DIGITAL
Guidelines for the Collaborative Management of Persons with Age-Related Macular Degeneration by Health- and Eye-Care Professionals
Background

Age-related macular degeneration (AMD) is the most common cause of severe visual impairment in adults in the developed world. Statistics released by the CNIB report that AMD now represents more than 50% of new referrals to their organization.\(^1\) Considered in light of the growing incidence and prevalence of this disease and an aging population, AMD poses a major public health challenge.

As its name suggests, AMD is an age-related degenerative disease affecting approximately 1.5% of Canadians by age 40 years, rising to affect a full 25% of society by age 75. It begins with the development of drusen, yellowish deposits of waste material within the macula. This gradually progresses with advancing age and may result in the loss of central (detail) vision. Such progression ultimately affects a person’s ability to read, drive, and perform many other activities of daily living.\(^2\) AMD is typically divided into two forms:

1. Non-exudative or dry AMD, which affects approximately 85% of patients with AMD, but typically progresses slowly and causes less visual impairment.

2. Exudative or wet AMD affects approximately 15% of patients with AMD, but is responsible for greater visual impairment that can occur within weeks or months of development.

The Age-Related Eye Disease Study (AREDS) defined four categories of AMD, summarized as follows:\(^3\):

### AMD Classification as per AREDS

<table>
<thead>
<tr>
<th>AREDS category 1 – no AMD</th>
</tr>
</thead>
<tbody>
<tr>
<td>AREDS category 2 – early AMD: small and intermediate drusen, little or no pigment epithelial abnormalities, generally normal central visual acuity</td>
</tr>
<tr>
<td>AREDS category 3 – intermediate AMD: extensive intermediate drusen or ≥1 large drusen, geographic atrophy (GA) not involving the center of the macula</td>
</tr>
<tr>
<td>AREDS category 4 – advanced AMD: neovascular (wet) AMD or GA involving the center of the macula, visual acuity is usually affected, may have one or more zones of well-defined retinal pigment epithelium atrophy, drusen and other pigmentary abnormalities surrounding atrophic areas, choroidal neovascularization (CNV), serous and/or hemorrhagic detachment of the retinal pigment epithelium (RPED), disciform scarring</td>
</tr>
</tbody>
</table>
AMD has been clearly shown to have a strong genetic component. This confers higher risk upon individuals with first-degree relatives who have AMD. Several genotypes have been detected that result in a significantly higher risk for the development of late-stage dry and wet AMD. In addition, several studies have shown a clear relation between smoking and the progression of AMD to the exudative form.

In the Beaver Dam Eye Study, approximately 22% of patients with advanced wet or dry AMD in one eye developed advanced wet or dry AMD in the fellow eye within five years, while in the Age-Related Eye Disease Study, subjects with advanced AMD in one eye or vision loss due to non-advanced AMD in one eye had a 43% probability of progressing to advanced AMD in the fellow eye at five years. The AREDS data also indicate that the probability of intermediate AMD progressing to advanced AMD is approximately 18% within five years.

Although visual loss from dry AMD cannot be prevented at this time, clear evidence for the benefits of early detection and intervention exists. AREDs showed a modest but statistically significant benefit (20–25% risk reduction) to patients with intermediate AMD in one or both eyes who received high daily doses of supplements containing a combination of antioxidant vitamins and minerals (see Appendix 1A). In doing so, this landmark study provided the foundation for early intervention.

AREDS2 examined the benefit of omega-3 fatty acid supplementation, the effect of lutein and zeaxanthin, and the impact of reducing zinc in the original AREDS formulation. Results of this study were comparable to the original study, showing that no additional benefit was realized in adding lutein and zeaxanthin or omega-3 fatty acids to the original formulation, but that lutein and zeaxanthin could be substituted for beta carotene (which may increase the risk of lung cancer in smokers or recent ex-smokers), with no loss of effectiveness. Effects (and side effects) of low- and high-dose zinc were similar (see Appendix 1B).

Extrapolating even a modest treatment effect in a disease as common as AMD provides significant public health benefit. That being said, these treatment benefits can only be attributed to supplements identical to the AREDS or AREDS2 formulations taken at the appropriate dosages, and caution must be exercised with accruing benefit to any other (even comparable) formulations and/or dosages. Practitioners should be aware that some controversy has recently arisen around AREDS/AREDs2 supplementation and the role of tailoring treatment on the basis of individual genetic profiles. Staying abreast of the current literature is of critical importance to ensure excellence in patient care.

Although no cure for wet AMD currently exists, several studies clearly demonstrate that visual loss from wet AMD is best prevented through early detection and intervention. These interventions include the use of thermal laser, photodynamic therapy (PDT) with verteporfin, and intravitreal injections with agents currently including ranibizumab, bevacizumab, and aflibercept. As the population ages and the demand for AMD screening, intervention, post-intervention monitoring, and intra- and post-intervention visual rehabilitation grows exponentially, eye care providers will face growing challenges in the management and coordination of care for patients with AMD. The delivery of eye care must provide cost-effective and efficient use of resources to minimize preventable vision loss.

Even after optimum treatment, the associated vision loss in moderate and advanced AMD leads to disability (inability to undertake desired tasks because of vision) and impacts on quality of life. Visual impairment is associated with increased risk to the individual in six main categories (National Coalition for Vision Health, 2011):
i. Functional decline (e.g., activities of daily living, driving, reading, walking)

ii. Dependency (e.g., nursing home placement, long-term care admission, being a burden on family members and caregivers, loss of employment, loss of privacy, decreased income)

iii. Injury and accidents (e.g., falls and fractures, driving accidents, pedestrian injuries)

iv. Social isolation (e.g., reduced social participation, social withdrawal, loneliness) and emotional distress (e.g., depression, grief, anger, diminished sense of control)

v. Increased morbidity (lower quality of life, increased suicide rates, increased risk of mortality, increase of comorbidities)

vi. Increased risk to others and society (public health burden, burden on family)

Vision rehabilitation reduces the disability, thereby striving to ameliorate these broad impacts. It involves a functional assessment, followed by interventions that may include low- and high-technology devices for magnification, tints, environmental modifications, training to optimize the use of eccentric vision (after central vision loss), non-optical devices for daily living skills, orientation and mobility training, counselling, and support. The aim is to enhance remaining visual function, help the patient meet their individual goals, increase independence, and optimize safety.

GOAL

The goal of these guidelines is to coordinate the services of primary health care providers, optometrists, and ophthalmologists in the management of patients with AMD, thereby ensuring the most efficient use of these professionals in the interest of patient safety, quality of care, accessibility, and cost-effectiveness.

MANAGEMENT OF AMD

Management of patients with AMD should be consistent with generally accepted protocol. The following criteria should be considered:

(A) NO AMD BUT POSITIVE FAMILY HISTORY

Generally, patients at risk for but without AMD should be monitored by their optometrist or ophthalmologist as part of a comprehensive ocular examination at intervals, consistent with current guidelines, and with specific attention paid to best-corrected visual acuity and stereoscopic examination of the retina. To date, no evidence exists suggesting benefit to early intervention with AREDS or AREDS2 supplementation. Smoking cessation is to be encouraged.

