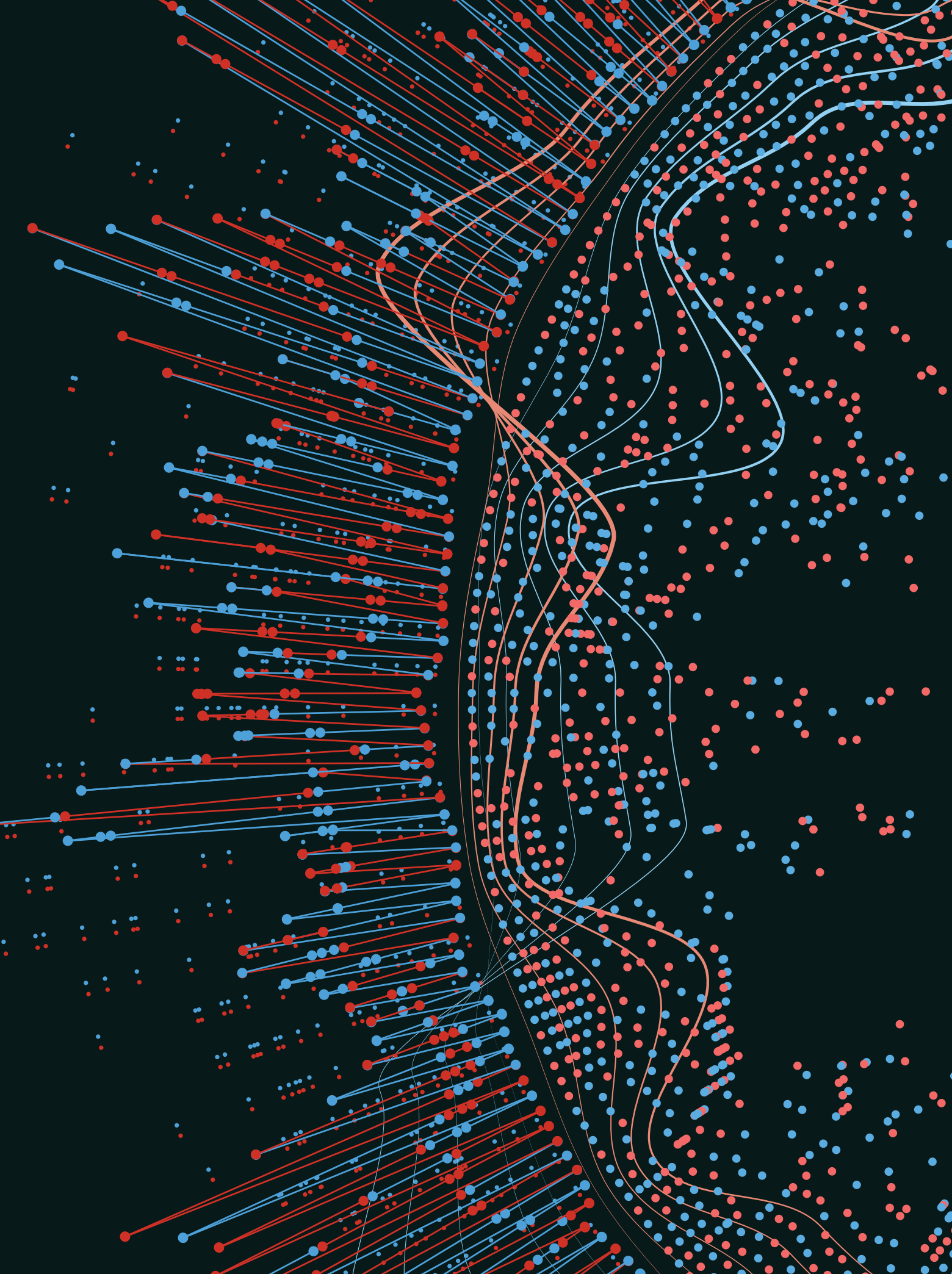


UTILIZING DATA TO BUILD AND MANAGE AN EFFECTIVE CLINICAL TEAM

Adrienne Lloyd, MHA, FACHE, and Heidi Campbell, COT

The only certainty in healthcare reform is that we will receive less revenue per patient and must optimize our processes and resources. The most valuable resource in our practices continues to be our team members. By effectively utilizing clinical data, we can better collaborate with them to reach optimal efficiency, while providing the highest possible care and value for the patients. Here's how we did that at our practice.

