Patient-physician communication: Overcoming barriers for better overall health management
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From the publisher

This issue’s feature article presents several scenarios where communication gaps, language barriers, and misunderstandings impacted patients’ care. “Communication with patients is a non-technical skill that you have to practice and work on if you want to do it well,” Michael Marks, MD, said. Read “Patient-physician communication: Overcoming barriers for better overall health management” to learn about the potential issues and tips for improving communication, such as watching patients’ body language and encouraging patients to bring a family member or professional translator to the appointment.

Are you looking to grow your practice with refractive cataract surgery? If so, you will want to check out “10 tips to grow your refractive cataract practice.” In this article, John Hovanesian, MD, shares helpful advice, such as being clear about price and following up on the outcome. David Hardten, MD, and Kevin Corcoran, COE, offer their insights as well, which include addressing astigmatism during surgery and having a plan for unhappy patients.

With more patients venturing online to choose an eyecare provider or find other ophthalmic information, it is essential for ophthalmic businesses to develop and optimize their online presence. According to Medical Consulting Group, most successful online presences are developed and sustained using four common tactics: building a technically sound website, composing content that patients will actually read, crafting an engaging and aesthetically consistent website design, and coordinating interactive social media and online marketing campaigns. Read “Online and in sight: Building a prominent online presence” to find out more.

Ophthalmology practices can benefit from reaching out to local healthcare entities for insights; they may provide information that can help practices grow or avoid trouble down the road. “Some practices who were deeply concerned about their position in the market have had their fears laid to rest,” John Pinto said. “Other practices that were pushing hard to go in a particular direction learned that would not be a good direction to go in or something would be blocked for them, so it saved them a lot of money in what would have been wasted efforts.”

Mr. Pinto and Mark Kropiewnicki discuss who to talk to and what to ask in “When to talk to local market leaders.”

We hope that you have a chance to relax and enjoy time with family and friends this summer. If you are able to get away, take Ophthalmology Business with you, and if you have an idea for a future article, please contact us. Thank you for reading!

Donald Long
Publisher
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10 tips to grow your refractive cataract practice

by Vanessa Caceres, Contributing Writer

**Provide consistent patient education, get all staff on board with premium technology**

Be ready to commit to refractive cataract surgery if that’s how you want to grow your practice, recommended John Hovanesian, MD, clinical instructor, Jules Stein Eye Institute, University of California, Los Angeles. During the 2017 ASCRS•ASOA Symposium & Congress, Dr. Hovanesian shared pearls on the topic during the session “Secrets of Highly Successful Refractive Cataract Practices.” David Hardten, MD, Minnesota Eye Consultants, Minneapolis, and Kevin Corcoran, COE, CPC, Corcoran Consulting Group, San Bernardino, California, also shared insights. Here are 10 tips from Dr. Hovanesian.

1. **Believe in the technology.** This faith in refractive cataract technology should extend to everyone at the practice, from office staff to surgeons. “Develop enough comfort with the subject to take the hesitation out of your voice,” Dr. Hovanesian said. Spend time discussing refractive cataract options with all patients even if they are not candidates, so they are at least aware of what’s available. There is another important reason to discuss options with all patients, even if they are not candidates: This can help shed light on why their friend or neighbor has amazing vision with the help of a particular IOL, even if your patient doesn’t qualify.

2. **Understand how discussions with patients help identify better vision goals.** The desire for better vision with premium lenses is something that Dr. Hovanesian likens to smartphone use. In other words, everyone lived without smartphones before, but most people would be hard pressed to give up that technology now. Similarly, many people will say that they are satisfied with their vision in glasses and don’t mind wearing them. Still, “we need to educate patients about what’s possible,” he said.

3. **Designate the doctor as the educator about premium technology.** Although physicians may sometimes feel as though they are coming off like a salesperson when they discuss the technology, Dr. Hovanesian reframes this to focus on the physician’s role as an educator. The physician has the most trusted role in a practice, which also means he or she should take the lead in education.

Dr. Hovanesian recommends surgeons become familiar with implanting different types of lenses because no technology is appropriate for all patients. He also suggests that surgeons let patients know there are different types of lenses, but make a recommendation for a specific lens to each patient.

Source: John Hovanesian, MD
4. **Understand the patient’s perspective.** “They assume their vision will stay the same,” Dr. Hovanesian said. A myope will assume they will still be able to see up close, and a hyperope will assume that distance vision is maintained. As you review options, focus on choices that help patients maintain their visual area of strength, to boost patient satisfaction.

5. **Offer more than one type of implant, but focus mainly on the IOL you recommend for them.** Again, this addresses the importance of educating patients about their various options, Dr. Hovanesian said. “You shortchange opportunities if you don’t offer more than one IOL type,” he said. However, you don’t want to overwhelm patients, which is why you should focus the most on the IOL type that is potentially right for the patient.

   Dr. Hovanesian cautioned against using the word *premium*. The term is used a lot with multifocal and accommodating IOLs, but he has seen it as a turn-off for many elderly patients, who tend to say they just want what’s standard. An alternative phrase you could use is *high-tech*.

6. **Keep it simple.** Patients want to know how good the IOL is, how long the crisp vision with the chosen IOL will last, and any downsides. Although educating about options is crucial, bogging them down with details is not.

