2026 LEADERSHIP PANEL

Presented by Nicole Smith, COT, CTC, Veronica Plessinger, MBA, COMT, and Amy Jost, MEd, COMT, CCRC

FINANCIAL DISCLOSURES

- Nicole Smith, COT, CTC: None
- Veronica Plessinger, MBA, COMT: Alcon, Abbvie
- Amy Jost, MEd, COMT, CCRC: None

OVERALL OBJECTIVES

- Identify ways to increase clinical efficiencies and improve quality of care
- Outline best practices for documentation and coding
- Identify an effective strategy for coaching and training ophthalmic personnel

Leadership Panel | Efficient | High Quality

Increase Clinical Efficiencies and Improve Quality of Care

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OBJECTIVES

Efficient Protocols

Identify appropriate ways to create efficiencies.

Right and Wrong Ways

Differentiate between efficient and lazy.

Avoid Errors

List several examples of when shortcuts led directly to poor patient care.

Clinical Efficiencies

Work Smarter, Not Harder

Efficeint = Completed with accuracy and swiftness

Lazy= Minimalistic, with (or without) the intent of being fast

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There's a Fine Line Between Lazy and Efficient

As a clinical leader, find ways to make clinic run smoothly and efficiently.

From beginning to end, the process should be fluid.

SWOT Analysis

Strengths

– Make a list of what your clinical team excels at

– Recognize those who are ready for more (responsibilities, tasks, training, promotions, etc.)

– Identify your leaders, mentors, and trainers

- Use SOPs, doctor preference sheets, and other pre-determined protocols

Weaknesses

– Identify areas for improvement of clinical flow (bottlenecks in testing, front desk, techs)

– Observe the staff in their natural environment for areas that need improvement (talk a lot, long breaks, gets off track, makes lots of errors, etc.)

– Doctors on time in clinic? Available for phone calls/patient portal questions that require their attention?

Opportunities

– Call out any opportunities for growth (training, schedule optimization)

– These are external factors, such as pre-visit patient education, e-forms completion, phone calls explaining expectations

– Identify clinic needs (need more rooms, equipment, time or staff?)

Threats

– Mention any challenges, obstacles, or risks that your practice is facing (funding, staffing cuts, hiring freeze, budgets not approved, decreasing Medicare reimbursments, etc.)

– Turnover rates are high, often many “new staff” working in clinic-still need mentor/supervisor to help them

– Expectations to work FASTER may lead to errors, waste

High Quality Patient Care

Great Patient Experience

Consider the consequences of NOT performing tasks correctly.

Scheduling Appointments

LAZY

- Assumes too much
- Does not ask the right questions
- End of the day, so waits until tomorrow
- Avoids asking questions or…
- Asks TOO many questions of the doctor or lead tech
- **May lead to scheduling errors, confusion, frustration**

EFFICIENT

- Listens to the patient/caller
- Asks a few relevant question
- Triages and schedules appropriately
- Gets a doctor or lead tech involved as needed

Pre-Registration Phone Calls

LAZY

- Assumes insurance information is the same
- Does not check if address/phone # is correct
- Decides the Tech can check previous health conditions when patient arrives in office
- **May lead to unreceived mail/phone calls, billing errors, delayed/lost payments**

EFFICIENT

- Verifies insurance information is up-to-date
- Verifies address/phone #/email
- Asks about ocular/systemic health conditions
- SAVES a lot of time in the long run

Check-in/ Check-out

LAZY

- Does not acknowledge patient until finishes task
- Does not collect co-pay at check-in
- “Just lay your check-out form on the desk and we’ll call you”
- **Feels cold, unfriendly, non-welcoming- bad first impression**

EFFICIENT

- Addresses patient as they walk up
- Collects co-pay upfront
- Takes time to answer questions, schedule next appointment, fill refills, provide other information

Patient Navigation to or within the Office

LAZY

- Gives complicated directions to destination
- “Just go down the hall, turn left, then at the corner turn right… it’s the 3rd door on the right”
- **May lead to patient being confused, lost, frustrated, and embarrassed.**

EFFICIENT

- Provides simple directions, map, or escorts pt to destination within the office
- “Let me show you”

Chart Shopping

LAZY

- Avoids the longer “harder” exams
- Only takes the “nice” patients
- Conveniently takes a quick break when the next patient is ready for work-up
- Disappears without notifying team
- **May lead to unnecessary waiting for some patients; gets patients out of order; burden falls to other techs**

EFFICIENT

- Willingly takes next chart in queue
- Accepts all patients, all personalities, all challenges
- Takes breaks at appropriate times
- Communicates with the team

Chart Documentation

LAZY

- Pre-charting/Post-charting
- Assumes info is correct/Does not update information in the chart
- Minimizes exam procedures performed
- Skips steps if rushed or unsure of process
- **May cause unnecessary delays; high risk of documentation errors and chart fraud**

