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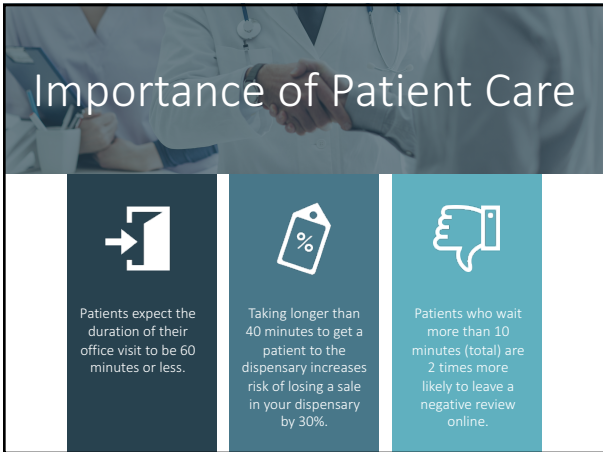
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**50%** Half of all patients who walk out of the optical because they ran out of time will make a purchase elsewhere.

**25%** Those patients that come back at a later date typically spend 25% less in your dispensary because they can't remember the recommendation the doctor made in the examination.

**25%** 25% of patients who wait longer than two weeks for an appointment will seek an appointment elsewhere.

**\$15** On average, about \$15 of dispensary revenue is lost for every minute a patient waits.

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LET'S TALK ABOUT TECHNICIANS



**SCRIBE**  
*is defined as*

A person who writes, translates, or takes dictation

Maybe, the person who assists during the patient exam *is/should/could be* much more than a person who writes, takes dictation or translates.

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LET'S TALK ABOUT TECHNICIANS

WHAT SHOULD/COULD THEY DO?

Scribe	Clinical Data Collector
Clinical Assistant	Contact Lens Technician
Optician	Patient Advocate
Pre-Appointment Specialist	<b>AN EXTENSION OF YOU!</b>

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## WORKFLOW & STAFF

Best approach?	What are the advantages for your patients?	What are the advantages for you?
What are the advantages for your staff?	How much will it cost?	How many do you need?

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## BEST APPROACH?

### CONCIERGE APPROACH

	Technician greets the patient and transitions through all phases of the visit. As the exam progresses the technician assumes the appropriate role.	This works best in a practice that schedules less than 17 exams per day. The data collection component will likely begin to break down at a higher volume.
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### CLINIC/OPTICAL DISPENSARY SPLIT APPROACH

	Tasks are split between the clinic and the optical/dispensary. This is used by many practices due to the difference in the skills required to be a successful optician.	In our practice, we were unable to make this model efficient. We suffered a loss of information at each handoff, and patients complained about the loss of continuity. However, it may work well in your practice.
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## CLINICAL DATA TECH/SUPER TECH SPLIT SPLIT APPROACH

	Tasks are split between the <b>Clinical Data Tech</b> and the <b>Super Tech</b> .	It becomes very easy to over burden your Clinical Data Tech in a high volume practice. This is, of course, dependent on the number workflow tasks involved.
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This approach required a free floating optician in our dispensary to assist walk-in patients. Without the free floating optician, your super techs may become detained in the dispensary which is disrupting to the clinical workflow.

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**CLINICAL DATA TECH/SUPER TECH  
SPLIT APPROACH**

**Pre-test Protocols**  
Different approaches based on patient demographics may buy you time

Patient profile:  
Age 55 and above.

Patient Profile:  
Age 25 to 40

Patient Profile:  
Age 40 to 55

Patient profile:  
Age 8 to 25

Patient profile: Contact lens  
wearer (established or new)

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**AGE 55 AND ABOVE**

Pre-test sequence: Screening fields, Auto-refractor/Keratometer, Optomap, Specular Microscope, Visual acuities, Color Vision, Stereopsis, Tonometry, History, Pupil evaluation, Entering of information into the phoropter and loading the information to increase the ease of access for the doctor and chairside assistant followed by dilation immediately before leaving the exam room.

The sequence is important and may vary a little from patient to patient. However, a pupil evaluation and tonometry need to be done prior to dilating the patient so as not to miss a pupil defect or elevated IOP. This entrance IOP also makes it very simple to assess the impact of dilation on the IOP by allowing post-dilation IOP to be taken by the doctor or the technician without creating another encounter.

In this case the advantage of dilating the patient prior to the doctor entering the exam room is multifaceted. The pupil will hopefully be between 3 and 5mm during the refraction, which may decrease the influence of diffraction or fluctuating depth of field and depth of focus allowing for a more accurate and precise refractive outcome. *The negative influence on accommodation is usually outweighed by the natural loss of accommodation due to aging.* There can still be accurate evaluation of phoria's at distance and near.