7. **Be unapologetic about IOL limitations.** “Anticipate sources of dissatisfaction,” Dr. Hovanesian advised. He’ll let patients know that 90% of patients with high-tech technology can pass a driver’s test and read the newspaper without wearing glasses. He also sets the expectation that they may need to use reading glasses from time to time for tasks such as reading a medication bottle. “We don’t have an implant that will make you 21 years old again with perfect vision, a perfect face, and a perfect body,” Dr. Hovanesian tells patients. “Accept that you will need glasses for some things.”

8. **Be clear about price.** Dr. Hovanesian thinks it is the physician who should broach the subject of price with patients because of his or her trustworthy role within the practice. This is what he will typically say to a patient:

   “They assume their vision will stay the same,” Dr. Hovanesian said. A myope will assume they will still be able to see up close, and a hyperope will assume that distance vision is maintained. As you review options, focus on choices that help patients maintain their visual area of strength, to boost patient satisfaction.

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**5 bonus pearls to grow your practice with refractive cataract surgery**

- **Plant the idea of premium technology with a questionnaire about vision goals.** A questionnaire can help you spot areas of interest related to refractive cataract surgery.

- **Think about how you would explain refractive cataract options to your mother or father,** Mr. Corcoran said. “You want to be clear, answer questions, and be truthful. Think of a way you can explain this in under 30 seconds,” he recommended.

- **Address astigmatism during surgery to boost patient satisfaction,** Dr. Hardten advised. “They’re not going to be happy if they are 20/40 and have some astigmatism,” he said.

- **Have a plan for unhappy patients,** Dr. Hardten suggested. With expectations high from patients who pay out of pocket, be ready to respond to them thoughtfully. In fact, Dr. Hardten likens presbyopic IOL treatment to a chess game, where you always need to think a couple steps ahead of the patient in terms of their satisfaction.

- **Wait on postop enhancements.** Dr. Hardten generally waits about 1 to 2 months for IOL rotation or exchange and 3 to 6 months for laser vision correction. If patients are still unhappy and think they want a monofocal IOL exchange, he will let them know it’s possible but that they’ll still need reading glasses more regularly. Sometimes just offering that as an option prompts patients to rethink things and stick with what they have. When Dr. Hardten does need to exchange a presbyopic IOL he inserted when a patient wants a monofocal instead due to issues, he will not charge the patient for it.
When what a patient reports is different from what’s on

by Liz Hillman, Staff Writer

Recent studies show discordance between symptoms reported by patients and medical records, between pediatric patients’ viewpoints and those of their parents

How a patient describes his or her symptoms and visual quality might seem like some of the most important pieces of information that can be collected in an assessment along with the objective measurements and observations obtained in the exam. But recent studies show how what the patient reports could potentially be skewed by other factors, such as what is recorded on the chart or by a caregiver’s perspective.

According to a paper published in JAMA Ophthalmology, what a patient describes of his or her symptoms and what a physician records on an electronic medical record (EMR) do not always match up entirely. The research included 162 patients (324 eyes) at the University of Michigan’s Kellogg Eye Center from Oct. 1, 2015, to Jan. 31, 2016, who took a self-reported eye symptom questionnaire. The results from these questionnaires were then compared to what was documented in the EMR. Exact agreement between the patient’s reported symptoms and what was recorded on the medical record only occurred in 38 cases.

Discordant reporting between the patient and the EMR was seen in 91% of patients who complained of glare, 80% who noted redness, and 74.4% who said they had pain. Conversely, blurry vision was included more often in medical records than it was reported in the questionnaires.

“Issues with doctor-patient communication are age-old, and some of
those issues will continue regardless of whether notes are taken on paper or in an electronic health record,” said Maria Woodward, MD, MSc, assistant professor of ophthalmology and visual sciences, University of Michigan, Ann Arbor. “However, in the era of paper charts, the purpose of a medical record in a single physician’s office is so that the physician can document the history of the illness and the diagnosis and plan for each patient and ensure the ability to follow the patient’s progress. The purpose of the medical record is not to be a compendium of information to facilitate the measurement of the quality of care delivered. Because the electronic health record allows researchers, payers, and administrators to extract information in a way that has never been previously possible, the implications of capturing patient data in the most accurate way becomes much more imperative. The data captured in the electronic health record, if it is highly accurate, can be used to improve the quality of care that we deliver in a way that data captured on disparate paper charts never made possible.”

Some of the disconnect between patients’ self-reported symptoms and what was on their medical records could mean that doctors are unaware of important symptoms. Dr. Woodward said for their study, they felt at least a modest degree of matching between the two sources was important. “If we want to fully capture patient symptoms and other patient-centered outcome measures like quality of life and function, patients could complete questionnaires as part of every visit. Instead of just recording patients’ height, weight, blood pressure, and lab work at each visit, patients would fill out questionnaires about their symptoms and how they are coping with them at each visit to be able to see how functional status improves over time with treatments,” Dr. Woodward said.

Clinics across Michigan Medicine at the University of Michigan are piloting pre-appointment questionnaires that are completed on tablets, Dr. Woodward said. The answers to questions, which include ones tailored to the clinic as well as some about the patient’s symptoms, will be uploaded and viewable from the patient’s medical record.

“This is a pathway I see as very feasible for resolving this disconnect in the near future; the infrastructure is already there,” Dr. Woodward said of the pilot program in a press release statement.

continued from page 7

The biggest costs are covered by your insurance, including the operating room, anesthesia fees, fees for my surgery, nursing, and supplies. All those add up to about $____ per eye, covered by insurance. Adding a high-tech implant adds about $____ per eye that is not covered by any insurance. It’s optional. Not everyone can afford this. About three out of four of our patients do choose the laser/high-tech implant, and our staff can tell you about financing options that make it as affordable as a few dollars a day.