EFFICIENT

- Verifies information is correct (ocular/systemic history, medications, BS/HbA1C, pharmacy information, best contact info, people authorized to receive info, referring doctors/OD/PCP, etc.)
- Performs exam procedures as outlined in practice guidelines AND does more/less based on patient's condition

History, CC/HPI

LAZY

- Notes insufficient CC, “1mo ck”
- Asks the same HPI questions of everyone, regardless of reason for visit
- **May cause confusion, over/under billing; revenue loss; adds time to physician’s questions for patient**

EFFICIENT

- Clearly identifies CC/ reason (condition/ symptom) of visit and timeline, “1-day corneal abrasion, OD”
- Customizes HPI questions based on patient’s condition

Abbreviations

LAZY

- Overuse of abbreviations
- Makes up their own abbreviations
- **May lead to documentation errors; Confusion for others involved with correspondence**

EFFICIENT

- Avoids abbreviations in chart which may be viewed by the patient or pulled into referral letters
- Uses standardized, approved abbreviations

Medications

LAZY

- Misspells medication names
- Does not confirm dosing, assumes doctor's orders are being followed
- **May lead to unaddressed compliance issues; medical/surgical treatments may be affected; patient care may be interrupted or ineffective**

EFFICIENT

- Spells medication names correctly
- Confirms how often the patient is taking the medication (& how much)
- Identifies non-compliance issues and reasons

Pulling Information from Last Exam

LAZY

- Pulls it all forward from last exam
- Does not recheck testing
- Assumes the same results
- **May lead to inaccurate results, documentation of tests that did not get performed, and chart fraud**

EFFICIENT

- Checks results from last exam for conditions noted
- Always rechecks testing before documenting results
- Leaves field blank if testing was not done at time of today's visit

Lensometry

LAZY

- Does not ask about age of current Rx
- Assumes glasses worn today are same as on record from last visit
- Simply does not record lensometry for other reasons
- Performs lensometry by loosely holding in place, not leveling the glasses on the stand
- **May lead to incorrect measurements**

EFFICIENT

- Confirms with patient how old their current glasses Rx is
- Performs lensometry if do not have on record, or unsure which Rx the patient is wearing today
- Properly performs lensometry, using the table, accurate axis

Pupil Assessment

LAZY

- Turns off one light, but room still moderately lit
- Does not accurately check in dim and bright light
- No patient instruction on where to look, does not correct patient if looking at the examiner (near target)
- Goes too fast on pupil exam
- **May miss pupil abnormalities**

EFFICIENT

- Darkens the room to maximize pupil size and better check responses
- Has the patient focus on a distance target
- Checks both direct and consensual responses
- Uses proper technique on swinging flashlight test

Vision Assessment

LAZY

- Gives poor patient instructions
- Uses same letters all the time, even though patient seems to have them memorized
- Does not accurately document visual acuity
- **May collect inaccurate information**

EFFICIENT

- Provides good instructions to patient so that the test is performed correctly
- Changes the letters from time to time to truly test visual acuity
- Documents appropriately

Confrontation Visual Fields

LAZY

- Does not properly provide patient instruction on where to look/fixate
- Does not fully extend arms (target) into peripheral view, especially temporal
- Does not home in on VF defect
- Uses kinetic vs. static method inconsistently
- Presents targets at awkward angle
- **May miss VF defects**

EFFICIENT

- Provides good patient instruction
- Extends target to far periphery of patient's visual field
- Rechecks surrounding area to identify edges of scotoma
- Uses static method (or kinetic) method properly
- Presents targets in an easy to see fashion using 1, 2, or 5 fingers

Refractometry

LAZY

- Uses an outdated Rx, or not the most recent Rx/MR on file
- Starts with glasses Rx for a post-op cataract surgery patient
- Only checks for Spherical changes
- Does not use Jackson Cross Cylinder
- **May lead to inaccurate refraction**

EFFICIENT

- Uses a reasonable starting point… neutralize glasses, most recent Rx, last MR on record, auto-refraction, retinoscopy, etc.)
- Starts from scratch as appropriate
- Performs refractometry by proper methods, sphere, cylinder, axis (add power)

Tonometry

LAZY

- Does not check cornea before performing applanation tonometry
- Hogs the Tonopen…. Keeps in their exam lane or in their pocket
- **May lead to corneal injury; may create unnecessary delays**

EFFICIENT

- Checks cornea and angles with slit lamp just before performing applanation tonometry
- Stores the Tonopen in a mutually agreeable shared space so that all techs may find/use the Tonopen

Efficiencies + Quality Care
= Great Patient Experience

Thank you!

