Wrongdoing and rationalizing

Physicians and staff need to understand what moral transgressions look like—and how easy it can be to overlook such misbehaviors

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From the publisher

Everyone misbehaves occasionally. Some people have a deep-seated psychological need to understand themselves as ethical and upstanding, so they learn to rationalize their wrongdoings. In this issue, John D. Banja, PhD, presents the case of Lance Armstrong as an example of rationalizing bad decisions. Dr. Banja then details two instances where physicians and staff might consider “bending the rules.” As tempting as it might be to rationalize their behavior, physicians have suffered career-ending penalties for such transgressions. Read more in “Wrongdoing, rationalizing, and Lance Armstrong,” on page 14.

This issue contains a variety of articles that we hope you find useful and informative. In “Is bigger always better?” (page 8), contributing writer Enette Ngoei presents the advantages and disadvantages of working in a smaller practice. Sarah Cwiak, PhD, administrator of an ASC, gives “Four tips for OR efficiency” (page 18). She focuses on optimized scheduling, team flexibility, streamlined paperwork, and smart outsourcing. In “Recruiting an administrator for your practice,” (page 20), Brad Ruden, MBA, discusses tips for hiring a practice administrator, which begins with a clear idea of your needs and the skill set necessary to fulfill them. Finally, Michael D. Brown, CHBC, offers his suggestions for making yourself invaluable to an employer.

As always, thank you for reading.
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Is bigger

by Enette Ngoei Contributing Writer
always better?

Ophthalmology Business takes a look at some of the advantages of a small practice

Since the 1990s, with the first healthcare reform during the Clinton Administration, there has been a consolidation of smaller independent practices into larger practices, said John Pinto, president, J. Pinto & Associates, San Diego. At the same time, Mr. Pinto said that according to his estimates, probably more than half of the ophthalmic practitioners out there are practicing in a small context of one to three physicians.

“I think it was in the 90s when everyone said the solo practice is dead. There is a similar drum beat occurring today saying it’s going to be impossible to practice as a soloist. I think that’s premature,” he said.

While it may be a greater challenge today to stay small, Mr. Pinto said, a physician should still be able to practice in whatever context allows him or her to thrive.

When smaller is better

The advantages of being in a smaller setting can be summed up in the potential diseconomies of scale when you get over about five or six doctors in a practice, Mr. Pinto explained.

“The sweet spot is between three to five surgeons, and this is true not only in ophthalmology but also in other surgical specialties,” he said.

Any fewer than that and it becomes harder to share resources like equipment and staff. Any larger than that and it starts to fold in on itself and the profit margins shrink in percentile terms, he said.

“In addition, smaller practices can be much more nimble, and in the current environment, being able to shift quickly, getting in and out of services can be an advantage,” Mr. Pinto said.

From a subjective standpoint, a smaller practice results in a more human scaled organization. If it’s a small two-doctor practice, everyone is in one building, he explained. It is easier having 15 people around the table deciding together what’s going to be happening in the next week than if you have a much larger organization.

Certainly, being part of a smaller practice could be a bit less frustrating.

“I would say in my solo, two, and three doctor client practices, the surgeon owners are happier in that setting than they are in much larger groups. As Ted Turner once said, ‘Complexity and frustration in an organization is equal to the number of people squared,’” Mr. Pinto said.

According to Derek Preece, principal and senior consultant, BSM Consulting, Orem, Utah, from the standpoint of negotiating with larger entities like insurance companies and accountable care organizations, it’s usually not advantageous to be in a smaller practice. However, he said, sometimes larger practices get set in their ways so it’s difficult to make a decision because there are so many different opinions. A smaller practice

continued on page 10
could conceivably be quicker to make decisions and commitments, so that might have an advantage.

Having a smaller practice allows a bit more flexibility with management. It’s not uncommon in one, two, and three doctor practices that the physician is the manager as well as being a doctor, Mr. Pinto said. That can save some costs if the practice possesses a physician who has some business instincts and the desire to handle the business aspect of things.