9. Tell patients what you would do. Although patients should be part of their care decision, they want to know what you advise as best for their long-term visual needs. Make sure to tell them.

10. Follow up on the outcome. You want to make sure they are happy postoperatively, but if they are not, you need to step in to correct it. Dr. Hovanesian shared the story of a 62-year-old female accountant who had cataract surgery with a multifocal IOL. She saw her community optometrist at 4 months postop but did not have any further treatment. At 6 months, an electronic follow-up using MDbackline software found that she was dissatisfied with her vision. As it turned out, she had posterior capsule opacification. Once that was treated, the patient was happy with her vision and referred friends. “The patients you treat are ambassadors to others,” he said. OB

Editors’ note: Mr. Corcoran and Dr. Hardten have no financial interests related to their comments. Dr. Hovanesian is the founder of MDbackline (Laguna Hills, California).

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Another study published in the British Journal of Ophthalmology found a disagreement in how visually impaired (VI) children and their parents viewed the child’s vision-related quality of life (VQoL) and functional vision (FV).2

The study involved 99 children (10–15 years old) and their parents who took a child and proxy survey, respectively, that the investigators wrote included “novel instruments assessing VQoL and FV of children with VI—the vision-related quality of life instrument for children and young people (VQoL_CYP) and the functional vision questionnaire for children and young people (FVQ_CYP), respectively.”

The researchers found that, on average, parents rated their child’s vision-related quality of life and functional vision as lower than their child’s rating. The investigators noted, however, that the range of disagreement between parents’ ratings and children’s ratings was wide, and parents overestimated and underestimated their child’s vision-related quality of life. They more consistently underestimated their child’s functional vision, the study authors wrote.

“These findings may have potentially important clinical implications in the scenario of distress and depression in teenagers with rapid loss of vision and function; knowing the child-parent agreement is higher for this group may be helpful in the clinical monitoring of and research with children who may be too distressed and thus potentially unable to self-report themselves at particular stages,” the study authors wrote.

What’s more, the results show that “information provided by children and their parents should be viewed as being complementary, rather than interchangeable.” OB

References

Editors’ note: Dr. Woodward has no financial interests related to her comments.

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We hope that CSU provides each and every one of you with guidance and mentorship as you embark on your personal journey to a successful and fulfilling career in ophthalmology!

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Online and in sight: Building a prominent online presence

by Brendan Gallagher, Chase Rabourn, and Leah Taylor

In the past, patients primarily sought out face-to-face interactions with ophthalmic businesses to purchase products and services. These days, the convenience of the digital world has lured many of those same patients to seek out customer service experiences online. In fact, 86% of patients conduct a health-related search before scheduling a doctor’s appointment.¹ To keep themselves in the patients’ line of sight, ophthalmic businesses need to develop and optimize their online presence.

While having an online presence simply means that a business may be found online via a search, many businesses are unaware of how complex it is to create and maintain one in the digital coliseum. There are thousands of other ophthalmic competitors to consider, as well as the patients’ high expectations of the online experience. It is not enough to buy a URL, slap a summary of services on a website homepage, and never touch it again. An online presence demands constant attention combined with careful strategy, and the strongest often include more than a website.

At Medical Consulting Group (MCG), our team of digital marketing specialists has found the most prominent online presences are developed and sustained using four common tactics: building a technically sound website, composing content that patients will actually read, crafting an engaging and aesthetically consistent website design, and coordinating interactive social media and online marketing campaigns.
Build a strong, secure, and responsive website

Developing an online presence often begins by building a website. Many factors contribute to a website’s stability, the first of which is selecting a reliable web host. Web hosting services should include good bandwidth, uptime, current hardware, and tech support. It is also vital that the web host stay current with the latest software updates and patches, which are essential for security.

Most current websites will use a content management system to simplify this process. Which system to use is a matter of personal preference, but all must be actively monitored as new security threats and useful features come out daily.

“Mobility first” is the modern method of website development. Responsive web design technologies have made that possible. It allows the web developer to account for a variety of screen sizes, devices, and web browsers. Having a content rich responsive website is important not only for usability but for marketing and search engine optimization (SEO). SEO is a marketing tool used for growing visibility in search engine results. Optimizing SEO makes it more likely that a website will appear at the top of the Google page and increase its chances of drawing clicks to the site.

Compose content that is targeted, tone-smart, and searchable

After constructing your virtual business, it is time to fill it with content that targets the right audience, sets the right tone, and incorporates the right keywords.

Audience
The audience of most ophthalmic business websites is current and potential patients, so the language used in the copy should be appropriate for someone who is not highly familiar with medical terminology. Content is also most effective when written concisely. A study by the Nielsen Norman Group shows that 79% of the users tested scanned a webpage instead of reading it word for word.²

Tone
Strategic word choices help shape the tone of a website and signal to patients what kind of culture or personality a business represents. For example, note how each word sequence in the following list suggests a different tone:
• Highly professional, committed to innovation, state-of-the-art, upgraded facility
• Patient-focused, family of eyecare professionals, compassionate and quality care
• Established, more than 20 years of experience, generations of proven eyecare

Determine which words express a business’s personality, and use those words to bring its online presence to life.

Keywords
Keywords are another group of carefully chosen words used to boost SEO. When choosing which keywords to include in a website’s copy, think like the audience. Someone looking for less dependence on glasses and contacts rarely goes online searching for “laser-assisted in situ keratomileusis.” Instead they type in the more general and memorable term LASIK.