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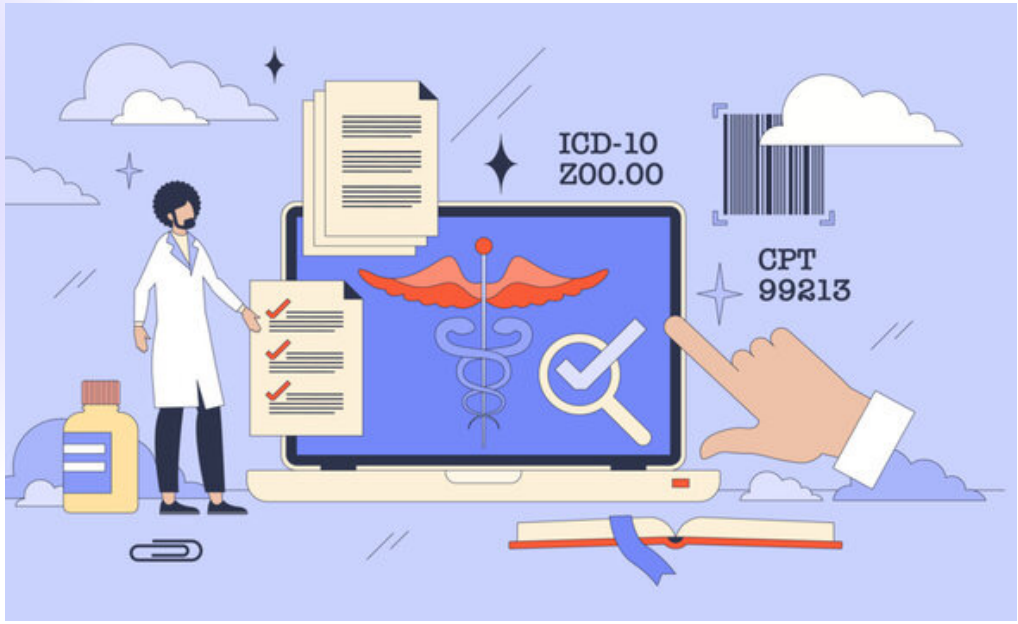
DOCUMENTATION & CODING

LEADERSHIP PANEL



Veronica Plessinger MBA, COMT

Director Of Clinical Operations

Eye Care Associates Inc.

OBJECTIVES

Outline best practices for documentation and coding – Leadership Panel

Importance of Accurate Documentation

Accurate documentation is essential to clinical practice and supports effective patient care and reduces risk.

Accurate Charting	• Clearly documented CC/HPI, technican exam elements, physician exam, impression, plan, follow up and coding.
Compliance and Legal Standards	• Documentation must meet regulatory and institutional standards to ensure billing compliance and legal protection.
Impact on Patient Outcomes	• High-quality documentation directly contributes to improved patient outcomes and continuity of care.

Principles

10 principles to demonstrate medical necessity for services reported – According to AAPC

1. List the principal diagnosis, condition, problem, or other reason for the medical service or procedure.
2. Be specific when describing the patient's condition, illness, or disease.
3. Distinguish between acute and chronic conditions, when appropriate.
4. Identify the acute condition of the emergency situation (e.g., coma, hemorrhage, etc.).
5. Identify chronic complaints, or secondary diagnoses, only when treatment is provided or when they affect the overall management of the patient's care.
6. Identify how injuries occur.
7. Assign diagnosis codes to the highest documented level of specificity.
8. For office and/or outpatient services, never use a "rule-out" statement (a suspected but not confirmed diagnosis). If a definitive diagnosis is not determined, report symptoms and/or signs, instead.
9. All facts must be substantiated by the patient's medical record, and that record must be available for review upon payer request.
10. When reporting a patient encounter, select codes that best represent the diagnoses addressed *during that visit*.

Verhovshek (2018)

