SECTION

4

OFFICE ADMINISTRATION and HUMAN RESOURCE ISSUES

Office Organization, Structure, and Systems

CHAPTER 16

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Good order is the foundation of all good things.
Edmund Burke *Refl ections on the Revolution in France*

Many practices struggle because the practitioners believe that "because they understand how to do the technical work—the work of the doctor—they understand how to build a successful business." Gerber describes this scenario in his book *The E-Myth Physician*. In the past, it was possible for practitioners to completely ignore the business operation of a practice and concentrate on serving patients, yet still earn a comfortable income. Today, with the soaring cost of operating an optometric practice, the increase in third-party reimbursement, a competitive marketplace, the expanding need for sophisticated instrumentation, and the influence of managed- care organizations on health care services, neglect of business issues results in inefficient practice management systems. This lack of efficiency will require the practitioner to work longer hours to meet expenses and will impact the quality of care.

There are two components operating in the management of an optometric practice: a professional component and a business component. The professional component involves the practitioner's efforts at providing quality care to patients. The optometrist is trained to provide quality care; thus a practitioner spends most of the day in this area. To provide quality care, the practitioner invests time and money to improve technical skills and purchases modern instrumentation to improve accuracy and efficiency of testing. The business component involves the administration of the practice. Even though the optometrist might not be trained in this area, it should be given as much time, effort, and energy as the professional component. The skills and personality needed to be an effective manager and administrator are different from the skills required to be an effective health care practitioner. Maximizing the efficiency of the business component of a practice will result in an environment in which the practitioner will be able to provide the best quality of care for patients. If a practice is not efficient, organized, and properly managed, the quality of care eventually will be compromised. In any community, the most successful practitioners are those who provide a high quality of care integrated with successful and accepted business practices.

There are basic guidelines for organizing a private practice. The process begins with the structure of the practice, which is developed concurrently with a systems approach to organization.

STRUCTURING A PRACTICE

The structural approach to business originated in 1911, when Frederick W. Taylor, the father of time and motion studies, divided tasks into parts and designed organizations for maximum efficiency. Over time, others, such as Henri Fayol, Lyndall Urwick, and Luther Gulick, expanded Taylor's "scientific management" approach.

People prefer structure. Moeller studied the effects of structure on teacher morale in two school systems. One school system had a centralized hierarchy, with a clear chain of command and tight control. The other school system encouraged wide participation in decision-making and was loosely controlled. Moeller discovered higher faculty morale in the school system with tight control. Adler and Borys argue that structure enhances morale if it helps get work done but has a negative impact if it interferes with getting work done.

Exceptions exist. Nordstrom department stores are known for extraordinary customer service. New employees are handed a rulebook containing only one rule: "Rule 1: Use your good judgment in all situations. There will be no additional rules." (The necessity to hire staff who possess good judgment is thus imperative!)The balance between rigidity and flexibility and between autonomy and inconsistency are core issues in the structural approach to business.

Bolman and Deal identify six assumptions to help guide the structural organization of any group:

- Organizations exist to achieve established goals and objectives.
- Organizations increase efficiency and enhance performance through specialization and a clear division of labor.
- Appropriate forms of coordination and control ensure that diverse efforts of individuals and units mesh.
- Organizations work best when rationality prevails over personal preferences and extraneous pressures.
- Structures must be designed to fit in organization circumstances, including its goals, technology, workforce, and environment.
- Problems and performance gaps arise from structural deficiencies and can be remedied through analysis and restructuring.

Once it has been decided how to organize the business, the next step is to define the business structure and determine if this structure can deliver the services and materials promised. Successful practices use lateral and vertical structures to achieve the practice goals.

Lateral structure is achieved through office meetings, task forces, committees, and network structures. Lateral structure tends to be more flexible than vertical structure but has the potential disadvantage of squandering excessive amounts of time and energy, as well as being the source of conflict and confusion. To maximize the efficiency of lateral structure, controls must be put on time, process, and content.

Several approaches can be used to achieve vertical structure. The most common forms of vertical structure are command structure, functional structure, and classic structure.

Command structure is typified by military organizations. In an eye care practice, the command structure typically is: doctor (owner) then office manager then staff members. The advantage to this approach is the very clear command lines. All decisions are made by the doctor-owner. The disadvantage to this approach is the bottleneck that can form when the doctor- owner is in the examination room and a decision outside the examination room needs to be made. Smaller to midsize eye care practices tend to use the command structure.

A functional structure is often used to divide the eye care practice into the following segments: front office, back office, clinic, and dispensary. The front office has the responsibilities of patient reception, "front desk" duties, and patient flow. The back office has the responsibilities of accounting and billing. The clinic has responsibility for anything that occurs in the clinical portion of the practice (e.g., pretest, examination room supplies, and auxiliary testing). The dispensary would be responsible for everything that happens in the dispensary. Small to midsize eye care practices tend to use this structure.

A classic structure is used by most businesses today. Common subdivisions of classic structure are human relations, procurement, information technology, operations, finance, quality control, public relations, and administration and management. Larger eye care practices tend to use this type of structure. A typical breakdown of the subdivisions of the classic structure is listed in Table 16-1.

In a smaller practice, all of the activities listed in Table 16-1 are divided among the office staff. Since the office staff has fewer people, each person may have multiple responsibilities. In a larger practice, one person may be assigned to each area. It is becoming more common to see specialized areas subcontracted from other businesses. Two examples of this would be human resources and information technology. Because of the importance and effort required to properly manage the area, it is not unusual to see scheduling given its own subdivision for emphasis in a larger eye care practice. The amount of attention paid to each area is a measure of the business effectiveness of the practice. The more attention paid to each area, the more effective the practice will be as a business.

Vertical structure may be used to organize work responsibilities in the practice, while the flexibility of lateral structure may be used to achieve practice goals, solve practice problems, and communicate with staff. For example, if a reduction in remakes is desired, vertical structure is employed to assemble a task force that would include at least representation from human relations, operations, quality control, and administration and management. (Other areas might be information technology and finances.) Having assembled a task force, lateral structure allows these individuals to problem solve how to reduce the number of remakes, run a pilot program to ensure success, and then make system changes within the practice. This task force should be given a time deadline and a representative from administration and management should work with the task force to make sure meetings are run efficiently and effectively.

TABLE 16-1

Classic Structure Subdivisions

Human relations
Hiring and Training
HR Reporting and Management
Firing
Procurement
Equipment
Clinic Supplies
Inventory
Information Technology
Computer System
Telephone System
E-Mail and Website Management
Operations
Scheduling
Examination
Treatment and Dispensing
Finance
Revenue
Expenses
Tax Reporting
Quality Control
Staff Proficiency Testing, Education and Discipline
Patient Quality Control
Laboratory Quality Control
Public Relations
Internal Marketing
External Marketing
Success Stories
Administration & Management
Risk Management
Future Planning
Practice Management

CREATING SYSTEMS

It has been observed that "great businesses are not built by extraordinary people but by ordinary people doing extraordinary things." To produce consistent results, there must be a system, or "a way of doing things," to permit ordinary people to do extraordinary things. Systems are the tools that staff uses to increase productivity, to get jobs done consistently, and

to successfully differentiate a practice from its competition, according to Gerber in *The E-Myth Revisited*.

The actual work of the practice is delivering services and materials to patients. A systems approach is the best approach to ensuring high quality delivery of services and materials. This approach allows for the delivery of each service or material in the practice in a consistent manner.