Some doctors prefer to be in a small practice where they can have more influence on the decisions that are made, Mr. Preece said.

“When you get into a practice of 10 doctors, you only get 10% of the vote. If you’re in a practice by yourself or just one other doctor, it’s just people talking to each other,” he said.

Some physicians feel a need to have more control or influence over what happens in a practice and may feel limited by a larger practice, he added.

Surgeons in a smaller practice are more likely to practice a more comprehensive span of services because there may not be subspecialists on staff to pass along glaucoma or retina patients to, Mr. Pinto said.

On the other hand, there are times when subspecialty practices like a retina practice with two retina specialists may find that a larger practice doesn’t meet their needs very well; they may find it more beneficial to become independent and break off into a smaller practice, Mr. Preece said.

For some physicians, it could make financial sense to join a smaller practice.

**Case in point**

**James Salz, MD,** Los Angeles, was a partner at a practice with four partners, two to three independent contractors, and a staff of 20 or more for about 13 years before he decided to move to a smaller practice.

Dr. Salz said he was getting to the age where he would soon retire, so although he wasn’t unhappy at his previous practice, he had a sizeable overhead responsibility. There were staff overheads, which included parking and some health benefits, and he couldn’t take two weeks off and not pay any overhead, he said.

The smaller practice only had two partners and three employees in total. Where his previous practice employed five or six people in the billings department, this new practice outsourced its billing services. The new practice already had an electronic health records system in place, which his previous practice did not, which would eventually be another big expense.

The large overhead in his previous practice was not met with large cash flow either, Dr. Salz said. While they did a good amount of regular cataract surgery, there weren’t a lot of premium lenses being implanted.

In addition, Dr. Salz said he does more LASIK than cataract surgery and hardly anyone in his previous practice was doing LASIK. Moving to a smaller, more efficient office was the right choice for him.

“The positive to me is [the new practice] is a very efficient office, we’re not usually behind like we were in the big office with six or seven doctors working at the same time. It’s more of a boutique kind of practice, which lends itself well to my LASIK practice,” he said.

Dr. Salz now has a favorable overhead formula where if he doesn’t go into the office for two weeks, like this summer when he’s taking time off to play golf, he won’t make any money but he won’t lose any either.

“I won’t be paying any overhead. I’m only paying on a percentage of what we collect in my name so if I don’t collect anything, I don’t pay anything. That wasn’t true in the bigger practice where I was responsible for a percentage of overhead even if I wasn’t there,” he said.

“This was a very attractive way for me to phase out my practice.”

Dr. Salz is now 73 years old and still doing surgery.

“I’m still doing OK but I’m obviously not going to do this forever and at some point, I’ll probably give up the surgery and just do medical ophthalmology. If my mind stays sharp I can do that for a long time,” he said.

Most of his 7,000 patients from the previous practice followed him to the new one. Many of them have early cataracts and will eventually need surgery, and his new partner will gain those patients. **OB**

Editors’ note: Dr. Salz, Mr. Pinto, and Mr. Preece have no financial interests related to this article.

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Medical tourism: Increasing revenue

by Michelle Dalton Contributing Writer

Traveling for eye surgery becoming more common; here’s what you need to know

By definition, “medical tourism” is when an individual’s primary reason for travel is to secure healthcare abroad. In the European Union, a 2007 survey indicated 4% of citizens sought medical treatment in a different country than their own, and estimates suggest there may be anywhere from 600,000 to 5 million people actively traveling for medical purposes. For some, shorter waiting times may be the primary reason; for others, it may be an opportunity to combine a vacation with a surgery most individuals consider “basic,” such as LASIK, said Jonathan Edelheit, chief executive officer, Medical Tourism Association (MTA), West Palm Beach, Fla. Almost 8% of U.K. residents who participate in medical tourism sought LASIK (dentistry and cosmetic procedures were the top two treatment areas; LASIK was third). More than 27% of U.K. residents wanted to combine their vacation and surgery/treatment. In the U.S., those figures are much smaller, with only 3.4% of medical tourists seeking ocular surgery, but almost 10% of those in the 46- to 55-year-old range sought eye surgery.²