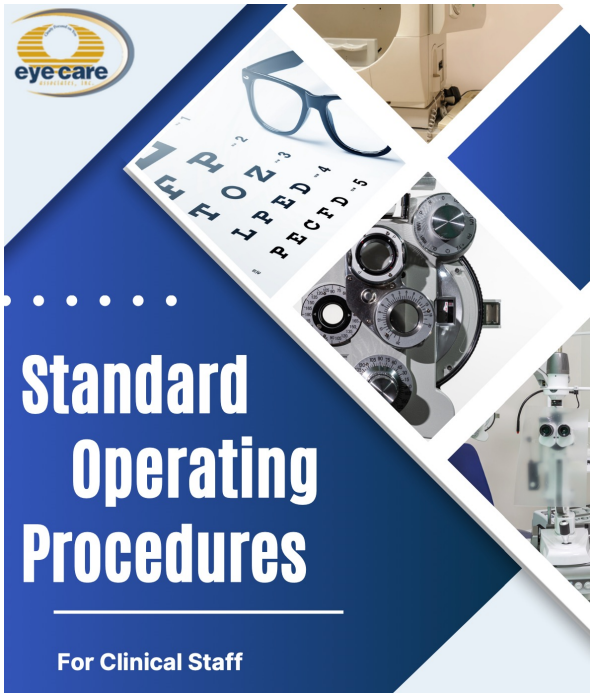
STANDARDIZATION

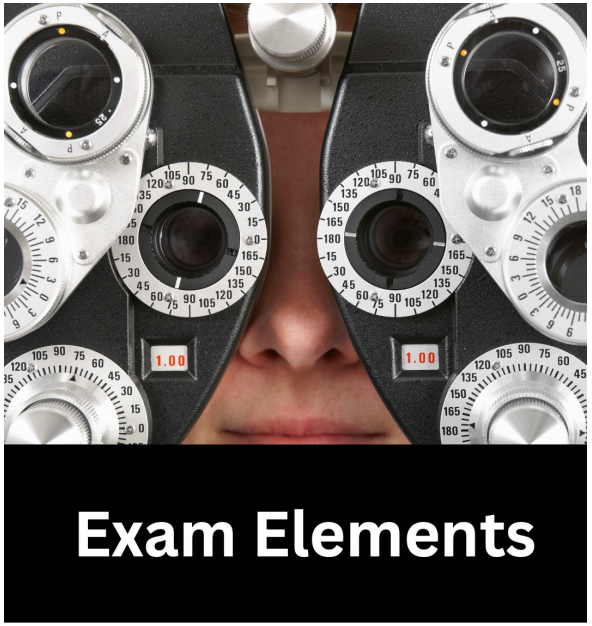
Standard Operating Procedures

Templates

Access to Resources

Checklists & Standardization





Testing Interpretation Templates

Order

Test Performed

Indication for Testing

Findings
OD & OS
•Structural/Functional Results:
•RNFL / GCC Thickness:
•Macular Findings:
•VF Pattern: (e.g., MD value, specific defects)
•Disc/Macula/Cornea:
•Other Notes:

Comparison to Prior Studies
•Stable / Progression Suspected / Progressed
•Changes Noted:
•Date of Prior Test(s):

What auditors are looking for:
For any tests delegated to ancillary staff, you need to document an order in the chart. It should indicate:
the test(s) to be performed
1.in which eye(s)
2.the medical necessity

E&M Code	Description	MCR	Comm
99202	Office visit New Pt L2	66.6	61.68
99203	Office visit New Pt L3	104.54	93.73
99204	Office visit New Pt L4	157.24	137.15
99205	Office visit New Pt L5	207.97	176.33
99212	Office visit Est Pt L2	52.31	41.75
99213	Office visit Est Pt L3	85.17	68.3
99214	Office visit Est Pt L4	120.16	95.06
99215	Office visit Est Pt L5	168.9	134.37

Eye Code	Description	MCR	Comm
92002	New Pt Intermediate	76.58	67.02
92004	New Pt Comprehensive	135.64	120.06
92012	Est Pt Intermediate	80.56	67.78
92014	Est Pt Comprehensive	114.45	97.56

*Yell = MCR Best Choice Eye vs E&M
*Pink = Comm Best Choice Eye vs E&M
If qualify for either Eye or E&M

Customized Tools For Physicians and Scribes

Code	Descirption	MCR Allowable
76512	Bscan	43.83
76514	Ultrasonic Pachymetry	10.5
92015	Refraction	50
92020	Gonioscopy	24.97
92025	Corneal Topography	33.21
92060	Sensorimotor examination	58.35
92081	Visual field 1 Isopter	30.41
92082	Visual field 2 Isopters	42.49
92083	Visual field 3 Isopters	57.21
92133	OCT Nerve	28.08
92134	OCT Mac	29.58
92136	Optical Biometry	43.18
92240	Fluorescein Indocyanone	211.25
92250	Fundus Photography	33.64

RESOURCES

Coding Assistant

- AAO developed these modules to guide ophthalmologists and their staff to:
- Document patient encounters and procedures per payer policies.
- Code complex subspecialty cases correctly the first time.
- Report accurate and timely claim submissions.
- Avoid claim denials.
- Achieve prompt payment from payers and patients.

https://www.aao.org/practice-management/coding/coding-assistants

Codequest™

CATARACT AND ANTERIOR SEGMENT

INTRODUCTION

This module is a part of the Academy's Coding Assistant to the Subspecialties series. This series was developed to help you:

- Document the patient encounter in a way that meets the physician's and payer's requirements.
- Report accurate and timely claim submissions.
- Achieve prompt payment from payers and patients.
- Avoid claim denials.

The fact sheets, checklist, sample forms and FAQs included here provide you with what you need to know to ensure appropriate billing.

- Cataract Surgical Options
- What Is Billable in Traditional Cataract Surgery
- Checklist to Determine the Need for Cataract Surgery
- Visual Functioning Index VF-8R
- Complex Cataract Surgery
- Surgeons Performing and Billing for Their Own History and Physical Prior to Ophthalmic Surgery
- Billing for Premium IOLs
- Appropriate Billing for Optiwave Refractive Analysis or ORA System During Cataract Surgery
- Comanagement: Completing the CMS 1500 Form or Electronic Equivalent
- Comprehensive Guidelines for the Comanagement of Ophthalmic Postoperative Care
- Exam to Determine the Need for YAG Laser Capsulotomy
- Wrong-site, Wrong-procedure, or Wrong-patient Errors
- Implantation of Iris Prosthesis
- Ask the Coding Experts

For those who need to learn about the basics of or get a best practices refresher on ophthalmic coding, *Fundamentals of Ophthalmic Coding, Ophthalmic Coding Coach™: Complete Reference* or the online *Ophthalmic Coding Coach 2.0* are the resources for you. Additionally, visit aao.org/coding for more resources.

