Rebuilding Your Team[1]

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Historically, as practices grow, additional staff are hired to provide clinical services for the new doctor(s). Diagnostic testing is often absorbed by the current dedicated testing team. As schedules fill, techs may be pulled to work up patients for "other" doctors.

When techs work exclusively for one ophthalmologist (often traveling with the doctor to satellite locations), they become fairly knowledgeable in that physician's protocols. They can anticipate his needs, are familiar with his patient education preferences, and are able to communicate his pre- and post-op protocols to the majority of his patients. Yet techs may become comfortable with the limitations that come with working for only one doctor. For example, they often remain unaware of other skills and tests that are mainstays in various ophthalmic subspecialties. The staff members on the busiest doctors' teams may develop some animosity toward those working for lower-producing physicians when noticing they are working up fewer patients and seemingly have more time on their hands.

Doctors tend to prefer this "dedicated" approach, particularly if they have had a devoted staff for many years. Reluctant to familiarize themselves with the strengths, weaknesses, and even handwriting of new staff, physicians may understand the need for sharing techs, but prefer their associates try it first.

Tech teams pose liabilities for the associated administrator. Because the technicians work so closely with the doctor, the techs may go to their doctor with inappropriate comments. These include time-off requests, comments regarding other staff or policies, and even the need for wage increases. It is necessary to remind doctors and staff alike to whom these comments should be directed.

Patients, too, are impacted by whether techs are pooled or teamed. Every patient believes that he or she is the most important one in your waiting room. When patients are called in order of appointment time and arrival, you are reinforcing this positive belief. If, however, patients are left waiting and observe that others who arrived later are called in first, they believe you forgot about them, often questioning the check-in staff if this occurred. Although the concept of devoted techs for each doctor may make sense when all doctors run on time, the patients are left feeling as though they have been overlooked, not understanding your policy, when the schedule runs behind.

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It takes a great deal more time, effort, and organization to develop a technical team that works up all patients for all doctors. Yet, in my opinion, the results from this effort have wide-reaching benefits, the most important of which is patient perception and enhanced patient satisfaction.

When there is a pool of technicians working up all patients, the practice is more likely to call in the patients in a more consistent, timely manner. Patients begin their appointments confident that no one is overlooked because systems are in place to assure them of that. (Some may wait longer than others to see the doctor, depending on physician style.)

However, because each ophthalmologist has his or her own preferences, it behooves the staff to be familiar with each one's idiosyncrasies. This can be simplified by finding commonalities among work ups and listing exceptions separately. For example, if all doctors expect patients to be dilated with phenylephrine and tropicamide, but Dr. Peds prefers Cyclogyl, this drop preference should be noted in an exception column. An alternate method of providing work-up staff with protocols is to put each doctor's protocols on color-coordinated index cards. Each technician should have his/her own copy for reference.

When the same expectations are made of all techs (i.e., they work up all doctors' patients), I find there is a greater sense of teamwork since everyone has the same goal. There will be an acceptance of one another's strengths and weaknesses. It is easier to determine who the highest producers are when the expectation is that the patient load should be shared equally by a larger group. When this is not the case, and one person is noticeably slower than her peers, it becomes apparent who needs remedial training.

If you are considering pooling your techs, I suggest you first track the effects of repeated absences on your providers' schedules. Which techs are pulled from which doctors? Are those doctors running behind as a result of staff shortages? Use this data to convince the providers that tech pooling is necessary to keep the schedules on track. It is possible that once complete, you may find you are actually *over*staffed, which may ultimately reduce your HR budget.