Thousands of patients come to the U.S. every year because “they believe they’re getting the best doctors with the best experience,” Mr. Edelheit said. According to Patients Beyond Borders, the top 10 destinations for medical tourism are Brazil, Costa Rica, India, Korea, Malaysia, Mexico, Singapore, Taiwan, Thailand, and Turkey, but countries like China, United Arab Emirates, and the U.S. (including Puerto Rico) are also becoming more popular destinations. Healthcare standards of the destination country and cost of treatment are by far the two most important factors for U.S. residents when choosing a medical tourism destination.
For surgeons, medical tourism can be a way of adding revenue to a practice, but can also be a means of improving surgeons’ “brand,” Mr. Edelheit said, by noting patients from around the world seek out their particular services. One clinic in Cuba performs more than 30,000 procedures yearly on Russian travelers; Mr. Edelheit said some travel agencies now specialize in putting together vacation-surgery trips.

**Smaller but growing demographic**

A third contingency comprise people who are returning to their home country for surgery.

“That’s a particularly common situation for our patients in south Florida,” said William Trattler, MD, in private practice, Miami, whose patient base is surprisingly “comfortable” leaving the U.S. to have an elective procedure in their home country—including laser vision correction.

“There are a number of outstanding surgeons in central and South America who have advanced laser technologies that are similar to what is available in the U.S.,” he said, and for patients who travel it may be because “they have more family support during and after their procedure.”

Likewise, the Wellington Eye Clinic (Ireland) has patients who opt for surgery “back home,” and those patients have mostly been referred by friends or family, said Arthur Cummings, MD. “They have a back-up at home while recovering from their surgery; once they’ve returned here we treat them like we do our own except that we bill them for their visits. Our own patients who had LASIK with us don’t have follow-up costs for one year following the surgery.”

Those details should be considered and patients need to be educated about those topics, Mr. Edelheit said. Bilateral LASIK costs about $4,400 in the U.S., $2,000 in Colombia, $500 in India, but $5,000 in Jordan and $6,000 in Korea. Making medical decisions based on price (or destination) alone is ill-advised, Mr. Edelheit said.

His group encourages its clients “against going overseas on a whim. We tell patients to get the right diagnosis—both by the domestic and the foreign physician—and ensure the local doctor will continue follow-up upon their return.” If those criteria cannot be met, Mr. Edelheit advises against the surgery.

**Complication management**

Both Drs. Trattler and Cummings noted that as with any ocular surgery, there may be complications. Dr. Cummings is a bit less sympathetic when problems crop up if the patient has opted for surgery elsewhere simply based on price. That said, however, “if we manage the problem and treat them well at the same time, they are very likely to advise their friends to come and see us instead of travelling after the apparently cheaper deal elsewhere,” he said.

A good percentage of Dr. Trattler’s practice involves providing second opinions, so while his approach to evaluating and treating the patient remains the same regardless of where the surgery occurred, obtaining records from foreign colleagues has proven difficult unless Dr. Trattler has a personal relationship with the treating surgeon.

When patients “end up off target, they need to schedule a return international trip for an enhancement procedure with their home country physician,” however, when issues such as epithelial ingrowth or ectasia develop, patients have to decide whether to return home or have their condition treated locally, Dr. Trattler said.

“We have an approach that any patient who sees us for a second opinion or in a similar scenario to that outlined before is a golden opportunity to show off our skill sets and technology but also our caring and service side, and that’s far more likely to generate business for us” than berating the patient for seeking surgical expertise elsewhere, Dr. Cummings said.

