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The Technician Point System: How to Improve Practice Accountability and Bottom Line

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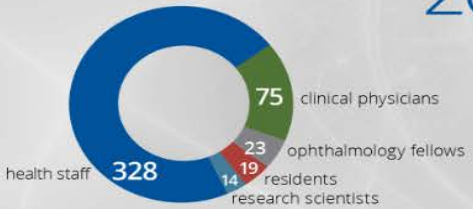
Financial Disclosures

No Disclosures from any Panelist

The Technician Point System: How to Improve Practice Accountability and Bottom Line

Duke Eye Center

2021 Stats **Duke Eye Center**



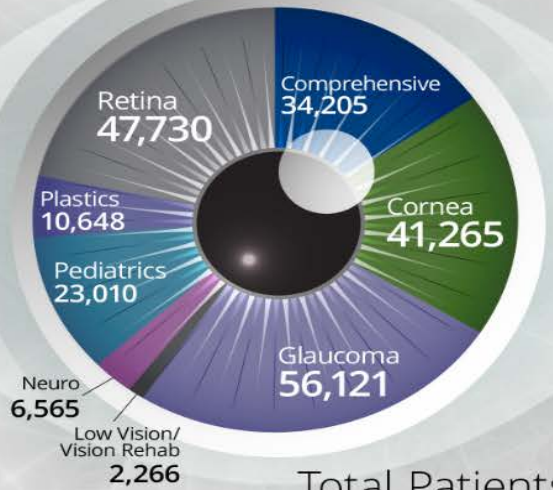
490 Faculty, Trainees and Staff

6 Ranking
US News & World Report
Best Hospitals in Ophthalmology

10 NIH Funding Ranking

270 Total active sponsored research projects (FY21)

Award Funding
$23,674,232
$9,318,715 Federal
$14,355,517 Non-Federal



Total Patients
221,810

7 Locations

16,465 Surgeries

DUKE EYE CENTER 2022

Where and Why Did We Start?

Why?

We did not have any operational standards in place for all of our sites.

We had one clinic that had high patient, employee, and provider satisfaction. We used this clinic as our standard.

Where?

We started with the implementation of standard work and processes one clinic at a time.

We began the improvement initiative in our satellite practices in 2013.

2013: Duke Eye Center of Cary

- Multi-Specialty Practice (Cornea, Glaucoma, Pediatrics, Retina)
- 13 exam lanes
- Seeing over 17,000 patient visits a year
- Tier 3 Employee Work Culture Score
- Physicians reporting delays in flow
- Patient Satisfaction Scores Below Target

Focusing on the Patient Flow

- Almost every negative comment via patient satisfaction survey was related to the patient's wait time in the clinic which indicates a possible flow issue

- Based on the patient feedback, we decided to look at the visit flow through the clinic as one area to improve patient satisfaction

Why is the Visit Taking So Long?

Focused Problem: Patients complain that the visit length is too long.

1. Why?
   - Depending on the reason for visit, a patients flow through the clinic can vary.
2. Why?
   - Patients that need more than one type of test or imaging workup may be handed off to multiple employees, which causes additional wait time due to bottlenecking.
3. Why?
   - Techs stay with an assigned Doctor based on the Doctor's specialty, familiarity and imaging requirements.
4. Why?
   - The Techs are not cross trained to work with all specialties and all diagnostic equipment.
5. Why?
   - There is no training plan or policy requiring Techs to be cross trained.

Conclusion: Techs should be cross trained to work in all specialties and with all diagnostic equipment.

Defining the Technician's Role

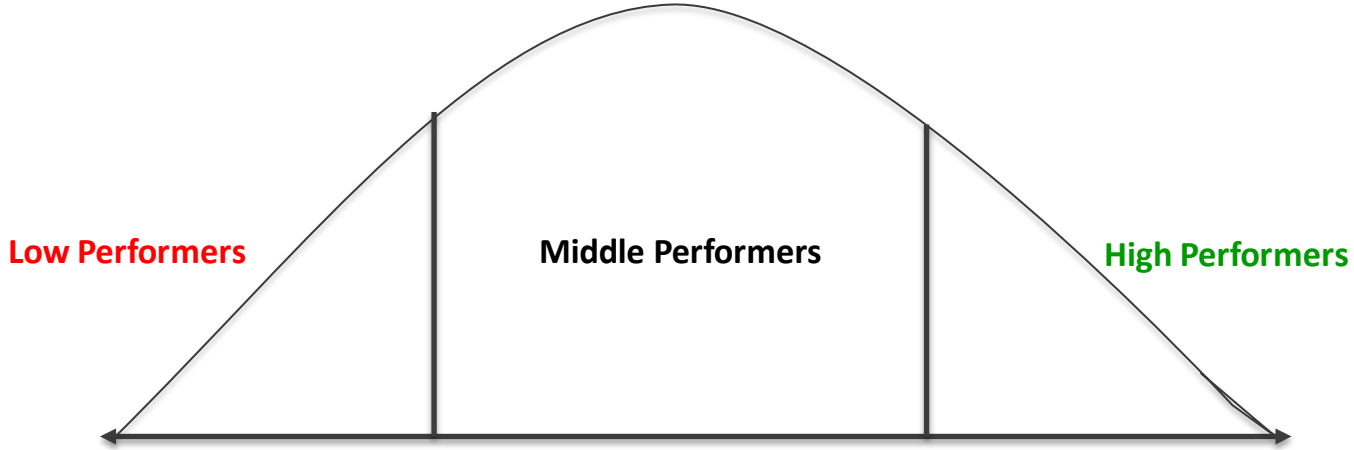
- *5-Why Opportunity: Increase Tech Skills and Consistency*
- Job expectations for technicians updated:
  - To include cross-training on multiple examination devices
  - To rotate to multiple locations as needed
- To implement fully, needed standardized diagnostic equipment across sites
- Training existing employees on all equipment; new hires are shadowed during orientation to assess skills and refine training
- Labor can now be shared across sites based on demand

Accountability

- Now that all technicians would be sharing the daily workload of patients, how would we hold them accountable for their daily productivity?

- If technician A sees 10 patients in a day and technician B sees 15 patients in a day, who worked harder?

