

Utilizing ODs and Technicians to Increase Throughput: Experiences of a Model Practice

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Abstract: This large, multi-specialty practice is successful because it leverages the services of ODs and technicians in such a manner that physicians are largely freed to focus on patient care requiring their unique expertise. This greatly increases the surgical volume of this practice and ensures that more high quality care is available to the community that the practice operates in. The practice also benefits greatly from its size and associated economy of scale, professional management, structured technician training and labor specialization benefits. Additionally, lanes are intelligently equipped so that multiple physicians can use the lanes while still keeping equipment utilization high. While the practice does not have a modern EMR system, it does make very effective use of an older CMR system.

I. MARKET AND PRACTICE DESCRIPTION:

This practice is a large group practice with a clinical staff of 43 ophthalmologists, 9 employed optometrists and 142 technicians. The practice is located in a city with approximately 2 million people and a large poor population. Approximately, 65% of the practice's patients are Caucasian with the remainder coming from minority groups, with African Americans being the most prevalent group represented. The practice estimates that 51% of the population is covered by managed care contracts while 46% are Medicare covered. The median age of the patients seen at the practice is 61.

In 2006, the practice performed a total of 11,875 cataract surgeries (5,548 of which were conducted in its own ASC), 1,286 refractive surgeries (all performed in its Laser Center) and a total of 3,658 other surgeries (of which 1,767 were performed in its ASC). The procedures performed outside of the ASC were performed either in an ASC partially owned by the practice or at another outside facility.

In the same market, there are approximately 41 other ophthalmologists and 400 ODs. There are three other multi-specialty, multi-office group ophthalmology practices in the same city, but neither is near the size of the model practice. One of the practices has a significant marketing presence for cataract and refractive surgery and a referral network of optometrists. In addition, there are 2 corporate LASIK groups in the area.

This model practice has a three level main office that encompasses 115,000 square feet of clinical and administrative space including in-house billing and phone operator facilities. This also includes an ASC with 6 ORs and a Laser Refractive Surgery Center. Approximately 65% of business is conducted in this main regional facility. In addition, there are 18 satellite offices distributed across the region encompassing a radius of approximately 50 miles. The practice works closely with a large referral network of community-based optometrists who manage the vast majority of primary eye care in the area. Patients are referred when a level of care beyond that of the OD is required and then are sent back to the referring OD once that care has been rendered.

The practice employs 142 technicians which equates to an average of 3.2 technicians per physician. 14 scribes used by one-third of the physicians and scribes typically perform other duties as well such as transcription, administrative duties, PT workup, etc. The practice also employs 28 receptionists, 24 patient accounting staff, 46 administrative staff, 100 non-clinical staff (HR, IT, Finance, Billing and Maintenance), and 22 executive staff including a leadership team led by a CEO, CFO and a COO.

The regional facility has 70 exam lanes and 24 dedicated work-up lanes. Most exam lanes contain an acuity chart, a phoropter (although not in retina exam lanes), a slit lamp and an indirect. Work-up lanes typically do not have indirects. Lanes will vary depending on the nature of the practice of the utilizing ophthalmologist (e.g., general, glaucoma, vitreoretinal, etc.) and some lanes may not have any of the above equipment. In order to allow for shared space and to minimize the need to purchase duplicate equipment, the exam rooms are outfitted to allow several different ophthalmologists to utilize the room at different times.

The main office and some of the larger satellite offices have a dedicated testing area with IOL Masters, immersion A-scans, topography, autorefractors, autokeratometers, keratometers, phoropters, ECC unit, ultrasonic-imaging unit and B-scans. Additionally, the main office also has a large photography center with Fluorosecein Angiogram Cameras, OCTs, Visual Fields, Slit Lamp Cameras, Nidek Cameras and Electroretinograms.

In 2006, the practice implemented a computerized medical record system (CMR). The system allows users to write on paper and have the notes scanned into the system at the end of each day so all notes are accessible at any office, at any time. Alternatively, notes can be entered directly into the system using electronic forms. Currently, the system does not function as a full EMR.

This practice does not have an optical dispensary.

Physicians

This practice is comprised of 43 ophthalmologists, most having sub-specialty training in retina, glaucoma, cataract, anterior segment reconstruction, cornea and neuro-ophthalmology. Pediatrics is not a subspecialty represented. There are 9 practicing ODs in-house. The average age of all ophthalmologists and optometrists is 50.