Dr. Cummings also suggests patients’ return to the original surgeon where possible for enhancements. His main concern is that he often has no idea “what I might encounter—previous flap size, flap thickness, bed quality, residual bed thickness, etc.—so the surgery is in fact a little more challenging” in those kinds of enhancement cases, he said.

For physicians interested in becoming a “go-to” source for medical tourism patients, Mr. Edelheit suggested contacting some of the larger brokers who work with networks of hospitals, clinics, and other providers in dozens of countries as well as hundreds of employers.

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**Contact information**

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Wrongdoing, rationalizing, and Lance Armstrong

by John D. Banja, PhD
Physicians and staff need to understand what moral transgressions look like—and how easy it can be to overlook such misbehaviors

When Lance Armstrong admitted his doping use to Oprah, my first reaction was, “How was he able to deny and lie about it for more than a decade?” Probably a huge factor motivating Mr. Armstrong’s concealment of the truth was his fear of lawsuits because his doping use had breached multiple, high-dollar contracts with sponsors that required him to avoid doping agents. Still, I wondered about how he was able to live with himself for so long. Moral psychologists talk about “cognitive dissonance” which, in Mr. Armstrong’s case, hypothesizes that he had to figure out a way to “spin” his lies to himself such that overall, he could still perceive himself as a decent, even ethical, person.

This is important: Most people, especially Westerners, have a deep-seated psychological need to understand themselves as moral and upstanding persons despite the fact that no one is morally perfect. In his hierarchy of needs, Abraham Maslow emphasized the importance of self-esteem, which fits hand in glove with my perceiving myself as a respectable, moral human being. On the other hand, everyone commits moral transgressions from time to time like cheating on their taxes, lying to their spouses, or engaging in excessive risk taking that can harm others (like driving too fast, eating or drinking too much, working too hard, and refusing to care for themselves in healthy ways). Still, we all have to face each and every day—laden as we are with these all too human faults—and still feel good enough about ourselves to go about our business. Consequently, whether we’re talking about fairly modest human failings or whoppers like Mr. Armstrong’s, human beings learn to implement cognitive strategies that allow them to “make room” for their misdeeds so that they don’t become psychologically overwhelmed by them.

Perhaps the chief mechanism used for that purpose and which seems especially likely in Mr. Armstrong’s case is that he had an enormous capacity to rationalize his misbehaviors (assuming that he wasn’t suffering horribly from a crushing sense of guilt that he stoically tolerated on a daily basis). The cognitive dissonance model would say that Mr. Armstrong somehow managed to compartmentalize or minimize his lies in a way that allowed his maintaining a positive enough self-image that got him through the months and years. That is always the goal of moral rationalization: to make the stronger argument or course of conduct, which in Mr. Armstrong’s case would have been to fess up, appear weak or stupid against arguments encouraging his ongoing deceit that, through rationalization, would appear strong and persuasive.

Implications for ophthalmology

So what in the world does this have to do with ophthalmology? I participated in a session at the 2013 ASCRS®ASOA Winter Meeting in Aventura, Fla., where ophthalmology administrators offered some cases for ethical discussion that were taken from their personal experiences. Consider these two:

1. The owner doctor starts a new type of cornea procedure that is refractive in nature but he adamantly insists on identifying a reimbursement code for billing and receiving payment from an insurance company. The administrator refuses to bill the insurer, but the ophthalmologist threatens to fire the administrator if he doesn’t.

2. As a new administrative employee, you discover that your ophthalmologist’s practice has not made any effort to refund patients’ excess payments above allowables for several years. He only refunds patients who complain.

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but you know there are many patients due refunds for the past five years.