In addition to writing for the patients, businesses must incorporate keywords customized for search engines. This means using words and phrases that are relevant to what the site is offering (ophthalmic services).

Design a website that makes a good first impression

In 2010, The Gomez report showed that 88% of online consumers were less likely to return to a site after a bad experience.³ Seven years later, and with even higher expectations for online experiences, that percentage may have actually increased. Because so many people make a health-related search prior to making an appointment, a website is often an ophthalmic business’s opportunity to make a good first impression.

How? Catch the eye of potential patients and keep their attention. Forbes released the results of a study that listed busy or complex layouts, pop-up advertisements, small print that is hard to read, unappealing or uninteresting web design, and slow site and page load times as key reasons users mistrusted a website.⁴ Designing strategically is a crucial part of instilling confidence in potential patients and assuring them that they have chosen the right eyecare provider.

Again, another vital factor in effective web design is ensuring that
a site is responsive, or easily accessible across all platforms. It’s not only important to ensure that your site is technically viewable from multiple devices but also that the aesthetics stay intact across all platforms. Doing so will greatly improve the user experience, and search engines reward websites that invest the time into making their websites responsive and user-friendly, resulting in better business search rankings.

**Interact with patients via social media and utilize Google AdWords**

The information age has not only made sites like Facebook a commonly viewed form of media but also a great method for exchanging ideas, products, and services. Social media turns an online presence into a conversation, allowing ophthalmic businesses to talk about their services as well as reveal the human element behind the business. It provides a relaxed, carefully monitored line of communication between the patients and the business itself.

It costs nothing to set up a business page on most social media sites (Facebook, Twitter, Google+, Instagram, etc.); however, paid advertisements are an essential part of establishing a fan base and presence. Setting a budget for these ads in the beginning helps grow your audience faster, allowing for more opportunities to engage current and potential patients. Combined with a reputation management program, social media can serve as a highly useful tool when building an online presence.

Another well-known online marketing platform is Google AdWords. This web service allows a business to set up targeted ads and bid for keywords most relevant to its services. The ads with the highest quality scores (determined by Google) will show up at the top of Google search results. The websites connected to those top ads will then benefit from increased traffic. Businesses are required to set up a budget from the start to create Google ads and bid for keywords.

If a business has a high-quality website, a thought-out marketing strategy, and the funds, it should strongly consider implementing AdWords. It helps create a custom online strategy and has been shown to deliver measurable ROI for thousands of businesses.

**Conclusion**

Now that more patients than ever are venturing online to choose an eye-care provider or find other ophthalmic information, an online presence is not only a good idea but essential to business success. Many businesses already have a website, but ensuring that it is meeting patient and SEO expectations concerning security, usability, content, and design is a continuous chore. New online tools and social media resources offer a number of opportunities but take time to plan and implement. Consulting digital marketing and strategy experts—particularly those that specialize in ophthalmology and offer a full range of web development, management, copywriting, and social media expertise—is one way to ensure that an investment in online presence development results in a satisfying ROI. **OB**

**References**

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Patient-physician communication: Overcoming barriers for better overall health management

by Liz Hillman, Staff Writer
Imagine this scenario: A worker’s comp patient enters the ER, complaining of back pain. He is given a prescription for physical therapy, a muscle relaxer, and oxycodone/acetaminophen, and told to see a doctor after 10 days.

When Michael R. Marks, MD, MBA, saw this patient a week-and-a-half later, he found he hadn’t gone to physical therapy and hadn’t filled his prescriptions, seemingly ignoring and non-adherent with the ER physician’s orders. But Dr. Marks dug deeper. Why hadn’t he gone to physical therapy? Why weren’t these prescriptions filled and the drugs taken as directed?

Dr. Marks learned this patient didn’t have time for physical therapy. He worked at night, and when he got home in the morning, he, as a single father, had to get his children off to school. Once they were gone, he had to sleep, and then be up to receive them home from school before heading back to work for the night shift. As for the prescriptions, the muscle relaxer, the patient said, was not affordable to him at $384, and as a recovering drug addict, clean and sober for the last 2 years, he wasn’t about to start taking the oxycodone/acetaminophen.

Dr. Marks said a doctor who didn’t ask these open-ended questions might have completely misunderstood the patient’s non-adherence. Dr. Marks, who owns Marks Healthcare Consulting, a healthcare communications firm in Westport, Connecticut, said the ER doctor in this case failed.

“One of the things that you need to do when you talk with a patient is say, ‘This is what I’d like to do for you … do you think you can do these things?’” [The doctor] wouldn’t have wasted time writing a physical therapy prescription if the [patient] had explained to him, ‘It’s not going to work for me.’ He wouldn’t have written him a narcotic if the [doctor] had inquired if [the patient] could take the medication. [The doctor] had a choice of different muscle relaxers, and he picked one that was $384 when he could have picked a generic for $16,” Dr. Marks said.

Situations like this and others, resulting from communication gaps, language barriers, misunderstandings, and more, happen all the time, he said.

“I think to some extent [physicians] recognize [the need for improved patient communication], and because of all the time pressures, everyone is afraid that if they ask open-ended questions, it’s going to take more time, when these things actually save time,” said Dr. Marks, who is a consultant for the Institute of Healthcare Communications, providing communication training to physicians around the country. He also continues to provide clinical care for the indigent in Norwalk, Connecticut, after 23 years as a full-time orthopedic surgeon, followed by a role in hospital administration.