Not all work in a practice is created equal. The practitioner must decide what is most important to produce in the practice and must identify a way of measuring the end product of each service or material that is considered to be most important. Then the flow of each of these services must be mapped from start to finish. A process map is a useful tool that can be used to do this. First, each step is identified, and then the system is constructed to make sure the services or materials are delivered consistently with high quality. Once the work to be done has been identified, the number of staff members needed to manage the system can be identified.

Systems require documentation. Without an office procedures manual for each system, all work turns into exceptions. Documentation provides structure and instructions on the most efficient and effective way to get jobs done, including the exceptions. Written standard operating procedures (SOPs) are tools used to reduce performance variance.

MANAGING SYSTEMS

"To measure is to know" and "If you cannot measure it, you cannot improve it" are two statements by Sir William Thomson (also known as Lord Kelvin) that are often quoted. Without measurement and management based on measurement, the operating mode of a practice is based on gut instinct and assumptions about how the business is performing. Utilizing management based on business metrics, sometimes called *key performance indicators* (KPIs), is essential in today's business environment (see Chapter 36). Management based on business metrics is different from just reviewing historic practice numbers. Unless the practice business metrics are reviewed in the context of future goals, all a practitioner is doing is looking in the rearview mirror. The following seven-step process can be used to get started with business metrics.

1. Define the numerical goals to be achieved.
2. Define the metrics to be measured.
3. Benchmark current status.
4. Create a system to monitor and report metrics.
5. Communicate metrics with employees.
6. Review the metrics and make decisions.
7. Promote successes.

Just as there are many ways to measure physical health, there are many business metrics you can measure in any practice. Table 16-2 lists 15 important business metrics that can provide a good overview of the health of a practice. If you are not familiar with the process of managing by business metrics, the process may seem overwhelming at first. To make the task more manageable at the start of the process, consider the following three guidelines:

TABLE 16-2

Important Business Metrics

TOTAL DOLLARS

- collected
- spent on cost of goods sold
- spent on payroll including wages and benefits
- spent on marketing
- spent on occupancy costs
- spent on overhead
- collected from self pay patients

TOTAL NUMBER OF

- self pay patients
- staff hours worked
- examinations seen
- new patients
- hours the practice was open
- full-time employee equivalent (FTE) staff members
- full-time equivalent (FTE) doctors

NET INCOME

Rule, Roger C.; The Rulebook of Business Plans for Startups: The Oasis Press/PSI Research; Central Point. Oregon; 2000; P. 36.

1. At first, focus on only a few important metrics.
2. As quickly as possible, find the right frequency of meas ur ement (i.e., daily, weekly, monthly, quarterly, or yearly)
3. Reevaluate metrics at least quarterly to make sure the correct metrics have been identified and the appropriate frequency of measurement is used.

The value of a systems approach has been summarized by Gerber in *The E-Myth for Physicians* as follows: "As you probably already know, people are almost impossible to manage. What's more, they are inconsistent, unpredictable, unchangeable, unrepentant, irrepressible, and generally impossible. The time has come to grasp what management is really all about. Rather than managing people, management is really all about managing a process, a step-by-step way of doing things, which, combined with other processes, becomes a system."

REFINING SYSTEMS

Over time, as practice control improves, managing by business metrics becomes easier. It is interesting to note that focusing attention on any aspect of a practice tends to increase the performance of that area. It could be a result of the old adage that people do not always do what you expect, but most of the time they do what you inspect. Attention must be paid to the key areas of practice that are essential to delivering high-quality services and materials to patients. When a problem is identified in the delivery of a service or materials, systems must be reviewed to determine where the breakdown occurred. When that is accomplished and the problem is fixed, the staff must be retrained to ensure that the problem does not occur again. A common mistake is to address the problem without adjusting the system. Although this will fix the problem temporarily, it will be just a matter of time before the problem resurfaces.

Gerber offers the following questions to help refine systems:

- What is the result we intend to produce?
- Are we producing that result every single time?
- If we are not producing that result every single time, why not?
- If we are producing a result every single time, how could we produce even better results?
- Do we lack a system? If so, what would that system look like if we were to create it?
- If we have a system, why are we not using it?

Selecting the best structure for the practice makes sure proper attention is being given to all the functions of the practice and that proper responsibility has been assigned for every area. Creating, managing, and refining the systems of the practice ensure that consistent, high-quality services and materials will be delivered to patients.

CHOOSING A BUSINESS ORGANIZATION

A key decision when starting a new practice involves the choice of business organization under which the practice will be conducted. Selecting the right business organization is essential to providing the best legal and tax protection for the practice. The organizational and administrative demands of different types of business entities vary considerably, as do the tax, accounting, and liability issues for these entities (see Chapter 3). In ascending order of complexity, the choices of business organization are as follows:

Sole Proprietorship. One person owns the entire business and keeps all the profit. Setting up the sole proprietorship requires minimal paperwork and cost. The administration of the practice is at the discretion of the practitioner. The sole proprietor is liable for all debts and legal claims involving the practice. Taxes are paid by the practitioner on the profit earned from the business.

General partnership. Two or more practitioners may create a partnership. Filing of paperwork and organization of the business must comply with state law. Articles of partnership are used to describe the organization and administration of the practice. Sharing of income is usually in proportion to the percentage of ownership among the partners. Each of the partners is individually responsible for the debts and other legal claims (such as malpractice) of the business. The partnership itself is not taxed, only the partners are taxed, based on the share of profit each receives.

Limited liability company (LLC). One or more persons may form an LLC through the filing of documents in accordance with state law. The administration of the LLC is controlled by an operating agreement, and administrative duties are usually shared by the members. The LLC is responsible for contracts and provides protection for the members from personal responsibility for debts, obligations or other liabilities. An LLC pays no federal income tax, and members pay taxes based on their share of business profit. State laws differ as to how the LLC is treated for state income tax purposes. Some states do not allow health care entities to operate as an LLC.

Subchapter S Corporation. An S corporation can consist of one person or up to 100 individuals. To form an S Corporation, documents must be filed with the state to create a corporation. Then, within a specific period of time, additional paperwork must be filed with the Internal Revenue Service (IRS) to elect to do business as an S corporation. In addition, shares of stock must be provided for the owners, meetings must be held to elect the board of directors and officers, and bylaws must be drafted for the administration of the practice. Periodic meetings and recorded minutes are an administrative obligation. Debts and liabilities are the responsibility of the Subchapter S corporation, not the shareholders, thus there is some protection from individual liability. The S corporation pays no tax—all profits (including dividends) are passed through to the individual shareholders.

Professional association (PA) or professional corporation (PC). A PA or PC can be formed by one or more persons, but they must all be licensees. Articles of incorporation are filed with the state, stock is divided among the owners, and elections are held for the board of directors and officers. Bylaws must be adopted, and minutes of meetings recorded. These are the regular obligations of doing business as a PA or PC. Because the corporation is an artificial entity under law, it can enter into contracts and litigate legal disputes in its own name. This standing also allows the PA or PC to provide limited liability for the owners, both for debts and for liability claims. The corporation must pay taxes on profits, and shareholders must pay taxes on wages, bonuses, or dividends.

The different tax requirements of these business organizations are described in Chapters 3 and 39.

GETTING STARTED

When beginning a private practice, it is essential that the practitioner obtain a support network of advisors. Professional consultants can provide valuable advice, and good business strategies are as important to the stability of a practice as are satisfied patients. The practitioner should establish relationships with a banker, attorney, accountant, and insurance agent. These relationships are essential to the organization of a practice. A banker is needed because loans and checking accounts need to be obtained at a full-service bank. An attorney can be consulted for advice and assistance related to the type of business organization being formed and the legal steps required to begin the business. An accountant is needed to provide advice and assistance about the withholding and paying of taxes. An insurance agent should be consulted to obtain office contents, disability, office overhead, life, and premises liability insurance; malpractice coverage; or any other insurance coverage needed for the protection of health, home, and personal property (see Chapter 23).