High, Middle, Low Performers



Nothing will make your high-performers leave more quickly than seeing the low-performers get away with not doing their share of the work!

Creation of Technician Point System

1. Collected cycle time data per visit type (tech in, tech out, testing start, testing end, etc.)

2. Cross referenced data per visit type to get accurate reflection of total technician work up time per visit type

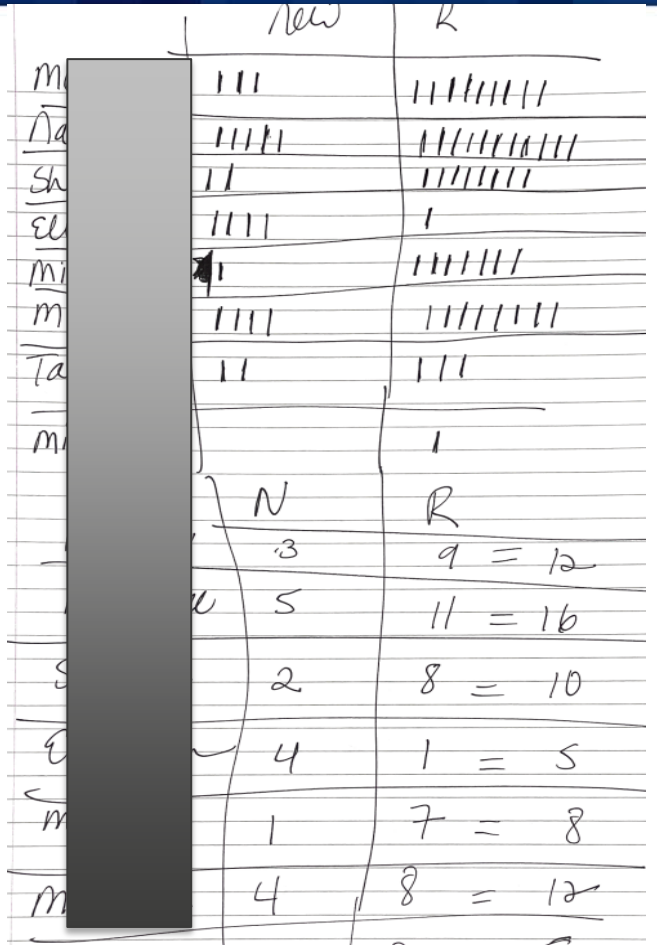
3. Using that data, assigned value of 1 point to equal 15 minutes of technician time

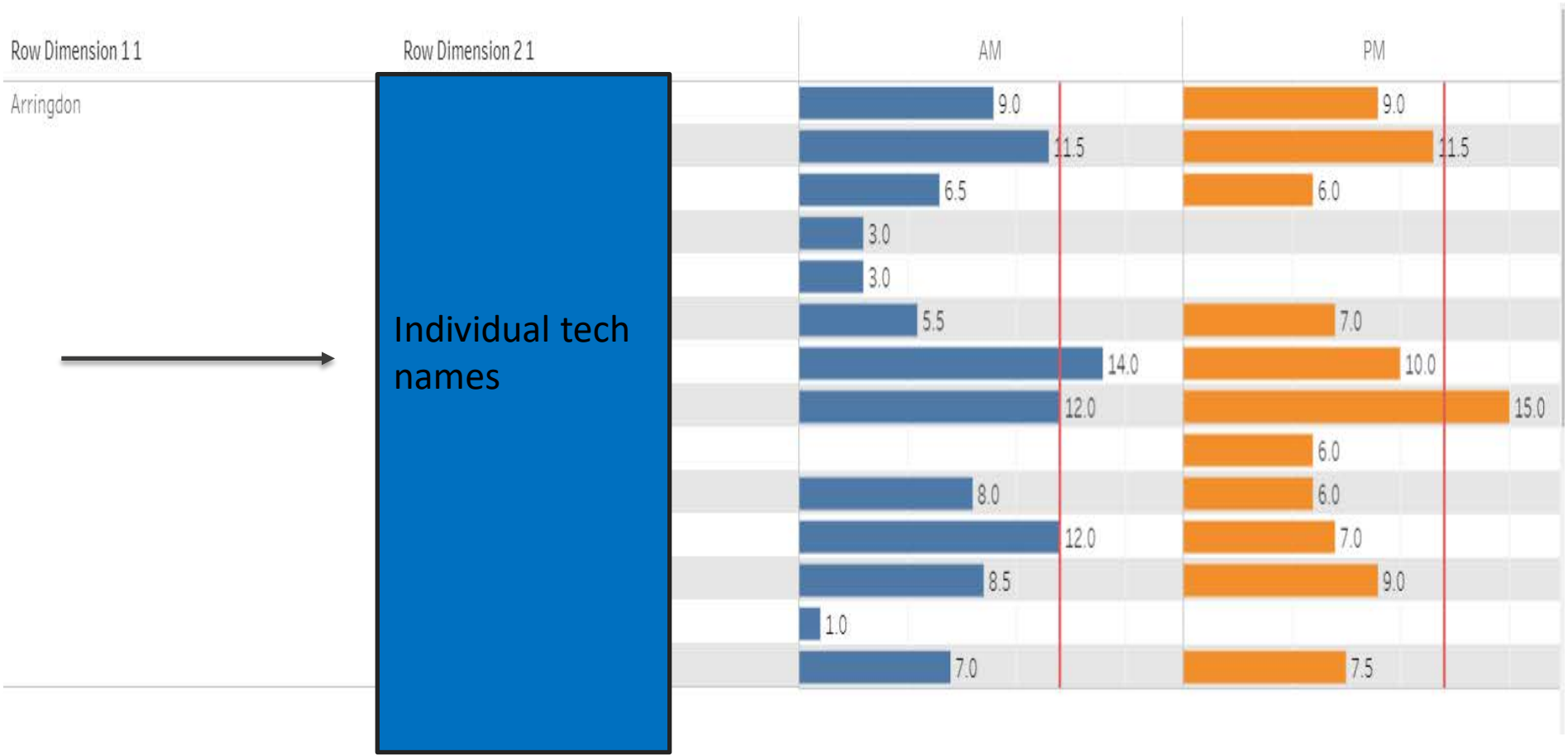
- If one point = 15 min you can determine the amount of productive time you expect each technician to have per session

