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As 2013 comes to an end, it’s an ideal time to identify areas in need of improvement in both your practice and your personal life. This issue of Ophthalmology Business addresses some of those areas and provides solutions so that you can start 2014 off on the right foot.

Speaking to an employee about unacceptable behavior is never easy, but it must be done so that the problem doesn’t get worse. “Confronting problem employees” (p. 14) presents a stepwise approach to dealing with this behavior when you notice the first signs of trouble. Or perhaps the issue is between yourself and one specific employee. “Healing a broken relationship at work” (p. 25) offers six tips on mending connections.

If you determine that an area in need of improvement in your practice is dealing with unhappy patients, you will want to read “Communication key with unhappy patients” (p. 23). This article describes how body language, tone of voice, vocal speed, and posture can help maintain good communication with patients.

Perhaps you are hoping to bring some new employees into your practice in 2014. “Attracting, qualifying, hiring, training, and keeping top talent is one of the most challenging endeavors an ophthalmologist takes on, and, quite often, it is sorely overlooked and mismanaged,” says Mitch Levin, MD, CWPP, CAPP. He presents some key principles in “How to attract and retain top talent” (p. 12).

Finally, if you fear physician burnout, read “The perils of perfection” (p. 20) to learn about the factors that affect it and 10 steps you can take to prevent it.

We hope you find these articles useful. Thank you for reading!

Don Long
Publisher, Ophthalmology Business
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Personal health records give patients a close-up view of medical history

by Vanessa Caceres Contributing Writer
PHRs present opportunities for both patients and ophthalmologists

Imagine this scenario: A new patient with suspected glaucoma comes into your practice from an optometrist referral. The patient comes to the appointment ready with thoughtful questions about glaucoma diagnosis and treatment. You ask the necessary health history questions; the patient has answers for all of them. You ask for names of other doctors the patient sees regularly—the patient has that information as well, and even phone numbers for their offices.

When you diagnose the glaucoma and prescribe specific medications the patient should take daily, the patient tells you that remembering to take the meds won’t be a problem.

Does this scenario sound too good to be true?

It doesn’t have to be. This could be the wave of the future as personal health records (PHRs) become more common.

A PHR—or a personal medical record (PMR), as it’s sometimes called—is a tool someone can use to collect, track, and share information about his/her health—or the health of someone he/she cares for, according to the American Health Information Management Association (AHIMA).

“It’s a tool for consumers as they seek healthcare in any place,” said Julie Wolter, MA, RHIA, FAHIMA, interim director, Program in Health Sciences, Doisy College of Health Sciences, St. Louis University. Medication information, lab work results, history and physical reports, and glasses or contact lens prescriptions are all examples of information that can be kept in a PHR, Ms. Wolter said.

A PHR can be in paper format, perhaps with papers organized neatly in a folder or a three-ring binder. Or it can be in an electronic format via a software program or an app for a smartphone or tablet.

Although a PHR is geared toward a patient’s health history in general and not specific to ophthalmology, there’s plenty of vision-related information that can be included, said Leonard Bielory, MD, previously professor of medicine, Pediatrics, and Ophthalmology, Rutgers University, New Jersey Medical School, Newark.

This might include glasses and contact lens prescriptions, medication use information, visual field results, reminders to take medications, and names of specialists related to eyecare, said Dr. Bielory, who has developed a $1.99 iPad PHR app called Raphael PMR (STARx Technical Corporation).

Patients can also use their PHR to track health information for their own benefit, such as daily calorie counts, daily blood pressure results, and blood sugar measurements, Dr. Bielory said.

Although collecting information for a PHR might sound like a lot of work, some patients may already take small steps toward the data collection, said Ms. Wolter. Pediatricians’ offices typically provide parents with paper or email copies of children’s health information. Other patients may hold on to their medication information sheets or the explanation of benefits they receive from insurance companies, both of which provide pieces to their personal healthcare puzzle, she said.

It’s no coincidence that PHRs are growing in popularity as electronic medical records (EMRs) become a regular part of many physicians’ offices. “All of healthcare is now entering a phase where increased documentation is necessary through EMRs,” Dr. Bielory said. Patients can use their PHRs to track health information much in the same way that an EMR might.

The benefits for eye doctors

PHRs may make life easier for eye doctors by saving time, said Ms. Wolter. Take, for instance, the com-

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PHR resources

My PHR
www.myphr.com
This comprehensive website from AHIMA and the AHIMA Foundation explains what a PHR is and how to create one. There are links on the site for physicians, seniors, parents, caregivers, and the chronically ill.

Raphael Personal Health Record
starxtech.com/starxtech.com/Raphael_Personal_Medical_Record_App_Overview.html
An overview of the PHR mentioned in the article, created by Leonard Bielory, MD.

What Is a Personal Health Record?
www.healthit.gov/providers-professionals/faqs/what-personal-health-record
A federal government resource that explains what a PHR is.
The common question about what medications a patient uses. “A new patient walks in to see the cataract surgeon and is asked what medications she is on. The patient typically might say ‘I don’t know’ or hand over a bag with every medication bottle she has. You’re dealing with an older population that tends to have more medication,” Ms. Wolter said. “With a PHR, [patients] can say ‘I take X, Y, and Z,’ or simply show the doctor a list.” A PHR program may even remind patients to include over-the-counter medications or herbal supplements on their medication list—two areas that patients frequently exclude.

Another scenario might be people who have to get a medication list to their parent’s eye doctor. With an electronic PHR, people can easily send the medication list to that doctor, Dr. Bielory said. Then the doctor can quickly find out if the patient uses drugs that would trigger further cautions or assessments related to eye care.