Example from AAO

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Protecting Sight. Empowering Lives.®

American Academy of Ophthalmic Executives®

Final Determination Table for Medical Decision Making

To arrive at the final level of exam, 2 of 3 components (problems, data and risk) must meet or exceed the same level of complexity (straightforward, low, moderate or high).

COMPONENT	STRAIGHT-FORWARD	LOW	MODERATE	HIGH
Number and/or Complexity of Problems Addressed at the Encounter	**Minimal** 1 self-limited or minor problem	**Low** 2 or more self-limited or minor problems; ***Or*** 1 stable chronic illness; ***Or*** 1 acute, uncomplicated illness or injury *Or* 1 stable, acute illness *Or* 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Moderate** 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; ***Or*** 2 or more stable chronic illnesses; ***Or*** 1 undiagnosed new problem with uncertain prognosis; ***Or*** 1 acute illness with systemic symptoms; ***Or*** 1 acute complicated injury	**High** 1 or more chronic illnesses with severe exacerbation, progression or side effects of treatment; ***Or*** 1 acute or chronic illness or injury that poses a threat to life or body function
Amount and/or Complexity of Data to be Reviewed and Analyzed	**Minimal or none**	**Limited** 1 of 2 Categories must be met Category 1: Tests and documents. Any combination of 2 from the following: • Review of prior external note(s) from each unique source; • Review of the results(s) of each unique test; • Ordering of each unique test; ***Or*** Category 2: Assessment requiring an independent historian(s)	**Moderate** At least 1 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test; • Assessment requiring an independent historian(s) ***Or*** Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/QHP (not separately reported); ***Or*** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)	**Extensive** 2 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test • Ordering of each unique test; • Assessment requiring an independent historian(s) ***Or*** Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/QHP (not separately reported); ***Or*** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)
Risk of Complications	**Minimal** Minimal risk of	**Low** Low risk of morbidity from	**Moderate** Moderate risk of morbidity from additional testing or	**High** High risk of morbidity from additional diagnostic

https://www.aao.org/Assets/f3c72898-c1a1-487d-b975-375ddf1ff133/638645195094230000/e-m-final-determination-table-office-pdf?inline=1

STRATEGY

- Creating internal audit programs
  - Coding
  - Documentation – Tech / Scribe
- KPI dashboards for coding & documentation
  - Coding Accuracy rate
    - % of encounters coded correctly on first submission
      - Includes correct CPT, ICD10 and Modifier
  - Modifier Accuracy
    - Correct use of modifiers
      - 24,25,
  - Audit score
    - Internal audit % of accuracy
    - Documentation % of accuracy
  - First pass claim acceptance rate
    - % of claims accepted by payor on first submission
  - Denial Rate by reason
  - Diagnostic testing utilization
- Managing provider behavior/drift

There are five basic self-audit rules medical professionals can use to get started with audits - CMS

1. Develop and implement a solid medical record documentation policy if there is not one in place. If there is one in place, ***make sure the policy covers meeting Federal and State Medicaid regulations***. The policy should address what actually happens in everyday practice.

2. Develop or use one of the available standard medical audit tools. The tool should cover the documentation policy criteria and coding standards as part of the review.

3. Choose a staff member who understands documentation and coding principles to ***select a random sample of records for a specific time period***. Decide how many records should be reviewed, and then pull every "nth" chart for that time period.

4. ***Resist being the one to choose and audit your own charts***. Most professionals can read their own writing and understand the meaning of records they wrote even if the documentation is not in the record. Removing bias is important. For best results, make the audit as realistic as possible.

5. Use the self-audit results for improving practice compliance. ***There is no real value in conducting a***

Chart Audit Checklist

AAO Recommended Pre-Audit Steps
☐ High-volume targets selected
☐ Payer requirements + LCD/LCA reviewed
☐ Checklist updated to current AAO guidance
☐ All chart documents compiled (IDs, signatures, orders)

Encounter Details
☐ Patient Information complete
☐ Date of service documented
☐ Provider identified
☐ Visit type selected

History
☐ Chief complaint documented
☐ HPI complete
☐ Pertinent ROS reviewed
☐ Past ocular history documented
☐ Medications and allergies updated
☐ Relevant family/social history included

Exam
☐ VA
☐ IOP
☐ Pupils/EOM/VF confrontation performed
☐ External + Slit lamp exam
☐ Dilated fundus exam or reason deferred
☐ Refraction when relevant