- Our current goal is 12-14 points per session

Visit Type	Point Value
NCE	3
New Glaucoma	3
Dry Eye Consult	3
New Patient	2
Return Visual Field	2
Return	1.5
Post-op	1


N
R
N
R
2/26/15
sick


New
R
N
R
3
9 = 12
5
11 = 16
2
8 = 10
4
1 = 5
1
7 = 8
4
8 = 12


Row Dimension 1 1
Row Dimension 2 1
AM
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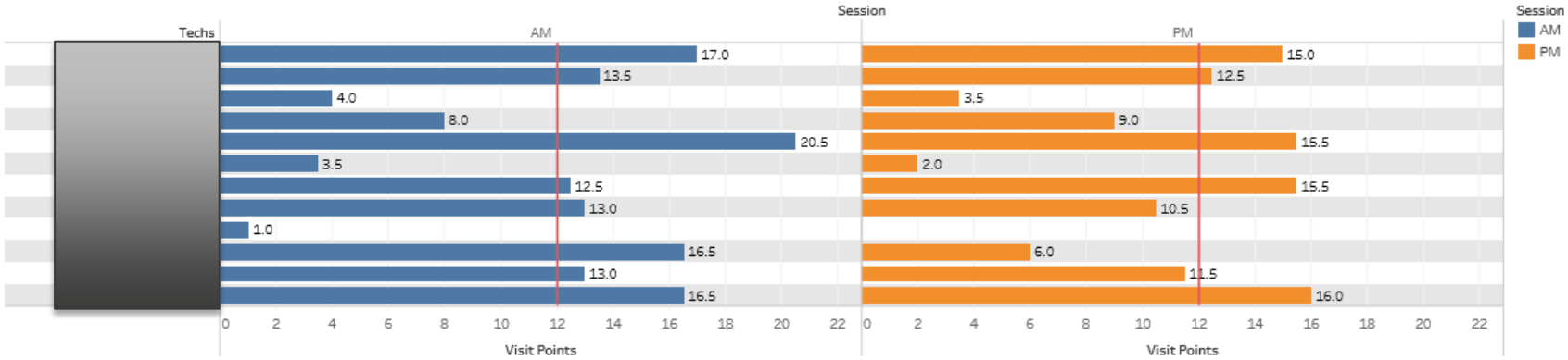
Individual tech names

Points Transparency



Points are posted on manager's office door daily. Scribes are not counted in daily point totals, however, as you can see most scribes work up for their Provider when there are no patients ready for them to see (lower point totals).

Duke Eye Center

Overview

Row Dimension 1	Row Dimension 2	2022 February				
		Number of Distinct Sessions	Number of Sessions That Met Goal	Percent of Sessions That Met Goal	Point Goal Per Session	Points
[redacted]	-	27	5	19%	12	203
	-	1	0	0%	12	4
	-	39	25	64%	12	467
	-	22	4	18%	12	178
	-	14	1	7%	12	91
	-	35	13	37%	12	368
	-	36	20	56%	12	445
	-	35	0	0%	12	174
	-	33	20	61%	12	387
	-	18	0	0%	12	93
	-	33	14	42%	12	340
	-	16	3	19%	12	120
	-	31	19	61%	12	345
	-	24	8	33%	12	231
	-	37	3	8%	12	299
	-	3	1	33%	12	35
	-	22	4	18%	12	161
	-	30	8	27%	12	261
	-	30	8	27%	12	278
	-	13	4	31%	12	88
	-	29	11	38%	12	282
	-	22	11	50%	12	231
	-	27	0	0%	12	142
	-	27	9	33%	12	246
	-	25	8	32%	12	246
	-	11	0	0%	12	46
	-	38	6	16%	12	285
	-	23	0	0%	12	141
	-	34	2	6%	12	217

Additional Points Benefits

- Forecasting:

HCA: (All)

Daily Prospective Points

Manager	Location	Department	Provider	Session	Days Out	Values	Visit Type
(Multiple values)	(All)	(All)	(All)	(All)	7	Points	(All)

Appointment Date

Department	Session	2022-05-31	2022-06-01	2022-06-02	2022-06-03	2022-06-04	2022-06-06	2022-06-07
Cary Eye Center	PM	80	28	6			72	63
	AM	91	37	14	56		77	77
	Total	171	64	20	56		149	140
Eye Center Arringdon	PM	72	53	96			81	114
	AM	90	52	148	6		87	136
	Total	162	105	244	6		168	250
Eye Center Holly Springs	PM	58	66	49			23	48
	AM	66	66	52	33		39	67
	Total	124	131	100	33		62	115
Eye Center South Durham	PM	88	129	113	43		124	127
	AM	108	184	157	186	2	134	128
	Total	196	313	270	229	2	257	255
Eye Center Winston Salem	PM	58	78		29		88	57
	AM	53	81	12	25		87	52
	Total	111	159	12	54		175	109
Eye Comprehensive Durham	PM	1		14			13	13
	AM	2		24	18	8	26	23
	Total	3		38	18	8	39	36
Eye Cornea Durham	PM	34	20				34	58
	AM	77	45	54	51		68	72
	Total	111	65	54	51		102	129

FTE Justification

- Clinic manager requesting additional staffing, but has employees never meeting points, will be denied

Overview

2022
May

Row Dimension 1	Row Dimension 2	Number of Distinct Sessions	Number of Sessions That Met Goal	Percent of Sessions That Met Goal	Point Goal Per Session	Points
[redacted]	-	29	10	34%	12	255
	-	1	0	0%	12	5
	-	33	4	12%	12	281
	-	1	0	0%	12	9
	-	17	6	35%	12	164
	-	23	8	35%	12	209
	-	32	8	25%	12	265
	-	21	8	38%	12	204
	-	24	8	33%	12	231

A Quick Word About COVID

- Standardizing technician training and overall operations was a key component in our initial response to COVID as well as ability to recover

Incentive for Provider Productivity

- Staffing was the biggest shared resource for the providers. The point system provided metrics for the technician accountability, but provided another opportunity to place metrics around exam rooms as well as scribes.