A patient with a PHR can help ease communication among specialists involved with eye care, such as allergists, rheumatologists, and immunologists, Dr. Bielory said. Patients can share reports or medication prescription copies among the specialists required for their care, instead of practice staff spending time on the phone to track down crucial information.

“People in healthcare want to communicate, but we don’t. So who else can we turn to but the patient?” Ms. Wolter said.

**The benefits for patients**

Of course, a PHR is naturally more geared to benefit patients, even though physicians indirectly benefit from them, said Ms. Wolter.

One patient benefit is that PHRs force patients to take an active role in their healthcare. “If they are an active member of the team, it will help them make the healthcare decisions they need,” she said.

Ms. Wolter told the story of going to a doctor’s visit with her PHR in a three-ring binder that she carried with her. As the doctor started to take notes about her problem, she started to take notes about what he said to her. The doctor asked what she was doing—and was amused but impressed by her diligence.

Having a PHR helps patients to prepare for productive doctors visits, Ms. Wolter added. “Doctors are short on time and as patients, we have to be succinct to get as much out of the visit as possible. With a PHR, patients walk out of the office smiling because they got what they needed and had a great communication with their doctor,” she said.

Results from a focus group of glaucoma patients on what they think of PHRs was published in the August issue of *Ophthalmic & Physiological Optics.* The 71 participants expressed enthusiasm for PHRs, with some favoring electronic records while others preferred a low-tech format. The authors concluded that a patient-centered PHR may serve as both a health record and a self-educational tool for better glaucoma care.

**PHR challenges**

Although the idea of patients proactively collecting their health information in an organized fashion sounds great in theory, it does come with some challenges, Ms. Wolter said.

First, patients have to know what to ask for. They may not know they can ask for copies of lab work or history and physical reports and similar data, she said.

Health literacy plays a role in the data collection as well, both in terms of patients knowing they can ask for their personal health information and for understanding the results, she said. The internet can get in the way of patients accurately understanding medical information.

These challenges create extra work for physicians, who may need to spend more time coaching patients on health information. “When patients are sitting face-to-face with their doctors, the doctors become the front-line educators and may need to say what resources and tools they would like to see patients use,” she said.

Going forward, PHRs have great potential to expand. More electronic PHRs will be developed, and insurance companies or large hospital systems may find ways to link their EHRs with PHRs, said Ms. Wolter. PHRs are even becoming available for pets, both Dr. Bielory and Ms. Wolter said. **OB**

**Reference**


**Editors’ note:** Dr. Bielory is the creator of Raphael PMR. Ms. Wolter has no financial interests related to this article.

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Drawing app offers new way of creating images

by Erin L. Boyle Senior Staff Writer

The ophthalmology version of the drawMD app features interactive visual guides to enhance patient understanding of procedures and diseases.

A new drawing application, drawMD, is providing a seamless, visually enhanced option to ophthalmologists to show and share images with patients in real time.

The app, released in August, adds to 12 other drawMD applications across medical specialties, starting three years ago with urology under a business then called Urologymatch.com. Now expanded to ophthalmology and under a different company name, the drawMD app allows users to illustrate complex ophthalmic procedures and issues and then provide a copy of that image to the patient.

“We wanted to create a tool that was easy for a physician to pick up and use without a whole lot of training, without a whole lot of integration or disruption of current work-
flows,” said John Cox, president, CEO, and co-founder of Visible Health, which now produces the app.

The app, which is free and for the iPad, can be found at the App Store.

“[With the app], it’s very easy to create a customized explanation for your patients,” Mr. Cox said. “It’s about efficiency and creating a personalized experience for the patient and about making the patient feel confident about the surgeon, about the procedure, and about his or her decision-making.”

About the app
The company behind drawMD, Visible Health (Austin, Texas), was founded by two physicians and Mr. Cox in 2012 to expand the company’s reach beyond urology and use technology to “help improve the collaboration between clinicians and their patients.” The drawing app was designed to make the process of a physician explaining a medical procedure to a patient more technologically advanced than pen and paper.

“Historically, a lot of physicians, when getting ready to explain a procedure, will grab the exam table paper, pull it out, and draw out rough sketches—‘Here’s the anatomy, here’s the malignancy, and we come along with the device here and remove this,’” Mr. Cox said.

“Visual paradigms tend to help in explaining medical issues. That was the original impetus.”

Each app, including the new ophthalmic version, is created with the assistance of practicing physicians in that specialty. Physicians determine the top 80% of procedures that typically lead to patient consultations in their specialty. They explain the artwork needed to illustrate those procedures to artists, who then create professional medical artwork for the app.

How it works
The app is simple to use, Mr. Cox said.

“You pick from a handful of templates that are basically different anatomic views. You open that up and on each of the templates, you can customize it by drawing with your finger,” he said.

“You can add text and annotations to it or you can add ‘stamps,’ which are variations. For example, you might have a close-up of the eye, and you might add a stamp that’s a cataract or you might add a stamp that represents a LASIK procedure that alters the image behind it, and you can resize and move everything around.”

Other images can be uploaded to the app and used as starting points for drawings.

The drawing can be created in front of patients in the exam room, so that patients can discuss the procedure or disease displayed in more detail with physicians in real time as they draw it on the iPad.

When the physician is finished, patients can take the image home as a printout or receive it in an email.

“Then the patient has an artifact,” Mr. Cox said.

Feedback
Visible Health is always looking for feedback about the app, Mr. Cox said, and he encourages physicians to offer their thoughts on everything from images to features.

“The basic philosophy behind the app is [it’s] not intended necessarily to be exhaustive,” he said. “We want to put an application out there that’s got a lot of medical artwork in it that supports most of the conversation, but we want our users to help us drive and improve that content.”