One of the most valuable means of evaluating a potential advisor is asking other professionals about the advisor's reputation. If other health care providers have found the advisor's services to be helpful and reasonable, it is a good sign. A meeting should be scheduled to discuss how the advisor can

be helpful, as well as the cost of the advisor's assistance. At this meeting, it is appropriate to inquire about the advisor's years of experience and how the advisor keeps up-to-date with current trends, legislation, and client needs.

A key task for the beginning practitioner is the formation of an office staff. To identify potential staff members, advertisements or other means of contacting qualified applicants should be used. The standard process for interviewing and evaluating candidates should be followed (see Chapter 17).

Another important task is to contact representatives of optical laboratories and frame and contact lens manufacturers. A frame and contact lens inventory must be assembled, and accounts must be opened at the optical laboratories with which the practice will be doing business. In addition, inventories of supplies, such as ophthalmic drugs and solutions, stationery, business cards, appointment reminder cards, recall notices, magazine subscriptions, prescription pads, examination forms, and record folders, should be ordered. Fee schedules also need to be set (see Chapter 33).

The practitioner must enroll as a provider in thirdparty health care plans such as Medicare, Medicaid, Vision Service Plan (VSP), and medical insurance (e.g., Blue Cross/ Blue Shield). Although Medicare and Medicaid are federal programs, enrollment is performed at the state level, through bureaucracies that administer these programs. If there are health maintenance organizations (HMOs) or other types of managed care panels in which the practitioner wishes to participate, enrollment must be solicited (see Chapter 34). It usually requires several weeks for the enrollment process to be completed, and ample time should be allocated.

If the practitioner is not already a member of the state optometric association, an application should be obtained and submitted.

Telephone service should be initiated (deadlines for inclusion in the annual directory need to be determined), and accounts with utility companies (electricity, gas, and water) should be opened. Answering and paging services should be contacted, and janitorial services need to be obtained.

The visibility of the practice is important in attracting patients. Signs for the office, announcements of the opening in the newspaper, Yellow Pages listings, and other means of putting the public on notice should be secured. An Internet site may be established.

These are but a few of the many tasks that await the new practitioner. A checklist should be devised so that omissions are kept to a minimum (Box 16-1).

BOX 16-1

Time Table of Things to Do When Starting a Private Practice

1 YEAR BEFORE STARTING A PRACTICE

Obtain demographic and health resource data on the chosen practice location from books, guides, and the local Chamber of Commerce.

Visit the community to discuss the need for optometric services (optometrists, dentists, physicians, pharmacists, bankers, teachers, school nurses, real estate agents).

Talk with representatives from ophthalmic laboratories about opening a practice in the community. Make site visits to determine the practice location. If possible, make a final decision on the practice location.

Contact the state board of optometry about the requirements for licensure. Obtain a copy of the state optometry laws.

Check on membership in local, state, and national professional societies.

Determine the date that information must be submitted to be included in the white and Yellow Pages telephone directories. If possible, reserve an office telephone number.

Visit banks to meet bank officers. Obtain a loan application from the loan officer and determine the information and format needed to submit a proposal to obtain practice financing.

At the bank selected, open personal and business checking accounts.

Prepare a loan proposal to obtain the necessary capital for equipment and operation of the practice. Submit the application within the appropriate deadline.

9 MONTHS BEFORE STARTING A PRACTICE

Check the office site and determine whether leasehold improvements will be needed. Obtain necessary estimates for the improvements.

Check with the local city hall or zoning board to determine the requirements of zoning ordinances that apply to the site chosen.

Determine office layout and design.

Determine office and professional equipment that will be needed. Select professional advisors (accountant, attorney, banker, insurance agent, real estate agent).

Obtain bids on the purchase of office and professional equipment. Compare leasing versus purchasing.

6 MONTHS BEFORE STARTING A PRACTICE

Obtain the services of an answering service (physician's exchange, beeper service, call forwarding).

Meet or talk with representatives of Medicare, Medicaid, and other third-party insurance carriers. Obtain provider numbers, prevailing fee schedule (Medicare), insurance claim forms, and copies of procedure codes (CPD-4) and diagnostic codes (ICD-9).

Obtain application for hospital privileges.

Order office record system.

Plan and order an accounts receivable or payable system.

Plan and order payroll accounting system.

Order sign for office.

Notify frame, contact lens, and pharmaceutical representatives of the practice.

Obtain county and city occupational licenses (from the county or city clerk or city hall).

3 MONTHS BEFORE STARTING A PRACTICE

Obtain professional liability insurance coverage.

Obtain office insurance (office overhead coverage, office liability, business interruption, employee fidelity bond, office

Continued

BOX 16-1

Time Table of Things to Do When Starting a Private Practice-cont'd

contents). Umbrella coverage provides comprehensive catastrophic

coverage for liability claims that are beyond the limits of regular insurance.

Determine whether worker's compensation is required by state law by consulting with the state worker's compensation board or industrial commission.

Obtain health and accident insurance coverage for yourself and employees.

Obtain disability insurance coverage.

Obtain life insurance coverage.

Obtain automobile insurance coverage.

Arrange for telephone service and installation. Determine the telephone equipment and system to be purchased.

Order office opening announcements. Discuss the placement of advertisements in local newspapers.

Meet with local physicians who are potential referral sources.

Send follow-up letters.

If there is a local referral service through the optometric society, provide the information needed to be listed.

Check on membership in local civic and religious organizations and join as appropriate.

Arrange for movers, if necessary.

Write preliminary job descriptions for employees. Obtain a sample office procedures manual.

Begin the effort to locate employees for the office (advertising, interviewing).

Apply for a federal employer identification number from the Internal Revenue Service (Form SS-4).

Apply for a state employer identification number through the state employment office or Department of Labor.

Obtain the Small Business Tax Guide (Publication 334) and Your Federal Income Tax Guide (Publication 17) from the Internal Revenue Service. Obtain the appropriate tax forms from the IRS and the state employment office or Department of Labor.

Obtain payroll withholding booklets for federal, state, and local taxes from the IRS.

Review tax withholding and reporting requirements with an accountant or tax attorney.

Choose and order an appointment scheduling book or system.

Arrange for appropriate office support services as needed (janitorial, snow removal, laundry service, lawn care).

Order clinical supplies and set up an inventory control system.

Order necessary business supplies (appointment cards, business cards, letterhead stationery and envelopes, patient recall notices, petty cash vouchers, deposit stamps for checks, prescription pads, purchase orders, preprinted telephone message pads).

If desired, meet with collections attorneys or agencies about the collection of unpaid accounts.

Determine fee schedule.

Select and order magazines for the reception area. Also select and order professional journals.

Purchase office equipment and furniture and arrange for their delivery to the office.

Arrange for laboratory services at optical laboratories.

Notify area pharmacies that you are starting a practice.

Select any patient information materials and have them printed or delivered.

Obtain a postage meter and a bulk mail permit, if necessary.

1 MONTH BEFORE STARTING A PRACTICE

Start setting up the office.

If necessary, have the utilities turned on.

If not previously arranged, have signage displayed.

Hire and begin training office personnel, with emphasis on telephone techniques, appointments, collections procedures, office policies.

Begin making appointments.

Establish a petty cash fund.

Have announcements of the office opening published in the local news media.

Mail announcements of the office opening to local physicians, pharmacists, health groups, school nurses, and others as appropriate.

Hold an "open house."

Begin seeing patients.

Modified from Park DL: *Optimum timetable for starting your practice.* Uriah, CA, 1990.