Cultural change is a long-term process. Barriers to improvement MUST be addressed

Sustainment of change is based on constant remeasuring and education around company objectives to influence behavior and success

Getting the Providers on Board

Leadership 101 (not really)

- Some leadership concepts are trivial, silly, or obvious – and I disagree with most of them
  - 99% of success is showing up
  - Most overnight success takes 5 years
  - When you lead your real job is to create more leaders, not followers
  - 7 traits, four types, 3 roles, and other hoo-ha, etc, etc

- 3 keys to Buy-in
  - Listen
  - Identify needs
  - Connect the dots

The individual

- Communication skills
- Energy
- Kindness in the face of other
- Firmness without aggression
- Altruism!
- Long term view and constant, honest reassessment
- Keep various and sometimes disparate, unaligned groups, aligned
- When times are good prepare for a future where they are not (or, leave before the downturn, as so many at the highest level seem to do – ie “failing up”!!)
- To be a good leader, you have to try to know yourself… your own hot buttons, strengths and weaknesses, tendencies, biases, etc
- Know why you are doing it
- Lead by example

Why lead?

- If you are doing it for a specific personal reward or “teaching to a test/metric” I’d argue you ought to move on (fail up, perhaps)

- The reward is reaching a better state, solving a problem, delivering better care, improving education, improving culture, improving the lives of those you **serve** (patients and co-workers), etc.
  - The real rewards are indirect - anything else is icing on the cake

- **Leadership *is* service**
  - Requires a group effort
    - An aligned, honest, communicative group

Alignment of leadership group

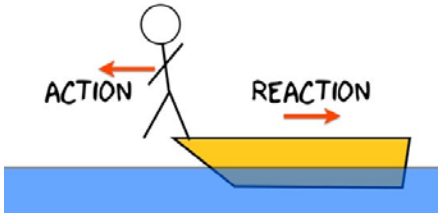
- Not the alignment most espouse, frankly

- Instead:
  - Consistency
  - Shared problem solving
  - Shared goals
  - Open and honest communication

- It is not really about “I got your back” as much as it is that we are on the same page and communicate with each other effectively and honestly and will work together toward shared goals

Implementation and Newton

- Newton's 3rd Law of leadership - Any major change (e.g. point system), strategy or tactic is typically complicated by significant headwinds
  - General stasis
  - Fear of the unknown
  - Lack of trust
  - Lack of data (unclear reality, bad metrics)
  - Lack of understanding of specific and greater issues, greater good, population needs
  - Infrastructure issues**
  - Physician reticence**



- You have to identify these headwinds in advance and address them to make change possible and successful
  - May vary depending on situation
    - For example, point system (accountability, relationships, and change, generally) vs flow/imaging change (quality concern)
- You need to identify these forces as they apply to the physician group, specifically, to get buyin

- Leadership must be aligned

Successful shared and aligned leadership

- Examples
  - Point system
  - Imaging and patient flow
  - Injections and CMAs
  - Clinic bays
  - Physician accountability
  - COVID response

- And, it doesn’t always work

Point system

- Headwinds = fear of change, accountability and established relationships (mom vs dad), loss of control
- Address these issues with DATA whenever possible
  - Define the problems of current status = inefficient clinics, low performer harming high, patient care (wait, cycle, volume), physician stress/frustration, volume
  - Define selling points/expected improvements= increased volume, staff and patient satisfaction, improved flow and decreased stress, take work off physician plate (vs loss of control)
- Share all of this, as well as proposed changes and expected outcomes, with docs
- Get the buy-in for a trial
- With a successful trial, more physicians on board to spread the gospel
- Implement and then monitor and report back, modify prn

TBH

This one required several walks around the block and similar “outings” with various Division Chiefs, to explain, to reassure, to educate, and to check in along the way

- You do what is necessary

Imaging

- Headwinds = quality of images and effect on clinic flow if techs doing imaging

- Main selling points
  - Decreased cycle time and patient waits
  - Increased volume
  - Guarantee quality
    - We had to figure out a way to prove this would work
      - “certification” process, feedback loop
- You go through the same process
  - Recognize the headwinds
  - Define the problems you will address
    - In this case, we included training/“certification” of techs
  - Communicate with data
  - Do a trial
  - Spread the word
  - Generalized implementation and follow-up ie normalization

Injections and CMAs

- Headwinds = fear of change, qualifications necessary/QOC concern
- Main selling points were indirect:
  - Improvement in clinic staffing and flow via right-tasking
    - Free the more highly-trained techs to do tech work
- Goodwill and trust

- You go through the same process
  - Recognize the headwinds
  - Define the problems you will address
  - Communicate with data – docs love data
  - Do a trial (sometimes not necessary)
  - Spread the word
  - Generalized implementation and follow-up ie normalization

A comment on physician accountability

- Not only do you have to bring physicians along, but physicians must also be accountable
  - Physicians must set the example and tone in a practice and be held to the highest standards

- Tough
  - Can be a terrible myriad of legal and other issues
  - Because of confidentiality reporting back is generally limited
  - Most difficult issues center around professionalism, or the lack thereof
  - A physician leader has to be fair, but must also address issues of professionalism head on
  - And a note for folks working in this area - repeat offenders generally don't change
    - Lack of self-awareness seems evident in most

- Restorative justice

COVID

- All of this was tested, over and over and over again
  - In clinics, in the OR
- One or two silver linings
  - Even greater team integration – hospital nursing, anesthesia, and clinic
  - Triage systems set, communication, and group interactions and responsibilities clarified
    - Allow for faster implementation in case of future emergency
  - Process streamlining (e.g. imaging)
  - Have a playbook for future events
- Recovery led Duke and most practices
- It ain’t over…

Not everything works

- Identified issue = Culture
- $$, events, “advertising" and selling of concepts
- It has not worked, really
  - Failure predicted and inevitable and started before COVID
- What was ignored = Headwinds. Actual infrastructure, policy and HR changes that would strengthen the base of the pyramid and solidify any changes that relied on that infrastructure.
  - The headwinds were ignored
  - A lovely bridge with insufficient support wont last long

So

- Due diligence and identification or underlying issues and headwinds is key
  - Take them seriously, address them head on, as soon as possible
  - Use data, be smart about metrics
- Openness and communication within leadership team and leadership to all
  - It takes an aligned and committed team to lead a complex organization
- Follow-up, flexibility, and modification
  - All living processes must continue to evolve