Now, let us hope that the number of ophthalmologists who would actually engage in such practices is minuscule. The ethical point I nevertheless want to make is that just like Lance Armstrong, ophthalmologists who would knowingly and willfully engage in fraud would probably rationalize their wrongdoing. They might deny that they are committing fraud at all; they might delude themselves into thinking that some of their colleagues do the same kinds of things so why not them; they might desensitize their moral feelings to downplay the gravity of their wrongdoing or minimize its significance; they might convince themselves that their reimbursements have been so unfairly reduced over the years that they must resort to such fraudulent practices just to survive.

Notice how tempting it is to think like that so as to reduce and remove whatever guilt feelings might attach to committing the transgression. But consider the consequences. Once serious violations of the law or a physician’s code of ethics are discovered, it’s too late. And office administrators who are aware of any kind of illegalities occurring in their practices should realize that by concealing the wrongdoing, they might be regarded as complicit in it and face penalties themselves. Consequently, the best strategy is to address the temptation of wrongdoing directly because temptation will always be present. We must educate ophthalmologists and office administrators to understand what moral transgressions like fraud look like. We must admit how easy it can be to overlook such misbehaviors and, indeed, to “normalize” them as “business as usual.” If we cannot teach people to be morally disgusted by unethical or illegal behaviors, then ophthalmologists and their administrative staff should be made acutely aware of the kinds of career-ending penalties that physicians and their practices have suffered when they became ethically lax and callous. So, if the demands of ethics aren’t powerful enough to discourage wrongdoing, then maybe the threat of the slammer might be.

Ophthalmology administrators who find themselves doing things that cause them to feel uncomfortable should first determine whether their discomfort is justified or not—in other words, they should do their homework to determine whether the behavior in question is acceptable or not. If it turns out that it isn’t, they must find a means to address it and implement a remedy. Failing that, they should quit and work somewhere else (and seriously consider reporting their experience to the authorities, which would require a column in itself).

When ethical sensibilities break down, such as in Lance Armstrong’s case, there can be unspeakable anguish and penalties. We should therefore be keenly aware as to how rationalization can blind us to our moral transgressions, and we should recognize but staunchly resist its seductive charms, literally at all costs. OB

Dr. Banja is a professor and medical ethicist, Emory University, Atlanta, and public trustee of the ASCRS Board of Directors. He can be contacted at jbanja@emory.edu.
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4 tips for OR efficiency

by Sarah Cwiak, PhD
As the administrator of an ambulatory surgery center (ASC) and executive director of a five-location professional practice, increasing efficiency is a top focus for me, as it is for our doctors. In our ASC, we have identified a number of ways to keep things running as smoothly as possible.

1. **Optimized scheduling**

With the recent addition of a femtosecond laser to our ASC, we have shifted the emphasis away from how many cases per hour we are able to complete. The femtosecond allows us to actually slow down a little bit, while still maintaining a good level of productivity. At the same time, we have looked at ways that we can schedule procedures most efficiently and predictably for our surgeons. We now have a goal of a 50% conversion rate for the femtosecond laser, which allows us to float the surgeons in a pattern in which they always know where they’re going. With this pattern, surgeons transition back and forth consistently between performing traditional phaco and femto-assisted phaco.

2. **Team flexibility**

Our ASC used to be very rigid in the way we scheduled patients and the processes we used to check them in and care for them through their surgery. We assigned a preop nurse, a postop nurse, and a floater each day, who had their own defined responsibilities. While this system meant that each nurse knew exactly who was responsible for which duties, it also occasionally led to what we called “Lucy moments,” which refers to the classic episode of *I Love Lucy* in which Lucy and Ethel couldn’t quite keep up with the chocolate conveyor belt. With this system, a hiccup in one part of our “conveyor belt” could disrupt our processes both downstream and upstream.

Now, we have transitioned to a much more flexible and fluid schedule, and have trained our staff to work accordingly in order to avoid those “Lucy moments.” We still have three nurses on staff each day, but each nurse is cross-trained for any necessary duties and can help patients at any point in the process. Using this approach, if a patient changes his mind about a lens or a procedure on the day of surgery, we are better able to make changes swiftly and keep the process moving. We ask our staff members to think on their feet, communicate among themselves, and work as a team in order to meet the challenges of the day. When problems occur, the nurses are able to step in to help their teammates, as opposed to being tied to one single assignment.