Diagnostic Testing
☐ Physician order present for each test (test name, eye, indication)
☐ Quality/reliability documented
☐ Findings documented
☐ Comparison to prior studies
☐ Interpretation in provider's words

Medical Decision Making
☐ Problem list severity/status documented
☐ Risk assessment documented
☐ Comorbidities integrated when relevant
☐ Independent historian/records noted when relevant

*Time Attestation
☐ Documented if billing based on time

Assessment & Plan
☐ ICD-10 accurate (laterality, stage, severity)
☐ Treatment and follow-up documented
☐ Follow Up - Next testing/orders specified

Billing & Compliance
☐ Billed E/M or eye code
☐ Modifier use correct
☐ Procedure notes complete
☐ Consent present when required
☐ Medication reconciliation complete
☐ Time-out/correct site documented
☐ MIPS/QPP elements met when applicable
☐ Signature/attestation present

Results
☐ Coding Accuracy ☐Correct ☐Up-coded ☐Down-coded

Corrective actions:

☐Provider education

☐Corrected claims/refunds

☐Re-audit require

Chief Complaint				
Did the narrative tell the Dr. what the patient is here for?				
HPI				
Were there sufficient HPI Elements?				
History Taking				
Allergies Noted				
Past Ocular Procedures Incl. Dates				
Ocular Meds Complete				
Systemic Meds Complete				
Diseases – duration – control				
Previous other surgeries including Dates				
Most Recent BS noted if diabetic				
Family History Noted				

References

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PEARLS FOR LEADERS

Presented by Nicole Smith, COT, CTC

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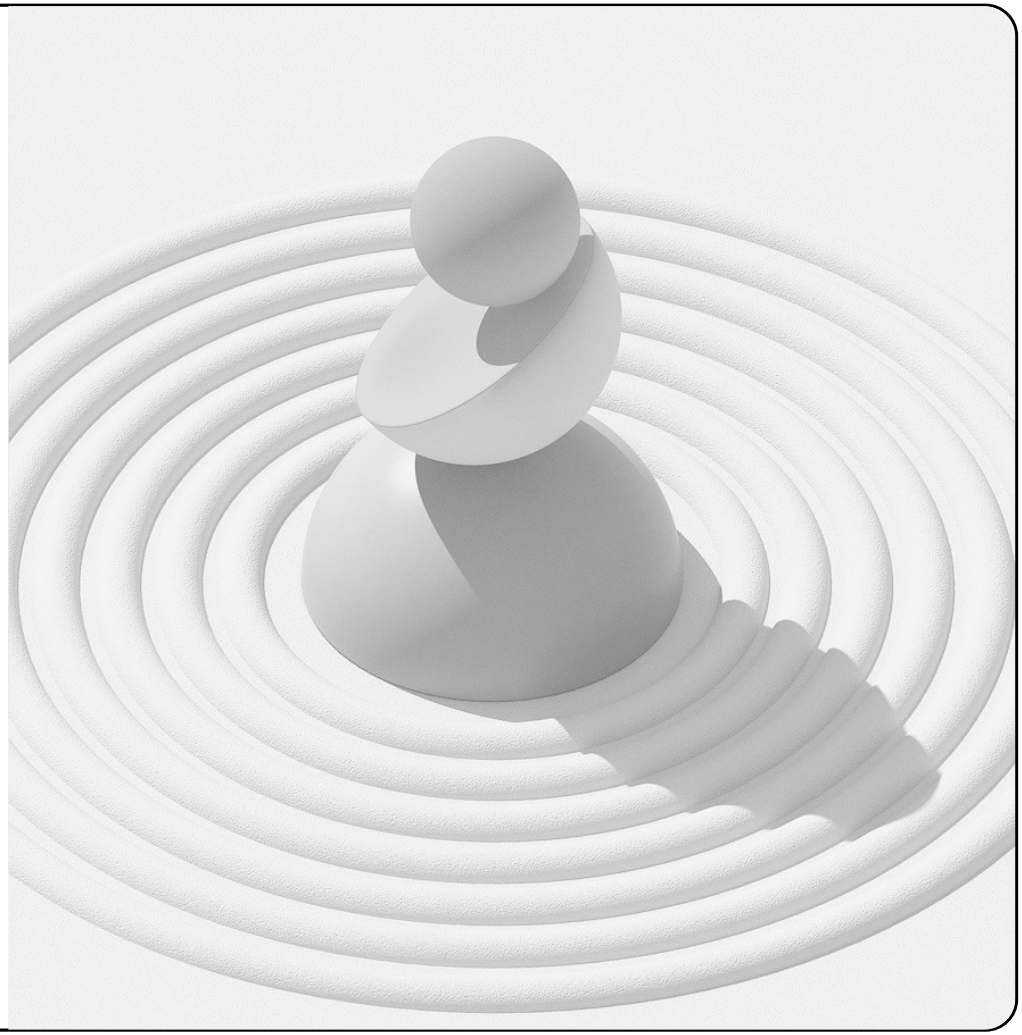
WELCOME

Leadership Training

- Employee Satisfaction
- Employee Engagement
- Workplace Culture



EMPLOYEE ENGAGEMENT & SATISFACTION

What's the difference

HOW ARE THEY DIFFERENT?