By registering within the app, ophthalmologists can provide that feedback, and will have access to additional customized “premium features” when they are released. Those include the ability to add other resources such as documents, videos, and animations.

Another feature will be a secure portal that allows exchange of information with patients without the use of physicians’ email addresses. This way, physicians will never need to use a personal or work email account with patients when sending information.

“We’re really excited about this app,” Mr. Cox said. “We’re really excited about serving the ophthalmology community.”

Editors’ note: Mr. Cox is president, CEO, and co-founder of Visible Health.

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Attracting, qualifying, hiring, training, and keeping top talent is one of the most challenging endeavors an ophthalmologist takes on, and, quite often, it is sorely overlooked and mismanaged. Far too few are aware of the amount of business lost each year due simply to inadequate or poor quality front desk personnel alone. Here are a few key principles to help you stay a leader in your market.

First, ask “why?” What is the purpose for this new position?

Think strategically. You will notice that I describe this as a position, not a person. How will this position make you more money or free your time to pursue more valuable or recreational tasks with confidence?

You should only create and hire for a position if you do not have the
skill required, the time to do the job yourself, or if your time and energy needs to be spent on higher value responsibilities. This position should be created to take away from you “lower value” tasks. It is outsourcing or, as Adam Smith proposed, a “division of labor” (one of three characteristics that describe how an economy functions). Once you have answered the strategic question of “why,” there are other more tactical questions.

Are you profitable (i.e., can you really afford it)? Here is how to calculate this: Take all of your compensation as owner/operator of the practice. Add in the other owner benefits that you deduct through the practice, such as meals, travel, car, and so on.

Then subtract what you would pay someone else to replace your surgeon skills only, while you remain as president and chief executive of the “business or operational department.”

Then subtract what you would have to pay yet another person to fill that role of president and chief executive. Be sure to “gross up” these numbers to include employer taxes and benefits (usually an additional 20%).

The remainder is true profit. (It would be highly unlikely and wonderful for you if your true profit ever exceeds 20%, and most would be happy with 15%).

Are you looking to fill the right position? Many times you would be more profitable and happier if you had lower level positions filled to enable you to be more efficient and effective. Then you do not have to worry about the importance of prior experience, education, or skills as much.

Often the most valuable skills are the intangible ones.
- Personal skills
- Appearance
- Emotional intelligence
- Cultural fit
- Ability and willingness to add to the practice overall

These factors are most critical to your success.

Even if the needed position is another doctor, these intangibles are still most important. How many times have we seen “platinum trained” doctors who could not diagnose or operate with the same exceptional skill you possess?

So look for the correct person to be in that correct position.

Advertising for that person can be done in many forms. Word of mouth is easiest, yet not always the most successful. There are professional journals, social media sites, and “headhunters.”

These points should be in every advertisement:
- A good headline to grab their attention
- A description of the ideal candidate
- A benefit for the intended recipient
- A call to action
- “Must haves”
- “Should haves”
- “Desirables”

Compensation is important, of course, although it is definitely not the most important. It is where you may spend an unnecessary amount of time.

Make the compensation fair, clear, and well defined by roles and goals for increases or bonuses. Most of all, the compensation must work for you. All too often we see too-generous doctors over compensate their staff. This often leads to resentment and ultimately failure at the position.

Once you have identified the person to fill the role, his/her training and education along with providing frequent, specific, meaningful, uplifting, nurturing, and motivational feedback (and often in public) is much more important than compensation.

Any critiques should be in private, be specific, and without emotional overlay. Be certain to comply with all Department of Labor Regulations, as well as our Professional Code of Ethics, and your own personal code. Any violation will put you in jeopardy; it is easier to avoid them and not worth the consequences.

Using these few principles as guidelines can help you attract and retain the right people, for the right positions, because you are assuming and fulfilling the leadership role too often lacking in a thriving ophthalmology practice. Leadership training often is overlooked or undervalued in med school, residency, and even fellowship. I cannot emphasize enough how powerful good leadership training can be. It can change the landscape of your business, increase your profitability, and make you happier doing it.

I know you are busy seeing patients and staying in front of your continuing education, the new rules and regulations, techniques and technologies. You are “in the trenches.”

However, it is your practice, your passion, your livelihood, your license, your money, and your reputation. It is your responsibility to be a good steward of your resources, for which you paid dearly. The best practices have the best leaders—

Dr. Levin is CEO and managing director, Summit Wealth Partners, Orlando, Fla. He can be contacted at MLevin@mysummitwealth.com.

December 2013 • Ophthalmology Business 13
Confronting problem employees

by Ophthalmology Business Staff Writer

Stepwise approach to dealing with problem behavior at work

Whether the problem is simply tardiness or as serious as sexual harassment, confronting an employee about unacceptable behavior is seldom easy. When dealing with such a situation, John Riordan, senior consultant with Cindy Zook Associates, Leesburg, Va., advises that managers first consider what he calls the “20-60-20 model.” The model reminds managers that in any large organization there will be some proportion of employees who are high performers (e.g., 20%), a larger proportion who are potential performers (e.g., 60%), and inevitably some employees who are nonperformers (e.g., 20%).

“It’s simply a bell curve that serves as a check point to [determine if] this is a problem employee as in, ‘I still see potential and I think we can turn this around,’ or this is a problem employee as in, ‘They’re bringing weapons to the work place or using drugs,’” he explained.

Mr. Riordan said it’s an important check point because he’s learned the hard way, having seen people use the wrong approach to solve a problem.

It is important for a manager to pause and consider just how serious the problem is—that is, determining if this is a matter of giving feedback, monitoring performance and encouraging development, or whether it crosses a line, which may require formal discipline, he said.

