AVOIDING BURNOUT

Identifying Signs and Changing Behaviors

Editorially independent content supported with advertising by Bausch + Lomb and Regeneron
Treat MEfRVO With EYLEA
From the Start

The Majority of Patients Achieved Significant Improvement of ≥15 Letters at 24 Weeks

<table>
<thead>
<tr>
<th>Study</th>
<th>% Patients Gaining ≥15 ETDRS Letters at 24 Weeks</th>
</tr>
</thead>
</table>
| VIBRANT (MEfBRVO) | 53%*  
EYLEA 2 mg every 4 weeks  
(n=91) |
| COPERNICUS (MEfCRVO) | 56%  
EYLEA 2 mg every 4 weeks  
(n=114) |
| GALILEO (MEfCRVO) | 60%  
EYLEA 2 mg every 4 weeks  
(n=103) |

*BCVA, as measured by ETDRS letters.

**VIBRANT study design:** Randomized, multicenter, double-masked, controlled study in which patients with MEfBRVO (N=181, age range: 42-94 years, with a mean of 65 years) were randomized to receive 1) EYLEA 2 mg administered every 4 weeks or 2) laser photocoagulation administered at baseline and subsequently as needed (control group).

The primary efficacy endpoint was the proportion of patients who gained at least 15 letters in BCVA at week 24 compared to baseline.

**COPERNICUS and GALILEO study designs:** Randomized, multicenter, double-masked, sham-controlled studies in patients with MEfCRVO (N=358, age range: 22-89 years, with a mean of 64 years). Patients were assigned in a 3:2 ratio to either 1) EYLEA 2 mg administered every 4 weeks (monthly) for the first 6 months or 2) sham injections (control) administered every 4 weeks (monthly) for a total of 6 injections.

In both studies, the primary efficacy endpoint was the proportion of patients who gained at least 15 letters in BCVA at week 24 compared to baseline.

Contraindications

- EYLEA is contraindicated in patients with ocular or periocular infections, active intraocular inflammation, or known hypersensitivity to aflibercept or to any of the excipients in EYLEA.

Warnings and Precautions

- Intravitreal injections, including those with EYLEA, have been associated with endophthalmitis and retinal detachments. Proper aseptic injection technique must always be used when administering EYLEA. Patients should be instructed to report any symptoms suggestive of endophthalmitis or retinal detachment without delay and should be managed appropriately. Intraocular inflammation has been reported with the use of EYLEA.

- Acute increases in intraocular pressure have been seen within 60 minutes of intravitreal injection, including with EYLEA. Sustained increases in intraocular pressure have also been reported after repeated intravitreal dosing with VEGF inhibitors. Intraocular pressure and the perfusion of the optic nerve head should be monitored and managed appropriately.


Please see Brief Summary of Prescribing Information on the following page.
In Prespecified Analyses, EYLEA Reduced Central Retinal Thickness\textsuperscript{2-4}

Mean change in central retinal thickness (µm), as measured by OCT, at 24 weeks from baseline\textsuperscript{2,4,\ast}

<table>
<thead>
<tr>
<th>Study</th>
<th>Baseline Change (µm)</th>
<th>Treatment Change (µm)</th>
<th>Significance vs Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>VIBRANT (MEFBRVO)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EYLEA 2 mg every 4 weeks (n=91)</td>
<td>-281\textsuperscript{\dagger}</td>
<td></td>
<td></td>
</tr>
<tr>
<td>control (n=90)</td>
<td>-128</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPERNICUS (MEFCRVO)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EYLEA 2 mg every 4 weeks (n=114)</td>
<td>-457\textsuperscript{\dagger}</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sham control (n=73)</td>
<td>-145</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GALILEO (MEFCRVO)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EYLEA 2 mg every 4 weeks (n=103)</td>
<td>-449\textsuperscript{\dagger}</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sham control (n=67)</td>
<td>-169</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{\ast}Last observation carried forward; full analysis set.
\textsuperscript{\dagger}P<0.01 vs control.
\textsuperscript{\ddagger}P<0.01 vs sham control.

The analyses of these endpoints were not multiplicity protected and are descriptive only.
Anatomic measures were not used to influence treatment decisions.\textsuperscript{1}

Visit HCP.EYLEA.US for a closer look at the data

WARNINGS AND PRECAUTIONS (cont’d)

• There is a potential risk of arterial thromboembolic events (ATEs) following intravitreal use of VEGF inhibitors, including EYLEA. ATEs are defined as nonfatal stroke, nonfatal myocardial infarction, or vascular death (including deaths of unknown cause). The incidence of reported thromboembolic events in wet AMD studies during the first year was 1.8% (32 out of 1824) in the combined group of patients treated with EYLEA compared with 1.5% (9 out of 595) in patients treated with ranibizumab; through 96 weeks, the incidence was 3.3% (60 out of 1824) in the EYLEA group compared with 3.2% (19 out of 595) in the ranibizumab group. The incidence in the DME studies from baseline to week 52 was 3.3% (19 out of 578) in the combined group of patients treated with EYLEA compared with 2.8% (8 out of 287) in the control group; from baseline to week 100, the incidence was 6.4% (37 out of 578) in the combined group of patients treated with EYLEA compared with 4.2% (12 out of 287) in the control group. There were no reported thromboembolic events in the patients treated with EYLEA in the first six months of the RVO studies.