(B) EARLY DRY AMD

Patients at this stage merit disease-specific monitoring by an optometrist or ophthalmologist at least every 12 months (as described above). Patients should specifically be counselled on the merits of smoking cessation, monocular use of an Amsler grid, and specific signs and symptoms of concern that may herald the development of wet AMD. To date, no evidence exists suggesting benefit to early intervention with AREDS or AREDS2 supplementation. As soon as vision loss causes visual disability, vision rehabilitation should be initiated. Visual disability is typically found when visual acuity falls below 6/12.

(C) MODERATE TO SEVERE DRY AMD

These patients have more extensive and/or larger macular drusen, often associated with changes in the RPE, and therefore represent a higher risk for progression to visual loss from advanced dry AMD (geographic atrophy, GA) or wet AMD. Patients with this level of disease should initiate, and be encouraged to continue daily use of, ocular vitamin supplementation as per AREDS/AREDS2. Regular monitoring at least every 6 to 12 months by an optometrist or ophthalmologist (as described above) is suggested. In some cases, particularly if visual changes
have occurred, ancillary testing (including but not limited to optical coherence tomography [OCT] and fundus autofluorescence [FAF]) may be considered to further assess risk of progression to wet AMD. Vigilant self-monitoring for visual changes suggestive of the development of wet AMD should be emphasized at each visit. At this and more advanced levels, vision loss is present and the eye care professional should provide vision rehabilitation or refer to other eye care professionals who do provide this service.

**D) SUSPECTED OR ESTABLISHED WET AMD**

In a patient with moderate or severe dry AMD, development of any of the following necessitates immediate referral to an ophthalmologist or retinal specialist for further evaluation and possible treatment:

1. Subretinal or intraretinal fluid evident on OCT
2. New onset macular blood
3. New onset central or paracentral visual loss or distortion

Therapy may involve thermal laser for small extra-foveal lesions, albeit rarely, but usually involves intravitreal injection of anti-vascular endothelial growth factor (anti-VEGF) agents. Photodynamic therapy or combination therapy is sometimes used in recalcitrant disease. Immediate implementation of anti-VEGF therapy has been shown to limit the occurrence of moderate visual loss in 95% of patients and may provide improvement of visual acuity in 30% of cases. Benefit of treatment is sustained only through regular monitoring and retreatment through the remainder of the patient’s life, imposing a significant burden on patients and providers.

Several anti-VEGF agents have been employed in the treatment of AMD, including pegaptanib, ranibizumab, bevacizumab, and aflibercept. The largest body of randomized clinical trial (RCT) evidence surrounds the use of monthly ranibizumab; however, aflibercept has been shown to be non-inferior when used every two months. The Comparison of AMD Treatment Trials (CATT) demonstrated that the off-label use of bevacizumab monthly is non-inferior to monthly ranibizumab; however, this equivalence was not shown for as-needed (PRN) dosing. Whether monthly use accelerates the development of GA remains to be seen. As the evidence evolves, treatment paradigms will continue to change. Please see Appendix 3 for the current Retina Quality-Based Procedures recommendations for the use of anti-VEGF injections.

**ROLES**

**PRIMARY HEALTH CARE PROVIDER**

Primary health care providers (PCPs, including family physicians and nurse practitioners) should make every effort to ensure all patients aged over 60 years obtain a yearly eye examination from an optometrist or ophthalmologist, allowing a risk assessment of both AMD and glaucoma, a silent and similarly blinding eye condition that increases in prevalence with advancing age. PCPs should be knowledgeable about AMD and its common symptoms, including sudden-onset blurred central vision, central visual loss, and/or distortion of vision that may signify the progression of dry AMD to wet AMD. **PCPs must recognize the urgency of referring patients who present with any of these symptoms for an immediate ocular examination.** Delay in the diagnosis and treatment of wet AMD often results in significant and permanent visual loss and must be avoided. Patients should be counselled on the benefits of smoking cessation and maintaining a healthy diet.

It is important to note that OHIP insures patients of any age if they have a medical condition that their PCP or eye-care provider identifies as needing regular monitoring, such as AMD.
Optometrists should assess patients at risk of developing AMD with a dilated fundus examination at least annually for any clinical manifestations of the disease. In patients with several intermediate-sized drusen or extensive small drusen, the negligible risk of developing advanced AMD (1.3%) does not justify preventative treatment. Optometrists should provide counselling to patients within higher risk categories on the benefits of AREDS/AREDS2 supplementation and to all patients with dry AMD on the benefit of smoking cessation and maintaining a healthy diet. The importance of home monitoring with regular monocular use of an Amsler grid should be emphasized (see Appendix 2). Patients should be made aware of symptoms for which they should seek additional care and reassessment.

The optometrist may monitor patients with dry AMD on an annual or semi-annual basis, as long as visual acuities remain stable and dilated fundus examination does not suggest the presence of wet AMD. Supplementary evaluation with OCT might be considered for patients within higher risk categories when wet AMD is suspected. In cases where wet AMD is strongly suspected or confirmed, optometrists should promptly refer the patient to a general ophthalmologist or retinal specialist. The referral should include a clear and concise report outlining the nature of their concern and the urgency for evaluation by the ophthalmologist. The referral should be copied to the PCP.

Ophthalmologists are responsible for assessing and (if necessary) treating AMD to prevent, minimize, stabilize, and/or restore vision loss. Following the clinical evaluation of suspect patients, determination of the need for supplementary evaluation with OCT and/or intravenous fluorescein angiography (IVFA) will be made. If necessary, these procedures should be provided in a timely fashion. Subsequent to any evaluation of patients with suspected wet AMD, a report to the optometrist and PCP should be provided, outlining clinical findings, treatment decisions, and follow-up plans to ensure continuity and coordination of care.

Both ophthalmologists and optometrists have a responsibility to recognize, assess, and either provide low vision rehabilitation themselves or refer to a colleague or low vision clinic where that intervention is available. All professionals share the common role of ensuring their patients are educated on AMD in general and on their specific clinical situation, including low vision rehabilitation when appropriate.

