

## **Utilizing Ophthalmic Technicians to Increase Throughput: Experiences of a Model Practice**

By Dr. David Durfee

Abstract: This solo practice is generates about 15 physician RVUs<sup>1</sup> per hour. It does this because it is successful in leveraging five technicians and a scribe who free the physician to do more complex tasks. It also has an efficient patient flow process that effectively utilizes exam rooms and is enhanced by strategic patient scheduling and technician cross training. The practice also frequently experiments with its patient flow / internal processes. While many of these experiments are not successful, the experiments create an environment of constant innovation that has improved the practice's efficiency. The practice also uses various techniques to maintain good relations with area ODs who refer patients to the practice.

### **I. INTRODUCTION AND MARKET /PRACTICE DESCRIPTION**

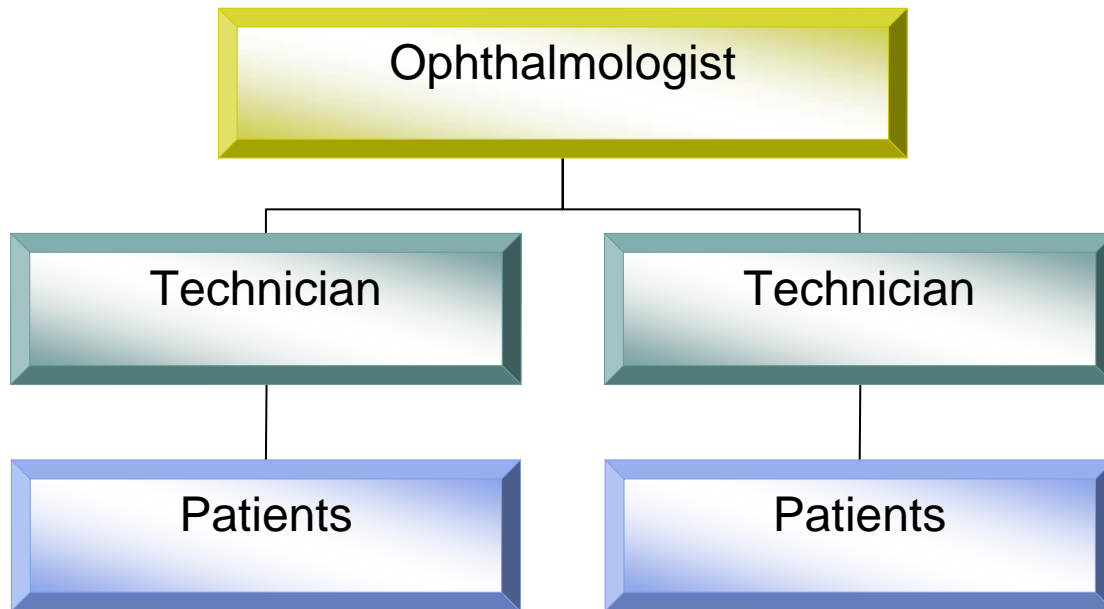
This is a solo practice that utilizes multiple technicians in the delivery of clinical care. The practice focus is comprehensive ophthalmology with an emphasis on cataract surgery. The practice does no refractive surgery, but co-manages that aspect with a local refractive surgeon. The physician performs SLTs but refers severe or complex glaucoma cases to a local specialist, and retinal cases to a local retina group. An OD works as an independently scheduled provider, but is not a physician extender.

The practice is located in a metropolitan area with approximately 1.8 million people. The practice is well established in its market area which has one of the highest penetrations of managed care in the country (70%). Despite this, only 35%-40% of patients at this practice are enrolled in managed care plans.

The back office consists of six technicians and one scribe. The OD works with one technician. The ophthalmologist uses the other five technicians and the scribe. The front office has 4 receptionists, 2 billers, 1 surgery scheduler and 1.5 administrative personnel. The physician owns an optical shop with 3 employees as a separate entity.

The physician is 62 years old and starts his day at 8:00 am and works continuously through the lunch hour. His day usually ends at 6:00 p.m. The physician spends 165 full days in the office and 60-65 days in surgery annually. He had more surgery days in 2007 than any previous year. At least 40% of his patients are over the age of 65.

### **Graphical Description of Practice Care Model**



## II. WHY IS THIS A MODEL PRACTICE?

This practice processes more than 4 times the national average of cataract cases on a per physician basis and generates 153 RVUs per physician office day worked or approximately 15 RVUs per hour. With the physician working 165 days last year, this generated over 25,000 RVUs. This throughput is due to the practice effectively utilizing physician extenders (technicians) as well as an efficient patient flow process that makes the most of its exam rooms.

## III. PATIENT FLOW DESCRIPTION: WHAT WORKS WELL AND WHAT DOES NOT

The physician sees between 65 and 75 patients per day while the OD sees 15 to 20 patients per day.