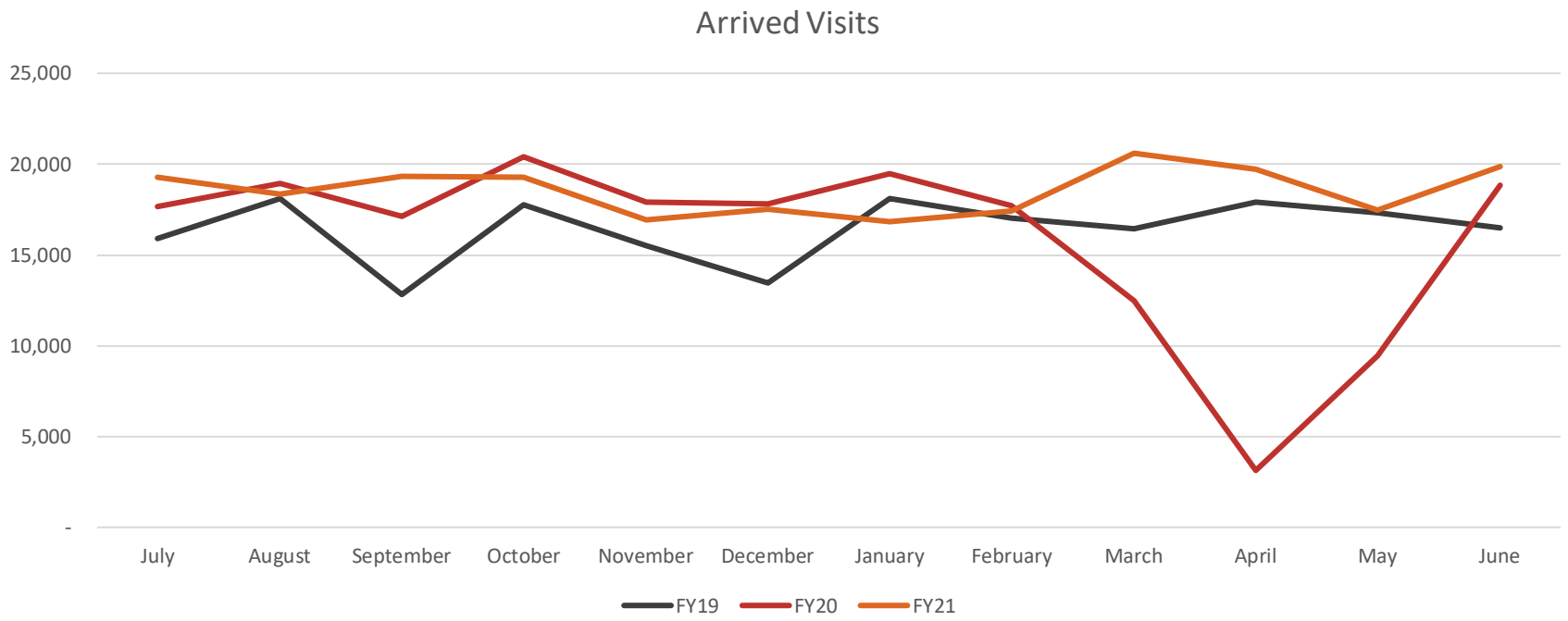
- Finally, don't give up. Real change is hard, seems to take more time than it should, and requires more effort to bring folks along than one might initially expect. You learn all this by doing.

Financial Impact

Impact and Recovery from COVID

- Clinic volumes were down 86% at the worst (with a 68% decrease in revenue March-May 2020)
- Surgery was only performed on true emergencies – from an average of 400/week to 8 at the low point.
- We were the hardest hit, but fastest to recover at Duke. Why?

Impact of COVID – Arrived Visits



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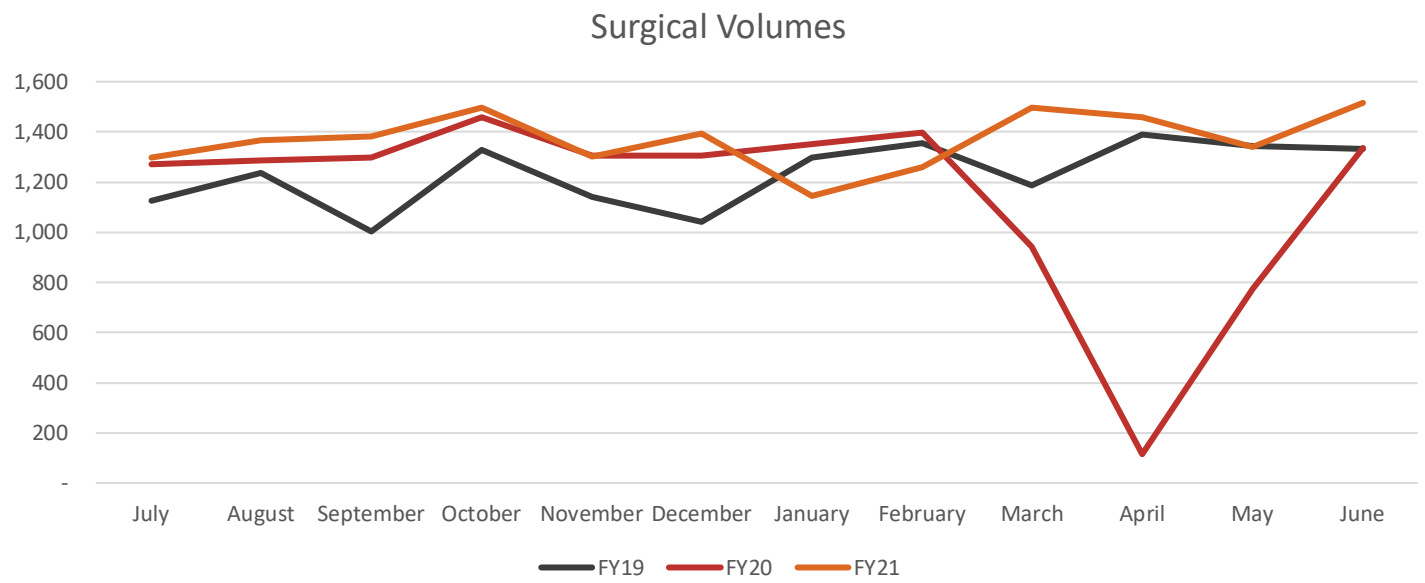
Impact of COVID – Surgical Volumes