ADVERSE REACTIONS

• Serious adverse reactions related to the injection procedure have occurred in <0.1% of intravitreal injections with EYLEA including endophthalmitis and retinal detachment.

• The most common adverse reactions (≥5%) reported in patients receiving EYLEA were conjunctival hemorrhage, eye pain, cataract, vitreous detachment, vitreous floaters, and intraocular pressure increased.

INDICATIONS

EYLEA (aflibercept) Injection 2 mg (0.05 mL) is indicated for the treatment of patients with Neovascular (Wet) Age-related Macular Degeneration (AMD), Macular Edema following Retinal Vein Occlusion (RVO), Diabetic Macular Edema (DME), and Diabetic Retinopathy (DR).

EYLEA is a registered trademark of Regeneron Pharmaceuticals, Inc.

© 2020, Regeneron Pharmaceuticals, Inc. All rights reserved.
777 Old Saw Mill River Road, Tarrytown, NY 10591

05/2020
EYL.20.04.0075
Table 2: Most Common Adverse Reactions (≥1%) in RVO Studies

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>EYLEA (N=178)</th>
<th>CRVO (N=218)</th>
<th>EYLEA (N=95)</th>
<th>BRVO (N=187)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conjunctival hemorrhage</td>
<td>1%</td>
<td>≤1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Intraocular pressure increased</td>
<td>9%</td>
<td>1%</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>Retinal hemorrhage</td>
<td>3%</td>
<td>2%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Vision blurred</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Ocular inflammation</td>
<td>3%</td>
<td>2%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Iris atrophy</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Ocular hyperemia</td>
<td>4%</td>
<td>8%</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>Vitreous floaters</td>
<td>6%</td>
<td>7%</td>
<td>8%</td>
<td>10%</td>
</tr>
<tr>
<td>Iris exudates</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Conjunctival hemorrhage</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Table 3: Most Common Adverse Reactions (≥1%) in DME Studies

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>Baseline to Week S2</th>
<th>Baseline to Week 52</th>
<th>Baseline to Week 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conjunctival hemorrhage</td>
<td>2% (N=378)</td>
<td>2% (N=1572)</td>
<td>2% (N=837)</td>
</tr>
<tr>
<td>Intraocular pressure increased</td>
<td>1% (N=378)</td>
<td>1% (N=1572)</td>
<td>1% (N=837)</td>
</tr>
<tr>
<td>Retinal hemorrhage</td>
<td>1% (N=378)</td>
<td>1% (N=1572)</td>
<td>1% (N=837)</td>
</tr>
<tr>
<td>Iris atrophy</td>
<td>&lt;1% (N=378)</td>
<td>&lt;1% (N=1572)</td>
<td>&lt;1% (N=837)</td>
</tr>
<tr>
<td>Ocular hyperemia</td>
<td>8% (N=378)</td>
<td>8% (N=1572)</td>
<td>8% (N=837)</td>
</tr>
<tr>
<td>Vitreous floaters</td>
<td>10% (N=378)</td>
<td>10% (N=1572)</td>
<td>10% (N=837)</td>
</tr>
<tr>
<td>Iris exudates</td>
<td>&lt;1% (N=378)</td>
<td>&lt;1% (N=1572)</td>
<td>&lt;1% (N=837)</td>
</tr>
<tr>
<td>Conjunctival hemorrhage</td>
<td>1% (N=378)</td>
<td>1% (N=1572)</td>
<td>1% (N=837)</td>
</tr>
</tbody>
</table>

Table 1: Most Common Adverse Reactions (≥1%) in Wet AMD Studies

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>Baseline to Week 52</th>
<th>Baseline to Week 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conjunctival hemorrhage</td>
<td>2% (N=1824)</td>
<td>2% (N=1824)</td>
</tr>
<tr>
<td>Intraocular pressure increased</td>
<td>1% (N=1824)</td>
<td>1% (N=1824)</td>
</tr>
<tr>
<td>Retinal hemorrhage</td>
<td>1% (N=1824)</td>
<td>1% (N=1824)</td>
</tr>
<tr>
<td>Iris atrophy</td>
<td>&lt;1% (N=1824)</td>
<td>&lt;1% (N=1824)</td>
</tr>
<tr>
<td>Ocular hyperemia</td>
<td>6% (N=1824)</td>
<td>6% (N=1824)</td>
</tr>
<tr>
<td>Vitreous floaters</td>
<td>7% (N=1824)</td>
<td>7% (N=1824)</td>
</tr>
<tr>
<td>Iris exudates</td>
<td>&lt;1% (N=1824)</td>
<td>&lt;1% (N=1824)</td>
</tr>
<tr>
<td>Conjunctival hemorrhage</td>
<td>1% (N=1824)</td>
<td>1% (N=1824)</td>
</tr>
</tbody>
</table>

Adverse reactions reported in ≤1% of patients treated with EYLEA were hypersensitivity, retinal or choroidal edema, and endophthalmitis.

Diabetic Macular Edema (DME) and Diabetic Retinopathy (DR).