The practice has seven lanes that are similarly equipped. Three lanes are used by the technicians for workup; three lanes are used by the physician for exams and one lane is used by the OD. The physician's patients are first seen by a technician in one of the three workup rooms. Those patients that require a refraction start with an auto refractor by the technician. The technician then refines the refraction before the patient is seen by the physician who does the final refinement. The technician obtains chief complaint, reviews medical history and medications and obtains visual acuity or best corrected visual acuity if the patient is 20/40 or worse with their glasses. They take intraocular pressure by

applanation, check pupils, do confrontation visual fields and evaluate extraocular muscles. If the patient complains of any symptoms relating to dry eye, the technician checks lissamine green uptake and applies Schirmer's strips to test tear production. The dry eye work-up is always performed before intraocular pressure is taken, and prior to dilation. The technician then dilates the patient and then moves them to the dilation waiting area. If the visit is a follow up, the technician may only take the visual acuity and/or intraocular pressure measurement. When dilation is complete the patient is moved to one of the exam rooms used by the physician. The physician has a scribe in the room as he is seeing patients.

The OD has one dedicated room and at least one technician. Most of the OD's patients are seen independently from the physician. If consultation is necessary and non-urgent they are scheduled to return for another visit. In an urgent case, the physician will see the patient that day. Late patients are rescheduled if more than 15 minutes late.

The practice has a full array of diagnostic instruments, including perimeters, cameras, topographers and pachymeters. Typically one of the six technicians is responsible for testing on a given day. Visual fields and A-scans are scheduled separately but other diagnostic testing is worked in the day of the visit.

The physician believes that the following things work well in his patient flow:

1. Moving patients to the dilation area following dilation drops.
2. Scheduling medical exams and refractions/vision exams completely separate, regardless of patient insurance.
3. Keeping a scribe with the doctor at all times.
4. Using a lightbox system to communicate who is where and who needs what.
5. Having patients return another day for injections, lasers, special testing (if it can wait).
6. Scheduling "special needs patients" at the very end of the day to allow more time with them.
7. Scheduling glaucoma exams at spaced intervals (i.e., not back to back) to ensure testing is not backed up.

8. Assigning technicians a 'focus' for the day (testing technician, back-up scribe, work-up technician) and rotating that focus during the week.
9. Cross-training technicians so that all technicians can perform all diagnostics and exams.

The following things create bottlenecks, delays and disruptions in the normal flow:

1. Same day procedures, unexpected tests, injections ordered and performed the same day of visit rather than ordered and scheduled for another day.
2. Shortage of work-up rooms causes disruptions and delays.
3. The physician answering cell phone or other calls in the middle of clinic.
4. The physician returning late from surgery.
5. Improper scheduling of appointments (IOP checks scheduled back to back, etc.)
6. The lack of a scribe for the physician that requires the physician to do his own charting.
7. Scheduling several new patients in a row as this impacts check-in and slows patient flow.
8. Emergency work-ins (although they never turn them away)

What the physician has tried in his patient flow that has worked well:

1. Procedure afternoons (following surgery) for chalazions, injections, YAG lasers, Argon lasers, FA's, PRP's, in office injections for wet AMD, etc. The physician schedules these procedures since they have just one procedure room.
2. Using one or two scribes at all times (one filling rooms, one scribing)
3. Utilizing 2 auto-refractors and lensometers for greater availability.
4. Having A scans and visual fields on their own schedule with only the OD in the office.

5. Not “closing” the office for lunch or midday meetings.
6. Staggering shifts for technicians and offering alternate work schedules (4 10-hour days) to allow for greater coverage on busy days.
7. Making sure technicians take patients back in the order of their appointment times, regardless of which doctor they will see.

The physician has tried the following things and they have failed:

1. Leaving patients not requiring dilation in the work-up room to be seen by the physician instead of seating them in the dilating area to be moved to one of his exam rooms.
2. Not using a scribe.
3. Having patients refracted for glasses/receive Rx for glasses on the same day as a medical exam as flow is disrupted to check patient vision coverage.
4. Seeing a patient for a cataract evaluation, ordering cataract surgery, and performing the A scan that day after seeing the surgical coordinator to schedule the surgery. The visits are extremely lengthy, and a technician is taken off of work-ups to perform the A scans.
5. Having patients go to optical while dilating to look at frames (note that this did not work because of the office floor plan).
6. Having diagnostic machines in the lanes as the machines disrupt patient flow.
7. Assigning technicians to the same “focus” each day (testing, scribing, etc.). A more flexible labor pool has proven advantageous.

#### **IV. CONCLUSION**

While the physician commits himself to a long work day, this practice has achieved a high level of efficiency through the use of more lane space and more technician support. Strategic scheduling has also contributed to this practice’s smooth patient flow as has its emphasis on cross training.

It is important to note that the practice’s high volume of cataract is attributable to a substantial OD referral network. The practice is able to both benefit from owning an optical shop and not discourage OD referral by utilizing a meticulous



flagging system to ensure no OD referred patients are given Rx's for glasses or scheduled for routine exams. The practice can continue to add capacity by expanding its physical space and hiring more OD's.

<sup>1</sup>. RVU analysis is for the exam codes performed in clinic only and does not include tests done by the technicians. The full 2008 RVU is used, not just the Work RVU.