Each practitioner works at his or her own pace. Although there is shared overhead, each physician is charged for their personal staff and clinical space and earns only what he or she brings in. Therefore, each is motivated to be productive.

II. WHY IS THIS A MODEL PRACTICE?

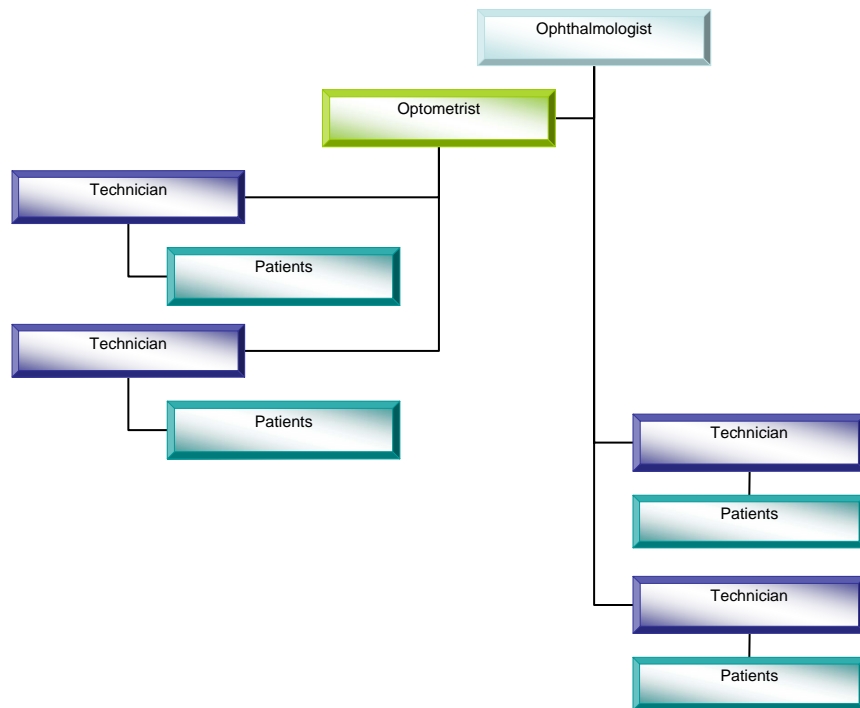
This practice is well positioned to handle the coming wave of baby boomer seniors requiring eye care. Its size allows for economy of scale benefits such as managed care negotiations, controlling overhead through shared expenses and negotiating with suppliers. It also allows for the hiring of talented, experienced practice administrators to help the practice navigate through potentially difficult times in the future.

At the same time, this practice model allows each practitioner to function at his or her own pace instead of requiring more patients per hour and/or more hours per day. It does this by allowing each practitioner, be he an optometrist, technician or ophthalmologist, to function at his or her highest level. In other words, if the surgeon can spend most of the time in the OR instead of conducting work that other practitioners can provide, more patients will benefit from the surgeon's unique expertise. Similarly, if a qualified optometrist can address routine eye exams or pressure checks from those who require more specialized medical or surgical care, more patients can receive the care they need at the level required. Optometrists can be utilized in-office or as a community based network in order to fulfill this role. In this practice model, the vast majority of care rendered by the ophthalmologist will not be routine yearly exams, IOP checks or postoperative exams, but instead by higher level consultations and surgeries. Routine exams are still provided for by optometrists in the office or in the community -- not by the surgeon.

One of the toughest challenges in most practices is finding time for all the necessary patient visits. It typically takes the general ophthalmologist 50 patient visits to schedule 3 or 4 patients for cataract surgery. Therefore, in order for 50 patients to receive cataract surgical care in a month's time, the general ophthalmologist will need to see 750 new patients or re-evaluations a month (not including post-ops). In the practice modeled here, the majority of these 750

patient visits are provided by the community or in-house OD. Therefore, the patient who presents to the surgeon has typically already been diagnosed with cataract and knows that they desire surgery to achieve better vision. Thus, in this practice, only 55 or 60 patients need to be seen by the surgeon to schedule the same 50 patients for surgery. This model therefore allows for these patients to have quick access to both primary and surgical eye care.