It’s helpful for managers to have a roadmap so they don’t get into a situation where somebody sneezes and they’re suddenly in a termination process. “Just because someone lost their temper once doesn’t mean you need to terminate them just yet. But you better make a clear choice about how serious it is and therefore which level of engagement you take. If they lost their temper and swore at another employee, that’s pretty serious—maybe they won’t be fired, but you have a spectrum of options,” he said.

First and foremost, all managers need to be thoroughly familiar with the company’s human resource policies so they know where they stand if the employee has done something

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illegal or is violating a clearly stated policy of harassment. Managers need to know the details like what exactly harassment, fraud, and inappropriate behavior mean. They could have a lawsuit on their hands if they treat the problem one way when they should’ve treated it a different way, Mr. Riordan said.

Managers should also proactively build strong relationships with human resource personnel who will be an invaluable resource when problems arise.

Broadly speaking, managers can approach problem employees through three progressive levels, Mr. Riordan said. They are classified as preventative action, informal discipline, and formal discipline.

The idea is to be doing the preventative work that keeps someone from becoming a problem employee and nurturing that person when he/she shows any signs of difficulty, he explained.

“In other words, you don’t want to wait until someone is sick to start running a health program. You’ve got to be proactive, you’ve got to put things in place, you’ve got to do regular training, coaching, and mentoring so that you can maintain the health of the organization and the individuals,” Mr. Riordan said.

Following preventative action, the next level is the informal approach, he said. This would mean moving from things like coaching, training, mentoring, and positive input, to informal discipline, which includes verbal counseling and then written counseling. The approach is stepwise, he said. Verbal counseling is less severe, and that can be anything from a gentle talk to a serious conversation.

Managers should also make sure to document the verbal counseling, Mr. Riordan said. Take note of the date and time of the conversation as well as the points that were discussed. If there is no change of behavior, the next step may be written counseling, he said.

“It’s not a formal letter of reprimand yet, but it is in writing that there are some serious issues to be addressed,” he said.

If informal discipline does not work, the next level up is formal discipline, and that’s a letter of reprimand, any kind of reduction in pay, suspension, or termination. These all occur in escalating levels.

Managers should be aware of competency issues as well, like safety concerns and technical competence.

“You may have a wonderful employee but if he or she keeps violating safety guidelines then that’s a problem,” he said.

Approaching the employee can be difficult, especially for managers who do not like confrontation. Mr. Riordan recommended two helpful tools that can prepare managers for that uncomfortable conversation.

One of the tools is called Crucial Conversations, which is a popular model.

“It is a model that helps develop a stepwise approach to a discussion starting with how do I engage this person? Is it an informal or formal conversation? Do I pop into their office, ask them to come to my office, or take them for a cup of coffee? It’s all about timing, the setting, and privacy—that’s critical,” he said.

The approach also helps managers consider what’s the right conversation to have, what their intent going into the conversation is, what are the facts involved versus feelings, and what are the emotions. It helps them catalogue what exactly needs to happen so that they can prepare to have the right conversation depending on how serious it has to be.

The second model Mr. Riordan likes to use is called SBID from the Center for Creative Leadership, which stands for Situation, Behavior, Impact, and Desired Outcome. It helps set the context for determining the situation at hand, what behavior to focus on, what’s the impact of that behavior that needs to be addressed, and what’s the desired outcome. It could be that a certain behavior should not be repeated or that there be an improvement in a certain area. It’s a formula that helps managers be better prepared to move into the discussion.

One of the key issues Mr. Riordan addressed was the difference between formal and informal action. If it’s a serious situation, then a manager should bring in someone from human resources or another manager, a doctor, or owner as a witness to the conversation. Depending on how serious the situation is, management needs to treat it accordingly.

Mr. Riordan reiterated that managers should address a problem at the level that the issue merits. “You don’t need surgery for a bothersome paper cut, but conversely you don’t want to give someone an aspirin when it’s actually a cancer situation. Good-natured people will often underestimate the potential seriousness of a situation,” he said.

Some people don’t want to make a big deal of it, but once managers see the first signs of a problem, they should treat it so it doesn’t get worse, he said. OB

Editors’ note: Mr. Riordan has no financial interests related to this article.

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As ASC development and management consultants, we are frequently asked to assess the operations of our clients’ surgical centers, to evaluate the current state of the center’s clinical and financial health, as well as identify opportunities for improvement.

While the ideal approach would be an objective third party assessment, your center can benefit from an annual internal evaluation of clinical and financial factors by the staff member responsible for the center’s day-to-day operations, typically the clinical director.

**Clinical factors**

**Interview** key stakeholders in the organization including the members of the governing body, the medical director, and key members of the clinical team. These discussions should be one on one and confidential so honest feedback is obtained.

**Inquire** about their perceptions of the quality of care being delivered, the working environment for the staff and physicians, concerns they may have, and suggestions on how the operations of the center can be improved. The results of these interviews generally influence the scope of the assessment in a number of areas that you may not have previously identified.

**Review** available information from:

- Trade sources that identify or detail specific industry issues or upcoming changes. These organizations should include ASCRS,

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AAO, the Outpatient Ophthalmic Surgery Society, and the ASC Association. If you haven’t previously done so, strongly consider enrolling in these organizations’ ASC-specific listserv forums.

- Agencies that monitor and evaluate changes in regulations, guidelines, and standards promulgated by agencies such as CMS, OSHA and your center’s accrediting body. Ensure that you are up to date with regard to changes effected by HIPAA, the HITECH Act, and other relevant legislation.

Develop a scope for the clinical portion of your assessment, based on the information you have acquired. Concentrate on areas where you think weakness may exist or substantial changes are being mandated.