Coordination of health care resources is essential in the care and treatment of patients at risk for the ocular complications of AMD. Annual or semi-annual optometric or ophthalmologic assessment of patients will identify those with or at risk for AMD and allow for the implementation of individual home screening and AREDS/AREDS2 supplementation. Early re-evaluation on detection of signs and/or symptoms allows for intervention and treatment through appropriate and timely referral for ophthalmologic care. Such coordinated effort will assist in preserving quality vision for patients with AMD. Mutually agreed upon inter-professional guidelines and generally accepted management and referral criteria will ensure appropriate coordination of care and the most effective use of health professional resources.
APPENDIX 1.  AREDS AND AREDS2 SUPPLEMENTATION

(A) The daily doses of antioxidants and zinc used in AREDS are as follows:

- **Beta carotene:** 15 mg (25,000 I.U.)
- **Vitamin C:** 500 mg
- **Vitamin E:** 400 I.U.
- **Copper:** 2 mg
- **Zinc oxide:** 80 mg

(B) The daily doses of antioxidants, fatty acids, and zinc used in the complex AREDS2 randomization are as follows:

- **Lutein + zeaxanthin:** 10 mg + 2 mg
- **EPA + DHA:** 650 mg + 350 mg
- **Vitamin C:** 500 mg
- **Vitamin E:** 400 I.U.
- **Copper:** 2 mg
- **Zinc oxide:** 80 mg or 25 mg

The levels of antioxidants and zinc used in AREDS/AREDS2 are much higher than what is found in standard daily multivitamins and are not achievable with diet alone. Studies have suggested, however, that diets higher in green, leafy vegetables (which are rich in antioxidants and carotenoids) reduce the risk of developing AMD.\(^i\)\(^i\)

AREDS/AREDS2 preparations are to be taken concurrently with any multivitamins already being used, as they do not provide a balanced supplementation. Care must be taken to ensure these combinations do not exceed the recommended maximum doses of carotenoids and zinc. The family physician should be made aware of their concurrent use; potentially serious interactions can develop when they are combined with some medications, particularly anticoagulants.

Caution must be exercised in using preparations containing beta carotene in patients with a history of smoking, due to an increased risk of developing lung cancer.\(^i\)\(^i\) Smoking cessation should be strongly recommended to all individuals, as the magnitude of risk reduction achieved with smoking cessation far exceeds that from other preventative measures, including antioxidant supplementation. AREDS2 results suggest that lutein and zeaxanthin may be considered appropriate substitutes for beta carotene in all populations, but should be mandatory in the cohort with a history of smoking.

Practitioners should be aware of some recent controversy around AREDS/AREDS2 supplementation and the role of tailoring treatment on the basis of individual genetic profiles.\(^i\)\(^i\) Staying abreast of the current literature is of critical importance to ensure excellence in patient care.
APPENDIX 2.  AMSLER GRID
Guidelines for the Collaborative Management of Persons with Age-Related Macular Degeneration by Health- and Eye-Care Professionals

APPENDIX 3. RETINA QUALITY-BASED PROCEDURES RECOMMENDED APPROACH FOR INTRAOCULAR INJECTION OF VEGF INHIBITORS FOR WET AMD

Patients with wet AMD have been shown in multiple randomized controlled trials to benefit visually from treatment with intraocular injections of VEGF inhibitors. Approximately 90% of treated patients stabilize vision and 30% will show significant visual improvement. Untreated patients usually go on to lose vision that limits their independence and quality of life.

As patients with disease in one eye have greater than a 50% risk of developing the disease in their other eye within 2 to 5 years, preservation of vision in the first eye is important, as it is not possible to predict which eye will ultimately retain better vision.

Regular follow-up and specialized diagnostic testing (OCT and sometimes IVFA) are required on an ongoing basis to detect recurrence. Data from several well-conducted studies show that, when vision worsens during treatment due to an undetected recurrence, it is unlikely to return to the previous level, despite reintroduction of therapy. Recurrences occur throughout the patient’s lifetime and have the potential to cause vision loss.

Because of this ongoing need for close monitoring and treatment, treatment of this disease imposes considerable burden on patients and their families, as well as on the health care system. It is important that patients who have the greatest potential to benefit are treated rapidly, yet it is also important to modify or discontinue treatment if it is not producing the expected response.

RECOMMENDED APPROACH FOR INTRAOCULAR INJECTION OF VEGF INHIBITORS FOR WET AMD

The practices outlined below are recommended as the best way to ensure that patients with wet AMD receive the best care. These recommendations encourage re-evaluation of treatment that is failing to achieve the desired endpoint, so as to reduce the burden of potentially unnecessary or inappropriate treatment on patients, their families, and the health care system.

GUIDELINES FOR INITIATION OF THERAPY

For patients undergoing treatment of wet AMD, and in order to receive treatment for wet AMD, the following criteria should apply:

- Aged over 50 years;
- Recent onset of decreased vision or distortion of vision;
- Presence of drusen;
- Presence of subretinal haemorrhage associated with retinal thickening; and/or
- OCT evidence of intraretinal fluid and/or subretinal fluid (but not solely pigment epithelial detachment [PED]), along with subretinal changes consistent with wet AMD;
- Absence of other pathology to explain visual change;
- Absence of medical or ocular contraindications to intraocular injection;
- Absence of ocular or systemic pathology that would negate the possibility of vision benefit with treatment;
- Patient agrees to return for regular follow-up at intervals as frequently as monthly and potentially for life if treatment is successful.
Some patients may not meet the criteria listed above for wet AMD treatment, but might still benefit from treatment. Obtaining an OCT, and often an IVFA, is necessary to confirm the diagnosis in this circumstance. Once a firm diagnosis of wet AMD is established, the conduct of therapy will otherwise continue as below.

GUIDELINES FOR CONDUCT OF THERAPY

• Treatment will normally be initiated with a series of three monthly injections of a VEGF inhibitor, with a formal evaluation of treatment effect occurring at the third or fourth month.
  
  o To continue in this treatment pathway, patients should demonstrate significant reduction (or absence) of intraretinal fluid or significant reduction (or absence) of subretinal fluid, haemorrhage, or retinal thickening. Patients who do not demonstrate these changes should be carefully assessed to determine the reason (incorrect diagnosis, inactive disease with findings mimicking activity, disease unresponsive to treating agent).

  o If none of these apply, a review by a retinal subspecialist (or a colleague experienced in the management of wet AMD if access to a retinal specialist is limited by geography) should occur and a mutually agreed upon treatment plan established.

  o Where geography limits access to specialist care, this review may also be conducted through teleophthalmology if available.

• Beyond this point, follow-up and treatment should continue with intervals not usually greater than three months, with vision, intraocular pressure, and a fundus examination documented for each visit.

• In the absence of visible subretinal blood and retinal thickening, an OCT should be obtained at each visit to document the ongoing effectiveness of, and need for, therapy. Increase in intraretinal or subretinal fluid or development of new haemorrhage should prompt a re-evaluation of treatment and frequency.

GUIDELINES FOR DISCONTINUATION OF THERAPY

• Loss of useful vision secondary to irreversible structural change

• Development of ocular or systemic disease precluding intraocular injection

• Inability to maintain regular follow-up

• Patient desire to discontinue treatment

NOTES


Assessment of HMC Service Quality


corporate report


Le rôle de l’optométriste dans une approche multidisciplinaire de réadaptation pour la clientèle aînée atteinte d’hémianopsie homonyme : un cas clinique

V. Moore, OD  
R. Dufour, OD, M.Sc.  
A. Mailhot, M.Sc.  
M. Carignan, M.Sc.

Résumé

L’hémianopsie homonyme se définit comme une perte congruente d’une moitié du champ visuel affectant les deux yeux. Elle est attribuable à une lésion cérébrale post-chiasmaticque. Cette analyse de cas unique montre que l’utilisation de différentes aides optiques (lentilles de Peli, lunettes de lecture et loupes) et l’entraînement au balayage visuel permettent d’améliorer grandement l’autonomie et la qualité de vie d’un usager ayant une hémianopsie. Par souci d’efficience, la réadaptation fonctionnelle des défauts de champs visuels chez les aînés aurait avantage à se faire au sein d’une équipe multidisciplinaire qui inclut un optométriste.