OUR TIPPING POINT

When we began focusing on improving the processes and culture in our clinics in 2014, we heard from the staff in one practice that management was inconsistent in enforcement of even the most basic policies, such as absences and cell phone/computer usage. And, most importantly, they were not ensuring a balanced patient workload across the technician group. We knew we had to act…and FAST… before we lost the high-performers who were carrying the majority of the workload and growing increasingly frustrated.

To address this, we developed a staff workload system (technician points system) that accounted for not only the volume of patients being worked up by each technician, but also the types of patients, categorized by appointment type, that more accurately reflected the amount of time each should take a technician to perform a complete and accurate work-up.

STEPS FOR IMPLEMENTATION

1. **Cross training.** We decided to cross-train technicians to work-up for all specialties and perform imaging on all devices (we did retain specialized staff for FAs, ICGs, ERGs, and B-Scans).
2. **Tracking.** We tracked patients through our EMR system and performed manual time observations (using paper) for each different patient appointment type, including the associated diagnostic

TIME OBSERVATION FORM

PROCESS: Cataract Patient Example						OBSERVER:								DATE:	
STEP #	PROCESS STEP		PATIENT 1	PATIENT 2	PATIENT 3	PATIENT 4	PATIENT 5	PATIENT 6	PATIENT 7	PATIENT 8	PATIENT 9	PATIENT 10	PATIENT 11	TASK TIME	REMARKS
1	Check- In	START													
		END													
2	Technician Work-Up	START													Technician direct patient time for points value
		END													
3	Technician Imaging - Topography	START													
		END													
4	Technician Imaging - IOL Measurements	START													
		END													
5	Technician Imaging - Pentacam	START													
		END													
6	Additional Technician Imaging, Other (If Needed)	START													
		END													
7	Dilation	START													
		READY													
8	Physician Encounter	START													
		END													
9	Surgery Scheduling	START													
		END													
10	Check-Out	START													
		END													
	TIMEs FOR 1 CYCLE														LOWEST REPEATABLE CYCLE TIME

Table 1. Time observation form

> By coupling the points data with chart reviews, our management team has been able to show providers who is actually working versus pretending to work and more quickly address the performance.

testing, since our technicians complete both the work-up and imaging. We collected at least ten cycle[1] times (measured as the start of workup to completion of imaging) per appointment type from our technicians who consistently performed a thorough yet efficient work-up based on feedback from our physicians and clinic managers. (See **Table 1.** Note that we used the median time and not the average because no patient experiences the average.[2])

3. **Base point value.** We set our base point value as 1 point equal to a 15-minute interval.
4. **Productivity targets.** We created a formula in which each technician is expected to complete at least 12 points in a half-day session or 4-hour period, which leaves them 30 minutes for break and non-direct patient care time as a buffer (**Table 2**).
5. **Data review.** We collected data for both retrospective and prospective purposes to manage our clinics. Retrospectively, we review the data by technician and across our multiple locations, looking for patterns or outliers. Prospectively, we project the number of technicians needed by site based on estimated points.

For the technician retrospective review, the system highlights low-performers who are not meeting

Duke Ophthalmology Point Scale

Visit Type	Points
New Cataract Evaluation	3
New Visual Field	3
New Dry Eye Evaluation	3
New Patient	2
Injection	2
Return Patient	1.5
Return Visual Field	1.5
Post-Op Patient	1

Table 2. Point scale

the 12-point per session target—and extremely high-volume technicians, which may signal that they are skipping steps. In the case of the high-volume technicians, clinic managers conduct focused chart audits and gather input from the physicians to make