PATIENT MANAGEMENT

Efficient patient management requires a coordinated effort from both practitioner and staff, combined with well-rehearsed patient flow, effective communication, scrupulous bookkeeping, and conscientious attention to detail. To provide orderly management, the practitioner must organize the facility, staff, and paperwork. Staff members must be instructed about how the system is to be run. Ongoing evaluation is an integral part of an efficient office; regular meetings between practitioner and staff to identify and eliminate deficiencies are necessary. Coordination of effort can be achieved with adequate planning and experience, but cohesion between practitioner and staff requires a different form of interaction: trust. The staff must trust the practitioner to establish a workable plan, and the practitioner must trust the staff to carry it out. The trust between practitioner and staff must be mutual; if it is not, it will be apparent to patients. Patients seek a satisfying relationship with both practitioner and staff. This requires that patients be treated with respect, be rendered competent service, and be given individual attention. When these objectives are achieved, trust is the result. Trust is the cornerstone of patient loyalty, and it is an inevitable ally of efficient management. The four cornerstones of effective patient management are availability, efficient patient flow, communication, and troubleshooting.

Availability

Inefficient appointment schedules present an obvious problem for optometrists. The availability of the practitioner is based on the following policy decisions adopted by the practice:

- What days will the office be open?
- What will be the office hours?
- How much time will be allocated for each appointment?
- How will the practitioner's absences be managed?
- How will emergencies or "walk-ins" be served?

These are decisions that must be made at the onset of a new practice. Modifications can be incorporated into the schedule as time permits.

Office Hours

Determining the days and hours available for patient examination depends on several factors: the cost of staff and office overhead, the needs of the patient population being served, the quality of life the practitioner wishes to enjoy, and similar considerations. When debating the scheduling of weekend or evening office hours, the practitioner should consider the long-term ramifications. Once these times are offered, it can be difficult to eliminate them. In competitive areas, where it is common to have two working spouses, it might be necessary to offer expanded hours of operation.

In many practices, the newest associates see patients in the evenings and on Saturdays. Since more than 70% of households in the United States have both the husband and wife working outside the home during the daytime hours, evening and weekend appointments are highly desirable in many communities. In fact, seeing patients in the evenings and on weekends allows new associates to develop their skills sooner and become partners. More important, patients deeply appreciate the extended office hours, and being open during unconventional business hours shows that the practitioner cares about the patients' needs.

Patient Scheduling

The allocation of time for appointments will differ according to service. Contact lens fittings, eye health assessments, glaucoma follow-ups, and low-vision examinations all require different amounts of time. The practitioner must determine the time to be allocated for each service, and the receptionist who schedules appointments must be told how to provide the proper amount of time for each patient. Particularly important is the use of pupillary dilation, which adds time to the examination and changes the flow of patients.

Patient scheduling is a reflection of the philosophy of care. In many practices, each patient is scheduled for 30 to 45 minutes or even an hour. The visual analysis not only consists of the traditional optometric procedures but also routine pupillary dilation and examination using the binocular indirect ophthalmoscope; assessment with a 60, 78, or 90 D fundus lens; Goldmann tonometry; blood pressure measurements; automated perimetry; and other tests such as intraocular imaging. It is common to recall patients every 1 or 2 years for a routine visual analysis.

Checkup visits for contact lenses are typically scheduled for 15 to 30 minutes. A patient who is interested in being fitted for contact lenses is scheduled for a 1- to 1½-hour examination. Office visits are usually 15 minutes. There are two basic scheduling methods. The "stream" method of patient scheduling requires appointments to be equally spaced throughout the day in 1-hour or 1½-hour intervals. The "wave" method entails scheduling patients in groups, for example, two patients are scheduled at 8 am , one at 8:45 am , and two at 9:30 am . If one patient is late or if the optometrist needs more time with a patient, the wave will help average the time spent with each patient.

The use of pupillary dilation extends the amount of time needed for examination and can disrupt the examination sequence. During the 15 to 30 minutes needed to achieve adequate dilation, the patient should be removed from the examination room so that the room can be used for the evaluation of another patient. A special room can be set aside for patients who are waiting for dilation. They can be taken to the dispensary, they can be given a visual field test, or they can be returned to the waiting room. Management must be coordinated between practitioner and staff to ensure that efficient use is made of this time and that unnecessary delays are avoided.

It might be necessary to rehearse the movement of patients on a drawing of the office layout and to have "walk-throughs" to ensure that patient flow is properly controlled. Meetings between the practitioner and staff members also can be used to identify problems and arrive at solutions.

Absence of the Practitioner

Practitioner absence not only affects availability but also disrupts continuity of care. If a practitioner is not available because of vacation, illness, or continuing education, a patient in need of care must seek another eye care provider. Coverage by other practitioners during these periods must be planned, and patients calling for care must be appropriately notified or directed to substitute clinicians by the practitioner's staff.

Patients seeking emergency or urgent care do not often call for appointments. An efficient office must be able to offer services to "walk-in" patients who require timely diagnosis and treatment. To manage these patients, many offices leave appointment slots open just before lunch and in the late afternoon to ensure that time is available.

When a patient calls for an appointment, the preferred method of scheduling is to offer the patient two specific dates and times and to permit the patient to choose the one that is most convenient. If neither time is acceptable, a third compromise choice can be offered. It is not a good idea to ask the patient "When would you like to come in" as the message perceived by the patient is "I can come whenever I want". That message leads to late arrivals, no shows or frequent rescheduling of appointments as the patient concludes that the doctor is really not that busy. The patient's name, status (new or former patient), and telephone number should be noted in the appointment log or computer entry. Because changes in scheduling of appointments are inevitable, log information is written in pencil. Erasures can be used when necessary to change and refill appointment slots. Computerized appointment systems also should be flexible.

The patient should be reminded of the appointment before the scheduled time, and the receptionist should note in the log that this reminder has been given. A list of each day's appointments should be prepared for the practitioner and posted in the examination room or on the door to the room. A master list of patients can be maintained on computer, which also can keep track of "no shows," recalls, and referrals.

Patient Flow

Patient flow for a new practice can be divided into the following three phases: the initial buildup of a patient base, which generally requires 5 to 7 years; the plateau, a period of 2 or 3 decades during which the practitioner enjoys a fairly stable patient base and income; and the preretirement phase, a period of declining practitioner involvement and patient flow, which can last 5 to 10 years.

For each of these phases, the demands of patient flow are different. At all phases, however, efficient movement of patients through the office is necessary to reduce patient waiting time, eliminate unnecessary delays, and keep "chair time" to a reasonable level. Efficiency is especially desirable when a practitioner has only one examination room. Scheduling patients is particularly important and has to be carefully planned but can be disrupted by the cancellation of appointments, appearance of unexpected "walk-ins," late arrival of patients, or misallocation of time for examination.

As soon as a patient enters the office, management is necessary. Time spent waiting to be examined should be kept to a minimum. This time can be used for the filling of forms and providing pertinent information. If a technician is available to assist the practitioner, the patient can be moved to a room for preliminary testing. This room can be an examination room or another room used for the purpose of initial evaluation. Then the patient can be moved to the examination room so that the practitioner can perform the necessary testing. After the practitioner has finished, the patient usually must be taken to the dispensary and after that, to the waiting room or administrative office where financial details can be settled.

Patient Communication

Nonverbal communication is of well-established importance: dress, conduct, and physical environment all assist in creating an impression, favorable or unfavorable, of the practitioner. Various written and verbal communications also are influential in the formation of a favorable impression of practitioner and practice. The most important forms of communication include the following:

- Reception of patients in the office
- Telephone conversations with patients
- Oral and written communications in the office
- Mailings to the patient

Each of these forms of communication requires a brief commentary.