- Employee Satisfaction-
    - Employee's contentment with their job and work environment. It's about feeling happy and fulfilled with the role and the organization. ***It creates the foundation for engagement to thrive.***
- Employee Engagement-
    - Goes beyond satisfaction to encompass an employee's *emotional commitment and dedication to the organization, their work, and their team.*
- It's about being driven by a strong connection to the work and contributes to the individual effort given.

SATISFACTION

1. Desires:
    1. Work-life balance, recognition, career development opportunities, and overall workplace culture.

2. Impact:
    1. Can influence absenteeism, turnover, and employee retention.

ENGAGEMENT

1. Desires:
    1. Strong connection to the organization's mission, a sense of purpose, and a feeling that their work makes a difference.

2. Impact:
    1. Can drive higher productivity, innovation, customer loyalty, and reduced turnover.

PUT IT TOGETHER

Action vs. Feeling:

1. Satisfaction is an internal feeling

2. Engagement is about how employees interact with the workplace and demonstrate their commitment

PUT IT TOGETHER

Scope:

1. Satisfaction is more about the specific aspects of the job and work environment

2. Engagement is broader and encompasses an employee's overall connection to the organization

PUT IT TOGETHER

Contribution:

1. Satisfied employees may simply be content to do the required work

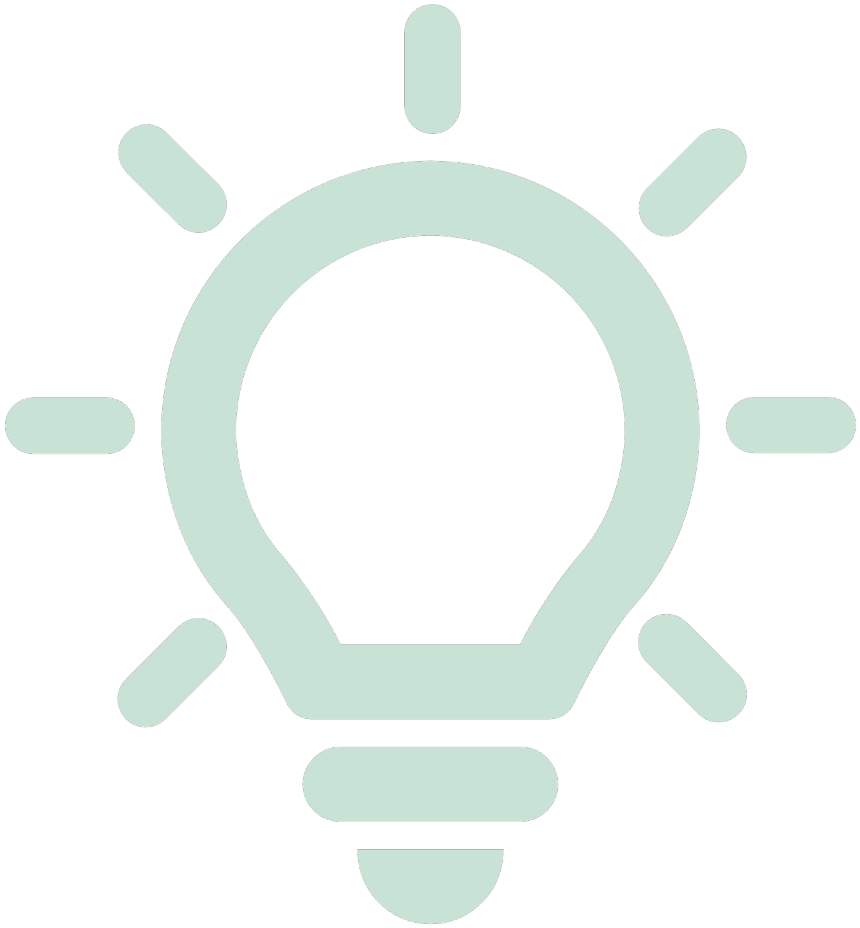
2. Engaged employees are more likely to contribute extra effort and dedication

HOW **CAN** YOU CONTRIBUTE.....

YOUR IMPACT

- Leadership continually underestimate their impact on employee engagement.

- The best leaders take responsibility in engagement.



"COMMITMENT AND RETENTION GROW WHEN EMPLOYEES ARE IN THEIR **IDEAL JOB**, DOING **MEANINGFUL WORK**, FOR A **GREAT BOSS**"

-JOE MULL, AUTHOR OR 'EMPLOYALTY'

PROMOTING ENGAGEMENT

- **Promote Mental Health Awareness:** Employees want improved access to mental health services, enhanced knowledge of mental well-being, and an empathic leader.
  - Empathic until it turns toxic

- **Encourage Focus on Career and Growth:** Employees are searching for opportunities to grow and advance in their jobs due to their financial security.
  - They actively seek guidance from a dependable boss regarding training and development possibilities. Companies that provide mentorship and training programs are generally preferred.