Depending on the size of your practice and the willingness of your ophthalmologists to share technicians, cross-training your staff may be met with some resistance. Doctors will be reluctant to give up "their" technicians; technicians will be forced to ex-

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Answers from your peers

- I'm in the process of credentialing right now. It depends on the carrier. Our Medicare carrier doesn't accept the application until 30 days prior to the doctor's start date but we had a provider number within a week. Some commercial payers take two to three months and not all of them allow you to bill retroactively. Our Blue Cross carrier did not issue the provider number retroactively. Lastly, if the application is outsourced to an organization called Aperture (a division of Ingenix), it is sent overseas (India, perhaps) and takes 90 days to complete.
- Our experience is that on average it takes two millennia to get a new doctor credentialed. And, yes, they do allow you to bill retroactively.

Q: We are having a problem with staff taking excessive time on breaks, multiple breaks, clocking in and 15 minutes later going to have breakfast, etc. I have discussed it with staff and supervisors but the problem continues and there is too many staff for me to be constantly monitoring. The doctors want to do away with breaks altogether or have staff punch in and out for breaks. What do other offices do?

Answers from your peers

- We had this issue in a previous practice and we started having staff clock in and out for breaks—they were paid breaks, but we were able to monitor how long they took, so that helped a bit. There were still staff who would clock back in and continue their break—those folks had to have counseling and in some cases be written up to change that behavior.
- We don't have scheduled breaks. If staff needs to get something to drink or use the restroom, they may do so in between patients. It's a small office and much easier to monitor. With a large office, where it is a little easier to get lost, I would have them clock in and out.
- Check your state's labor laws carefully on this one. California has spent the better part of a year litigating on not only what IS a break, but whether you have to insist it is taken and ensure it is taken versus making it available.

Q: For those of you who sell Latisse or write prescriptions, are you requiring patients have a recent eye exam?

Answers from your peers

- Yes. We also do pictures at the start of treatment, at 8 weeks, and at 16 weeks. You want to document changes.
- Yes, within the past two years. Failing that, either a brief exam as we would do for a new patient wanting a Latisse prescription, or a complete exam if they want that.
- We have designed a Latisse evaluation form that is extremely basic and can be completed by a tech. It consists of five items: three questions, visual acuity, and iris color. We also have a patient information and disclosure statement that the patient signs that explains the product, gives application instructions, possible adverse events, and the fact that we are not performing an eye exam.

Q: Can we put in our policy manual that salaries are not to be discussed and that we can terminate if they are? I know that as an "at will" state we can fire for no reason but did not know if we can put specifically that someone can be fired if salaries are discussed.

Answers from your peers

- I have always come from the place of "While you are not prohibited from discussing your salary with your coworkers, unless you can give me a valid reason for doing so, it doesn't seem like a conversation that is a win-win situation for anyone and can create some hurtful feelings. So while you can discuss it, if your discussion creates a less-than-positive atmosphere, this will contradict our 'employee expectations,' and you can expect to be disciplined for creating an atmosphere of 'ill will.'"
- I know in my state we cannot make a statement like that in our handbook. It has to do with the right of the employee to collective bargain for a competitive wage or something like that. Basically you have to give them the right to discuss salaries in order for them to get the best salary possible.
- I am going to steal your quote about sharing pay rates. We also do not prohibit it. Frankly, I can't eavesdrop on every conversation people who work here have when they are in and out of the office. I've read that this can be dangerous to discuss for another reason: If you make more than someone else, you have alienated that person. That could also be problematic for the sharer. AE

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pand their comfort zones.

There are usually one or two senior technicians working closely with each doctor. Consider having them train all staff members as the others are slowly rotated from doctor to doctor. This will provide consistency in training and communication of expectations. The doctors will feel more comfortable knowing that the lead team players are still part of their teams.

The learning process may be slow; "super" techs for one doctor may find their self-confidence wane as they learn the others' preferences. This may help the self-esteem of newer staff members who take to the training, demonstrating flexibility and the ability to adapt quickly. AE

[1] Thank you to Jack G. Muckleroy, COMT, FCLS, of Ophthalmology Associates of San Antonio, Texas, for suggesting the topic of pooled vs. team tech staff. This is a topic I am asked to address frequently. Like many stylistic differences, there is something to be said for each.

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