Abstract

Homonymous hemianopia is defined as a congruent loss of half of the field of view in both eyes and is caused by a post-chiasmatic cerebral lesion. This single case report shows that the use of different optical aids (Peli lenses, reading glasses and magnifiers) in combination with a visual scanning training, can improve the autonomy and quality of life of a user suffering from hemianopia. The functional rehabilitation of visual fields defects in the elderly population may be more efficiently managed by a multidisciplinary team that includes an optometrist.
Le rôle de l’optométriste dans une approche multidisciplinaire de réadaptation pour la clientèle aînée atteinte d’héminopsie homonyme : un cas clinique
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Peak performances at the American Academy of Optometry in Denver, CO

Kristine Dalton, OD, MCOptom, PhD, FAAO, FBCLA
AAO Faculty-Student Liaison for Waterloo

Etty Bitton, OD, MSc, FAAO, FBCLA
AAO Faculty-Student Liaison for Montreal and Committee Chair

The annual American Academy of Optometry (AAO) meeting had another record-breaking year in Denver this past November. A total of 6,323 attendees made this meeting the largest on record, despite the sub-zero temperatures and biting winds. Among the attendees were 218 Canadian optometrists and 71 students, residents, and librarians from both Canadian schools. Overall student attendance hit a record high this year, with 995 optometry students attending in total. The faculty and students from the two Canadian schools were once again very involved in the meeting, presenting posters, research talks, and CE lectures and being honoured with awards.

In just its third year, the student fellowship program offered by the AAO had a record number of students register (559) and complete the program (419). The student fellowship program offers first-time students the chance to collect points by attending different aspects of the conference program, including courses, papers, posters, symposiums, award ceremonies, and business meetings, as well as by volunteering. By attending these events, students have an opportunity to see what the AAO is all about. Fifteen students from the École d’optométrie, Université de Montréal, obtained student fellowship this year, so please congratulate them on this accomplishment when you see them wearing their lapel pin in clinic!

In addition to the annual student-networking luncheon, where students can receive information on residencies and graduate programs, the AAO held a students-only session in the exhibit hall. During this two-hour session, students had exclusive access to exhibitors and were encouraged to visit many booths by participating in an exhibit-hall treasure hunt. All students who completed the treasure hunt received an entry into a draw for a Zenlens™ scleral trial lens set, generously donated by Alden Optical. The students who participated enjoyed the individual attention they received from the industry representatives; it was a great opportunity for the students to jumpstart their networking.
**GRADUATE STUDENTS**

The AAO has always opened its arms to graduate students by providing them with the opportunity to present their work as posters or short research talks and by providing travel fellowships that make it possible for them to attend the meeting. This year there were eight graduate students from the School of Optometry and Vision Science at the University of Waterloo who presented posters and papers at the AAO, two of whom were supported by travel fellowships of $750 (Ali Almustanyir and William Ngo). A summary of optometry and graduate student presentations are presented in Table 1.

William Ngo, OD, a PhD candidate from Waterloo, was awarded the American Academy of Optometry Ezell Fellowship at this year’s meeting. Ezell fellowships are the flagship program of the American Optometric Foundation; they’re designed to encourage students who are enrolled in a full-time program of study and training in vision-related research that leads to a Master’s or PhD degree to pursue full-time careers in optometric research and education. Fellowships are awarded based on students’ research experience, scientific publication record, academic achievement, professional accomplishments, and recognition from mentors. Please join us in congratulating Dr. Ngo on the award.

<table>
<thead>
<tr>
<th>Author (s)</th>
<th>Presentation Title</th>
<th>Type</th>
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<tbody>
<tr>
<td>Almustanyir AH*, Hovis JK (graduate student, Waterloo)</td>
<td>Comparison of a prototype ColorDx and printed pseudoisochromatic color vision tests.</td>
<td>Poster</td>
</tr>
<tr>
<td>Babaei Omali N, Subbaraman L, Heynen M, Thangavelu M, Dare E, Canavan K, Fadli Z, Jones L (post-doctorate, Waterloo)</td>
<td>Protein deposition on senofilcon A contact lenses in symptomatic and asymptomatic lens wearers.</td>
<td>Poster</td>
</tr>
<tr>
<td>Boucher J, Roy E, Quesnel NM, Glasson C (optometry student, Montreal)</td>
<td>Does the freezing of disposable contact lenses affect their power and water content or the visual acuity or comfort of patients wearing those lenses?</td>
<td>Poster</td>
</tr>
<tr>
<td>Guilbert C, Phillie MP, Marinier JA (optometry student, Montreal)</td>
<td>Central scotomas detection with the Octopus-900 perimeter and the Amsler Grid in low vision.</td>
<td>Poster</td>
</tr>
<tr>
<td>Haines L, Sorbara L (graduate student, Waterloo)</td>
<td>Complications related to mini-scleral contact lens wear: case series.</td>
<td>Poster</td>
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<tr>
<td>Hui, A, Jones, LW (graduate student, Waterloo)</td>
<td>Uptake and release of myopia control drugs from commercial contact lenses.</td>
<td>Paper</td>
</tr>
<tr>
<td>Leger S, Lacroix Z, Bitton E (optometry student, Montreal)</td>
<td>Conjunctivochalasis: the other reason for dry eye.</td>
<td>Poster</td>
</tr>
<tr>
<td>Perugino C, Bitton E (optometry student, Montreal)</td>
<td>Demographics of a dry eye clinic.</td>
<td>Poster</td>
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*Supported by an AAO Student Travel Fellowship*
RESIDENTS

Each year the AAO hosts a dedicated residents’ day, where optometry residents from across Canada and the US have the opportunity to present posters and talks based on cases they have seen in clinic and to participate in a resident-practitioner networking luncheon, as well as unique education seminars exclusively designed for them. A highlight of this year’s meeting was the special residents education event, Clinical Problem Solving and the Study of Diagnostic Expertise, by Gurpreet Dhaliwal, MD, Professor of Medicine at the University of California, San Francisco. The event focused on the current understanding of how clinicians arrive at diagnoses and strategies that could be used to improve this vital skill. In addition to a lecture, students had the opportunity to participate in breakout groups to put their new knowledge into practice solving eye-specific cases in an evidence-based manner.

This year was a great year for Canadian optometry residents, with five of them attending the meeting and four presenting posters (Table 2). Chelsea Bray from the School of Optometry and Vision Science, University of Waterloo, was also the recipient of a Cornea, Contact Lens, and Refractive Technologies Resident Travel Fellowship, which helped her attend and present at the meeting.