PROMOTING ENGAGEMENT

- **Improved Communication:** 51% of Gen Z speak with their friends, family, and their co-workers face to face rather than from by text.

  - **Preferring phone/video calls over text**

  - **Managers should check in frequently**, provide insightful input, and schedule weekly feedback and performance evaluations.

HAVE YOU EVER SAID.....

COMMON MISCONCEPTIONS – HAYLEY BOLING

1. "We just need BETTER people"
2. "We need MORE people. It's a staffing issue"
3. "We need to give more money & incentives"
4. "We need to add more rules and policies"

COMMON MISCONCEPTIONS – HAYLEY BOLING

1. "People don't have good work ethic anymore"
2. "These Millennial's.... They just don't want to work. Gen Z wants a promotion after 4 weeks! They can't even show up for work. Gen X is quietly rolling their eyes, questioning my initiative and muttering. Those boomers can't adapt or let go of control. I don't even know what to think of Gen Alpha is going to be like someday!"

HOW **DO** YOU CONTRIBUTE.....

WORKPLACE CULTURE

- Shared set of values, behaviors, and attitudes that define an organization's environment and daily operations

- It is the "personality" of a company, influenced by leadership, policies, and employee interactions, which dictates how work gets done

"IF YOU DON'T DEVELOP YOUR CULTURE, IT WILL DEVELOP ITSELF. IT DOESN'T HAPPEN BY ACCIDENT, AND IF IT DOES, YOU'RE TAKING A RISK."

-MONIQUE WINSTON VICE-PRESIDENT, NATIONAL BUSINESS DEVELOPMENT EXECUTIVE AT WFG NATIONAL TITLE INSURANCE COMPANY/ENTERPRISE SOLUTIONS

UNDERSTAND THE RISK

- 42% of employee turnover is preventable but often ignored (Gallup)
- 80% rate employee experience as important/very important (Deloitte)
- 33% of healthcare workers report their employee experience meets expectations (Qualtrics)
- 23% are engaged at work. Which means 77% are either not engaged or actively disengaged (Gallup)
- 68% left due to Culture, Engagement & Wellbeing reasons, which is 4 times greater than Pay/Benefit reasons (Gallup)

POSITIVE CULTURE IS....

What **YOU** believe

How **YOU** behave

The environment **YOU** create

The experience **YOU** provide

What **YOU** stand for

HOW DO YOU LEAD?

- Culture is the character of your practice
- How do you lead?
  - Do you contribute to the gossip?
  - Share confidential information?
  - Are you acting in a way you'd want modeled by those around you?

HAVING A STRONG CULTURE

STRONG CULTURE

- Commitment –
  - This starts at the top. Leaders model the behaviors they want to see.

- Consensus –
  - Involve your team. Change works best when people help shape it

STRONG CULTURE

- Clarity –
  - People can't follow what they don't understand. Clearly define vision, direction, expectation.
- Communication –
  - Culture thrives on conversation.

BENEFITS OF A STRONG CULTURE

- A 40% reduced **employee burnout** rates, especially in high-stress environments (HBR)
- Engaged team = 78% reduction in absenteeism (Gallup)
- Strong culture = 20% + patient satisfaction scores (Journal of Healthcare Management)
- Patient safety = 58% decrease in **patient safety incidents** (Gallup)
- Companies with strong culture experience 4x revenues growth (HBR)

Culture affects patient outcomes, retention, burnout, malpractice, our bottom line.

FUELING THE MOMENTUM

- Celebrate Progress, NOT Perfection
  - Celebrate wins
  - Shout outs
  - Engagement committees

Be a thermostat and
NOT a thermometer

WHAT KIND OF LEADER ARE YOU?

LEADERSHIP STYLES

Authoritative

Emphasizes directness, confidence and a strong focus on bottom-line results.

- Decisive leaders that are particularly well suited to crisis situations

Strategic

Collaborative, can created goals and objectives and inspire their staff.

- They guide their staff to embrace plans and progress toward the long-term goal.

Transformative

Inspire and motivate staff to achieve outcomes and develop their potential.

- Guides organizations toward shared vision by setting clear direction.

Coaching

Focuses on developing individual team members

- Guides, empowers, supports the team to set goals and reach their potential.

Servant

People first, prioritize growth and well-being over their team.

- Act as mentors instead of bosses, sharing power, encouraging collaboration, and needs of others

FIRST IMPRESSIONS

- Do you go over the job description?
- Do you show them the type of leader they are getting?
- Do they know the corporation they are wanting to be part of?

THANK YOU

Nicole Smith, COT, CTC
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