Over time, the areas of emphasis for regulators may change, but certain key clinical areas remain constantly relevant, including infection control, governance and quality assessment and performance improvement.

Evaluate infection control. For the last couple of years, substantial emphasis has been placed on hand-washing policies and practice, utilization of devices labeled for single use (particularly knives and phaco needles), and items labeled for single patient use, like medications.

- “Secret shop” hand-washing activities by surgeons, anesthesia providers, and clinical staff. Your observations should be documented in writing in the form of a periodic quality assessment study.
- Regulators are increasingly including many staff members in their compliance surveys. They often focus interview questions on how your center handles single use and single patient devices and medications. Your evaluation provides an opportunity to conduct some mock interviews yourself, to prepare staff to answer these questions appropriately.

Evaluate clinical management and operations. Increasingly, the governing body is expected to exercise broad and effective oversight of clinical management and operations. We recommend auditing the performance and documentation of these activities. Documentation of these activities should include a periodic review of:

- Credentialing files, employee files, quality assessment studies, and peer review: Written summaries of these activities should be reported directly to the governing body and documented in regular meeting minutes.
- Quality assessment and performance improvement programs: These programs must be effective, ongoing, data-driven and designed to identify problematic areas, develop remedies, and follow up on remedial actions to determine that they were effective. Take advantage of this opportunity to ensure that your QAPI program and documents fulfill all of these requirements.
- The results of your patient satisfaction survey program: Patient responses shine a light on particularly sensitive issues, e.g., excessive waiting times for a small number of surgeons, personality issues with surgeons or specific staff members, etc. Objective data directly from patients provides the support needed to confront and resolve such matters.

Financial factors

It is easy to become overwhelmed by the myriad factors, both internal and external, that impact the financial health of the center.

Avoid becoming so enmeshed in the data that you begin to suffer “paralysis by analysis.” Focus on these truly critical financial factors that you must develop, compute and compare to benchmarks over time. Begin by capturing and summarizing critical data in a useful, timely, and concise format. Decision-makers can use this data to objectively evaluate your center’s business operations, to identify trends that impact current and future profitability, and to support and enable managerial decision-making.

With the federal Medicare system as the primary payer for most ophthalmic ASCs, long-term success depends on surgical volumes and management of operating expenses.

Evaluate surgical volume. Typically, surgical volumes will be somewhat seasonal, often low in the first calendar quarter and high in the fourth, and an individual ASC’s patterns become apparent over the period of a few years. Track your surgical volumes, both incisional and laser, at least monthly, with close focus on the trends.

A substantial decrease in surgical volume is a major red flag that danger is ahead. Review the volume trends and identify any other single events that have impacted volume adversely or might do so in the future, e.g., the retirement of a major producer. Highlight changes in trends or these material events in your report. With the cooperation of the governing body, develop strategies to cope with these changes.

Evaluate operating expenses. Many of the center’s operating expenses are, for all practical purposes, “fixed” and cannot be controlled in the short run. Examples include the monthly rent, utilities, property taxes, and debt service. Two major categories, however, comprise the bulk of your operating expenses and must be carefully managed. Review:

- Fully burdened labor costs, which include salaries, wages, and other
Surgical supplies expenses include everything from disposable items used to provide surgical care, such as surgical instruments and implants, to drugs and medications. These expenses can significantly impact your center’s ability to control costs.

- **Surgical supplies expenses**, including drugs and medications. Take a look at all disposables, consumables, and implants used to provide surgical care. In well-managed centers, the total of these costs is typically between 25% and 30% of net collections.

- "Pass through" expenses. These are items that generate roughly equivalent revenue and expense and are individually significant. “Pass through” items routinely seen in ophthalmic ASCs are presbyopia-correcting IOLs, toric IOLs, and cornea tissue. The benchmark percentages cited above have been adjusted to exclude these costs and revenues, by netting their costs against the payments received and reducing (or increasing) the net collections by the difference.

Consider a center that does a significant volume of PIOLs at an average cost of roughly $900 per lens. Leaving these costs in the surgical supplies expense total would likely raise the ratio well above the 30% level and lead you to conclude, erroneously, that your supplies costs are out of control.

**Identify and analyze case costs for major procedure by surgeon.**
This can be somewhat time-consuming and isn't routinely performed as a part of the annual assessment. Instead, consider using the information developed during your assessment to identify high-cost surgeons and procedures, then subject them to further analysis at a later date.

**Evaluate accounts receivable.**
The total outstanding accounts receivable should correlate closely with your surgical case volume. Take a hard look at:

- **The level of outstanding accounts.** A larger than normal surgical month will naturally increase the total outstanding, but as most accounts will be current, the increase is nothing to worry about.

- **The age of outstanding accounts.** Most managers already pay close attention to the aging of the accounts receivable. When we evaluate an ASC, we look for the current accounts (aged less than 30 days) to be between 50% and 70% of total receivables. Conversely, we expect the more than 90 day accounts to total less than 20% of the total; closer to 10% would be ideal.

**Anticipate capital purchases and debt obligations.** These obligations will have a claim on cash flow. Analyze the center's ability to handle these needs internally, and if you determine that external financing will be required, include that finding in your report to the governing body.

If you don’t have the time to perform an annual internal assessment ...

Nonetheless, you and the center's governing body need tools to aid in making decisions that impact viability and profitability. At the very least, develop continually update a set of benchmarks, both internal and external, and review them monthly, paying particular attention to their trends. You can always call in an objective third party expert to assess the factors we’ve detailed and identify opportunities for improvement.