Figure 1. American Academy of Optometry Ezell Fellow William Ngo (third from left) surrounded by former Ezell Fellows from Waterloo (from left to right: Lakshman Subbaraman, Kristine Dalton, Alex Hui, Vidyapria Sreenivasan, and Sruthi Srinivasan).
Table 2. Residents’ presentations at the AAO, Denver 2014

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<thead>
<tr>
<th>Author(s)</th>
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<tbody>
<tr>
<td>Arthurs M, Canuto T, Marinier JA (Montreal)</td>
<td>Visual rehabilitation for the achromatic patient: challenges and solutions.</td>
<td>Poster</td>
</tr>
<tr>
<td>Bray C, Yeung D, Haines L, Sorbara L (Waterloo)</td>
<td>Case report: management of keratoconic patient with neovascularization due to low Dk lens wear.</td>
<td>Poster</td>
</tr>
<tr>
<td>Mailanson-Tremblay S, Tremblay J, Michaud L (Montreal)</td>
<td>Comparative study of two strategies to reduce contact-lens-related eye dryness.</td>
<td>Poster</td>
</tr>
<tr>
<td>Pham MT, Marcotte R, Bitton E (Montreal)</td>
<td>Volume of tears in the inferior gaze: Schirmer versus the cotton thread test.</td>
<td>Poster</td>
</tr>
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</table>

OPTOMETRISTS

Every year, the AAO continues to grow and offer an increasing number of opportunities for attendees to participate in and obtain continuing education (CE) credit. This year the meeting included nearly 300 hours of CE courses in addition to company-sponsored breakfast courses to highlight new products, topic-specific symposia hosted by various optometry special interest groups (SIGs), clinical workshops and leadership programs, and a robust scientific program consisting of oral presentations (paper sessions) and poster sessions presenting the latest in research and/or clinical case reports that could be attended by all. Nearly all of these events offer CE credits to optometrists.

FELLOW OF THE AAO (FAAO)

Every year at the annual meeting, clinicians and researchers can sit for their oral examination to become a Fellow of the AAO (FAAO). Candidates who have successfully completed the registration process and submitted the required body of written work are invited for a peer-review interview process, which is held annually at the meeting. Candidates who successfully complete this last step (the interview) obtain their fellowship and are inducted at the annual Fellowship Banquet. This year 242 new Fellows were inducted, including 15 Canadians (Table 3). Among the Canadians were four from the École d’optométrie, Université de Montréal (Drs. Marie-Eve Corbeil, Anne-Josée Gauthier, Elise Kramer [presently in Florida], and Rim Maklouf [presently in Florida]), and five from the School of Optometry and Vision Science, University of Waterloo (Drs. Alex Hui, Alison Leung [presently in British Columbia], Christina E. Morettin [presently faculty at Illinois College of Optometry], Annie Valerie Micucci [presently in Ontario] and Averi Van Dam [presently in Manitoba]).

Table 3. New Canadian Fellows

<table>
<thead>
<tr>
<th>New Fellow</th>
<th>Alma Mater</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jim P Ng Cheong Tin, OD</td>
<td>Pacific College of Optometry</td>
</tr>
<tr>
<td>Marie-Eve Corbeil, OD, Msc</td>
<td>École d’optométrie, Université de Montréal</td>
</tr>
<tr>
<td>Anne-Josée Gauthier, OD</td>
<td>École d’optométrie, Université de Montréal</td>
</tr>
<tr>
<td>George Hanna, OD</td>
<td>Nova Southeastern University College of Optometry</td>
</tr>
<tr>
<td>Alex Hui, OD, PhD</td>
<td>University of Waterloo</td>
</tr>
<tr>
<td>Elise Kramer, OD</td>
<td>École d’optométrie, Université de Montréal</td>
</tr>
<tr>
<td>Andrea N Lasby, OD</td>
<td>Northeastern State University Oklahoma College of Optometry</td>
</tr>
<tr>
<td>Alison Leung, BSc, OD</td>
<td>University of Waterloo</td>
</tr>
<tr>
<td>Rim Maklouf, OD</td>
<td>École d’optométrie, Université de Montréal</td>
</tr>
<tr>
<td>Annie Valerie Micucci, OD</td>
<td>University of Waterloo</td>
</tr>
<tr>
<td>Christina E Morettin, OD</td>
<td>University of Waterloo, Illinois College of Optometry</td>
</tr>
<tr>
<td>Sunni Raman Patel, PhD, BSc (Hons Optometry)</td>
<td>Aston University</td>
</tr>
<tr>
<td>Annie Valerie Micucci, OD</td>
<td>University of Waterloo</td>
</tr>
<tr>
<td>Averi Van Dam, OD</td>
<td>University of Waterloo</td>
</tr>
<tr>
<td>David A Wilkinson, OD</td>
<td>Illinois College of Optometry</td>
</tr>
</tbody>
</table>
**Figure 2.** New Fellow Alex Hui, OD, PhD, University of Waterloo, proudly displaying his new Fellow yellow ribbon.

**Figure 3.** New Fellows (from left to right) Drs. Elise Kramer, Marie-Eve Corbeil, Anne-Josée Gauthier, École d’optométrie, Université de Montréal, proudly displaying their Fellowship certificates at the Fellowship Banquet.
MAINTENANCE OF FELLOWSHIP

Since 2010, the AAO has introduced a new resolution for fellowship maintenance. To encourage new FAAOs to remain active and continue to be at the forefront of information, a maintenance of fellowship (MOF) program was initiated. The MOF includes elements such as attendance to the annual meeting, presentation of a paper or poster, giving a course, publication of an article in a peer-reviewed journal, and more. Each of these elements offers one point towards the 15 points that are required every 10 years. Practitioners and researchers who have obtained their FAAO prior to 2010 do not need to participate in this program; however, all Fellows can track their MOF status on the AAO website under “My MOF” and submit their contributions directly to their profile.

FACULTY

Once again, the faculties from both Canadian schools were very involved in the annual meeting, making impressive contributions in leadership roles within the AAO as CE course presenters, clinical and basic vision science paper and poster presenters, and award recipients. A summary of the presentations from each school is included in Tables 4 and 5.