Improving basic physician-patient communication
A study published in 1984 found that less than a quarter of patients (23% of 74 patient encounters) were able to complete their opening statement to physicians.¹ Beckman et al. found the physician interrupted in 51 cases (69% of the time) to ask questions about a specific concern and in only one of these cases was the patient asked to finish the opening statement. On average, the physician interrupted the patient after 18 seconds. More than a decade later, a survey involving 264 patient-physician interviews revealed 75% of the time physicians asked patients about their concerns, but patients were interrupted 72% of the time after an average of 23 seconds.²

“We’ve not educated or trained as physicians to … let [patients] talk,” Dr. Marks said, adding that physicians might be inclined to avoid asking patients open-ended questions or interrupting when they’re under pressure to get to the next appointment and don’t know how long patients will talk.

However, one study found that, on average, patients’ spontaneous talking time was 92 seconds; 78% of patients finished their opening statement in 2 minutes.³

What’s more, asking open-ended questions can lead the physician to the root of the patient’s problem faster than yes/no questions or interruptions, and it also can result in a more satisfying experience for the patient, Dr. Marks said.

“You don’t get the flavor of what’s going on, what their goals are, what their desires are, what their long-term aims are, unless you ask open-ended questions,” he added.

“Another thing doctors rarely do is say, ‘What do you think is going on?’” Dr. Marks said later.

Malpractice companies recognize it: Physicians [who] communicate well don’t get sued.

—Michael Marks, MD
Dr. Marks provided another example to highlight his point. A woman in her 40s came to see him with a hurt back a couple of days after shoveling snow.

“The old Dr. Michael Marks would have said, ‘She sprained her back. She’s 42 years old, I’ll give her some medication, physical therapy, and I’ll be out of the room in 2 minutes.’ But that’s not the way you’re supposed to deal with patients,” he said.

He asked her what she thought was going on. “She told me, ‘I’m afraid I’ve got cancer in my back.’ I almost fell out of my chair,” Dr. Marks said. “I said, ‘That’s an unusual diagnosis, can you tell me why?’ I love the expression ‘Tell my why’ because you’re engaging the patient for more information.”

Dr. Marks learned the woman’s neighbor, who was a similar age, had hurt her back the previous year shoveling snow. This neighbor went from doctor to doctor trying to get an X-ray taken but to no avail. A few months later, the neighbor learned she had breast cancer that metastasized to her spine. She later died from the disease.

Dr. Marks then asked his patient, in light of this information, what she thought she should do. She wanted an X-ray. Dr. Marks told her the X-ray could come back perfectly normal, but his patient told him that it at least would calm her fears. The X-ray did indeed come back normal. Dr. Marks discussed options with her; she declined therapy and said she would take the anti-inflammatory medication. She was instructed to call him back in 10 days if she was still in pain. Ten days later, he got a call.

“I said, ‘Are you OK?’ She said, ‘Dr. Marks, I’m perfect.’ I said, ‘You’re perfect? Why are you calling?’ She said, ‘Because you listened to me, calmed my fears, and I think that if my friend had come to see you, she’d still be alive today.’ I still get chills when I think about that,” Dr. Marks said, adding that in all likelihood the friend’s cancer was probably advanced and her outcome would have been similar. “But it’s part of the reason that we know when a doctor has not addressed the concerns of the patient; they’ll continue to doctor shop because they didn’t get someone who agreed with their preconceived notion or addressed their concerns. You can’t know about their preconceived notion unless you ask them.”

Dr. Marks said he teaches a 4-hour physician communication course for residency programs, hospital systems, and others. Malpractice insurers have been requesting this course of those they cover as well.

“Malpractice companies recognize it: Physicians [who] communicate well don’t get sued,” Dr. Marks said.

“What we’re trying to do is convey to the surgeon, to the physician, any healthcare provider, is that communication with patients is a non-technical skill that you have to practice and work on if you want to do it well,” he added.

Rosa Braga-Mele, MD, professor of ophthalmology, University of Toronto, Canada, said she thinks ophthalmologists are, in general, sensitive to the fact that this specialty has its own unique medical jargon, even against other physicians.

“I think we do fairly well in communicating with our patients at a patient level, rather than a physician level,” said Dr. Braga-Mele, who has taught a course in patient-physician communication.

Anat Galor, MD, associate professor of clinical ophthalmology, Bascom Palmer Eye Institute, Miami, said speaking with patients in plain language is something that has come naturally to her.

“I always try to bring things down to very simple language to get the concept to be as well understood as possible,” Dr. Galor said.

Dr. Galor explained that some of her colleagues have performed experiments where they explained to a patient the options after cataract surgery and then gave the patient a quiz to see how much he or she got out of that conversation.

“It was shocking to see how little they got. I think we need to do a better job not only thinking about how we communicate but effecting patient understanding,” Dr. Galor said.

Dr. Braga-Mele said she’ll watch the patient’s body language while she’s explaining something (if they seem attentive or their eyes become glazed) to see if her points seem to be getting through. She’ll also ask patients if they have questions about anything she just said or will ask them to repeat back what they understand in order to assess how well she communicated with them.

She said if a patient is given bad news during a visit, it’s important to schedule a follow-up appointment for a short time afterward.

“If you’re providing bad news to a patient on the very first visit, they’re not going to hear anything but the bad news. They’re not going to hear their treatment options, they’re not going to hear what’s going on, so it’s very important to book a follow-up visit in a short period of time to make sure the patient has fully absorbed everything,” Dr. Braga-Mele advised.

Dr. Braga-Mele said she maintains an open door policy to take calls or fit patients in if they have follow-up questions.