The data described below reflect exposure to EYLEA in 178 patients with DME treated with the 2-mg dose in 2 double-masked, controlled clinical studies (VIDD and VISTA) from baseline to week 52 and from baseline to week 100.

Less common adverse reactions reported in <1% of the patients treated with EYLEA in the DME studies were corneal edema, retinal edema, conjunctival hemorrhage, and endophthalmitis.

5.1 Endophthalmitis and Retinal Detachments.

Intravitreal injections, including those with EYLEA, have been associated with endophthalmitis and retinal detachments (see Adverse Reactions [6.1]). Proper aseptic injection technique must always be used when administering EYLEA. Patients should be instructed to report any symptoms suggestive of endophthalmitis or retinal detachment without delay and should be managed appropriately (see Patient Counseling Information [7.5]).

5.3.5 Iris Exudates

No iris exudates were reported with EYLEA in any of the clinical trials of the same or another drug and may not reflect the rates observed in practice.

5.3.5 Iris Exudates

No iris exudates were reported with EYLEA in any of the clinical trials of the same or another drug and may not reflect the rates observed in practice.
Practice is taxing. Add a pandemic and it can be downright exhausting.

Doctors in the United States experienced high rates of burnout before the COVID-19 pandemic struck. The topic might be addressed here and there at various conferences and during staff meetings, but the underlying slow burn of exhaustion marched steadily forward.

As business leaders, we cannot effectively run a practice if we're in a constant state of fatigue. In this issue's cover focus, we turn to two consultants who specialize in identifying and reducing burnout.

Also in this issue, we interview David Xu, MD, who cofounded EyeGuru.org, a free resource for ophthalmology trainees who need a helping hand (let’s be honest—that’s nearly every trainee) during their education. In the Coding Advisor column, we address coming coding changes for 2021. And in the Your Money column, we consider the financial implications of joining a new practice.

ALAN RUBY, MD
SECTION EDITOR
Although changes to the guidelines for evaluation and management (E/M) codes don’t begin until 2021, understanding these changes and educating practice stakeholders about them is essential. Here is a summary of the key changes to expect starting on January 1, 2021.

WHY THE CHANGE?
CMS is making E/M coding and documentation changes to reduce administrative burden and decrease the need for audits. These changes simplify documentation requirements for exams. In making these changes, CMS is focusing on clinically relevant exams and histories, using medical decision-making as the driving factor to determine the level of service. The current 1997 E/M guidelines will be replaced by the 2021 revisions for office-based and other outpatient services.

HOW WILL THE CHANGES BE IMPLEMENTED?
A "medically appropriate history and/or examination" should be documented in lieu of the previously required history and examination elements. Under the new rules, an E/M code will be selected based on level of medical decision-making (MDM) or total time. Total time is defined as the total time the physician spent on the case on the date of service provided. The three categories for MDM will be updated with more specific definitions.

The level 1 new patient CPT code 99201 will be eliminated. New patient codes for levels 2 through 5 will remain (CPT 99202-99205) as will the five existing established E/M codes (CPT 99211-99215).

A series of shorter prolonged-service codes will be implemented. These codes will capture physician time in 15-minute increments and can be reported only with CPT codes 99205 and 99215. Prolonged-service codes can be used only when total time is the primary basis for code selection.

WHAT WILL REMAIN THE SAME?
For services for which the place of service is assisted living facility, skilled nursing facility, nursing home, emergency department, or inpatient hospital service, the E/M documentation requirement will not change. This would apply, for example, to an inpatient encounter for retinopathy of prematurity. Table 1 lists the appropriate place-of-service codes not affected by the 2021 revisions to E/M codes.

WHAT WILL BE DIFFERENT?
Medical Decision-Making
Beginning in 2021, regardless of place of service, all E/M codes will use the newly defined MDM criteria. The three categories for determining MDM level—number of problems, amount and/or complexity of data, and table of risk—will remain. However, these elements have expanded definitions, added examples, and ambiguous terms removed. Table 2 provides a comparison of MDM category definitions from the current and future schemes.
In 2021, time may be used to select the level of E/M service for office-based or other outpatient services, even if counseling or coordination of care does not dominate the encounter. This is a change from the 1997 guidelines.

When using total time to determine the level of E/M service, include the face-to-face time spent by the retina specialist. Activities performed by the physician preparing to see the patient the same day would count toward total time and should be documented. These may include communication with the referring physician and ordering tests, for example. Time that the clinical staff spends with the patient should not be included. Tables 3 and 4 outline the differences between the current and future guidelines.

Accurate chart documentation is imperative when calculating total time for E/M code selection. For those using paper charts, document the total physician time for the encounter. In an electronic health record, date stamp the initiation and conclusion of the physician face-to-face time with the patient. This documentation will be necessary in the event of an audit.

Start preparing for this transition by reviewing your paper chart notes or electronic health record templates for any necessary changes due to changes to E/M coding guidelines, including the history and examination elements.

Prolonged Services
The revised guidelines include prolonged-service codes for patients who require additional time with a physician. The new prolonged codes will be used only in an office-based or outpatient setting when total time is calculated, and only with level 5 new patient CPT code 99205 or established patient CPT code 99215.