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The perils of perfectionism

by Vanessa Caceres Contributing Writer

How physician burnout affects ophthalmology—and what to do to prevent it

Imagine this scenario for your day: It’ll be a full day seeing patients. You’ve got a grant proposal due in two days to review. There’s a new electronic medical records (EMR) system in your office that takes some getting used to. You’ve got some office staff turnover that will require new hiring. On the home front, your teenage children resist efforts to help around the house and do more than a mediocre effort with their homework.

Those responsibilities would be tough on anyone for a day—but if
your jam-packed schedule looks like this on most days, there's a chance you're headed for burnout.

Although we all can have bad days at work, burnout is actually “an erosion of positive enthusiasm,” said John-Henry Pfifferling, PhD, director, Center for Professional Well-Being, Durham, N.C. The center helps healthcare professionals manage burnout. A physician feeling burnout is emotionally exhausted and unable to give more to patients. In turn, the physician feels cynical and even depressed. Dr. Pfifferling said. That depression can come from grieving over the loss of one's original expectations of a medical career—and what today's realities are.

Plus, “there's a lack of sense of personal accomplishment, and that's associated with a desire to leave the job if not leave medicine altogether,” said Mark Linzer, MD, director, Division of General Internal Medicine, Hennepin County Medical Center, Minneapolis, who studies physician burnout.

It's unclear if physician burnout is actually more common nowadays, but there is more recognition of the phenomenon. “It may be more common now because we understand the process, and more people are willing to admit that they feel it,” Dr. Pfifferling said.

A study published last year in the *Archives of Internal Medicine* found that 45.8% of physicians from various specialties reported at least one symptom of burnout. Using a probability-based sample from the general U.S. population, the study investigators found that physicians were more likely to have symptoms of burnout and be dissatisfied with their work-life balance.

The study also found that physicians in specialties on the front lines (like family medicine, general internal medicine, and emergency medicine) were at the greatest risk for burnout.

### Burnout among ophthalmologists

That said, ophthalmologists have their own risk factors for burnout.

A 2008 study from the *Canadian Journal of Ophthalmology* found that more than 35% of ophthalmologists studied in Quebec felt high levels of burnout and psychological distress. Their main stressors were a growth in demand for services, an ophthalmologist shortage, amount of work to be done, budget pressures, and repeated training of new work teams.

To combat the stress effects, the ophthalmologists said they tried to work faster.

Burnout in ophthalmology is of critical concern because of the aging population, which is increasing the demand for eye specialists, the investigators reported.

Another study that focused on burnout among academic chairs in ophthalmology found that 9% of chairs surveyed were considered to have burnout, and 65% of those surveyed overall had scores consistent with low personal achievement, the highest risk factor for burnout. “Because the cost of burnout can be high, both in terms of a chair's psychological well-being and the actual cost associated with replacing a chair, it is important that strategies are put in place to reduce burnout in our academic leaders,” the investigators concluded.

Additionally, ophthalmologists often are perfectionists—making them more vulnerable to burnout, said Dr. Pfifferling. “They have expectations of themselves to be analytical, detail-oriented, and self-critical—and that all has consequences,” Dr. Pfifferling said.

The pressure of perfectionism is felt even more deeply by subspecialists, who often feel they are the beacons of care in their niche area. Dr. Pfifferling has observed that perfectionism can make many ophthalmologists excellent surgeons but that they may not take the time to seek adequate social support from friends and family to fight against stress.

### Other burnout factors

Other factors affecting burnout can be felt by any physician.

A study published in September in the *Journal of American Medical Informatics Association* found that, perhaps to no one's surprise, EMRs are contributing to physician stress—which could lead to more burnout. The study reported that physicians in offices with a moderate amount of EMR use reported greater stress and lower job satisfaction, said lead investigator Stewart Babbott, MD, professor of medicine, and director, Division of General and Geriatric Medicine, University of Kansas Medical Center, Kansas City. Physicians at clinics that use EMRs a large amount were more likely to feel time pressure during patient visits and more dissatisfaction and intent to leave the profession.

“Work is very different now,” said Dr. Linzer, a co-investigator on the EMR study. “There's a lot of time spent at a computer, and the rewarding part of the job with patients has been compromised.” In fact, he said some physicians may only be spending as little as 12% of their time with patients.

Finally, there's the stress of managing a demanding work life with a home life, said Esen K. Akpek, MD, associate professor of ophthalmology and rheumatology, and director, Ocular Surface Diseases and Dry Eye Clinic, Wilmer Eye Institute, Johns Hopkins University, Baltimore. “If you have a grant due next week and 17 surgeries to get through today and two kids at home, then when patients complains that they can't perform warm compresses and lid

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scrubs because they are too busy, it’s hard not to snap,” she said.

Women ophthalmologists are probably even more likely to experience burnout as they usually take the lead role in caring for children and aging parents, said Sandra Yeh, MD, Springfield, Ill. She recently has wrestled with feelings of guilt as she tries to balance the management of a busy practice with caring for children entering their teen years and putting her mother with Alzheimer’s disease in an assisted living facility.

“You especially see young women academics feel burnout due to unrealistic expectations of scholarly activities, caring for children, struggling to make ends meet on an academic salary, and the demand to put in long hours to teach residents and fellows,” Dr. Akpek said. Prior work from Dr. Linzer’s team also shows higher levels of burnout among women physicians overall.

**Preventing burnout**

One important reason to help prevent burnout is to avoid the high cost of turnover—an average of $250,000 for a primary care physician, Dr. Linzer said.

One solution to help prevent burnout is to recognize its symptoms, Dr. Pfifferling said.

Another is letting go of unrealistic expectations. Dr. Pfifferling said it can be helpful for physicians to participate in a retreat where members discuss what they do to handle the often unrealistic pressures that they feel they are under.

Talking to other ophthalmologists about their unique challenges can help, Dr. Pfifferling believes.