Tackling the issue of health illiteracy

According to the 2003 National Assessment of Adult Literacy, conducted by the National Center for Education Statistics, only 12% of the population was considered proficient in health literacy; 53% were considered to be at an intermediate level. Health literacy, according to the
report, is defined as, “The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”

The inability to do so, whether based on the issue of health literacy or the use of technical medical terms, jargon, or so-called “medspeak,” can not only result in confusion, but it can present a patient safety issue, said Patricia McGaffigan, RN, MS, former chief operating officer and senior vice president of programs, National Patient Safety Foundation (NPSF), Boston, and vice president of safety programs, Institute of Healthcare Improvement (IHI), Cambridge, Massachusetts.

An exercise in which undergraduate medical students translated medical documents to plain language resulted in them being more likely to use plain language during simulated patient encounters. Bittner et al. wrote that such translation activities could be used as a technique to improve plain language communication skills.

The IHI/NPSF has a free health literacy and educational program, Ask Me 3, to facilitate better communication and understanding of health conditions among patients’ families and providers:
1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

Ms. McGaffigan said this structured communications program is intended for patients and families to use in healthcare encounters, and is equally intended for providers to guide conversations with patients in a clear and systematic manner.

Dr. Marks said he provides patients with the opportunity to communicate back to him what they understand, but does so in a way that’s not condescending.

“A great phrase to use with a patient is, ‘I’ve given you a lot of information today that would be hard for almost anyone to understand. When you get home and speak to your husband, tell me what you’re going to tell him about your day’s visit,’” he said.

If “medspeak” is an issue, so is “no speak.” Ms. McGaffigan had one such experience herself in the emergency department a few months ago.

continued on page 20
“I was on a stretcher in a hallway for 9 hours, and then a nurse came to me after a shift change and asked me to sign my discharge instructions. I said I hadn’t even had a conversation with the healthcare team about my status and didn’t know what the discharge instructions were, given that no one had spoken to me yet,” Ms. McGaffigan recalled, noting that she also didn’t have her glasses at the time and yet the nurse pressed her to sign.

“There is a lot of production pressure that I think is causing our healthcare industry to forget about taking a moment to understand what’s happening with patients and family members,” she continued. “I hadn’t even been informed at that time about what the results of my test were. I’m someone who knows how to advocate for myself, but I couldn’t get the synapses of the system to recognize the fact that no one was clearly communicating with me about what was happening despite my requests for information and updates. It wasn’t so much that it was med speak, per se, it was no speak. When there is ‘speak,’ it’s important to keep in mind there are many situations where providers are speaking far beyond the capabilities of a patient’s and family’s understanding, and that increases the risk of healthcare-related harm.”

Dr. Braga-Mele said she’s found the baby boomer and younger, Internet-savvy populations seem to be coming in well informed of their ocular conditions and treatment options. However, she added, if patients are recent immigrants and English is not their first language, or if they come from a lower socioeconomic class, they can have less of an understanding of ophthalmology and medicine because they don’t have the language capabilities or facilities to research the topic on their own.

“That’s where you have to communicate on a different level with those patients, ask if they have someone they want to bring along to better understand what’s going on, specifically if there is a language barrier,” Dr. Braga-Mele said.

**When an actual language barrier exists**

Ms. McGaffigan, during that same visit to the emergency room, witnessed how a language barrier—where the patient and his or her caregivers do not speak the same language as the physician and other healthcare personnel—can impact care.

“There was an elderly patient occupying a hallway stretcher for many hours. She and her husband spoke Russian and her care could not proceed until the translator arrived, and there was a time delay in the translator’s ability to get to her bedside,” Ms. McGaffigan said, pointing out how one could see how critical that role was to understand the patient’s history, symptoms, and complaints, and communicate all of the options.

According to the 2011 American Community Survey, 60.6 million people (21% of the population age 5 and older) speak a primary language other than English at home. Of those, 7% speak no English at all (58% spoke English very well, 15% spoke English but not well). The Department of Health and Human Services issued guidance in 2000, under the directive of Executive Order 13166, to improve access to services to people with limited English. The legality of how to improve access or provide translation services, and who incurs that expense, varies from state to state.

“In aggregate these laws provide additional protection for [limited English proficient] patients,” said Chen et al. “However, individual laws vary tremendously in scope and impact, and together leave many important areas unprotected. Many focus exclusively on patient

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**Tips for effective physician-patient communication**

- Ask patients if they have any questions before they leave the office.
- To assess how well patients understood something, ask them how they’d relay this information to a spouse or other family member.
- Ask patients to tell you why they might think a certain thing to engage patients for more information and their perspective.
- Watch patients’ body language. Does it look like they’re following what you’re saying?
- When it comes to recommended care, ask patients if the treatment plan is something they would be able to adhere to.
- Consider having the patient bring a family member to act as a translator or use a professional translator or translation service to help bridge language and cultural barriers.
- Maintain an open-door policy so patients feel comfortable phoning or meeting with any follow-up questions.
- Use certified decision aids to ensure that decision tools meet the criteria for health literacy and comprehensiveness.
education, notification, or informed consent; some also target a specific healthcare setting, medical condition, or language.”

Chen et al. said that improving and increasing language access has occurred mostly at the state level. For example, some states have required that emergency rooms and others provide professional interpreters when needed, while others have expanded this to include all private managed care plans and individual and group health insurers.