The prolonged codes will be in increments of 15 minutes when total time for a new patient encounter is at least 75 minutes, or for an established patient visit is at least 55 minutes. Tables 5 and 6 reflect the levels of prolonged services for new and established patients, respectively, and outline a placeholder code (eg, 99XXX) that will be replaced with a permanent code in 2021.

INCREASED REIMBURSEMENT
As currently configured, E/M codes will be associated with increased reimbursement in 2021. Although this is good news for these services, the adjustment as proposed is budget-neutral and will reduce the allowable for other services such as intravitreal injection, laser application, surgery, and testing services. Increased reimbursement will not include eye visit codes.

The E/M code increase proposal will not be applied to underlying postoperative visits that are a part of global surgery packages. These changes will affect reimbursement for surgical codes next year. The AAO and other organizations continue to lobby for the E/M increase to include postoperative visits, which are an inherent part of the surgical code.

On a positive note, as of January 1, 2020, ophthalmologists are excluded from the total per capita cost (also called TPCC) measure in the Merit-Based Incentive Payment System (also called MIPS) cost formula. Previously, some providers may have used...
Burnout occurs in all professions. Ophthalmology, although reportedly lower on the subspecialty list for burnout, definitely has its share of personal and professional stressors. In the following interview, Retina Today Business Matters asked ophthalmic practice management experts John B. Pinto and Corinne Z. Wohl, MHSA, COE, to discuss strategies to avoid burnout.

**How prevalent is burnout in ophthalmology?**

John B. Pinto: As stressed out and burned out as one can become working in the ophthalmic field—whether you are a physician, an administrator, or support staff—the incidence of burnout is reportedly lower than in other medical specialties. According to a 2016 report, the physicians who most reported being extremely happy were dermatologists (43%), closely followed by ophthalmologists (42%). Therefore, although ophthalmologists are more stressed than the average person, they are doing fairly well compared with their peers in medicine.

**What are some common causes of stress and burnout?**

Corinne Z. Wohl, MHSA, COE: Everyone who works in ambulatory care is under stress for a variety of reasons. Those reasons could be divided into a list of excesses and a list of insufficiencies. For example, a surgeon experiences stress because of an excess volume of work and hours worked, or because of an excess of perfectionism. Personal financial considerations can also cause burnout and depression. Ophthalmologists are paid per unit of work, and it can be addictive to say, “I am seeing 20 patients this morning. I wonder if I can see 25.” That sort of competitive behavior, if driven or exacerbated by financial stressors, can lead to a slippery slope, and individuals can lose control over how much and how intensely they are working. Common insufficiencies can also cause burnout, such as not eating or sleeping well, not exercising enough, not maintaining healthy relationships, and not keeping one’s finances in balance. When physicians have an excess of some of these things and an insufficiency of others, it leads to stress and burnout.

In our firm, we use a model developed by Canadian...
researcher Hans Selye to discuss stress with clients. Many years ago, Dr. Selye said that stress is generated in an environment of change, and it does not matter whether it is distress, like the distress of getting a parking ticket, or eustress (eu-, ie, good, as in euphoria), relating to positive change such as buying a new home, getting a new job, or getting married. Whether change is positive or negative, it’s the change that can lead to a state of stress. Dr. Selye developed a useful scale for charting this. If people experience enough changes, especially compressed into a short time span, they will experience higher levels of stress until it starts to manifest as burnout. Burnout really can be thought of as stress sustained over time.

**HOW CAN ONE RECOGNIZE AND ALLEVIATE BURNOUT?**

**Mr. Pinto:** Think of any medical condition. It presents with certain impressionistic, subjective findings and is then examined with objective tests. A diagnosis is made, and a treatment plan is put in place. The same methods can apply here.

Stress-related burnout has various subjective manifestations, which as management consultants—not psychologists—we are in a position to observe, but obviously not diagnose. In more challenging settings, where a client’s stress interferes with the business entity we are trying to help, we refer the client to a mental health professional. Ultimately, it is something that can be diagnosed, and a treatment plan can be developed by the appropriate professional. Interestingly, we are often on the front line of discovering and discussing stress and burnout with a new client because they are comfortable discussing their problems with a business consultant but feel embarrassed (unnecessarily, obviously) to seek out a psychologist.

The diagnosis of stress and burnout can be made through observation of factors (eg, emotional detachment or depression) and unhealthy stress mitigation behaviors (eg, abusing alcohol or drugs). Personality shifts can lead to social isolation as friends or spouses pull away. This creates a feedback loop because, if one’s social support systems fall apart, one will be even more stressed and find it harder to emerge from an adverse cycle.

Once a diagnosis has been made, whether through self-diagnosis or by seeing a mental health professional, it is important for an ophthalmologist to realize that a big part of treatment involves setting limits and, if necessary, establishing an external source of discipline to stay within those limits.

Examples of limits include reducing the volume of patients seen in a given work session, the number of surgeries in a day, or the amount of money one tries to generate in a given month. It is appropriate to consider setting time limits. How many hours per day do you work? Do you include an hour-long break in the middle of the workday?