Creating an office environment that is collegial and enthusiastic also goes a long way toward preventing burnout, Dr. Pfifferling said. He has even helped to hire family and marriage therapists for physicians at practices to work out their differences and get along better.

A recent article coauthored by Dr. Linzer found 10 key ways to help prevent burnout (see sidebar for the 10 steps). Although the article focused on general internal medicine, Dr. Linzer believes they can apply to ophthalmology as well.

In addition to the tips shared in the sidebar, Dr. Linzer encourages physicians to spend at least 10% of their time doing what they feel most passionate about at work—be it teaching, patient care, or something else. Physicians who do not have that outlet are much more likely to experience burnout, he said.

Dr. Yeh believes that finding a family-friendly hobby and connecting with friends on vacations can help relieve stress and prevent burnout.

“Really though, my greatest source of energy is the happiness of my patients,” Dr. Yeh said. “We are so fortunate to be in such a great field—we touch the blind and make them see. On postop days, I hug my patients, we laugh, and I feel that wave of their gratitude and amazement at a whole new world, which is theirs after a wondrous surgery.”

**References**


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Communication key with unhappy patients

Body language and communication techniques can have major impact on physician/patient interaction

Communication between a physician and patient, at the best of times, can be fraught with complexities ranging from patients not understanding medical terminology to disliking the physician's bedside manner—but those complexities can be even more pronounced in cases of angry patients.

Physicians would do well to arm themselves with ways of improving their overall body language and communication skills, especially in dealing with unhappy cases, experts say.

“Usually the challenges of communication, at least in healthcare, are going to be challenges involving emotionally difficult, emotionally evocative situations, and those situations are usually going to be around painful feelings. [These feelings] involve, for example, a disappointing clinical outcome, having to break bad news, being with a patient who you don’t like,” said John Banja, PhD, Emory University Center for Ethics, Atlanta.

“[What] any healthcare professional needs to keep in mind in these kinds of situations is how important it is to be skillful at sensing and being able to shape the emotional atmosphere of the conversa-

tion,” he said. “That is critical because usually these kinds of communications are not about information. They are largely about feelings.”

Body language is important in helping to convey the feelings of both parties—as is the manner in which a person speaks and listens, among other actions. Body language “conveys a message, and physicians should be sure the message is what they want to convey,” said Doyle Stulting, MD, professor emeritus of ophthalmology, Emory University, Atlanta.

“I think it’s important that we have a relaxed interaction with patients, and we convey to them friendliness and openness without authoritarianism,” said Nick Mamalis, MD, professor of ophthalmology, John A. Moran Eye Center, Department of Ophthalmology & Visual Sciences, University of Utah, Salt Lake City. “Patients already view doctors as an authority figure, and we want to be very careful that we don’t come across as someone who is superior.”

Dealing with angry patients

The physician/patient relationship can break down when patients are unhappy with care. According to information provided by Dr. Banja, angry responses from patients can range from “Do you people really know what you’re doing?” to “Are you licensed?” to “Let me tell you something … ” Patients can target physicians with the worst of their anger about medical outcomes, he said.

Patients want four basic responses from physicians—understanding, respect, curiosity, and vitality, Dr. Banja said.

Patients want to be heard. They want an empathetic response from their physicians. But communication will sometimes fail if patients are
angry about their care, their diagnosis, the results of a surgery, or other issues. These cases pose a possibility of miscommunication, loss of a good working relationship with the patient, or in advanced situations, litigation, Dr. Stulting said, and as a result require a great deal of empathic care.

“Those communications are all about the astute and skillful shaping and maneuvering and choreographing of the emotional atmosphere,” Dr. Banja said.

Physicians need to match their behavior to the situation. For instance, if the situation is serious, the physician should be serious.

People’s natural inclination is often to avoid such situations, Dr. Banja said, but this can worsen the issues.

“It’s very important for health professionals to recognize that, in these unpleasant situations, you will be very tempted ... to make the conversation end as soon as possible,” Dr. Banja said.

However, people who are effective at communicating continue the discussion, even when uncomfortable.

Physicians should put themselves in their patients’ position for a moment, Dr. Banja said, imagining how they feel when angry or disappointed. They should remember how they act in those situations, specifically how their tone of voice changes, how their vocal speed changes, whether they talk more or less, interrupt more or less, and if they become defensive.

“A skillful communicator will always be monitoring his or her communication,” Dr. Banja said.

“The way you’re going to be monitoring it is [to watch] how this is going down on the listener’s end. If the listener interrupts you, you should stop talking immediately. If the listener looks away from you, you should stop talking. If the listener asks you questions, you should respond to those questions.”

Dr. Stulting said when informing patients of medical errors, body language should “convey honesty, apology, desire to avoid similar errors in the future, willingness to rectify error, openness to accept comments from the patient.”

Dr. Mamalis said it is vital for physicians to give patients—especially those that are angry—their undivided attention. They should put the computer, chart, and other apparatus away, and make direct eye contact with patients. This is key in not only communicating well, but also in noticing how the patient is acting.

“You want to be aware of patients’ body language because body language can tell you if they’re having problems, or if they’re angry, or if they’re defensive. You need to look at them to be able to do that,” he said.

More tips

Dr. Stulting, Mamalis, and Banja have additional tips for maintaining good communication with patients:

- Don’t close your body by folding your arms or turning away.
- It is OK to touch the patient’s hands and arm below the elbow, if warranted.
- Facial expressions with the brows, lips, and jaw should show contriteness and empathy.
- Do not furrow the eyebrows, purse the lips, or clench the jaw, which can portray anger and irritation.
- Speak slowly and softly, modulating your tone to the patient’s hearing ability.
- Ask patients if they understand medical information, especially if they have a puzzled expression or appear to have stopped listening.
- Use language and terms that patients can understand.
- Practice empathetic skills regularly.
- Be humble.
- Listen.