But even when an official interpreter is an option, patients might opt for family members, and the situation can get dicey. Take the example presented by Glenn Flores, MD, in a perspective published in the New England Journal of Medicine. A 12-year-old boy came to the emergency room in Boston with dizziness and headache. His mother spoke no English and his was limited. Yet he acted as the interpreter between the physician and his mother. The mother, in Spanish, described how her son had been dizzy for a week with no fever and how his father's side had a history of diabetes.

The physician, after hearing the mother’s speech in Spanish, asked the child patient if his mother was saying he looked yellow. The boy repeated the question in Spanish to his mother, and from there, confusion ensued. The mother said he looked dizzy and pale; the son repeated in English that she said he was “paralyzed, something like that.” The boy, according to Dr. Flores, was treated inappropriately for his condition as a result of this miscommunication.

Language barriers can often lead to misinformation about how to follow medical instructions. A small study published in 2003 recorded 13 patient encounters in a 7-month period, resulting in 474 pages of transcripts. Interpreters in the encounters included professional hospital interpreters and “ad hoc” interpreters, such as nurses, social workers, and family members. The study authors found that 63% of errors resulted due to issues with medical interpretation, which could have had clinical consequences. These included not asking about drug allergies, not asking about dosage and other instructions for antibiotics and fluids, not explaining that a hydrocortisone cream had to be applied all over instead of only to the rash, and a mother who thought she was told to put amoxicillin in the patient’s ears rather than administering it orally. Ad hoc interpreters were more likely to have errors that could result in clinical consequences.

If a doctor is concerned he or she and the patient are not on the same page due to a language barrier, despite an interpreter, Ms. McGaffigan recommended asking the interpreter to ask the patient what they’ve heard, what they need to do, and why it’s important, and having the interpreter translate that back to the provider in a teach-back method. That could at least help identify if a misinterpretation occurred before treatment proceeds.

“I would try to use that third person as a guidepost to validate and verify what the patient knows,” Ms. McGaffigan said.

With big medical decisions, Ms. McGaffigan advised, “Having experienced translators is essential for shared decision-making, especially with respect to understanding what matters to the patient, making informed decisions, and determining plans of care.”

Ranya Habash, MD, assistant professor of ophthalmology, Bascom Palmer Eye Institute, Miami, said Bascom Palmer uses InDemand Interpreting services, which created a mobile app that physicians can use to reach specialized interpreters with dozens of different languages available. Dr. Habash said she recently had a patient who spoke only Creole. She used the app, and while the patient did not speak English, after communicating with her through the interpreter on the app, he said, “good technology!”

References

Editors’ note: The sources have no financial interests related to their comments.

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Vision practices see a wide array of patients with varying needs, but no matter what type of patient the physician sees, the patient experience is at the heart of a successful practice.

Many medical practices are beginning to understand the increasing importance of technology—although we’re only beginning to see the ways it can truly boost a patient’s experience, both in terms of satisfaction and outcomes. In particular, we’re focusing on technology that emphasizes patient relationship management (PRM), and how to most effectively deliver it and provide the greatest impact.

**Managing day-to-day challenges**

Technology can help practices better address their most pressing challenges, such as delivering personalized, professional care and standing out in an increasingly competitive environment while lowering costs.

One of the biggest challenges for our practice is ensuring we’re delivering personalized service to the wide spectrum of guests we serve. We treat patients of all ages and socioeconomic statuses, with vision goals that vary just as widely: Our 28-year-old, cash-pay LASIK patient has different expectations than our 79-year-old patient or our 14-year-old patient who’s interested in wearing contacts for the first time. We have to be able to connect with and serve each of these individuals through
Impacting the patient’s experience through personalized technology

They've had a positive experience. Their perception of the practice, staff, and doctors is enhanced, which increases the likelihood that they will refer their friends and family for care.

Keep patients coming back

With the proliferation of online physician rating sites, patients have become the ultimate consumers of medicine, always in search of the best physician or specialist who offers the most cutting-edge technology with the best in-office experience. Unsurprisingly, one recent study revealed that 72% of healthcare professionals think that health apps will encourage patients to take more responsibility for their health.

In order for our practice to help encourage that responsibility, and ultimately enhance that connection with the patient, we use PRM tools that integrate with our EHR to deliver timely, relevant information through devices they use every day.

We also use PRM tools to monitor social media and track patient satisfaction ratings through surveys. We save time and resources by eliminating the need to print out surveys, mail them to patients, and incur the cost of paper, ink, envelopes, postage, and staff time. Our practice now uses the saved time and resources to better connect with patients and focus on giving them the best experience possible, both in and out of the exam room.

It is our goal to provide an excellent experience for the patient every time, but if we fall short, we want to know about it. Social media reviews offer us the opportunity to connect with our patients in ways we may not have had the chance to do in the past. Half the battle of keeping patients happy is knowing when we fall short of an expectation. For each patient who expresses displeasure, there is an average of 26 others who do not say anything at all. Feedback is a gift, and the patients who care enough to let you know when you fall short of their expectations are those that can become some of your biggest advocates. In our experience, acknowledging that feedback and correcting what we can often makes a patient even more loyal to the practice.

Communication between both parties is key to great outcomes and a great patient experience. Utilizing technology that is available to us allows us to reach and educate our patients in ways we couldn't previously, allowing us to continually strive to exceed patient expectations. OB

Technology has also helped us lower our overhead costs. Patient no-shows are one of the biggest sources of financial loss a practice can face, and implementing a physical call reminder system allowed us to lower our no-show rate from 8–10% to 4–5%, which is where it currently stands. Last year we took it one step further by adding an automated email/text reminder system. This new software allowed us to take staff from their reminder call duties and focus more time on other revenue generating activities.