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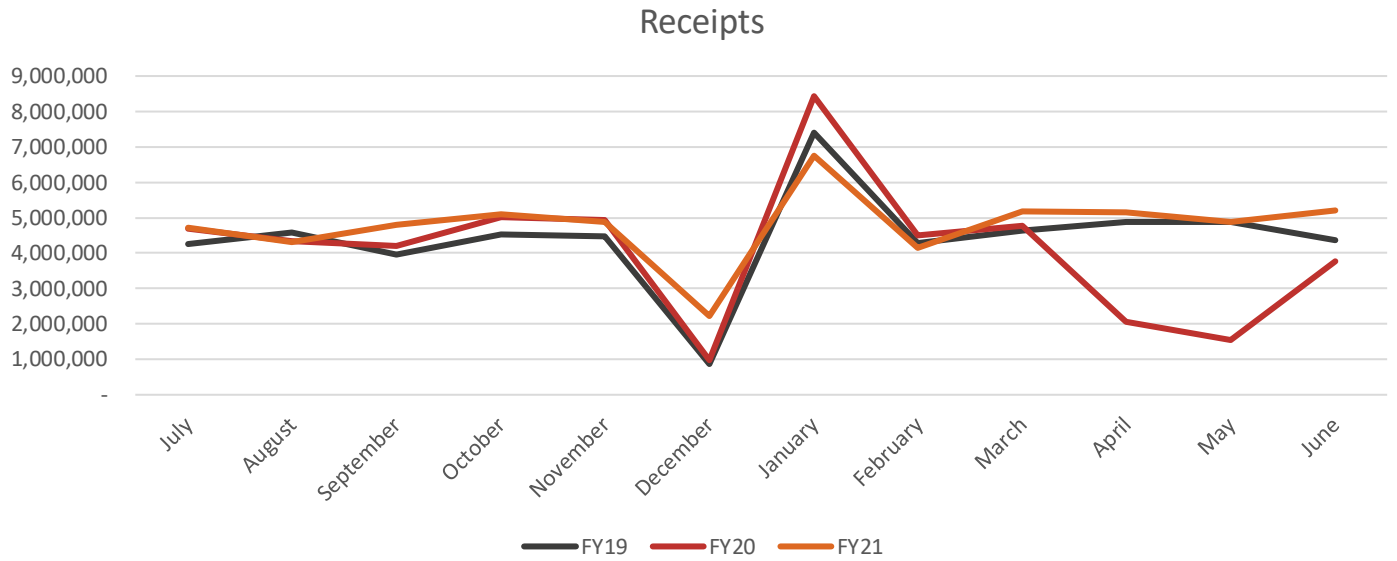
Impact of COVID – Receipts



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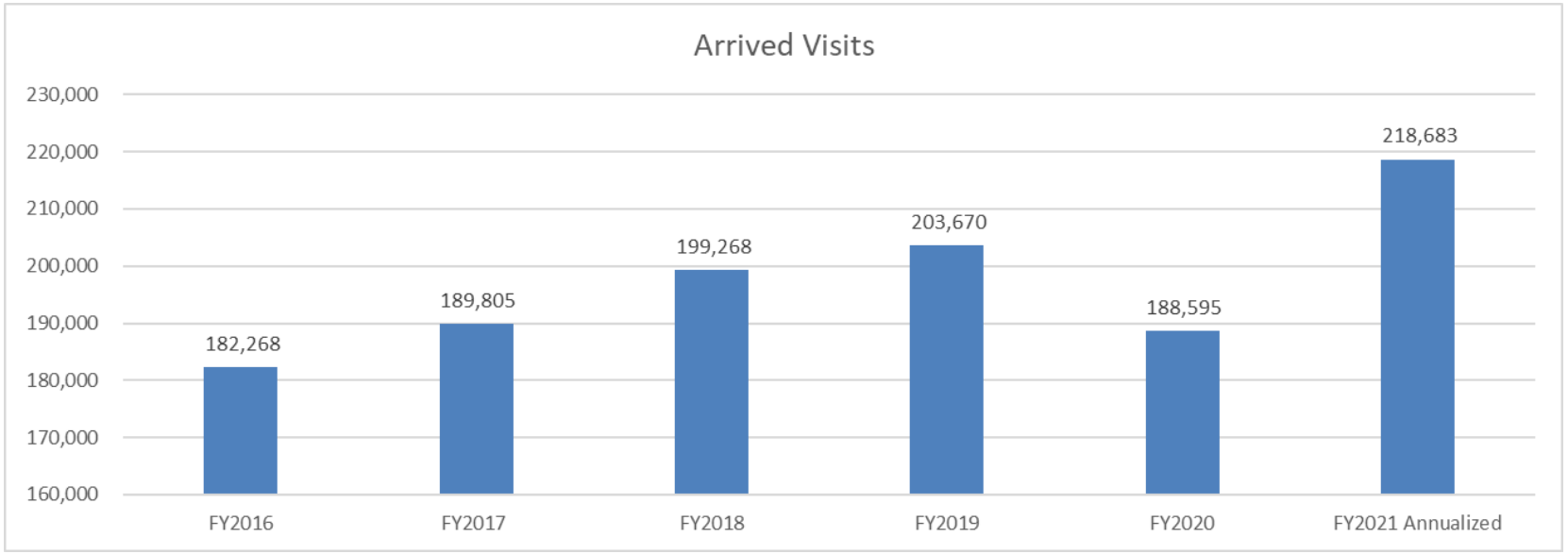
Arrived Visit Increase

- With all technicians working as one team, we were able to maximize each provider's template individually and on a clinic wide basis

- Patients were making their way to the providers faster, decreasing down time and allowing for additional appointments

Arrived Visit Growth



With wide-scale process improvements, template and staffing changes, and physician growth, Ophthalmology grew by 11.7% from FY16 to FY19.