**WHAT IS THE GREATEST SOURCE OF STRESS FOR OPHTHALMOLOGISTS?**

**Ms. Wohl:** A lot of the stress and the burnout associated with stress that we see in ophthalmology is financial. Several years ago, we conducted a modest study with Craig N. Piso, PhD, which identified that the greatest correlation of unhappiness for surgeons was their perception of what percentage of their income they lived on. Surgeons who thought they were living on 100% or more of their income scored very low on a standardized life satisfaction and happiness questionnaire. By contrast, doctors who believed they lived on 50% or less of their income had much higher happiness scores. In our consulting work, we go into settings where doctors are living from day to day on a significant majority of their income. They feel like gerbils on a wheel. For these doctors, easing their stress can be a matter of getting them to work with financial planners and with their spouses to make sure they have reasonable budgets in place that are in balance with their comfortable earning potential.

**WHAT ARE SOME SIGNS OF STRESS AND BURNOUT?**

**Ms. Wohl:** Like exposure to too many x-rays, exposure to too much work can sneak up on a surgeon. Years of slow accommodation to work and stress builds until a breaking point is reached. It’s too bad we haven’t yet invented a stress safety badge—like an X-ray technician’s dosimeter badge—that can register when stress levels are too high or too prolonged. If you notice any of the following common markers in your providers, they may be at or beyond the point of burnout:

- Arriving chronically late or at the last possible moment to the clinic or OR.
- Asking for an early payday or extra personal withdrawals, requiring putting off paying practice vendors.
- Canceling clinic sessions on short notice or excessively, often with no more excuse than, “I really need a break.”
- Avoiding staff and literally (or at least figuratively) flinching every time a staff member approaches with a question or request.
- A collapse in professional growth, withdrawal from new clinical or surgical opportunities, and backing off from continuing education responsibilities.
- Relatively good energy in the mornings followed by a weak finish toward the end of the day, and then dragging home.

**WHAT ARE SOME STRESS AND BURNOUT PREVENTION AND TREATMENT STRATEGIES?**

**Ms. Wohl:** It is important to cultivate support systems in one’s life before getting to the stage of burnout. When we meet healthy, relaxed doctors, the thing that they seem to do the best is to cultivate support systems—friends, spouses, partners, and professional caregivers. The wisest doctors stay on the right side of burnout by realizing that seeing a counselor, psychologist, or religious leader at regular intervals can help them avoid burnout.
It is important to discuss these things openly. A smart practice administrator can also help doctors stay balanced in the midst of a hectic professional life. We think it’s important that the administrator be tuned in to the potential for stress and burnout in their providers and to develop a positive, open, safe, and trusting working relationship with each doctor so that, when stress or burnout starts to occur, it is easier to initiate that conversation.

Every profession, whether it’s education, law enforcement, or medicine, brings its practitioners moments of acute stress. Our discussion here is not so much about how to respond to the acute stresses that are embedded in every professional life, but how to recognize and deal with the effects of the drip drip drip of the enduring stress that can lead to burnout.

**WHAT ACTIONS SHOULD A SURGEON CONSIDER TO AVOID BURNOUT?**

Mr. Pinto: For any active ophthalmologist who is fully engaged in his or her work, there is a kind of connectedness between personal and professional life. It can be difficult to divide mitigation strategies between one’s personal and professional lives, but the key is to remove as many stressors as possible and add as many stress mitigators as possible, including exercise, massage, meditation, counseling, hobbies, religious practice, and good sleep hygiene.

Remember not to cluster too many changes into a short time span, even if the changes are positive. If a practice is going to close one office and build another in the course of a year, that might not be the year when one would want to also add a new partner, get into a new service line like dry eye, and do a mission trip to South America. That would be a lot of change packed into a single year.

Likewise, if a surgeon knows that he or she will be changing jobs, moving his or her family to a new community and having another child—all in the same year—it might not be the best time to try to master a complicated procedure or start volunteer teaching at the university.

We each have a certain quantity of stress and change that we can accept. It’s different from individual to individual, but one should try to anticipate changes and limit the amount of change occurring in the aggregate dimensions of one’s life.

---

**JOHN B. PINTO**
- President, J. Pinto & Associates, San Diego
- pintoinc@aol.com
- Financial disclosure: None

**CORINNE Z. WOHL, MHS, COE**
- President, C. Wohl & Associates, San Diego
- czwohl@gmail.com
- Financial disclosure: None

---

**JOY WOODKE, COE, OCS, OCR**
- Coding and Practice Management Executive, American Academy of Ophthalmology, San Francisco
- jewoodke@aao.org
- Financial disclosure: None

---

**CODING ADVISOR**

(Continued from page 7)

**TABLE 5. LEVELS OF PROLONGED SERVICES FOR NEW PATIENTS**

<table>
<thead>
<tr>
<th>Total Duration of New Patient Office or Other Outpatient Services</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>Less than 75 minutes Not reported separately</td>
</tr>
<tr>
<td></td>
<td>75-89 minutes 99205 X 1 + 99XXX X 1 in unit field</td>
</tr>
<tr>
<td></td>
<td>90-104 minutes 99205 X 1 + 99XXX X 2 in unit field</td>
</tr>
<tr>
<td></td>
<td>105 or more minutes 99205 X 1 + 99XXX X 3 or more for each additional 15 minutes in unit field</td>
</tr>
</tbody>
</table>