Table 4. Presentations by faculty from the École d’optométrie, Université de Montréal

<table>
<thead>
<tr>
<th>Author (s)</th>
<th>Presentation Title</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bitton E.</td>
<td>Yellow, green or red: understanding ocular staining.</td>
<td>CE lecture</td>
</tr>
<tr>
<td>Gresset J, Marinier JA.</td>
<td>Cost and demographic trends in visual rehabilitation services in the province of Quebec, Canada, over a 12-year period (1999–2010).</td>
<td>Poster</td>
</tr>
<tr>
<td>Michaud L, Brazeau D.</td>
<td>Understanding the basic and not-so-basic essential tips in fitting scleral lenses.</td>
<td>CE lecture</td>
</tr>
<tr>
<td>Selvin G, Downie L, Hinel E, Michaud L</td>
<td>Ellerbrook presents: grand rounds II.</td>
<td>CE lecture</td>
</tr>
<tr>
<td>Wittich W, Johnson A, Overbury O.</td>
<td>Comparison of reading speed in persons with low vision using CCTV and iPad.</td>
<td>Poster</td>
</tr>
</tbody>
</table>
Table 5. Presentations by faculty from the School of Optometry and Vision Science

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Presentation Title</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dalton K, Hutchings N.</td>
<td>Visual characteristics of precision air pistol and air rifle shooters.</td>
<td>Poster</td>
</tr>
<tr>
<td>Freddo T.</td>
<td>A logical approach to differential diagnosis of peri-orbital lesions.</td>
<td>CE lecture</td>
</tr>
<tr>
<td>Freddo T.</td>
<td>Medical work-up of the Red Eye.</td>
<td>CE lecture</td>
</tr>
<tr>
<td>Hovis JK, Almustanyir AH, Reimer S.</td>
<td>Validity and repeatability of the color vision response time test.</td>
<td>Poster</td>
</tr>
<tr>
<td>Irving EL, Yakobchuk-Stanger C.</td>
<td>Myopia Progression Control (MPC) lens design reverses previously induced myopia in chicks.</td>
<td>Paper</td>
</tr>
<tr>
<td>Jones L.</td>
<td>Soft lenses: so much more than just a piece of plastic.</td>
<td>Glenn Fry Award Lecture</td>
</tr>
<tr>
<td>Lorentz H, McCanna D, Subbaraman L, Jones L, Salapatek A, Soong P.</td>
<td>Changes in cytokine expression for dry-eye and non-dry-eye subjects exposed to a low humidity environmental exposure chamber.</td>
<td>Paper</td>
</tr>
<tr>
<td>Luensmann D, Situ P, Fonn D, Jones L.</td>
<td>Evaluation of the performance of a new silicone hydrogel colour contact lens.</td>
<td>Poster</td>
</tr>
<tr>
<td>Paudel N, Jacobs R, Thompson B, Yu TY, Chakraporty A, Anstice N.</td>
<td>Do age appropriate clinical vision tests at 2 years predict visual outcome at 4.5 years?</td>
<td>Poster</td>
</tr>
<tr>
<td>Richdale K, Sorbara L, and CLAY Study Group.</td>
<td>Contact Lens Assessment in Youth (CLAY): case-control pilot study of patients with symptomatic corneal inflammatory events.</td>
<td>Paper</td>
</tr>
<tr>
<td>Sorbara L and CLAY Study Group.</td>
<td>Multi-center testing of a risk assessment survey for soft contact lens wearers with adverse events.</td>
<td>Paper</td>
</tr>
<tr>
<td>Leat S.</td>
<td>Catching up on falls: vision and falls in older adults and the optometrist's role.</td>
<td>CE lecture</td>
</tr>
</tbody>
</table>
Particular mention this year goes to Dr. Susan Leat and Dr. Sarah MacIver from the University of Waterloo, who had important roles within their respective Special Interest Groups (SIGs) at this year’s annual meeting.

Dr. Leat, now immediate-past chair of the Vision in Aging SIG, was acting chair of this SIG in Denver and was responsible for organizing the Vision in Aging Grand Rounds: Multidisciplinary Health Care and Insights symposium held on Saturday morning. This symposium comprised several speakers discussing the importance of multidisciplinary health care for our patients, challenges that can be encountered implementing this approach, and insightful solutions for working through them. With our aging population and the increasing rate of co-morbidities in individuals, this was a very timely and important symposium to be part of.

Dr. MacIver is a member of the AAO Nutrition SIG and was instrumental in conducting the “Feed your Eyes” study in the exhibit hall this year. The purpose of this study was to investigate the relationship between macular pigment, visual function, and diet. For the study, investigators asked participants to complete a short nutritional habits questionnaire online, in addition to measuring their contrast sensitivity and macular pigment density. The study was a joint effort by the Nutrition SIG and the Fellows Doing Research SIG. The booth was staffed by faculty, students, and residents from Waterloo, as well as by a number of faculty and students from other universities. It was a great success; no doubt the results will be very interesting!

The Fellows Doing Research SIG was created to attract interested Academy Fellows to become involved in active clinical research; they have been conducting annual studies in the exhibit hall at the AAO for the past three years.

Dr. Etty Bitton, in her second year as chair of the Faculty-Student Liaison Committee, welcomed the students at the student fellowship orientation breakfast and students’ networking luncheon and presided over the liaison’s meeting. Direct interaction with faculty and student liaisons from each school allowed for new initiatives to continue improving the student experience prior to and during the annual meeting and for mentorship through the fellowship process.

Contributors to the CE program included Dr. Etty Bitton and Dr. Langis Michaud (Montreal) and Dr. Susan Leat and Dr. Thomas Freddo (Waterloo).
AWARDS AND SPECIAL RECOGNITION

Every year the AAO, the AOF, and industry sponsors offer several student travel awards that partially alleviate the costs involved in attending the annual meeting. These travel awards are often competitive in nature, and some require that the student present at the meeting to be eligible. Industry sponsors and the AOF are to be congratulated in their continued efforts to provide travel grants for optometry students, residents, and graduate students. Award recipients are detailed below.

AOF-VSP/FYi (DOCTORS Student Travel Scholarship)
Zoé Lacroix (Montreal)
Ashala Mah (Waterloo)
Diane Sayah (Montreal)
Diana Trieu (Waterloo)

Essilor Private Practice Student Travel Fellowship
Judy Breskott (Montreal)
Stéphanie Leger (Montreal)
Alan Ng (Waterloo)
Wylie Tan (Waterloo)

Student Travel Fellowship
Ali Almustanyir (Frank W. Weymouth Student Travel Fellowship; Waterloo)

Section on Cornea, Contact Lenses, and Refractive Technologies–Resident Travel Fellowships
Chelsea Bray (Waterloo)

Figure 4. Danne Ventura, director of professional relations, Essilor of America, is flanked by Montreal student travel scholarship recipients Judy Breskott and Stephanie Leger.
In addition to providing students with travel fellowships, the AAO also honours people who have made significant contributions to the profession of optometry. Among this year's distinguished honorees were Dr. Jean-Louis Blanchard (Montreal) and Dr. Lyndon Jones (Waterloo).

Dr. Blanchard received the Section on Cornea, Contact Lenses and Refractive Technologies Founder’s Award for his pioneering, innovation, and dedication leading to the establishment of one of the eminent contact lens manufacturing labs in Canada and North America: Blanchard Laboratories. The Founder's award was established in memory and honour of Academy Fellows who were pioneers in the contact lens industry. Dr. Jean-Louis Blanchard graduated in 1946 from l’École d’optométrie, Université de Montréal, and started a private practice in Sherbrooke, Quebec. He quickly became interested in contact lenses as an option for optical correction, exploring scleral lenses and PMMA lenses, and later became one of the first practitioners to introduce soft lenses in Quebec. His interest in contact lens design motivated him to sell his practice and open VERACon lab in 1963 to produce contact lenses. The company grew to become Blanchard Laboratories in 1986, which remains the premier gas permeable and specialty lab in central and eastern Canada. Four decades later, Blanchard Laboratories has become a leader in specialty contact lenses. Dr. Jean-Louis Blanchard leaves a legacy we can be proud of.