Graphical Description of Practice Care Model



III. PATIENT FLOW DESCRIPTION

Before patient flow can be analyzed, training must be discussed. This practice model allows for highly specialized training and cross training of technicians. The well-trained technician can add tremendous efficiency to the ophthalmologist's practice. Proper training allows the technician to not only gather chief complaint and review of system information, but also to perform refractions, confrontational visual fields, pupil and EOM evaluation and IOP checks. Utilizing technicians to perform such functions greatly decreases the time required by the ophthalmologist or the OD to see each patient. Similarly, most glaucoma, diabetic and macular degeneration patients are followed in the community by their OD or by an in-house OD and referred to the ophthalmologist annually or when the disease progresses.

Technicians trained for and assigned these tasks will provide timely information for the ophthalmologist optimizing the physician's time. The ophthalmologist is then able to focus his or her patient time on the specifics of the condition, therefore streamlining the overall medical communication process. Such training can be obtained through such organizations as the Joint Commission on Allied Health Personnel in Ophthalmology (JCAHPO), which conducts numerous classes at major ophthalmology meetings across the country. However, nothing is more valuable than fine tuning your technician's training within your own practice to allow your technicians to reach the level of care that you specifically require.

The following are examples of exam elements conducted by technicians in this practice:

Short Exam: (Undilated post-op follow-up or IOP check)

The technician documents the reason for the visit and the current medicine/drops being used. He or she measures vision, evaluates pupils and checks confrontational visual fields. The technician then performs a manifest refraction if indicated and checks the IOP. The optometrist or surgeon then sees the patient for slit-lamp exam and discussion of the patient's progress.

Medium Exam: (Dilated post cataract surgery follow-up)

The technician documents the reason for the visit and the current medicine/drops being used. He or she measures vision, evaluates pupils and checks confrontational visual fields. The technician then performs a manifest refraction if indicated and checks the IOP before dilating the patient's eyes. The patient typically waits for dilation in a separate waiting area and sees the surgeon or OD in an exam lane once dilated.

Long Exam: (Cataract Consultation)

The technician documents the reason for the visit and the current medicine/drops being used. He or she measures vision, evaluates pupils and checks confrontational visual fields and EOMs. The technician then performs a manifest refraction and checks the IOP before dilating the patient's eyes. While dilating, the patient is taken to the testing room where designated testing technicians perform testing needed for cataract surgery such as IOLMaster measurements, manual keratometry and topography if needed. The patient typically spends a short time in the waiting room where there is the opportunity to view more educational material concerning cataracts and the available surgical options. The patient also completes a questionnaire about the desire for spectacle freedom. The patient then is moved into an exam room where the surgeon expands upon the chief complaint in the HPI, examines the patient and discusses the diagnosis, prognosis and, armed with a clear understanding of the pre-surgical testing

results, the IOL options best suited to the patient. Assuming the patient desires surgery and no further testing is needed, they then proceed to the surgery scheduler who schedules surgery for the patient before they leave the office.

Staffing and Resource Usage

The practice employs 142 technicians which equates to an average of 3.2 technicians per physician. Technicians typically have permanent assignments with a specific MD, but may provide coverage to another physician. Specific staffing ratios are dependent upon subspecialty.

The practice employs 9 ODs who primarily support physicians in glaucoma, retina, cataract and refractive (LASIK). Some ODs are shared and some are exclusive. Many community-based ODs serve as the “primary eye care” givers and refer patients requiring higher levels of care to the practice.

14 physicians use scribes for their clinics. Scribes are typically not shared and most perform other administrative duties when not scribing.

Each subspecialty group within the practice also has a lead technician that is responsible for the daily operations and flow.

Rooms are shared by sub-specialists and the number is dependent upon specialty. For example, retina specialists share 5 work-up lanes and 5 exam lanes while cataract specialists share 3 work-up lanes and one or two exam lanes.

Patient Flow Statistics

1. Average physician time for each exam type: 3-5 minutes for return and post-op; 7-10 minutes for new patients; 5-10 minutes for Lasers; and 2 minutes for injections. Cataract consult visits are now requiring slightly longer times (10-15 min) due to the longer discussions required for premium IOL choices. The practice has found that over a full day exams average 7 minutes per patient.
2. Average technician/OD time for each exam type: 15-20 minutes for new patients; 5-7 minutes for all others. The average technician time for a full cataract consult is 35 minutes.
3. Patient exams per day: This varies widely between surgeons, but ranges between 50-70 per day.