**TABLE 6. LEVELS OF PROLONGED SERVICES FOR ESTABLISHED PATIENTS**

<table>
<thead>
<tr>
<th>Total Duration of Established Patient Office or Other Outpatient Services</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99215</td>
<td>Less than 55 minutes Not reported separately</td>
</tr>
<tr>
<td></td>
<td>55-69 minutes 99215 X 1 + 99XXX X 1 in unit field</td>
</tr>
<tr>
<td></td>
<td>70-84 minutes 99215 X 1 + 99XXX X 2 in unit field</td>
</tr>
<tr>
<td></td>
<td>85 or more minutes 99215 X 1 + 99XXX X 3 or more for each additional 15 minutes in unit field</td>
</tr>
</tbody>
</table>

Eye visit codes to avoid reaching the 20-patient case minimum for this measure when reporting E/M codes. Under this revision, using E/M codes will not affect MIPS TPCC cost.

**EDUCATION AND ADJUSTMENTS ARE KEY**

Although these E/M revisions will not begin until 2021, it will take significant time and ongoing education to implement these changes within your practice. AAO resources are available, and future *Retina Today* articles will explore the use of these guidelines in daily practice. This is the first change to E/M guidelines since 1997, and successful implementation will require a commitment to embrace this paradigm shift.

*Conquering the New E/M Documentations Guidelines for Ophthalmology* is available at aao.org/store. For additional retina practice management and coding updates, visit aao.org/retinapm.
Whether you are an ophthalmologist just finishing residency or one who is already in practice and considering a move, the process of evaluating new job opportunities can be a daunting one. The decision is extremely important, as it could affect you and your family for years, if not decades.

Unfortunately, many physicians—both new and established—do not have the time, tools, or experience to accurately evaluate employment opportunities, and are ultimately disappointed when circumstances are different from what they envisioned. Sadly but commonly, this situation often leads to significant personal and family stress, professional insecurity, and financial hardship.

According to various reports, more than half of all physicians will change jobs during their first 5 years of practice. Although factors such as family circumstances, location, and practice conditions can play a role in a young doctor’s decision to change jobs, dissatisfaction with one’s financial situation is one of the biggest contributors.

In this article, a pared-down selection from our most recent book, *Wealth Planning for the Modern Physician*, we present a simple method doctors can use to financially model their net worth in prospective job opportunities. We also discuss secondary financial factors to consider when comparing job opportunities, including state tax rates and benefit plans.

**MONEY IS NOT THE ONLY FACTOR...**

A job’s financial situation is not everything. Like many Americans, some physicians will gravitate toward the highest paying career opportunity, only to realize after a few years that one with a better lifestyle balance or a more suitable location would have been the better fit. It is important to focus on the big picture during your career search.

**...BUT IT IS STILL IMPORTANT**

Often, physicians leave a practice because their income expectations were different from what they ended up making. This situation is often made worse by complex compensation formulas, overhead costs, and partnership costs in some practice environments in our health care system.

**THE TOOL EVERY PHYSICIAN SHOULD USE**

Financial modeling, in the finance world, is the process of creating a summary of a company’s or project’s expenses and earnings in the form of a spreadsheet that can be used to calculate the impact of a future event or decision. Executives frequently use these tools to guide decisions and estimate stock prices, relying on the current value of future cash flows. Despite these seemingly complex uses, the financial modeling process is relatively straightforward and may be of value to physicians—executives of a sort for their own careers—in their job decision-making.

At its core, financial modeling employs a simple sensitivity analysis, similar to those used by professional analysts, to financially simulate various “what if” scenarios. The purpose of financial modeling is to simplify complex compensation arrangements typically seen in physician employment and identify large discrepancies in compensation or risk to the doctor early in the job search process.

Microsoft Excel, or a similar spreadsheet program, is a great tool to create a financial model. You create a row in the spreadsheet for each job opportunity, with columns for each financial factor (salary, range of likely productivity bonuses, reimbursement for continuing education, etc.) in each year of employment.

Be sure to include a partnership buy-in amount in the year that will happen, and consider that a negative income number, as you may use cash flow from that year (or over a few years) for the buy-in. Ideally, when compared to a nonpartnership employed position, the cost of the buy-in will be more than made up over future years through higher income and practice profitability.

Another significant buy-in/early/pay-off-later scenario to model might be ancillaries, such as practice real estate, surgery center, or other related opportunity. It is important to include these in the model if such opportunities exist. These ancillaries are often very profitable and can make a significant difference in overall compensation for the physician.

**SECONDARY FINANCIAL FACTORS**

**Taxes**

Do not ignore state and local taxes. State income tax rates vary widely.
across the United States, from 0% in Florida, Nevada, Texas, New Hampshire, and others, up to 13% in California, and more than 12% in New York when state and city taxes are combined.

Consider two different ophthalmology positions with identical income prospects in your financial model. One is located in California and the other across the border in Nevada. Given the difference in state taxes, the bottom-line difference for the physician could be in the six figures—every year! Compounded with even a conservative growth rate, this would mean millions of dollars of difference over a career.

**Benefit Plans**

As we describe in our books, proper use of benefit plans can be a significant factor in reaching long-term financial and retirement goals. By benefit plans we mean primarily qualified retirement plans and nonqualified plans, topics that go beyond the scope of this article.