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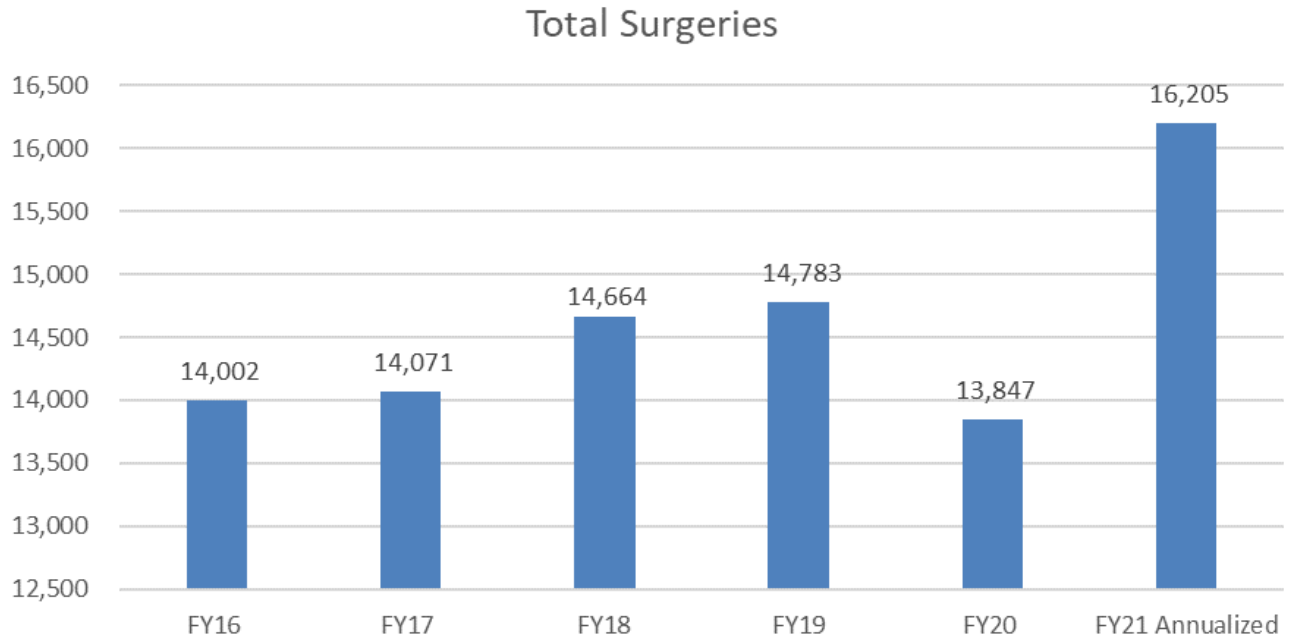
Surgical Volume Growth



FY21 Surgical volume grew by 2,203 cases or 15.7% from FY16 to FY21 annualized.

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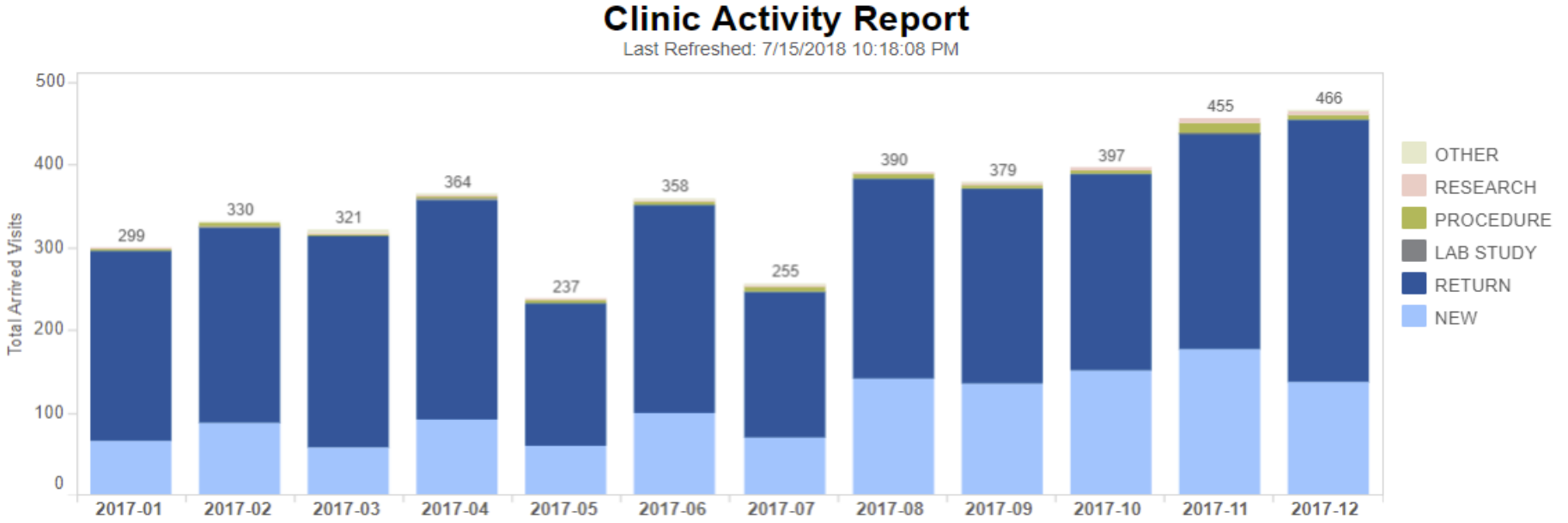
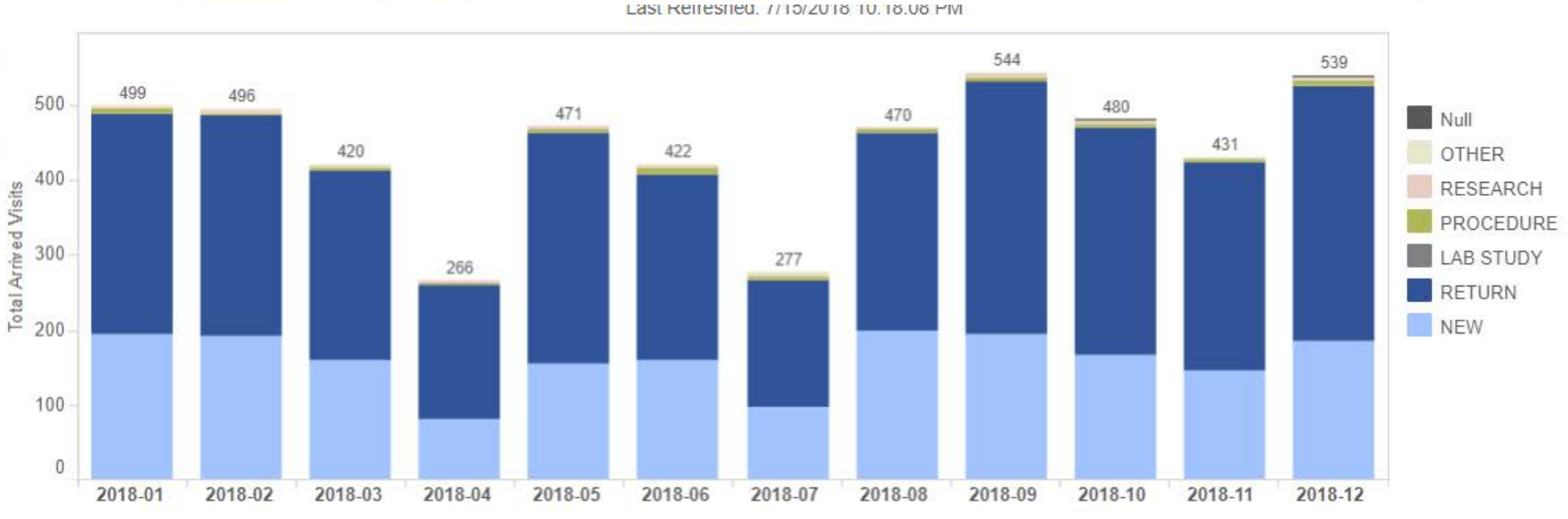
Comprehensive Provider Arrived Visits FY17