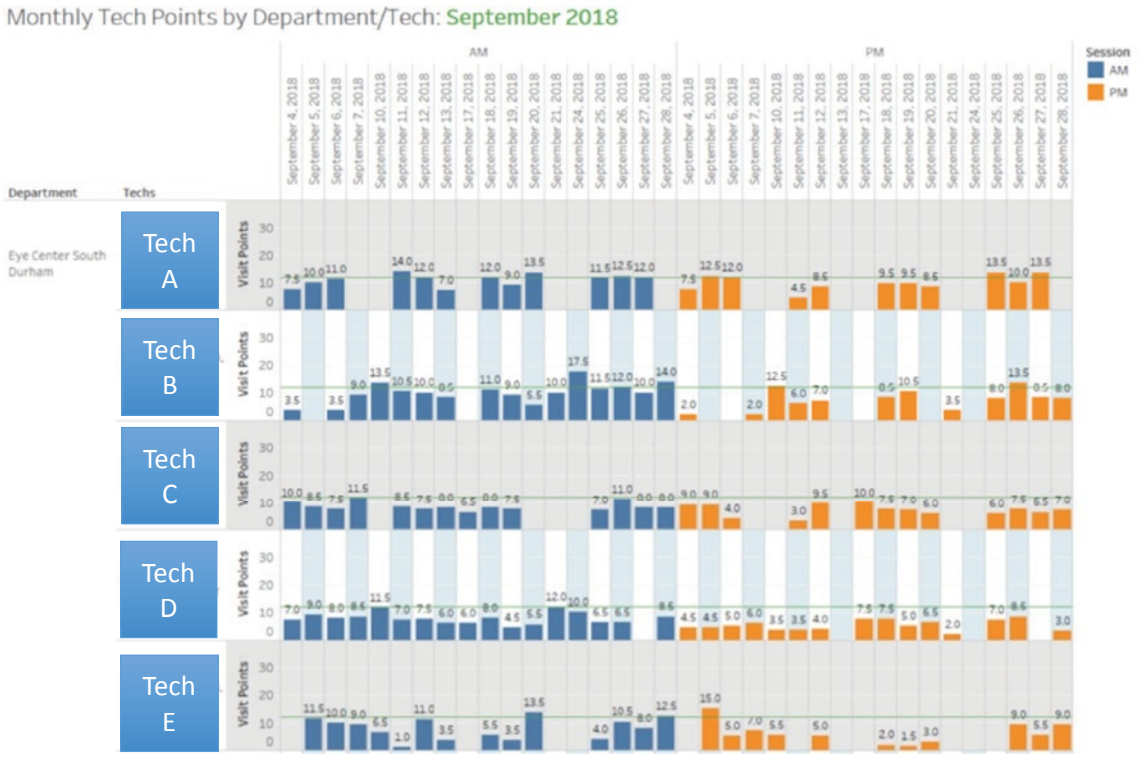


Figure 1. Monthly tech points—Retrospective

sure the work-ups are thorough. If incomplete, they have a conversation with the employee to address the importance and implement additional training. For those technicians who consistently do not meet target (relative to their colleagues), the clinic management team will assess if it is a skill or motivation issue and then work to either provide additional training on the EMR or imaging, or place the individual on a performance improvement plan (**Figure 1**). We are now able to review patient points per paid technician full-time equivalent (FTE) across all our sites, which allows practice leadership to assess incremental staffing needs. This has been a big part of our success in reducing our "Clinical Expenses per RVU" by more than 6%!

For the prospective review, patient points are totaled the Friday prior by location for the next week. Because all technicians are expected to complete 12 points per each half-day session, this report allows the management team to review all locations and determine how many technicians each needs to provide adequate and timely flow. The clinic managers then work together to redistribute staff across sites. An added benefit of this approach is that we can allow more technicians off at any one time because we are working with a larger pool of equally trained staff.

If volumes are unexpectedly low across all the sites or, if after rotating staff to the higher volume sites, managers still find they are under their points targets, they will encourage staff to consider taking time off. This helps both balance practice expenses and increase the likelihood that staff will be available when the volumes are higher (**Figure 2**).

BENEFITS

By developing and implementing a staff workload system for your practice, you can establish clear expectations based on your goals, and evaluate individual and team performance. Once staff are held consistently accountable, it will be apparent which fall into the high and low-performing groups. Assess technicians who are not performing to standards, even after additional training, to determine if they are unwilling to work efficiently to meet those metrics or if they truly are unable to do so. (There is a difference between *cannot*

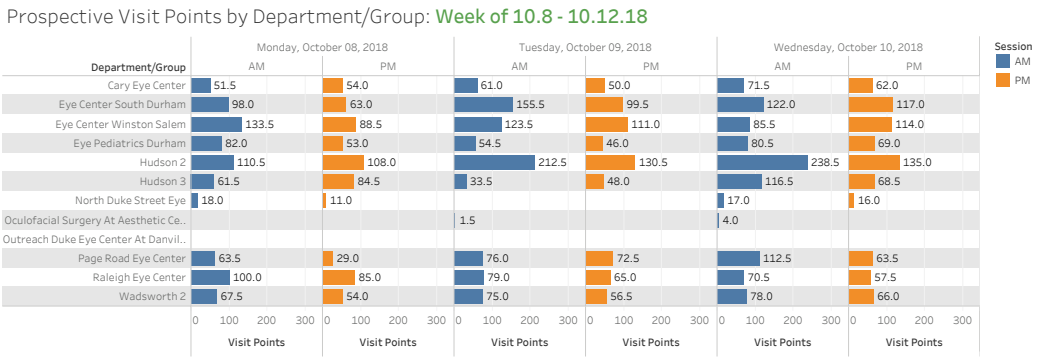


Figure 2. Weekly point count—All locations—Prospective *(chart continues on p. 43)*

do and *will not* do!) When you have a motivated individual who is just unable to move as quickly, then this may highlight an opportunity for job reassignment.[3]