Figure 5. Dr. Jean-Louis Blanchard accepting the Founder’s Award from the Section on Cornea, Contact Lenses & Refractive Technologies at the annual meeting in Denver, CO.
Dr. Jones (Waterloo) received the Glenn A. Fry Lecture Award, sponsored by the American Optometric Foundation (AOF). The award is given annually to a distinguished scientist or clinician scientist in recognition of the quality, significance, impact, and relevance to optometry of their current research contributions. Dr. Jones’ lecture on innovations in contact lenses highlighted a significant number of major developments in contact lens use over the past two decades and provided an exciting glance into the future of the industry. As director of the Center for Contact Lens Research (CCLR), Dr. Jones and his team of dedicated researchers and graduate students continue to push the boundaries of contact lens care, developing innovative new materials and furthering our understanding of how contact lenses interact with the human eye.

We heartily congratulate both honorees for their prestigious awards!

Dr. Kristine Dalton (Waterloo) was the recipient of two Beta Sigma Kappa Research Fellowships awarded this year at the AOF celebration luncheon. These fellowships are sponsored by the Beta Sigma Kappa International Optometric Honor Society and the AOF and benefit individuals early in their career whose academic curiosity has them asking professional questions covering a wide area of vision science, clinical practice, or eye-related public health. Congratulations on this achievement!
THE LOST FACULTIES

Attendees of the AAO in Denver were treated to the final performance of The Lost Faculties (Waterloo) at the Australia Party on Friday night. Faculty members at the School of Optometry & Vision Science, University of Waterloo, founded the band in 2000 for the annual student skit night competition. This year they said their final goodbyes to a fabulous crowd in Denver and will be remembered fondly. Thank you for 14 amazing years of music and entertainment and good luck to you all!

Figure 7. The “Lost Faculties” play for the last time at the famous Australian party of the AAO.

Next year’s meeting is scheduled for October 7–10, 2015, in New Orleans, Louisiana. Mark your calendar now so that we can set new records in the home of Mardi Gras!
“My practice had an unique opportunity to do an independent trial of three recently released OCT models from three major suppliers. At the end of this process, we chose the Topcon Maestro because of its space-saving compact instrument design, enhanced diagnostic tools, powerful software, usability, spot-on measurement of optic nerve and macula in one scan, and outstanding image quality.”

Dr. Joseph Chan, Optometrist at Queensway Optometric Centre and former president of the Vision Institute of Canada as well as the Ontario Association of Optometrists.

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- Anterior segment OCT
- Space saving compact instrument design with rotating monitor

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Pauline Blachford consults optometrists on how to reduce unbooked appointments, increase eyewear sales, and improve employee productivity. She has abundant experience in the eye health industry, including 17 years at White Rock Optometry in B.C. Pauline frequently presents at optometry conferences and is a regular columnist for the CJO. For more information, visit paulineblachford.com.

Summer is a wonderful season for optometrists. It’s a time to take that much-needed vacation, to rest-up, spend time with your family, and enjoy the fruits of your hard work.

One of the greatest things about owning a practice is that your business can continue to heat up, even while you cool down poolside, icy drink in hand. All it takes is a little bit of foresight and planning.

In anticipation of my favourite season, here are four recommendations I give my clients to ensure they maximize their revenue potential and improve their business practices, all while they and their staff take time for fun in the sun.

1. Strategic Telephone Recalling

Over two decades in the eye health field, I have found that summer can be one of the busiest times of year. This contradicts the wide-held belief that summer is inherently slow because our clients are on holiday.

The key to maximizing bookings during the summer is strategic telephone recalling. If your clinic does not already have a rigorous telephone recalling strategy, read my article, Take Action to Ensure Client Loyalty.

Strategic telephone recalling is when your “recaller” phones clients based on a particular characteristic in each client’s profile—not just because the client is the next person on your list who is due for an exam.

In preparing for the summer, I coach recallers to target their senior citizen clients when booking appointments for June. This is when young families are busy with exams, class parties, graduations, the works. Things settle down during the summer, and that’s when I coach my recallers to reach out to families. It goes something like this:

“Hi Mrs. Smith; it’s Suzie from Brooksfeld Optometry. I’m calling to book Jimmy and Ashley for their yearly eye health exam. I thought it would be good to book them in July, when they’re not busy with school. You’re also due for an exam . . . ”

This type of recalling will keep your practice busy right through the summer. And the children you serve this summer will be the adolescents and adults you service in years to come.
2. Hire A Locum
Maximizing your revenue means maintaining momentum and continuing to operate your business, even when you are on vacation. Doing this requires having an optometrist on staff to carry your workload forward. Hiring a locum generates revenue in the short term, while providing the long-term benefits that come from offering your clients the continuous care they deserve.2

I always tell my clients, if it takes more than five to seven days for your patients—especially your new patients—to get an appointment, then you’re doing a favour to the optometrist down the street.

Our CAO president, Dr. Geneau, has worked as a locum and hired locums himself. He says he only hires locums he is sure will provide high-quality service to his patients. He asks optometrists he went to school with to fill in for him or to recommend someone trustworthy.3

3. Cross-Train Your Staff
Having a cross-trained staff brings big benefits to your business all year round. Research shows that when each of your employees knows the roles, responsibilities, and duties of her colleagues, it helps to provide quality control2, pleases patients, promotes teamwork, generates greater employee buy-in, and boosts morale.4

If you still expect your practice will slow down come summer, use this extra time to cross-train your staff. This will give you experienced substitutes when employees take vacation. It will also serve the practice when an employee falls ill or takes parental leave. Cross-trained staff provides affordable options for mitigating the impact of labour shortages.5

Implementing an effective cross-training program, however, requires a plan.6

Start by having your staff identify the skills they hold as a team. This talent inventory will highlight team strengths and hidden skills, while illuminating areas where a staff shortage could result in operational challenges.

From there, establish job-training sessions that focus on the areas where your practice could grow or improve. These can range from hiring a skilled expert to coach certain members of your team to having your employees take turns shadowing one another.

4. Catch-Up and Improve
If your practice does experience some downtime in the summer, another way to stay productive is by completing the chores that have piled-up over the year4.

Begin by asking your staff to compile a list. Start now, while your practice is busy; that's when uncompleted chores and inefficiencies are most glaring.

Items on the list may include catching up on telephone recalling; updating your website; calling patients who have not picked up their contact lenses; sorting and re-ordering contact lens samples; purging your inventory of expired products; shipping back returned items; cleaning; scanning paper files into your computer system, or catching up on other filing.7

Leading up to the summer, have each employee sign up to complete one or two of the chores on the list. To motivate your staff, talk to them about how much better it will be once these tasks are complete. Have them decide how the team will celebrate at the end of the summer, if everyone completes their chores.
Summer brings just as many opportunities for your practice to shine as it does occasions for great holidays. Vacation time and staff shortages don’t have to burn your bottom line. Strategic telephone recalling and a trusted locum can make this summer your most profitable yet. And if your business does see some downtime, make productive and profitable use of it to enhance your employees’ skill sets, and knock off piled-up chores so your practice can hit the ground running in the fall.

