



# TACKLING TECHNICIAN PRODUCTIVITY

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**T**ackling practice inefficiencies surrounding patient flow, wait times, patient volumes, and doctor productivity can be stressful. These issues were impacting the positive, patient-centered environment we worked so hard to create in our practice; getting through the day became an exercise in frustration for patients, employees, and especially, the doctors. A serious problem was brewing. Solving this problem became a priority.

## A MULTI-STEP PROCESS

We used a multi-step process to identify and clarify the problem, followed by a process of open communication and implementation to change behaviors and achieve results.

The analysis portion of the process was perhaps the most challenging in that it forced us to look at every area of patient flow, but then also to assign blame to some degree to what we discovered. After addressing areas outside the clinical setting such as

templates, scheduling protocol, and check-in procedures, we then focused attention toward the clinical setting and technician productivity. Here are the steps we took.

- 1. Assess each component** of the patient work-up and then record on paper the doctors' expectations for work-up protocol for each type of patient visit. (It is difficult to hold employees accountable to something if expectations are not set beforehand.)

FIGURE 1. SAMPLE TECHNICIAN WORK-UP PROTOCOL

“Ex” exams require 20 minutes or more, “Lo”, 12–15 minutes, “Im”, 8–12 minutes, “Sh”, 6–10 minutes

Appt Type	Ex	Ex	Ex	Ex	Ex	Ex	Lo	Lo	Lo	Lo	Lo	Lo
	New Patient Exam	LASIK/Lens Eval	Cat Eval	Cornea Eval/ KPRO	PCO Eval	Return PK, possible suture removal	Follow-up	Glaucoma	1 Day Post-Op Cat	3 Wk Post-op CaU/YAG	6 & 12 Mo PK	6 Wk PK/ DSAEK/ DMEK
Pt Hx (includes Complaints, general health, meds, allergies)	X	X	X	X	X	X	X	X	X	X	X	X
VA (distance & near)*	X	X	X	X	X	X	X	X	X	X	X	X
Lensometry	X	X	X	X	X	any time new glasses						
Refraction	X	X	X	X	X	possible	possible	possible	X	possible	X	
Glare Testing**			X	X	X							
Confrontational Field	X	X	X	X	X	X	X	X	X	X	X	
Motility	X	X	X	X	X	X	X	X	X	X	X	
Pupillary Ex	X	X	X	X	X	X	X	X	X	X	X	
IOPs	X	X	X	X	X	X	X	X	X	X	X	X
Dilate	X	X	X	X	X	yearly	1st visit;yr		X		X	
Pachymetry		X		X			1st visit					
Topography		X	X	X		X				possible		
Keratometry												
IOL Master/Ascan		for ICL	X									
Specs				Endo disease								
Fundus Photos							1st visit					
Visual Field							2nd visit					
OCT							2nd visit w/ VF					
Cycloplegic		X										
Shirmer's		X										
Amsler Grid		as needed										
AR & K's		as needed										

\* If VA is 20/30 or worse, Pinhole

\*\*Need for glare testing must be noted in Chief Complaint

Note: DMEK patients get specs at ALL visits after 3 months

Sample protocol grid (not our recommendation for work-up protocol). Each practice office is different. The point of this grid is to put expectations in writing.

See Figure 1 for an example of this “protocol grid.”

**2. Assign internal time expectations**

for each step in the work-up protocol outlined in step 1. Cross-reference industry benchmarks on time averages for each component of the work-up, then apply those benchmarks to what you have established for your own practice.

Referencing industry norms is a non-emotional way to gauge reality and provides a great “gut

check” about whether your expectations are realistic. How do your technicians compare to what is considered “standard” across similar settings?

It is important to do this step on each component of the work-up, and not the work-up as a whole. Simply saying to the technicians “a return should take 12 minutes” does not give them focused feedback on which area of their work-up might be falling outside the

time expectations. This process also allows you to set realistic expectations for what you are requiring from your technicians. If step 1 above creates a work-up protocol for a patient exam that includes history, VA, lensometry, refraction, fundus photos, and counseling, for example, and you have assigned the time values for each step as 3 minutes, 2 minutes, 2 minutes, 4 minutes, 2 minutes, and 5 minutes, then it would be unrealistic to ex-

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pect anything less than 18 minutes to complete a work-up on this particular patient and still meet the time expectations.

3. **Host a clinical meeting** to discuss your assessment and findings about your current environment. At this meeting, outline the expected work-up protocol that is now published for everyone's review, share industry benchmarks to support the discussion, and then be open and receptive to their feedback. (The implementation phase might require a more authoritarian approach, but this meeting should be a positive discussion that allows the technicians to be a part of the solution.) It also allows open communication about a particular problem and really drives home the message of customer service and patient expectations.
4. **Audit technician work-up times for one week** during the implementation phase, then have a follow-up meeting to share the results with the

group, to incorporate feedback, and to address any concerns. We found that once we put a spotlight on the expectations and started sharing results, the technicians started to self-manage quite well.

5. **Offer training** and an environment of support for the lower performers. Don't hold it against techs if they weren't trained well in a previous practice. Offer training, but then hold them to the outcome. Kindness and forgiveness gets you to point A. Training gets you to point B. Hard work gets you to point C. If you are the low performer and/or become negative or dysfunctional by point D, another setting might be more appropriate for you.
6. **Implement a time study.** Ours is done one week per month and is simply a sheet attached to each router that captures the in/out time for front, tech, doc, and schedulers, as well as the total time in office. One employee is responsible for implementing and one is responsible for tallying the results. We use a historical spreadsheet as a resource for analysis if productivity drops or wait times increase.
7. **Do not add more layers** (such as additional staff or new equipment) until the existing employees have risen to your new expectations. It takes two full weeks to implement change, so be patient and enforce, enforce, enforce, until those changes start to stick.
8. **Think outside the box.** Are there other bottlenecks to maximizing productivity? Would one of the technicians becoming a scribe, or assuming a flow role, be helpful? Would creating a testing template be helpful? What about moving the autore-

fractor to another room to create better patient flow?

9. **Hire a consultant if needed.** An external consultant can sometimes create progress when internal efforts fall short.

#### ACHIEVING POSITIVE CHANGE

During this process, our technicians were as committed to the practice and to providing a great patient experience as we (management and doctors) were. By including the technicians in the process and listening to their ideas, a potentially negative process became positive and productive. Providing the feedback and tools necessary to empower technicians to improve customer service, patient flow, and technician productivity can achieve positive change. *AE*



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## ADDITIONAL RESOURCES

*For more perspectives on patient wait time and technician productivity, see also the following recent AE articles:*

- "A New View on Patient Wait Times" by Susan Thomas, COE, in the July/August 2014 issue.
- "Zero Wait Times—An Attainable Goal" by John Cassidy, COMT, OCS, in the Summer 2013 issue.

## IN A BLINK

- Use a system of analysis to identify the issues.
- Integrate the affected employees in the solution.
- Explore new ideas by incorporating industry benchmarks and best practices.