Column 1	Total Arrived Visits	% New Patients	No Show Rate	Average Cycle Time (min)
Eye Center - Main	3,021	21.9%	11.4%	65.5
Health Center of Southpoint	1,230	49.4%	12.8%	62.5
Grand Total	4,251	29.9%	11.8%	64.6

Comprehensive Provider Arrived Visits FY18



Column 1	Total Arrived Visits	% New Patients	No Show Rate	Average Cycle Time (min)
Eye Center - Main	2,872	29.5%	11.5%	67.7
Health Center of Southpoint	2,443	44.5%	13.9%	66.7
Grand Total	5,315	36.4%	12.6%	67.2

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Increase of over 1000 visits per year, with overall cycle time only increasing by 2.6 minutes

Financial Impact

Div. Collections:
FY15 3,969,806
FY16 4,570,310
FY17 5,444,243

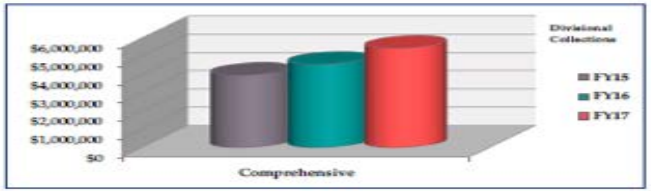
19% increase from FY16

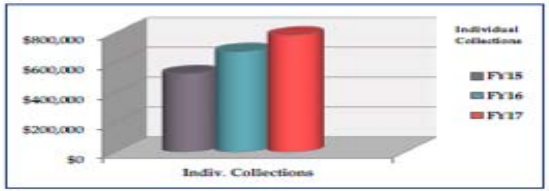
Individual Collections:
FY15 524,068
FY16 673,322
FY17 782, 321

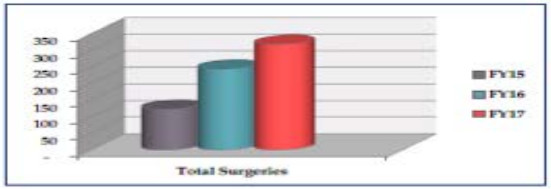
16% increase from FY16

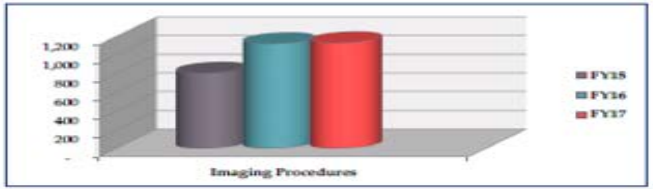
Surgical Volume Increase of 30%!

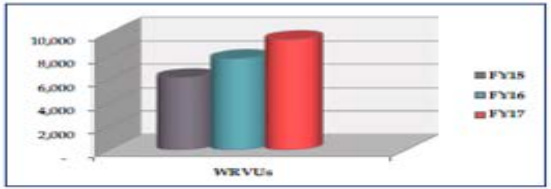
	FY15	FY16	FY17	FY17-FY16 Variance $ Change	FY17-FY16 Variance % Change
Div. Collections	$3,969,806	$4,570,310	$5,444,243	$873,933	19.1%
Indiv. Collections	$524,068	$673,322	$782,321	$108,999	16.2%
Arrived Visits	3,355	3,730	4,251	521	14.0%
Total Surgeries	123	244	318	74	30.3%
Imaging Procedures	806	1,123	1,133	10	0.9%
WRVUs	6,182	7,800	9,431	1,631	20.9%











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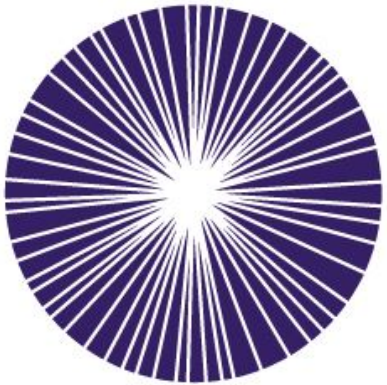
Financials: Then vs. Now

- FY14, our Clinical department financials were $2.5M in the red
- The way we were heading was not sustainable and substantial changes needed to be made
- Many factors played into our financial recovery, but revenue growth through staffing efficiencies (points system) made the largest impact

Financials: Then vs. Now

- Between FY16 and FY18 our patient revenue increased by 17%

- This resulted in higher compensation for providers through our compensation model



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