All potential jobs are not equal in terms of the quantity and quality of the benefit plans offered to the physicians. Moreover, the long-term financial benefit of such plans can be extremely significant, allowing the doctor who has access to superior plans a more comfortable or earlier retirement. Physicians looking at different jobs should examine and understand the benefit plans that each position offers and attempt to quantify the long-term value of each.

**TAKEAWAYS**

Searching for a job, whether as a young or experienced physician, is one of the most stressful times in a career. Although financial aspects should never be the most important factor in choosing a position, too often doctors poorly understand their compensation expectations before signing, and this can lead to discontent later.

Financial modeling is an effective tool that can help physicians simplify the complex compensation arrangements often seen in physician contracts. Layering in an analysis of secondary financial elements, such as local taxes and available benefit plans, is worth the time and effort.

**SPECIAL OFFER:** To receive free print copies or e-book downloads of *Wealth Planning for the Modern Physician* or *Wealth Management Made Simple*, text RETINA to 47177, or visit [www.ojm-bookstore.com](http://www.ojm-bookstore.com) and enter promotional code RETINA at checkout.

**Disclosure:**

OJM Group, LLC (“OJM”), is an SEC registered investment adviser with its principal place of business in the State of Ohio. SEC registration does not constitute an endorsement of OJM by the SEC nor does it indicate that OJM has attained a particular level of skill or ability. OJM and its representatives are in compliance with the current notice filing and registration requirements imposed upon registered investment advisers by those states in which OJM maintains clients. OJM may only transact business in those states in which it is registered or qualifies for an exemption or exclusion from registration requirements. For information pertaining to the registration status of OJM, please contact OJM or refer to the Investment Adviser Public Disclosure website at [www.adviserinfo.sec.gov](http://www.adviserinfo.sec.gov).

For additional information about OJM, including fees and services, send for our disclosure brochure as set forth on Form ADV using the contact information herein. Please read the disclosure statement carefully before you invest or send money.

This article contains general information that is not suitable for everyone. The information contained herein should not be construed as personalized legal or tax advice. There is no guarantee that the views and opinions expressed in this article will be appropriate for your particular circumstances. Tax law changes frequently; accordingly, information presented herein is subject to change without notice. You should seek professional tax and legal advice before implementing any strategy discussed herein.

David Mandell, JD, MBA, is an attorney and author of more than a dozen books for doctors, including *Wealth Planning for the Modern Physician*. He is a partner in the wealth management firm OJM Group ([www.ojmgroup.com](http://www.ojmgroup.com)).

**David Mandell, JD, MBA**

- Partner, OJM Group, Cincinnati
- david@ojmgroup.com
- Financial disclosure: Employee (OJM Group)

**Jason O’Dell, MS, CWM**

- Partner, OJM Group, Cincinnati
- odell@ojmgroup.com
- Financial disclosure: Employee (OJM Group)
STARTING A NOT-FOR-PROFIT RESOURCE FOR STUDENTS

How EyeGuru.org was born.

AN INTERVIEW WITH DAVID Xu, MD

Retina Today Business Matters: How did you come to found EyeGuru.org?

David Xu, MD: In 2016, I cofounded EyeGuru.org with Benjamin Lin, MD, and Shawn Lin, MD, MBA. Ben was a medical student at UCLA at the time, and Shawn and I were second-year ophthalmology residents at UCLA. We all came up with a similar idea around the same time, and after some collaboration we founded EyeGuru.

RTBM: What is EyeGuru?

Dr. Xu: The chief mission of EyeGuru is to facilitate efficient learning for ophthalmology residents. We do that with learning tools such as spaced repetition learning, flashcards, and video tutorials. EyeGuru tries to fill in the blanks left by other ophthalmology resources. We don’t limit ourselves to any one subspecialty. We’re for all of ophthalmology.

RTBM: What need did you see in the field to start the company?

Dr. Xu: My cofounders and I noticed that ophthalmology has one of the steepest learning curves of any field of medicine, and we wanted to assist future ophthalmologists in their training. We knew firsthand the volume and variety of obligations that ophthalmologists-in-training juggle, and we thought we’d try to help. We were residents, not content experts, when we founded the site, but we knew best what a resident needed to know at every stage. This has given us an edge in creating useful and relevant content.

RTBM: Not-for-profits enter a marketplace in the same way a for-profit entity does. What was that experience like?

Dr. Xu: We knew we wanted to create a resource for trainees. This wasn’t a vanity project. It was a mission-driven organization. We carefully analyzed the other players in the space, thought about what unique offering we brought to the table, and built our website around our novelty. Focusing on the core of our product offerings allowed us to build a strong foundation.

RTBM: You mentioned that you and your cofounders all had the same approximate idea at the same time. What did EyeGuru look like in its earliest formation?

Dr. Xu: The original iterations of what eventually became EyeGuru were “virtual clinics.” During those early phases, we realized that pattern recognition was so important to learning and practicing ophthalmology. We realized that having a library of images, rather than a single image, was important for learning diseases. Finally, we realized that creating frameworks of understanding were incredibly important for a new learner.