This system functions well in our two-OR practice. We still assign scrubs for each day, and we also have assigned nurses in each of the ORs, but the other nurses know that their job is simply to clock in at the beginning of the day and provide patient-centered care, wherever it is needed.

3. **Streamlined paperwork**

We ask our doctors to bring a “cheat sheet” on each patient having surgery, which includes all of the basic information that OR staff need to quickly access on surgery days. This cheat sheet is hung on the base of each bed, where it is easily accessible for quick reference and time-outs. We find this to be a great timesaver, keeping all of our need-to-know information within easy reach.

We also ask each patient to bring a complete health history and physical to the facility, which allows us to simply recheck the information instead of having to fill it out for the first time. There is no more waiting for patients to root through purses looking for pill bottles or to make phone calls for information.

4. **Smart outsourcing**

Every practice likely sees patients who are high risk, have special needs, or are not able to travel far for surgery. It is of course vital to provide these patients with the best possible level of care, which we sometimes determine would be better provided in a hospital setting than in our ASC. When we decide this, we are still able to arrange for our surgeons to have continuity in their technology and to provide the same high level of service we provide in the ASC. We contract with Sightpath Medical (Minneapolis) to provide our surgeons with the same surgical technologies they are accustomed to using in the ASC. Sightpath brings its mobile equipment to the rural hospitals in communities where we serve patients, or to our local hospital to treat high-risk patients, and the service is paid for on a per-case basis. With this arrangement, we are able to treat high-risk or special needs patients in a hospital, which not only better serves their needs, but allows us to keep the ASC running most efficiently with more standard cases.

We have seen excellent results using these four approaches to optimizing efficiency. By refining our scheduling, empowering our staff, simplifying paperwork, and taking advantage of outside services, we are able to focus our attention in the ASC on providing the best possible care for patients.

Dr. Cwiak is executive director, The Vision Companies, Louisville, Ky. She can be contacted at sarahelizabethcwiak@gmail.com.
Recruiting an administrator for your practice

by Brad Ruden, MBA

Recruiting and hiring an administrator for the practice—whether replacing someone or recruiting one for the first time—can be a daunting task. In many ways, recruiting an administrator can be more difficult than recruiting a doctor for the staff, as there are no residency or fellowship programs turning out ready-made practice managers.

Furthermore, the skill set for each candidate can vary widely based on experience. Additional training usually only improves current skills. It is very difficult to develop a practice manager from scratch.

Administrative levels

In my experience, there are three broad levels of practice managers:

- Office manager: This is one who oversees limited day-to-day functions of the practice, but the owners make all major decisions (financial, hiring, firing, strategic planning, etc.).
- Administrator: The bulk of practice managers fall into this category. They will run the activities of the practice and make most decisions, while reporting to the owners for input/oversight. This level allows for substantial authority to make decisions without owner input.
- CEO: Few practice managers are CEO-types as there are not many practices run like corporations. This position is seen in some of the larger practices in the country. The CEO typically has autonomy to run all activities of the business with the owners acting as a board of directors.

Define the position

The first step is to determine the skill set necessary for running the practice as well as define the level of authority/autonomy the position will provide.

The most common skill set areas for a practice administrator are:

- Financial (budgeting, accounting, etc.)
- HR (hiring, firing, etc.)
- Marketing (promotions, referral sources, web management, social media, etc.)
- Contracting (insurance plans, maintenance agreements, etc.)
- Strategic planning
- Optical dispensary oversight
- ASC management

You may want to identify the percent of time you anticipate the administrator will spend on each of those areas and weigh each category.

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**I. Position summary:** Provides leadership to the employees of the clinic.