4. Typical patient waiting times: The range is between 20-80 minutes with an average wait time of 25 minutes.

Policies and Procedures:

1. Late arriving patients: For any patient who is more than 15 minutes late, the practice calls back to the physician's staff to ask if the patient can still be seen. If not, the patient is rescheduled. If rescheduled, the patient is not assessed a fee.
2. Emergency patients: This practice has an Urgent Eye Clinic that operates 6 days per week. All patients are added to the schedule and seen. This minimizes interruptions for other doctors. Of course, if the urgent patient needs subspecialty care immediately, those triaged patients are worked into the appropriate sub-specialist's schedule.
3. Special testing (during patient flow, separate times): The regional facility has 3 separate "testing" departments for photography, visual fields and special testing (e.g., IOL master, topography). Each department accommodates the anticipated number of patients through the normal office visit flow and maintains a separate scheduling template for "testing only" appointments. The practice finds that most patients prefer "one-stop-shopping" and would rather have one long visit than several short visits. Additional visits are also an unnecessary burden on family members who are often required to bring the patient to the office.
4. Physician distractions: The lead technician or clinic manager is responsible for facilitating clinic. Physician offices are located on a separate floor from the clinic to decrease physician distraction by tasks other than seeing patients. However, each exam area has a kiosk available to physicians for computerized chart review, etc. All drug representatives and other solicitors are asked to schedule appointments.
5. "Next patient" direction: The practice employs a light system for facilitating patient flow.
6. Appointment reminder calls: Appointment reminder cards go out via an automated system after running a pre-set report from the scheduling system each day.
7. Recall: Patients needing to make an upcoming appointment further than one year out are entered into a recall system. A postcard is automatically generated 3 months prior to the identified month for the return visit and

mailed to the patient. The patient is instructed to contact the Patient Intake Department to schedule their return visit.

8. No-shows: The patient's appointment will be removed from the schedule in the practice management system. A no-show e-form (in the CMR system) is completed that specifies the necessary action to be taken to have the patient rescheduled. The practice does not charge the patient a "no show" fee.
9. Technician recruitment and training: At this time, technicians are hired with or without experience and then are trained by the clinic manager and other staff. The practice is currently developing a 4-6 month training program for new hires that it plans to implement in the next few months.
10. Physician Preference Cards: Most the of staff work with one specific doctor. When the staff works with other doctors, they have access to doctor preference cards.

SOME THINGS THAT ENHANCE PRODUCTIVITY AND PATIENT FLOW

1. Multiple workup lanes for each exam lane: Technician/OD workup time required is generally longer than the physician time and therefore multiple work-up lanes can greatly facilitate patient flow. Once worked-up, the patient is moved into a waiting area if the physician is not yet ready for the patient.
2. The use of ODs for primary eye care: This allows each practitioner to function at his or her highest level, decreases the surgeon's non-surgical patient load, and ultimately expedites the patient's access to needed care.
3. Utilization of dedicated testing personnel for IOL calcs, photo, etc.: Dedicated personnel naturally become quite skilled and develop a routine that maximizes patient flow and quality of care. Some level of cross training is still necessary, however, to retain a flexible labor pool.
4. The use of CMR: Until a more standardized EMR system is developed, the CMR makes good sense for this practice. It is much less expensive, can be use as an EMR for most visits, and creates an electronic record that eliminates the need to search for charts.
5. Leaving optical dispensing to the community ODs: This helps to cement relationships with these ODs and frees the surgeons to do what they do best: higher level medical and surgical eye care.

6. Mailing registration and informational literature prior to the visit: Patients who call to schedule an appointment can be mailed an informational brochure that includes registration material, a review of systems, and more detailed patient education materials regarding the patient's condition/care. Doing this saves valuable time for the patient and the doctor alike.

What causes patient flow to break down?

1. When patients are significantly late for appointments, the practice typically still sees them. This can cause a back log.
2. MDs not staying on task, due to personal phone calls, etc.
3. Rotating urgent patients to sub-specialists causes significant delays in the schedule and many unhappy patients.

IV. CONCLUSION

The demographics of the aging population will continue to present challenges to all practices. This practice will meet this challenge by using technicians and ODs to free physicians to focus on higher level care. This practice also leverages its size and professional management to achieve economy of scale and flexible labor pool benefits that generate further efficiencies and reduce overall administrative burden on physicians.