My colleagues and I loved flashcard-based learning because it allowed us to digest and repeat knowledge at our own pace rather than a textbook’s pace. We knew that we wanted to make a resource that helped users learn in a similar way. Doing so meant that we could learn anywhere—at home, on our cell phones, at a workstation at the hospital. EyeGuru was specifically optimized for mobile devices so our users could access it from their phones. We wanted to make sure that no matter where you were, you were getting the same content.
ENTREPRENUERSHIP

14 RETINA TODAY BUSINESS MATTERS | VOL. 3, NO. 3

**RTBM:** Describe how the organization has grown since its founding in 2016.

**Dr. Xu:** We’ve grown substantially. When we first started, hardly anyone knew about us. Now, our estimates indicate that between 50% and 75% of incoming ophthalmology residents in the United States use EyeGuru. We have more than 1,000 page views per week.

**RTBM:** How do you add content to the site?

**Dr. Xu:** We’ve added a lot. EyeGuru has five arenas that users can access: essential residency articles, imaging practice modules, flashcards, video tutorials, and a blog on periodical content. We’ve collaborated with faculty mentors at UCLA, where my cofounders and I conceived of this idea. We’ve also collaborated with the Retina Vitreous Group in Los Angeles and have expanded our international collaborations with Aravind Eye Hospital in India.

**RTBM:** Creating a company that runs for profit is one thing. Creating a not-for-profit entity is another. At what point did you and your cofounders decide to take a not-for-profit route?

**Dr. Xu:** We knew we wanted to be a not-for-profit resource from the moment we started. We make that as clear as possible on the website—we say that it’s 100% free on the homepage’s banner. To stay true to that spirit, we collaborate with trainees for content creation. They help us identify knowledge gaps, and they allow EyeGuru to provide comprehensive and efficient learning.

**RTBM:** Even not-for-profit businesses have operating costs. Is EyeGuru generating income?

**Dr. Xu:** We are committed to the not-for-profit model, so our collaborations with industry exist only insofar as they enhance the educational experience for our users. Some industry members such as Alcon have been open to providing educational grants. Others, such as Volk, have provided sample lenses so that our team can review them.

The chance to review lenses illustrates what makes EyeGuru unique. We know that ophthalmic lens

ARE YOU A TRAINEE SWIMMING IN ALPHABET SOUP?

The deluge of acronyms trainees encounter can be overwhelming. Why not consult a database that easily organizes them in a single place?

The OE Acronyms App is the latest free resource from OphthalmicEdge, a 501(c)(3) non-profit organization dedicated to providing resources to doctors, students, and patients. Download the app from the Apple App Store or Google Play.

For more info, visit OEAcronyms.com.
selection stresses some residents, and there is little guidance on how to select the lens that’s right for you. Our article reviewing lenses is one of our most highly read pieces. I’ve had many users comment to me about that article in particular. When a resident tells you, “Thank for helping me figure out which lenses to buy when I started residency,” you know that you’re doing a good job.

**RTBM:** What elements of EyeGuru became more important than you anticipated?

*Dr. Xu:* Search engine optimization was a key element to our success, as was improved user navigation. Those technical aspects play a crucial role in keeping a website functioning.

Beyond the technical side, reaching out to new residents is important. We’ve improved our process for doing so in the past few years. Our biggest push for new users aligns with the academic calendar—when the summer rolls around, it’s our time to inform new residents of this resource.

We don’t have a large budget—or any budget, really—for marketing. We rely on word-of-mouth. Over time, this has built a community-style resource with an intimate sense of learning. Encouraging dialogue on the site has helped, too. Access to certain elements of EyeGuru require signing up for a free membership. We ask that list of members to refer other trainees who may find the resource useful.

**RTBM:** Sometimes you nail it the first time. Which early successes of EyeGuru have had staying power?

*Dr. Xu:* We’re very proud of our “essentials” series of articles (Figure). We focused on what ophthalmology residents need to learn in day 1, in week 1, in month 1, etc. Rather than provide basic knowledge, these articles provide a framework of understanding your new role as ophthalmology resident. The traffic numbers for that series shows us that residents continue to find it useful.

**RTBM:** What is next for EyeGuru?

*Dr. Xu:* My cofounders and I are transitioning away from content creation and more toward an oversight role. Now that we are no longer trainees, we connect our contributors to collaborators and mentors. It’s been a really rewarding role. We hope to continue to grow the site.

Remember, when we started, we had just a dozen or so articles. Now, we have a full-fledged community of trainees who seek to better each other’s residency experience.

---

**DAVID XU, MD**

- Retina Surgeon, Mid Atlantic Retina, Philadelphia
- davidxu64@gmail.com
- Financial disclosure: Cofounder (EyeGuru.org)
As your trusted partner in ophthalmic surgery, Bausch + Lomb Surgical is committed to expanding our portfolio of products to offer you innovative and efficient solutions for your practice. That’s why we choose to invest in cutting-edge technology such as the Bi-Blade® cutter to support our groundbreaking vitrectomy platform, the Stellaris Elite®. Experience the difference of dual-port vitrectomy for yourself. Available in 23ga, 25ga and 27ga for your convenience.

Schedule a demo at bauschretina.com

*Compared to traditional single-port cutters in BSS.