Reception of Patients

The reception room should be comfortable, clean, and capable of putting the patient at ease. Numerous decisions must be made to create an environment that achieves these goals. Is smoking permitted? Is there a play area for children? Is there adequate room for all patients? Are toilet facilities conveniently available, and are they handicapped accessible? Is there a wide range of current reading material? Similar questions also need to be asked with regard to the decor of the reception room and the conduct of the receptionist. Unless all these considerations are planned for (and evaluated periodically), an undesirable impression can be conveyed.

Telephone Conversations

The manner in which telephone queries are handled by a receptionist is significant; patients are commonly won or lost on the basis of these brief conversations. Practitioners must ensure that receptionists receive proper training in this vital area of patient communication. Many sources can be consulted to obtain this training, including telephone companies, practice management consultants, and various publications. Some basic considerations include the following:

- The telephone voice and personality of the receptionist should be an asset at all times.
- Telephone "busy signals" should be avoided with the use of the proper telephone technology.
- The receptionist should be capable of succinctly answering patient questions about examination fees and charges for materials.
- Telephones should be available in key areas of the office such as the reception desk, the dispensary, and the practitioner's office.
- Receptionists should be able to triage patient complaints and schedule patients who require emergency or urgent care for same-day examinations.

Receptionists are often questioned by patients about matters of clinical care that are outside their area of expertise. Receptionists should understand how to manage these situations so that patients are not offended and erroneous information is not conveyed.

Paper Flow

The average office has the following three typical avenues of distribution and dissemination of paper: information given directly to patients; prescriptions and other records of care; and follow-up mailings such as bills, recall notices, and newsletters.

Patient information includes brochures, instructional booklets, fitting agreements for contact lenses, and similar documents. These items can be especially useful with contact lens patients, when medicines are prescribed, or if patient education is needed for a complex condition such as glaucoma.

Records should be carefully controlled, especially in light of confidentiality requirements established by the Health Insurance Portability and Accountability Act (HIPAA). Although the practitioner is the owner of the record, the patient has a right to review the information in the record and that

right should be respected. Policies for the release of contact lens prescriptions should be adopted in all offices and should conform with the requirements of federal and state law. When patients move or change practitioners and request the transfer of records, it is preferable to provide a summary of essential information rather than a verbatim copy. The practitioner should retain the original record for as long as practical, but at a minimum for the period required by law.

Follow-up mailings, such as newsletters, can be used to provide information on new services or instruments; cards thanking a source of referrals can be used as a practice builder; and computer-generated reminder notices can personalize the effort to provide recall. The ways in which follow-up mailings can be used to communicate more effectively with patients are limited only by the ingenuity of the practitioner.

Management does not end after a patient leaves the office. It might be necessary to schedule the patient to return for the dispensing of ophthalmic materials, to recall the patient for further examination, or to refer the patient to another health care provider. Appropriate steps must be taken to ensure that the patient understands when and where to go. Patient communication is an integral part of efficient management.

Troubleshooting It is inevitable that difficulties occasionally arise in the management of patients and that troubleshooting will be required. These problems are often of acute onset and can be trying to both the practitioner and the staff. If managed improperly, the effect can involve not just one patient but several. Patient control is more easily achieved if procedures have been developed for management. Also, patient satisfaction is more likely.

Although there are numerous potential sources of conflict with patients, the most common situations involve fees, ophthalmic materials, and prescriptions. Some pointers for troubleshooting in these situations include the following:

- With the complexities of third-party care, mistakes do occur. Make sure a knowledgeable staff member (or the practitioner) reviews the billing before telling the patient that no mistake was made.
- Complaints about fees should be answered honestly and openly; candor is never inappropriate in such a situation.
- Be certain that spectacles are correct before debating with a patient.
- Do not be reluctant to recheck refractions or other sources of patient dissatisfaction.
- If ophthalmic materials are incorrect, make them right.
- Try to resolve patient disputes in an amicable fashion. Arguments do not contribute to the benefit of the practice.
- Establish a written office policy for the release of contact lens prescriptions after fitting.
- To reduce conflicts over contact lens prescriptions, de-emphasize charges for materials such as contact lenses and place more emphasis on fees for services.
- Offer patients a spectacle prescription (if needed) after the examination is concluded.

One of the keys to effective troubleshooting is to project confidence when dealing with the patient. Confidence is an attribute that is easily communicated to a patient, and it also is just as evident in its absence. To feel confident, technical expertise is required. Education does not end after graduation from training; it persists throughout the professional lifetime of the practitioner and staff. Knowledge is often the difference between settling a problem and leaving the patient dissatisfied. Optometrists and staff should work diligently to keep up with technical developments and to use them for the benefit of those they serve.

Another key to projecting confidence is to have an established method for management of a problem. Such methodology is usually the result of experience or trial and error, but common sense often will go a long way in attempting to resolve patient disputes. Both practitioner and staff must discuss and develop ways of efficiently dealing with patient management problems. Efficiency is a learned skill that repays many times the time spent in its acquisition. It is of unquestionable assistance in developing effective patient control.

RECORDKEEPING

Recordkeeping is a necessary obligation in the practice of optometry. The primary reason for maintaining records is to facilitate management of a patient's case and to provide a current, comprehensive account of the care and treatment undertaken by the practitioner. It also is necessary to substantiate reimbursement under third-party vision and medical reimbursement plans, especially Medicare. Appropriate documentation is a necessary aspect of risk management and for the defense of malpractice claims (see Chapter 23). All optometrists should carefully organize, maintain, and preserve their patient records and be aware of the legal ramifications of recordkeeping.

Paper vs. Electronic Recordkeeping

A basic question facing any practitioner is how to maintain records: on paper, electronically, or a combination of the two methods? In 2004, President Bush outlined a plan to ensure most Americans have electronic health records within 10 years. The future of recordkeeping is clearly electronic (although the 2014 date may be optimistic).

The primary advantages to electronic health records are as follows:

- Access by doctors to complete patient records
- Reduced medical errors
- Increased access to medical alternatives
- Data mining
- Improved documentation
- Elimination of lost files
- Improved billing
- Reduced office space needed for physical files

There are two general categories of electronic records: the digital record and the scanned record. The digital record offers the advantage of data mining. Data mining is the most

important reason a practice should move to electronic records. The scanned record permits paper records to be attached to the patient's electronic record.

Whether to choose paper or electronic records often depends on the size and degree of computerization of the practice. Practitioners may believe they do not have the time and resources necessary to compile solely electronic records or convert paper records to electronic versions that can be called up, analyzed, and shared through computer programs (see Chapter 20). For this reason, the great majority of practices have paper records, although some patient information is recorded and transferred electronically (such as information for reimbursement under third-party programs). The value of electronic records is apparent, since doctors who have made the transition from paper to electronic records do not return to paper records.

Regardless of the manner in which patient information is maintained, there are important management issues that every practitioner must address, including ownership and control of records, form and content of records, the release of information, use of records as evidence, and retention of records.

Ownership and Control

Patient records are subject to several competing forces. Ownership vests in the doctor who owns the practice, and this obligation is accompanied by HIPAA-mandated requirements to safeguard patient records and protect the confidentiality of the information in them. Where the practice is a business organization and there are other owner practitioners, these responsibilities will usually be shared. Employees do not have an ownership right in records unless it is granted to them by the employer. If an employee leaves a practice, however, patients may ask that information be transferred to the departed employee and the employer would be required to provide the requested information.