**II. Reports to:** The partners of the practice.

**III. Job standards:**

1. Provides day-to-day leadership to employees at practice.

2. Assists with identifying the expansion of the practice and its referral base.

3. Develops and implements policies and procedures that guide and support the provision of services.  
   a. Reviews and revises current policies and procedures on a regular basis, as well as develops new ones relevant to the changing environment.

4. Recommends a sufficient number of qualified and competent persons to provide care, including treatment.  
   a. Maintains staffing levels to ensure the delivery of service in a timely manner, according to departmental policies and procedures.

5. Establishes the qualifications and competence of personnel who are not licensed independent practitioners.

6. Continuously assesses and improves the performance of care and services provided.  
   a. Maintains performance improvement plan in accordance with practice policies/programs.

7. Maintains quality control programs, as appropriate.  
   a. Ensures that equipment is functioning to manufacturer’s standards through regular maintenance as required.  
   b. Ensures that infection control monitoring is performed, as appropriate.

8. Ensures that complete orientation and in-service training and continuing education opportunities are provided to all persons in the areas.

9. Completes competency assessment for all direct patient care providers in key identified areas that are high risk or problem prone.

10. Recommends space and other resources needed by the practice/practitioners.

11. Participates in the selection of sources for needed services not provided by the practice.  

12. Develops operating and capital budget recommendations and is responsible for compliance with the approved budget.  
    a. Participates in practice-wide budgeting process.

13. Promotes and markets the services offered at the practice through regular attendance at community meetings and events like Chamber of Commerce, health and business expositions, and personal calls on businesses in the area.

14. Leads the development and implementation of the marketing plan of practice.

15. Develops strategic plans/objectives for practice, including product line development, physician recruitment, marketing, etc.

16. Works closely with the partners of the practice to accomplish the job standards listed above.

**IV. Required education, training, qualifications**

1. Experience managing a busy and growing ophthalmology practice with optical and ASC.

**V. Required:** BS in business administration or equivalent; MBA preferred.
accordingly. If you are replacing a retiring/departing administrator, it may help to have her define her job and estimate the percent of time she spend in each area.

See the sidebar on the previous page for a job description I put together for a client.

**Autonomy**

Once the position has been defined, you must decide how much autonomy/authority you will give an administrator to perform the necessary functions. I have seen administrators leave practices because, while they were held accountable, they were not given the authority to freely perform.

It is a very hard thing to cede control of your business to another. The success or failure of an administrator often lies in how much control the owners grant and how much they maintain for themselves.

It sometimes helps to define the administrator’s decision parameters accordingly:

The administrator will be responsible for directing the day-to-day activities of the practice with the following restrictions:

1. There shall be no hiring or firing of any staff without consent of the shareholders.
2. No agreements, contracts, or obligations can be made on behalf of the practice without the consent of the shareholders.
3. No decisions involving an aggregate dollar amount of five thousand dollars ($5,000.00) can be made without the consent of the shareholders.
4. The administrator shall schedule and lead once a month meetings with the shareholders to keep them apprised as to any decisions made or pending regarding the practice.

**Compensation**

Compensation for administrators can vary greatly depending on their responsibilities and the makeup of the practice (i.e., Does the practice have an optical dispensary? An ASC? Multiple locations?). An office manager position can pay in the $40-$50K range, the administrator level position can pay $60K-$100K+, and a CEO level position can range from $100K-$150K+.

In addition to base pay, some will have a bonus plan. There are many ways to approach a management level bonus plan. I am leery of basing it only on growth in collections or on profits. For one client, we designed the following:

1. **Bonus pool.** The bonus pool shall equal one percent of the adjusted annual gross collections of the corporation.

2. **Adjusted gross collections.** Adjusted gross collections shall be determined on a cash basis and is the sum off all collections minus write-offs, adjustments, cost of goods sold, refunds, etc.
   a. The calculations shall be made by the corporation’s regular accountant in good faith, employing consistently applied accounting and valuation methods, and such determination shall be final and binding.