REFERENCES

2. Here are some other suggestions for hiring a locum: Clarke, P. Locum finding tips 2002;38(38):37,39.
La plus belle saison

Pauline Blachford consulte les optométristes sur la façon de réduire les rendez-vous non pris, d’accroître les ventes d’articles de lunetterie et d’augmenter la productivité des employés. Elle a acquis une vaste expérience dans l’industrie de la santé oculaire, dont 17 ans pour White Rock Optometry en Colombie-Britannique. Pauline donne fréquemment des conférences sur l’optométrie et elle est une chroniqueuse régulière de la RCO. Pour de plus amples renseignements, consultez le paulineblachford.com.

L’été est une saison merveilleuse pour les optométristes : ils peuvent prendre enfin des vacances, se reposer, consacrer du temps à leur famille et recueillir les fruits de leur dur labeur. L’un des principaux avantages d’avoir sa propre entreprise, c’est que les affaires peuvent continuer à rouler, même pendant qu’on relaxe au bord de la piscine avec une boisson glacée; il faut simplement faire preuve d’un peu de prévoyance et de planification. Pour que mes clients et leurs employés puissent profiter au maximum de l’été – ma saison préférée – tout en maximisant leurs revenus potentiels et en améliorant leurs méthodes de travail, je leur adresse quatre recommandations.

1. Faire des rappels stratégiques

Depuis une vingtaine d’années que je travaille en santé oculaire, j’ai eu l’occasion de me rendre compte que l’été pouvait être une période très occupée, même si on croit souvent que les affaires ralentissent parce que les clients sont en vacances. Pour remplir au maximum votre carnet de rendez-vous pendant l’été, il faut faire des rappels téléphoniques. Si votre clinique ne s’est pas déjà donné une stratégie rigoureuse de rappels téléphoniques, lisez mon article Take Action to Ensure Client Loyalty.

Pour agir de façon stratégique, il faut rappeler chaque client en fonction de ses caractéristiques particulières – pas seulement parce qu’il est le suivant sur la liste. Lorsque l’été approche, j’explique aux employés qu’ils doivent cibler les personnes âgées pour les rendez-vous du mois de juin, car à cette période, les jeunes familles sont très occupées par les examens et les fêtes de fin d’année, les bals de finissants, etc. C’est pendant l’été, lorsque les choses se sont calmées, qu’il faut tenter de joindre ces familles, avec un message comme celui-ci : « Bonjour Mme Tremblay, c’est Suzie, chez Optométrie Caron. Je vous appelle pour fixer un rendez-vous pour l’examen annuel de Philippe et Geneviève. Ce serait peut-être une bonne idée de les voir en juillet, puisqu’ils n’ont pas d’école. Je vous rappelle que vous avez aussi besoin d’un examen de la vue... »

Ce type de rappel vous assurera des rendez-vous tout l’été, et les enfants que vous soignerez cette saison deviendront des adolescents, puis des adultes qui reviendront vous consulter pendant des années.
2. Embaucher un remplaçant

Pour maximiser vos revenus, il faut garder le rythme et continuer à faire fonctionner votre entreprise, même lorsque vous êtes en vacances; pour cela, il faut qu’un autre optométriste se charge de vos dossiers en votre absence. L'embauche d'un remplaçant génère des revenus à court terme, et le fait d'offrir à vos clients une continuité de service vous apportera des avantages à long terme. Comme je le dis à mes clients, si un patient – surtout un nouveau patient – doit attendre plus de cinq à sept jours pour avoir un rendez-vous, il ira voir un autre optométriste.

Le président de l'Association canadienne des optométristes, le Dr Geneau, a lui même travaillé comme remplaçant, et il en a embauché. Il dit n'embaucher que des remplaçants qui fourniront un service de haute qualité à ses patients; il confie sa clientèle à des collègues avec qui il a fait ses études, ou demande à ces derniers de lui recommander quelqu'un de fiable.

3. Avoir un personnel polyvalent

Avoir un personnel polyvalent est un avantage pour votre entreprise tout au long de l'année. Les recherches montrent que lorsque chaque employé connaît le rôle, les responsabilités et les tâches de ses collègues, le contrôle de la qualité s'améliore, tout comme la satisfaction des patients, l'esprit d'équipe, la motivation des employés et leur moral. Si vous vous attendez à ce que les affaires ralentissent pendant l'été, utilisez le temps ainsi libéré pour accroître la polyvalence de votre personnel. Les employés qui prennent des vacances, des congés de maladie ou des congés parentaux pourront ainsi être remplacés par des collègues expérimentés. La polyvalence du personnel permet de trouver une solution abordable lorsqu’un employé s'absente.

Pour améliorer efficacement la polyvalence de votre personnel, il faut avoir un plan.

Commencez par demander à vos employés de faire une liste des compétences qu’ils ont en tant qu’équipe; cet inventaire mettra en lumière les forces et les talents de l’équipe, tout en soulignant les secteurs où un manque de personnel pourrait entraîner des problèmes.

À partir de là, prévoyez des séances de formation pratique axées sur les secteurs qui pourraient être améliorés; il peut s’agir d'embaucher un expert pour encadrer certains membres de l'équipe, ou de demander aux employés de suivre, chacun leur tour, un collègue dans ses tâches quotidiennes.

4. Rattraper les retards et s’améliorer

Si votre entreprise ralentit pendant l’été, vous pouvez rester productif en réalisant les tâches qui se sont accumulées pendant l’année. Demandez d'abord à votre personnel d’en dresser une liste et commencez maintenant, pendant que les affaires roulent; c’est à ce moment-là que les lacunes et les tâches laissées en suspens sont les plus évidentes.

On peut inscrire sur la liste les rappels téléphoniques, la mise à jour du site Web, le rappel des patients qui ne sont pas venus chercher leurs verres de contact, le tri et la commande des échantillons de verres de contact, l’élimination des produits expirés, le retour de produits, le nettoyage, la numérisation des dossiers papier ou d'autres tâches de classement.

Demandez à chaque employé de se charger d'une ou deux tâches d'ici l’été. Pour les motiver, rappelez-leur à quel point ce sera agréable lorsque ce sera fini, et laissez-les décider comment célébrer en équipe à la fin de l’été si tout le monde a fini ses tâches.

L’été, tout en apportant un repos bien mérité, est pour votre entreprise une occasion de briller. Les vacances et les absences n’auront pas nécessairement des effets désastreux; grâce à des rappels téléphoniques stratégiques et à un remplaçant fiable, cet été pourrait être le plus profitable de votre histoire. Et si les affaires ralentissent vraiment, profitez de ce temps libre de façon productive en améliorant les compétences de vos employés et en vous débarrassant des tâches laissées en suspens afin d'avoir une entreprise en pleine forme pour l'automne.
REFERENCES

1. Comment faire le lien avec l’article Take Action to Ensure Client Loyalty?
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