We have also found that when we engage with patients in ways they prefer, they are more likely to feel customized means, ensuring we're meeting each guest’s personal vision goals and needs.

Technology is one way that helps bridge this expectation gap by helping us communicate with patients in the way that best suits them. For example, we're able to email an educational video to one patient, while handing out a brochure to another. We can text or email appointment reminders, as well as call the patient. We can show LASIK patients exactly how the laser will sculpt their cornea through a video or we can show cataract patients what their vision may be like after cataract surgery based on the type of lens they choose through an app. The plethora of communication options that technology allows us to have at our fingertips helps us meet patients exactly where they are and educate in the best way that suits them.

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When to talk to local market leaders

by Rich Daly, Contributing Writer

Other healthcare entities may provide practices with valuable insights

No ophthalmology practice operates in a vacuum, and often other healthcare entities have information that can help practices grow or avoid trouble down the road.

John Pinto, president of J. Pinto & Associates, San Diego, has seen many ophthalmology practices benefit from reaching out to other local healthcare entities for insights.

Such discussions can help determine the extent to which national trends are affecting a practice’s local market.

For instance, in some markets even the smallest boutique practice may be tenable for the next 20 years, but in other markets the actions of health systems or insurers may sharply limit opportunities for an independent practice, according to Mr. Pinto.

“So it’s important to know where your market is on that spectrum,” Mr. Pinto said.

To gain such insights, Mr. Pinto’s client practices have met with hospitals and other local health officials.

One practice planning a large capital project learned that a local health system was planning their own major eye department in the area. That knowledge gleaned by one practice in Ohio led them to shift investment into a different area.

“Some practices who were deeply concerned about their position in the market have had their fears laid to rest,” Mr. Pinto said “Other practices that were pushing hard to go in a particular direction learned that would not be a good direction to go in or something would be blocked for them, so it saved them a lot of money in what would have been wasted efforts.”

Who to talk to

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health system or hospital and sit down for half an hour and talk shop,” Mr. Pinto said. “They’re trying to learn about the community in their own right. By meeting with you they might learn something about what is happening in the eyecare space.”

Mr. Pinto noted that hospitals and health systems can complicate a practice’s plans in ways beyond expanding their own eye services or buying up ophthalmology practices. For instance, those organizations may be developing their own insurance products with provider networks that exclude the practice.

Mark E. Kropiewnicki, president and attorney, Health Care Law Associates, Philadelphia, said hospitals and insurers would likely have access to local information on demographics, trends, catchment areas where people are coming from, and the services that are needed. Although hospitals may not have much of an ophthalmology-specific focus, they at least have information that would be effective for medical practices generally. That type of information can help practices figure out where it’s best to place new satellite offices.

Mr. Kropiewnicki identified the launching of satellite offices as a trend in some regions, which is spurred by practices realizing they need to look at different areas with higher population growth or better patient demographics if they want to expand.

“Nowadays the idea is, ‘We will buy up a guy in the next town over, and then we already have a ready-made patient base and can increase our marketing from that base,’” Mr. Kropiewnicki said.

Others to talk to include senior provider-relations representatives at regionally important payers.

“We’ve talked to executive directors at large multispecialty clinics who are plugged into what is happening,” Mr. Pinto said. “We’ll often talk to ambulatory care business directors from expanding health systems that are growing beyond their original acute care mission. We even talk to health management professors at local universities.”

Healthcare management department educators often use their local marketplaces as labs to understand changes happening in the overall healthcare system.

Additionally, you can talk to include local optometrists, especially if you’re looking to add services that might benefit from their referrals, Mr. Kropiewnicki said.

“You want to make sure that the optometrists who are otherwise happy with your services and willing to refer to you understand what else you’ve got available,” Mr. Kropiewnicki said. “If they’re happy doing it for the cataract work, why wouldn’t they do it for glaucoma work?”

**What to ask**

Questions practice leaders should ask local healthcare leaders include:

- What is the current status of the healthcare system in the local area? How do they see that changing over the next decade? If the healthcare leader was CEO of their practice, what would they be doing differently to meet the future they envision? Who else should the practice leader meet with to get a better understanding of how the local market will align?

- “Those questions get you the answers you need to be able to make your own internal strategic decisions,” Mr. Pinto said.

For example, if the opinion of the people a practice leader approaches is that little change is expected, “then you’ve got a clear line with whatever strategic plan you have,” Mr. Pinto said. “If, on the other hand, the word from the local intelligentsia is, ‘You’re not going to be able to have access to patients outside of our health system,’ then you need to rethink what you’re doing.”

In terms of sensitive areas for the practice to avoid discussing, Mr. Pinto suggested just applying common sense.

“If you have strategically important information that you don’t want out of the bag, like where you’re going to open a satellite office or a merger that’s around the corner that is premature to announce, you certainly wouldn’t want to answer questions that reveal what you don’t want to disclose,” Mr. Pinto said.

**Long-term effort**

Talking to others in the local healthcare market should be an ongoing effort, Mr. Pinto said.

“It’s important to do this not just one time and say, ‘We’re done,’ but to do it once a year to once every two years—depending on how kinetic your market is. Get back out there and ask the questions again,” Mr. Pinto said. “Things could change.”

Practices have seen benefits from such long-term dialogue. One client of Mr. Pinto’s cited the relationship such discussions built with a hospital for leading that organization to ask the practice to join its diabetic screening program.

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