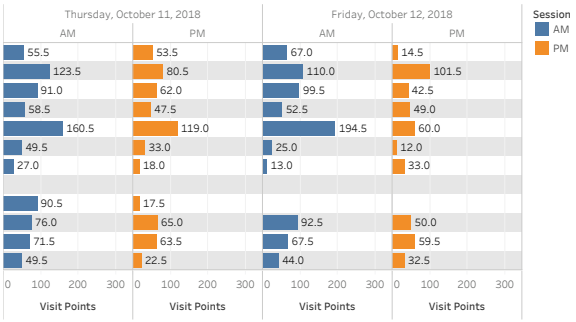
Another benefit of the points-system accountability culture is that high-performers see management holding other staff accountable. In turn, they are asking for opportunities to grow and help the practice succeed, such as serving as Joint Commission liaisons, training other technicians, or leading a process improvement initiative. Many high-performers have also moved into leadership roles and credit the point system for helping them sustain a culture of teamwork and mutual accountability.

With respect to staff who were not meeting standards and who did not have the right behaviors or other skills for alternate practice roles, the points system gave our management team data for having crucial conversations with the employee and physician leadership—who may have been historically supportive of the technician, even at times considering them their favorite because they are good at "looking busy." We learned many physicians and managers are fearful of losing even underperforming staff, because they are afraid they will not be able to replace them. We have found, however, that as we improved the culture of accountability and teamwork, we have been able to hire higher-performing

ADDRESSING "WORK IMBALANCE"

Every industry and organization has employees who fall into the high, medium, and low-performer categories. Unfortunately, your high performers are the individuals most likely to leave your practice. Sometimes this occurs because they are ready for a broader challenge, perhaps a leadership opportunity that, despite your best efforts, you are not able to offer. Often, however, this occurs because they are frustrated that their low-performing colleagues are getting away with not doing their share of the work. Then a new challenge emerges: your middle-performers begin to slide to the left, and you end up with the majority of your employees performing below your target goals…and, now, you need to hire more people!

We learned people do not mind high expectations, they just want to know what they are and want them fairly and consistently enforced—this is especially true for high-performers. A"points system" such as the one described in this article and coupling the points data with chart reviews allowed our management team to more quickly address poor performance.



staff who have surpassed their predecessors. Remember: Allowing low-performers to stay can create a toxic environment, putting you at risk of losing your high-performers and requiring you to hire even more people if they go![4]

By coupling the points data with chart reviews, our management team has been able to show providers who is actually working versus pretending to work and more quickly address the performance. This has allowed us to significantly decrease the time low-performers are merely hanging out in the practice before they either manage themselves up or opt out.

As part of our work to optimize our technician teams, we also created a clinical ladder with OA, COA, COT, and COMT job levels that includes pay incentives for each level. We have found this encourages our technicians' commitment to developing their own career, and the increased training produces more highly skilled staff who can more effectively work up patients and partner with the provider team.

RESULTS

In 18 months of using the points system and improving workflows across the first three clinics, our providers were happier and our volumes increased by more than 24,000 visits (62%). We were also able to bring all our clinics to the top-tier status for employee satisfaction, drastically reducing employee feedback that management was not holding the team accountable or treating everyone consistently.

While we want to support everyone, it is important to separate the person from the job. The job must be done, and if the individual in that role cannot or will not perform that role well, then it is best for the practice that they move on.

After deploying the system across six locations, we saw a more than 17% increase in points per technician, allowing each to see an extra three patients every day.

What could an extra three patients per tech per day and happier patients, providers, and staff mean to your practice? *AE*

NOTES

[1] A calculation of a specific step in the process from beginning to end, using the fastest reproducible time. To start your points system, we recommend using the median time from your stronger technicians for each appointment type.

[2]Remember the goal of any system is not necessarily a specific number but to *balance* the workload among team members and create standards so expectations are clear. Any system is going to have exceptions but if you create a system that accommodates 80% of the process successfully, then you will have flexibility for the outliers and be able to assess and then address patterns of performance that do not meet your expectations.

[3]We have had many technicians who make better scribes, sub-specialized patient educator/surgery schedulers, or triage technicians than work-up technicians. By considering alternative roles that are a closer fit, we have been able to serve unmet needs in the practice and retain these motivated staff. Previously, without a measuring system, we did not have a good way to diagnose this.

[4]For additional information regarding the impact of low-performing employees and recommendations on how to engage and motivate, please reference the Studer Group (www.studergroup.com), which has many resources on this topic.

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