The owner of patient records has the right of physical possession and control. As a general rule, such owners should not permit removal of the record from their control, except by court order. Therefore neither the patient nor the patient's authorized representative (i.e., attorney) has a right to possession of the original record, but the practitioner's right of physical control does not mean that the patient and various interested third parties have no legal right of access to the record and the information it contains. Patients and their representatives have a right to review the information that is in the records, including the right to inspect and copy information and to ask for the correction of inaccurate entries. These and other rights are part of the HIPAA law and thus apply in all jurisdictions.

Form and Content of Records

The form, organization, and content of an optometrist's patient records are best determined by professional standards and not by specific legal requirements. Professional standards of practice for optometrists require that entries in the patient record contain a certain minimum of information, which is intended to provide proper substantiation of the care rendered to the patient. In maintaining records, it is essential to document when and why the patient was seen, what was diagnosed, and what was done in terms of treatment. The problem-oriented record is an excellent way to organize this information.

The problem-oriented record system is solution-oriented and enables the practitioner to manage patients in a logical and efficient manner by helping to define problems, plan for their resolution, and properly monitor their progress. When used appropriately, the problem-oriented record system also provides the documentation that is essential for medicolegal purposes while needing minimal time for recording and interpretation.

There are four steps to the problem-oriented system of recordkeeping: formulating an adequate database, compiling a problem list, formulating a plan to solve the identified problems, and using progress notes for follow-up.

Database

The database begins with the collection of information sufficient to allow the practitioner to perform an adequate examination. Compiling an adequate database will vary from patient to patient and from case to case but should include the chief complaint and all information essential to the proper evaluation of this complaint (patient profile, history, and examination findings).

The patient profile should include data such as age, race, sex, marital status, occupation, avocation, and special needs.

The history should include the chief complaint, history of present illness, ocular history, past medical history (including review of systems), family health history, and affect (alertness). Examination findings should include all pertinent tests and observations necessary to satisfy the standard of care.

Various forms may be used to record this information, and there are many sources from which personalized forms may be obtained to inscribe patient data efficiently and thoroughly.

Problem List

The use of a problem list enables the practitioner to review past and current problems at a glance, thereby assuring thoroughness and continuity of care. The list is based on positive examination findings and is an ongoing account of the problems that require management. The list is added to as old problems are resolved or as new problems develop and forms the basis for the diagnostic or therapeutic efforts undertaken by the practitioner.

Plans

A plan must be developed for each problem, whether the problem is to be managed by the practitioner, co-managed in consultation with another health care provider, or referred to another practitioner for specialized care. The plan may consist of further diagnostic testing, the use of a specific treatment, or educational efforts directed at the patient. In formulating plans for specific problems, the practitioner should consider each of these components and note them in the patient record.

The importance of patient education should not be overlooked. In some cases the practitioner will have a clinical and legal obligation to communicate with the patient concerning examination findings, to inform the patient of meaningful symptoms, or to warn of the risks associated with the use of certain ophthalmic products. Better understanding may be achieved in many cases through the use of printed forms, which also can serve to remind the patient of the importance of timely care.

Progress Notes

A practitioner may use progress notes to monitor any efforts to solve a particular problem, and when used, the notes should be numbered and titled to correspond to the complete problem list for the patient. Progress notes also can be used for the evaluation of a specific chief complaint or for episodic care. In both instances the progress notes should follow a specific format, which requires a four-step evaluation, often referred to by the mnemonic SOAP:

Subjective complaint or updated case history

Objective findings or observations

Assessment of findings or progress of case

Plan for the problems listed in the assessment

The SOAP format is widely used by the medical profession and readily accepted in legal proceedings.

Release of Patient Information

One of the most important issues in the management of patient records is the release of information. There are significant differences in the obligation faced by practitioners, based on whether the information is being released to the patient or to a third party.

Confidentiality of Records and the Law

The right of patients to inspect and copy information in medical records was well established by both statutes and court decisions before the passage of HIPAA. Federal and state freedom-of-information acts require the release of copies of patient records on demand by the patient. State optometry practice acts provide for disciplinary actions to be instituted against practitioners based on allegations of unprofessional conduct if they refuse to comply with requests for information or copies of records. Optometry board rules or regulations also have been enacted that require optometrists to release patient information when presented with a valid request. Failure to comply subjects the optometrist to the possibility of disciplinary action.

In addition to these provisions, courts have been active in defining the rights of patients to medical information. Although decisions have recognized that health care practitioners have a right to withhold information from patients, the circumstances under which this right may be exercised are generally limited to life-threatening conditions and psychological dysfunction. In these cases the courts have weighed the patient's right to obtain the information and the practitioner's right to keep what is believed to be harmful revelations from the patient. Situations under which an optometrist could invoke such a defense would be extraordinary. Thus patients are generally entitled to obtain their health care information from optometrists.

The release of prescription information to patients is subject to special federal and state laws.

Spectacle Prescriptions. All practitioners are required to comply with the prescription requirements of the Federal Trade Commission's (FTC) Eyeglass Rule, which is applicable in every jurisdiction. The basic provisions of the rule are as follows:

- The doctor must offer a copy of the spectacle prescription to the patient at the conclusion of the examination.
- If the doctor determines that there is no reason to prescribe spectacles, no prescription needs to be tendered to the patient.
- If the patient is wearing spectacles and no change in the prescription is required, the prescription still must be offered to the patient even though there will be no change to what the patient currently has.
- The prescription must contain information sufficient for spectacles to be obtained, and it must be signed by the doctor; if state laws or board regulations require specific information to be provided, the doctor must include the additional information in the prescription.
- A doctor can charge a fee for writing a prescription if all patients are charged a fee for this service (and not just patients who choose to obtain their spectacles elsewhere).
- An expiration date can be placed on the prescription as long as it is reasonable (the expiration date may be regulated by statute or board rule in the jurisdiction—1 year is a commonly accepted period).
- A fee can be charged for verifying spectacles obtained from another ophthalmic provider.
- No disclaimers can be placed on the prescription. Violations of the rule are punishable by a fine of up to $10,000 per offense.

Contact Lens Prescriptions. The "Eyeglass Rule" does not apply to contact lens prescriptions. The release of contact lens prescriptions is controlled by the Fairness to Contact Lens Consumers Act, which is administered by the FTC. This federal law obliges eye care practitioners (optometrists and ophthalmologists) to provide not only contact lens prescriptions but also information necessary for the filling of prescriptions by a third-party seller. The Contact Lens Rule states the following:

- A copy of the prescription must be provided to the patient at the conclusion of the fitting process, which is defined as being a determination of lens specifications, an evaluation of the fit of the lens on the eye, and any medically necessary follow-up examinations.
- Patients cannot be required to purchase lenses from the prescriber as a condition for receiving the prescription.
- No fee can be charged for release of the prescription or for verification of lenses obtained from a third party seller.
- Prescriptions may not include disclaimers or waivers from responsibility for prescriptions filled by third parties; however, limitations of wear ("daily wear only") and any special instructions ("monovision fit") are permissible.

- The number of lenses or allowable refills may be specified on the prescription.
- Prescriptions may have an expiration date of 1 year, but a shorter period can be specified if "based on the medical judgment of the prescriber with respect to the ocular health of the patient" (medical documentation is required), and this expiration date cannot be less than the period of time required for reexamination; a period longer than a year may be specified if required by state law.

A contact lens prescription is defined under the law and must include the patient's name, examination date, lens issue and expiration date, lens power, material or manufacturer (or both), base curve (or appropriate designation), diameter (when appropriate), and name, address, telephone and fax number of the prescriber. This last requirement is included so that a third party seller of lenses can verify the lens parameters in the absence of a valid contact lens prescription.