3. **Bonus payout.** The bonus pool shall be paid out accordingly:
   a. **Part 1:** Part 1 represents twenty five percent (25%) of the bonus pool. Part 1 is earned and paid if the corporation’s adjusted gross collections exceed the adjusted gross collections of the previous fiscal year.
   b. **Part 2:** Part 2 represents twenty five percent (25%) of the bonus pool. Part 2 is earned and paid if employee receives a rating of “good” or “great” during a written performance review by the corporation’s owners.
   c. **Part 3:** Part 3 represents twenty five percent (25%) of the bonus pool. Part 3 is earned and paid if the corporation is not found in violation of any laws, statutes, medical practice guidelines, rules or regulations, etc.
   d. **Part 4:** Part 4 represents twenty five percent (25%) of the bonus pool. Part 4 is earned and paid if for nine (9) of the fiscal year’s twelve (12) months, the corporation reached monthly goals of patient volume and procedures performed.

4. **Bonus payout.** Any bonus monies earned shall be paid within sixty (60) days after the end of the fiscal year.

**Summary**

It takes a large amount of trust to turn control of your business over to another. The first step in creating trust is having confidence in the person you hire. That confidence will come from hiring the right person, and hiring the right person begins with a clear idea of your needs and the skill set necessary to fill them.

[Mr. Ruden is a Certified Valuation Analyst, MedPro Consulting & Marketing Services, Scottsdale, Ariz. He can be contacted at 602-274-1668 or bruden@medprocms.com.]
We have now seen the paradigm shift to where many physician practices are being sold to hospitals and/or carriers. We are on the cusp of the MEGA shift in healthcare unlike anything we’ve seen before. We are also starting to hear from these buyers about some early stage problems they are encountering concerning some of their physician purchases and the attitude displayed therein.

To investigate these issues, one must emphasis that you make yourself invaluable to your employer. This is exactly where the concept of maximizing the three “As” is essential and critical. You as physicians must make yourself:

- Available
- Affordable
- Affable

Each of these critical “As,” when accomplished, will make you invaluable to your employer.

**Available**

You must be available to work the hours needed for both patients and your employees. That means working extended hours and/or Saturday hours or simply non-traditional hours. Today patients have choices and demand convenient patient-driven hours. A more flexible schedule is a must in today’s healthcare world.

**Affordable**

This is the key to a successful business model that will allow you to be price sensitive to patients, carriers, and the market as a whole. In healthcare today, you have to have a price point that is median in the market. More and more patients are having a higher co-share, paying more and higher deductibles, and taking more of the burden of cost on themselves. Your fee schedule and management is critical to today’s market.

**Affable**

This is essential to survival in today’s healthcare environment. It is no longer acceptable to not be on time, pleasant, and knowledgeable of the history of the patient. The expectation of the patient at the minimum is to have a conversation with the doctor—conversation, not a one-way discussion. Having a pleasant personality and knowing the art of communication are demanded today. The number one complaint we see in our surveys is untimeliness of the physician and the lack of conversation; therefore, a lack of understanding leads to poor healthcare.

Patients leave practices for two critical reasons: personality and communication (the lack therein from the physician). These concepts are expected in today’s healthcare marketplace.

Expect your new employer, as well as the patients, will want a physician to be on time, price sensitive, caring, and personable.

We are on the verge of the biggest paradigm shift in healthcare we have ever seen. Physicians are being sold every day to hospitals and carriers, and those new buyers will only keep physicians who follow this creed.

These rules or guideposts are not new. We have been preaching these concepts for years. You must follow the three “As” to survive and be successful in today’s marketplace: affordability, availability, and affability (personality). Don’t think that today’s new employers are the same old, same old—they are not! They’re creative, resourceful, strategic thinkers, and know where they are going. Be invaluable so when the tram leaves the station, you will be on it. Don’t miss this one—it’s the last one out. OB