- Validate the patient’s response.

If all else fails and the situation is not working for either the patient or physician, Dr. Banja suggested referring the patient to another physician.

Body position

In addition to these tips, body position while speaking with a patient is of vital importance.

“Sit rather than stand, and adjust eye level to slightly lower than that of the patient, so as not to imply superiority,” Dr. Stulting said.

“Lean slightly forward, with shoulders slumped, knees apart, forearms on legs, hands open, expressing attention to the situation and willingness to listen.”

Dr. Mamalis said that when faced with difficult patients, physicians sometimes get defensive and lean back. He recommended that physicians be aware of their posture and how it might impact the patient, and lean forward in more volatile situations.

He sits on a rolling stool, which gives him the opportunity to slide closer to the patient based on the patient’s response and body language.

“You need to sit at the same level as the patient,” Dr. Mamalis said. “A lot of doctors will stand up or they’ll lean against one of the writing surfaces, but it’s important that you’re looking at the patient at the same level, instead of looking down at the patient.”

Editors’ note: The doctors have no financial interests related to this article.

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Healing a broken relationship at work

by Erick Lauber, PhD

Healing a broken relationship

So what can you do about your broken relationship at work? Is there a way to avoid being one of those martyrs who in some weird way seems to enjoy having a broken relationship? Fortunately, there is. But, like a broken leg, it will take some uncomfortable work.

1. Choose to heal. The first thing that must be done is to approach the situation correctly. You have to make a choice: Is this thing going to heal and get better or is it going to be a pain forever? This choice is completely under your control and it really matters which option you choose.

For example, martyrs won’t listen to any advice, even from professionals. They don’t believe the relationship will get any better so they won’t try anything. They stick to complaining as their only “therapy.”

But healers work toward a solution. They try things, they ask for advice. They refuse to accept that the future has to look like the present. They believe.

2. Avoid “compensatory” behaviors or workarounds. For example, those who don’t believe a relationship will get any better start to work around it. These are called “compensatory behaviors” because the person is “compensating” for the deficient limb or process. This can be a problem; first, because it puts extra strain on the other parts of someone’s life. Long-term problems can develop in those relationships that have to bear the extra

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weight. Second, compensating behaviors don’t allow the original broken relationship to fully heal. They simply hide it.

3. Use crutches and other aids temporarily. On the other hand, doctors do prescribe crutches and other aids when damage initially occurs. It is not unreasonable to keep weight off a relationship for a bit while the anger subsides. But importantly, doctors prescribe crutches so you can still function normally—not so you can avoid putting any and all weight on the foot. In real life, we still have to function even with a broken relationship. The proper temporary aids, like having a third coworker present or alerting another doctor to keep things operating smoothly, is allowable—but only temporarily and only in extreme situations.

Other temporary aids might include compliments and extra “thank yous.” Think of these as adding ointments or Icy Hot to a broken leg. They don’t really heal it from the inside, but they do ease the pain and make it more bearable while the real work of healing is being done.

4. Put it up at night. Everyone knows that a doctor will recommend putting a broken leg up at night. This helps it heal and can be thought of as “draining the blood out of it.” The same thing applies to broken relationships—you need to drain the blood out of them occasionally. Many a close friend and spouse have wished a loved one would put a broken relationship out of mind. Stop picking at the wound. If you wish, think of it as allowing your subconscious to work on the problem while your conscious self gets some time off. Either way, put it up at night. It will heal better if you don’t obsess and worry it constantly.

5. Exercise it as soon as you can. Eventually, every broken relationship, like a broken leg, demands exercise and real use. This is the part that most people are afraid of. What if it hurts? What if it doesn’t feel exactly like it did before it was broken?

One piece of advice is to go slow and gentle at first, listening for when you might be pushing too hard and then easing up a little. But every doctor knows waiting too long is a much more common mistake than jumping in too early. Avoiding pain is a built-in characteristic of all humans. But there’s a reason going “outside our comfort zone” is such a common expression in management and business. The difference between success and failure is sometimes just the difference between those who succumb to our natural human tendencies and those who climb above them.

6. The most important ingredient: trust. Did you know that a healed broken bone is often stronger than the original bone? It’s true! The biological processes that stitch bone back together produce stronger bones than the originals. Is that possible with your broken relationship? Actually, it is.

Consider: In our lives, accidents, miscommunications, and misinterpretations happen. Sometimes people will misbehave around us for reasons we could not possibly fathom because we are truly not inside their heads, so bumped and bruised relationships are inevitable.

But fundamentally, people are to some degree a little bit scared and insecure. They are worried other people won’t like them or will somehow “be out to get them.” They are also very worried that they can’t predict what other people will do. Somehow bad things will come their way, unexpectedly.

The best human relationships eliminate these two fears. A good friend is fundamentally (a) someone you know will not purposefully do things that damage you and (b) will act in ways that you can predict. We call this “trust” in our normal, social lives.

Our relationships at work require the same thing. We need to do things to communicate to people that they can trust us—that we won’t “act out” and purposefully hurt them, even when we feel bumped or bruised. We also need to demonstrate that our actions are understandable and normal. They can be predicted, even when we might have a “right” to act out. These two things help people trust us. And a healed relationship is one where there is trust.

Healing a broken relationship at work is perhaps harder than healing a broken leg, but it can be done. The bad news is that all broken relationships will require us to go outside our comfort zone and “put some weight” on the relationship, perhaps while we are still afraid—even when we know it might be painful. But in the end, a healed relationship, perhaps one so healed it is even stronger than before, is better than a broken relationship. **OB**

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