Third-party sellers are obligated to have a valid prescription to provide lenses, and if such a seller only has contact lens information, not a prescription, the prescriber must be contacted (by telephone, fax, or e-mail) and asked to verify the information. The prescriber must verify the information (providing correct information if necessary) within 8 business hours or the information will be deemed correct. (Thus a request received at or before 9 am must be verified by 5 pm , and a request received at noon would require verification by noon the next day, assuming customary 9 to 5 business hours.)

The request for verification from the third-party seller must include the patient's name and address, appropriate lens information (power, manufacturer, base curve or appropriate designation, and diameter when appropriate), quantity of lenses ordered, date of patient request, date and time of the verification request, and the name, telephone number, and fax number of the seller.

Verification is not necessary for decorative (plano) contact lenses, although they are included under federal law even though they have no lens power.

The law also requires a prescriber to provide a copy of the contact lens prescription if requested to do so by the patient's agent. A third-party seller can qualify as an agent. In responding to such requests, the prescriber should require the seller to establish in writing that it is the agent of the patient, and then contact the patient to ensure that the request for a copy of the prescription is valid, and if it is, obtain a written authorization from the patient to release the prescription.

A prescriber does not have to provide a copy of a prescription that has expired, or prescription information that has expired, to a third-party seller. Violations of the law are punishable by civil penalties, including fines of up to $11,000.

Because patients are not entitled to a copy of the prescription until a successful fitting has been obtained, it is wise to provide information about the release of contact lens prescriptions before patients are fitted. Doing so can prevent disputes over entitlement to prescriptions (after wear of the lenses), the filling of prescriptions (as written, without alteration by third parties), and the expiration of prescriptions (rendering them invalid). This prescription release information should be included in a brochure, fitting agreement, booklet, or other writing that describes the customary procedures used by the practitioner or clinic providing contact lenses.

Release of Information to Third Parties

The release of information to third parties has been the subject of considerable regulation by the government, particularly since the development of electronic records and reimbursement systems based on the transmission of information through computers. In general, it has long been held that patient information should not be provided to a third party without the patient's consent and that this consent is best documented through a signed release. In addition, whenever patient information is to be divulged to a third party, only as much information as is necessary to comply with the request should be provided. The full patient record must be released only on rare occasions (such as when there is a statutory obligation to do so or the practitioner has received a legal order to do so as a result of litigation). In most instances, a letter containing a summary is sufficient, and the practitioner should transmit only the information actually requested, retaining a copy of the summary for inclusion in the original record.

Because of third-party insurance programs and electronic transmission of information, concerns have arisen about the confidentiality of patient information and how it can best be safeguarded. These concerns have led to the passage of HIPAA.

Confidentiality and the Health Insurance Portability and Accountability Act

HIPAA was passed in 1996 to make health insurance "portable" so workers would not lose their insurance when they changed jobs, but the law also included provisions intended to increase the use of electronic transactions and established privacy protection for health care information. The US Department of Health and Human Services (DHHS) initially issued three types of regulations: setting standards for electronic transactions, setting certain security standards, and setting standards designed to ensure the privacy of health care information.

The HIPAA provisions apply to health care providers, health care plans, managed care organizations, and health care "clearinghouses," which are entities that standardize health information such as a billing service that processes or facilitates the processing of data from one format into a standardized billing format.

But the law does not apply to for-profit business entities. They must be contracted with as "business associates" but are not subject to HIPAA provisions. If a business associate breaches HIPAA requirements, the practitioner is not responsible as long as there is a business agreement with the associate that requires adherence to HIPAA.

The HIPAA "privacy rules" are extensive but contain the following three basic requirements:

- HIPAA creates restrictions on the use or disclosure of "individually identifiable health care information."
- Rights are established with respect to a person's own "individually identifiable health care information."

- Health care providers are required to take certain administrative actions that are intended to protect the privacy of "individually identifiable health care information." Any information created or received by an optometrist from a patient that identifies the patient is defined as "individually identifiable health care information" and thus subject to HIPAA.

The first HIPAA requirement involves restrictions on the use of health care information: optometrists "cannot use or disclose protected health information, except as permitted or required by the rules." However, there are 10 disclosure exceptions, the most important being the following:

- Without consent for treatment, payment, or certain "health care operations" (e.g., emergencies, if there are barriers to communication, or when transferring records)
- With a specific authorization (if disclosure is sought for reasons other than treatment, payment, or general health care operations)
- With a written contract for "business associates" (but optical laboratories are not designated as "business associates")

When using or providing protected health care information, reasonable efforts must be made to limit information to the minimum necessary to accomplish the use or disclosure.

The second HIPAA requirement establishes privacy rights for patients as follows:

- Every practitioner must have a "privacy notice" for patients, the contents of which are established by HIPAA.
- Patients are given the right to inspect and obtain copies of their medical and billing records.
- Patients have the right to ask the practitioner to amend records.
- Patients can request an account of all disclosures of personal health information by a provider within the preceding 6 years (except those for treatment, payment, or health care operations).

The third HIPAA requirement establishes the following administrative requirements to ensure compliance with the privacy rules:

- A "privacy officer" must be appointed by the provider.
- Employees must undergo training so they understand HIPAA.
- Safeguards must be put in place to ensure that the privacy of personal health information is protected.
- A complaint process for patients must be established.
- Sanctions must be imposed on employees who do not comply with HIPAA provisions.
- Patients cannot be required to waive HIPAA rights as a condition for treatment nor can they be punished for exercising these rights.
- Policies and procedures must be documented in writing.

Thus HIPAA obligates a practitioner to adopt a privacy policy that meets the law's requirements, to describe this policy in a printed document (the "privacy notice"), and to inform patients that the policy is HIPAA-compliant. The patient's signature is obtained, acknowledging that this disclosure has been made.

Sample agreements have been published by the American Optometric Association (AOA) to serve as exemplars for HIPAA documentation. This documentation includes a "privacy notice," which describes how patient information may be used and disclosed and how patients can get access to it, and a patient authorization, which allows for the release of identifying health information. Practitioners must have similar agreements and use them appropriately to avoid HIPAA violations.

HIPAA Security Requirements. The security rules were promulgated to complement the privacy requirements by ensuring the confidentiality, integrity, and availability of all electronic protected health information and by protecting against anticipated disclosures and threats to the security of the information. These regulations are divided into "required" and "addressable" standards.

Providers must assess how reasonable and appropriate implementation of the "addressable" standards would be and are obligated to implement them where appropriate. Where an "addressable" standard would be inappropriate, a provider may instead adopt an alternate means to achieve the same purpose or possibly forego the proposal altogether. However, cost alone is not a sufficient basis for declining to adopt a standard.

While the privacy regulations involve all protected health information (PHI) no matter what the form, the security rules cover all providers who transmit electronic PHI. Therefore even nonelectronic PHI requires security protection. As was the case with the privacy regulations, "business associates" and other entities may be required to comply with security rules, and violations by a noncovered entity may result in discipline of the provider.

The security standards have the following 3 components:

1. Administrative safeguards
2. Physical safeguards
3. Technical safeguards

Compliance involves both assessment of potential security issues and the implementation of measures to ensure security of information. Documentation of security efforts is also an obligation.

Administrative Safeguards

These requirements focus on workforce training and contingency planning. The cornerstones, however, are risk analysis and risk management and both are "required." Critical and thorough risk analysis must take place before an attempt at regulatory compliance is made. A practice's identified vulnerabilities will become the focus for security policies implemented to reduce the detected risks.

