively changing therapy, you can bill a 92012 code for your follow-ups instead of a 99213. These codes sometimes pay slightly higher. Just make sure you check the requirements for each code to make sure you've met them before billing. Use your 99- codes for maintenance follow-ups once stable treatment is established.

What is your treatment plan? Where do you start?

Treatment of dry eye is very patient specific. While you may start in the same place, typically artificial tears, where you go from there will vary. For some patients, one 3-4 week follow-up after starting tears will be enough. For others, you will need to enlist other modalities of therapy. Using a grading schedule to determine treatment will help clinicians know exactly where to start. One such example is below:

Level 1: these patients have mild symptoms, no staining, no CL issues, and no reduced TBUT. Treatment is often limited to new technology artificial tears such as Systane Balance, Refresh Optive Advanced, or TheraTears BID.

Level 2: patients that need ATs more than BID, have inferior SPK, and/or have mild to moderate symptoms are level 2 patients. They should be treated with tears plus a prescription therapy like Restasis, **Xiidra**, or a

steroid.

Level 3: these patients have central staining, more diffuse signs, and moderate/severe symptoms. They need lid hygiene (Avenova, bruder mask), coupled with any or all of the following: topical steroids, Restasis/Xiidra, plugs, and omega-3s. Amniotic membranes can be used to speed up healing.

Level 4: patients who reach this level have severe diffuse SPK and/or severe symptoms. These cases will need the kitchen sink thrown at them.

Regardless of the level of diagnosis and treatment a patient is at, be specific with your instructions. Once control is reached, you can work to taper off treatments while maintaining comfort and ocular surface health. Don't forget to have lifestyle conversations (increase water intake, decrease caffeine, don't sleep with a ceiling fan, etc.) no matter what level you may be tackling.

Some dry eye clinics sell products out of their offices. Are there any products you'd recommend ODs selling out of office?

Selling out of office is optional, but should an OD choose to carry products, Bruder masks and Avenova are common choices. Other options would be omega-3 supplements and artificial tears. Don't forget, Allergan allows Refresh to be sold directly out of optometrists' offices, creating a more prescription-like perception of the product. Whatever you choose to carry in office, make sure it is a product you believe in and think is the best option for your patients.

Final tips:

- If you really want to start treating more DES- learn about it. Attend workshops, read publications, etc.

- Remember that systemic conditions and medications can cause dry eye (DM, HTN, and Beta Blockers are examples).
- Start dabbling- talk to your patients, start staining, get a mentor that does a lot of dry eye. Keep in mind that building a dry eye clinic takes time. It is rewarding, but it's a process.
- Prescribe therapy! If it's not working, ask yourself "is there something else going on?" (demodex, blepharitis, lagophthalmos, systemic disease, etc).
- Get started! It won't add much time to your exam and the more you talk about it, the more comfortable you'll be. Don't be afraid to try something else if your first treatment doesn't work; the more you see the condition, the more you'll know why it isn't working (compliance issue vs truly not working).
- You can **increase revenue by simply looking and talking to your patients**- if you can help the 40 something dry eye mom, you get the whole family.