Additional "required" administrative safeguards include the following:

- Sanctions must be imposed for noncompliance by staff members.
- There must be tracking of security "incidents" and documentation of policies and procedures for dealing with incidents; any resulting harm must be mitigated.
- A "security officer" must be appointed—this person may also serve as the privacy officer.

Staff members must be allowed access to electronic PHI only where appropriate, and policies must be put in place to prevent unauthorized persons from gaining access.

Other "required" administrative safeguards include the following:

- Staff members must be trained on security issues, but training may be scaled to the size of the practice. Training must be performed in an ongoing fashion—a single session will not suffice. ("Business associates" must be aware of security policies, but providers are not obligated to train associates.)
- Contingency plans must be established for emergencies that damage systems with electronic PHI, including provisions for data backup, a recovery plan, and a means of ensuring the security of electronic PHI during emergency operations.
- Periodic evaluations of security preparedness must be conducted.

Physical Safeguards

These requirements are concerned with access to the physical structures of a practice and its electronic equipment. Electronic PHI and the computer system in which it is maintained must be protected from unauthorized access in accordance with defined policies and procedures. Some of these requirements can be accomplished through the use of electronic security systems.

"Required" physical safeguards include establishing policies for the attributes of, appropriate use of, and security for workstations that access electronic PHI and establishing policies for the addition, disposal, or reuse of hardware or electronic media that contains electronic PHI.

Technical Safeguards

These requirements may be the most difficult part of the security regulations to comprehend and implement because they require technical knowledge of computer systems. "Required" technical safeguards include the following:

Policies must be established limiting software program access to only those so authorized. Unique log-ins, either numeric or by name, are required—automatic log-offs are not. Procedures for obtaining necessary electronic PHI during an emergency are also required.

- Activity logs ("audit logs") must be maintained for all systems that contain electronic PHI.
- Policies must be established to protect electronic PHI from alteration and destruction.
- Procedures must be implemented as necessary to verify the identity of those seeking access to electronic PHI.
- Transmission of electronic PHI over a network must be protected by technical security policies. Encryption is an "addressable" standard.

Each of these security measures requires that policies and procedures be created, implemented, and documented. Compliance activities must be documented and retained for 6 years. Thus documentation is a major obligation of these rules.

Policies may be amended as long as documentation is also updated. The security regulations require periodic review of policies and appropriate responses to changes in the environmental security of electronic PHI, as is deemed reasonable for the practice.

HIPAA represents the first effort to impose national standards for the protection of health information. The DHHS enforces the HIPAA requirements, and penalties range from a $100 fine per violation to fines as much as $250,000 and up to 10 years in prison for malicious use of records.

Record Transfers and Destruction

Under HIPAA, a practitioner is allowed to disclose patient information without consent in order to get paid, provide care, consult, refer, or perform "health care operations." Numerous activities necessary to maintain and monitor care are deemed to constitute "health care operations"; these activities are conducting quality assessment and improvement activities; developing clinical guidelines; performing case management; reviewing the competence or qualifications of health care professionals; providing education and training of students and practitioners; operating fraud and abuse programs; initiating business planning and management; and importantly, selling or otherwise transferring patient records.

HIPAA specifically addresses the transfer of patient records as part of the sale or closure of a practice: a practitioner is allowed to transfer by sale or other disposition patient records to a successor practitioner, as long as that practitioner abides by HIPAA requirements to respect confidentiality. This requirement eliminates the need to personally notify all patients affected by the transfer.

The key consideration in a records transfer is to ensure that it is performed in a manner that preserves the confidentiality of the health information. This can only be achieved if the successor who takes ownership or possession of the records agrees to abide by HIPAA confidentiality requirements and is in fact HIPAA-compliant.

HIPAA also regulates the destruction of records. Paper containing sensitive information should be shredded or burned. Destruction can be performed in "distributed" fashion (e.g., by small shredders located near desks) or at a central location. Removable magnetic disks (floppy, disks or ZIP drives) and magnetic tapes (reels, cartridges) can be degaussed. "Fixed" internal magnetic storage, such as computer hard drives, can be cleansed by a rewriting process using software that overwrites the usable storage locations. Removable "solid state" storage devices ("flash drives") can also be cleaned by overwriting.

Records as Evidence in Litigation

The patient records of optometrists are generally open to legal scrutiny in virtually all jurisdictions, a fact that adds extra importance to a practitioner's recordkeeping burden. Whenever optometric patients are parties to litigation, the likelihood is great that the optometrist's records, if needed for the purposes of litigation, will be obtainable.

Attorneys will seek by means of pretrial discovery to obtain information from the records of patients who are parties to litigation or from documents that they believe will aid the preparation and trial of the lawsuit. Depositions and orders to produce will be the usual means of obtaining this information.

If the attorney seeks to have such information entered into evidence at court, the attorney will serve the optometrist with a subpoena duces tecum, which orders the optometrist to appear with the record in a court or other duly constituted tribunal that has jurisdiction over the pending litigation. In most instances, the optometrist will not be a party to the lawsuit, merely the person in possession of records that may or may not be relevant to the case. Therefore the fight over what is pertinent or admissible will be between the opposing attorneys, and the optometrist will rely on the rulings of the court as to whether to provide the information. If the optometrist is a party to the case, then the dispute is of more immediate interest, and the optometrist should obey the instructions of the optometrist's attorney in handling and discussing patient records. It should be mentioned that there is no privilege of confidentiality under federal law, thus the IRS can obtain access to optometric records for tax purposes.

Of course, the most worrisome type of litigation is a malpractice case in which the optometrist is the defendant. More likely than not, in such a lawsuit, the patient record will either be the cornerstone of the optometrist's defense or the optometrist's Achilles' heel. Well-documented records may be critically important in proving that no negligence occurred or in refuting the patient's allegations of improper diagnosis or treatment. Even though proper completion of all records on each patient is obviously time consuming and probably an active nuisance, an optometrist who is sued by a patient (usually a considerable time after treatment has been terminated) will be in a much more favorable position if the optometrist's records indicate clearly that proper treatment was given. On the other hand, records that disclose negligent treatment will materially benefit a patient's case. Records that have been altered for any reason, even the most innocent, should always include notations of the date and reason for the change. If a negligence suit is filed subsequent to alteration of a record and that alteration is apparent, it will undoubtedly be construed as a dishonest attempt to avoid liability.

Because patient records are entered into evidence with great frequency, extraneous comments should be assiduously avoided. In particular, comments that denigrate the patient or members of the patient's family should be omitted since they convey the impression that the doctor is not interested in the patient's welfare.

Retention of Records

An important consideration in the maintenance of records is how long they must be retained. Although optometrists do not collect the kind of information that is likely to be used in litigation, there is always a chance that an optometrist could be an important witness or party to a legal claim filed long after the patient has been dismissed. Ideally, no patient records should be thrown away, and there are ways to preserve records (especially if electronic copies are kept) without incurring great expense or requiring copious amounts of space. But, if records are to be eventually discarded, the optometrist should be sure that they have been retained for the period of time required to satisfy the following:

- State laws or optometry board rules or regulations (which may be as long as 7 years)
- HIPAA requirements (6 years)
- The statute of limitations for tort actions (usually 1 to 4 years but may be considerably longer for minors)
- The statute of limitations for contract actions (3 to 15 years)
- The statute of limitations for actions brought by Medicare or other third-party insurance programs (6 years)

These periods vary from jurisdiction to jurisdiction and range from 1 to 15 years. Most experts agree that at a minimum, patient records should be retained for 10 years after the last encounter.A prudent practitioner should consult with legal counsel before discarding patient records to ensure that pertinent time periods have been satisfied. If records are stored, they should be kept in a facility where they will not be damaged or destroyed.

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