By the time you finish the refraction, the external exam, the anterior segment exam and the posterior pole exam the patient is many times dilated well enough to complete the peripheral retinal evaluation. **This allows the doctor and tech to complete the record at that time and prevent turning one visit into two visits due to dilating the patient at the end of the exam.**

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**AGE 40 to 55**

Pre-test sequence: Screening fields, Auto-refractor/Keratometer, Optomap, Specular Microscopy, Visual acuities, Color Vision, Stereopsis, Tonometry, History, Pupil evaluation, Entering of information into the phoropter and loading the information to increase the ease of access for the doctor and chairside assistant. The pre-tester also peruses the patients' record for evidence of an add power of +2.25 or above. If the add power is indicative of very poor accommodation the pre-tester may be able to follow the above mentioned protocol and dilate the patient prior to the doctor entering the exam room. If the add power is indicative of an accommodation system that is still patent at a functional level, the dilation may need to be deferred to later in the encounter in order to evaluate the optimum near point solution. However, later is a relative term and may occur as early as immediately following the refractive sequence.

In this particular scenario as soon as I completed the refractive sequence, the "vision analysis" portion of the exam, I moved away from the patient briefly while my chairside technician instilled the dilating drops onto the patients' ocular surface. Thus, the dilation had begun. I then moved on to the external exam, the anterior segment exam and the posterior pole exam. Part of the "eye health" portion of the exam. By the time I had completed those tasks and the discussion of our resulting data, the patient had many times dilated well enough to complete the peripheral retinal exam. *Once again preventing one encounter from becoming two.*

If the patient was not sufficiently dilated, we prevented the second touch/encounter from taking any more time than absolutely necessary by the earlier discussion of the case points and counseling the patient about what we expected to see in the peripheral retinal evaluation and explaining that if we did not see something different than we expected, the follow-up encounter would not require more than a few minutes at most. Again, acknowledging respect for the patients' time.

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### AGE 25 to 40

Pre-test sequence: Screening fields, Auto-refractor/Keratometer, Optomap, Visual acuities, Color Vision, Stereopsis, Tonometry, History, Pupil evaluation, Entering of information into the phoropter and loading the information to increase the ease of access for the doctor and chairside assistant.

We then moved forward with the "vision analysis" portion of the examination. Again, as previously mentioned, as soon as I completed the refractive sequence, I moved away from the patient briefly, while my chairside technician instilled the dilating drops onto the patients' ocular surface. Thus, the dilation had begun. I then moved on to the external exam, the anterior segment exam and the posterior pole exam. Part of the "eye health" portion of the exam. By the time I had completed those tasks and the discussion of our resulting data, the patient had many times dilated well enough to complete the peripheral retinal exam. *Once again preventing one encounter from becoming two.*

If the patient was not sufficiently dilated, we prevented the second touch/encounter from taking any more time than absolutely necessary by the earlier discussion of the case points and counseling the patient about what we expected to see in the peripheral retinal evaluation and explaining that if we did not see something different than we expected the follow-up encounter would not require more than a few minutes and we would have them on their way. Again, acknowledging respect for the patients' time.

You may have notice that I did not mention Specular Microscopy in this example. While it certainly has undisputed value in this age range, we did not generally screen for endothelial problems in this age range unless the patient wore contact lenses or had an indication of problems in their personal or family history or manifested evidence of endothelial defects during the slit lamp exam.

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### AGE 8 to 25

Pre-test sequence: Screening fields, Auto-refractor/Keratometer, Optomap, Topography, Visual acuities, Color Vision, Stereopsis, Tonometry, History, Pupil evaluation, Entering of information into the phoropter and loading the information to increase the ease of access for the doctor and chairside assistant.

We then moved forward with the "vision analysis" portion of the examination. Again, as previously mentioned, as soon as I completed the refractive sequence, I moved away from the patient briefly while my chairside assistant instilled the dilating drops onto the patients' ocular surface. Thus, the dilation had begun. I then moved on to the external exam, the anterior segment exam and the posterior pole exam. Part of the "eye health" portion of the exam. By the time I had completed those tasks and the discussion of our resulting data, the patient had many times dilated well enough to complete the peripheral retinal exam. *Once again preventing one encounter from becoming two.*

If the patient was not sufficiently dilated, we prevented the second touch/encounter from taking any more time than absolutely necessary by the earlier discussion of the case points and counseling the patient about what we expected to see in the peripheral retinal evaluation and explaining that if we did not see something different than we expected the follow-up encounter would not require more than a few minutes and we would have them on their way. Again, acknowledging respect for the patients' time.

You may have noticed that I did not mention *Specular Microscopy* in this example. While it certainly has undisputed value in this age range, we did not generally screen for endothelial problems in this age range unless the patient wore contact lenses or had an indication of problems in their personal or family history. You may have also noticed that I did mention *Topography* in this example. We felt that it helped us reduce the risk of missing early "Keratoconus or Forme Fruste Keratoconus". We did not want to miss the window of opportunity for intervening with "Corneal Collagen Crosslinking" in these patients.

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### Contact lens wearer (established or new)

Pre-test sequence: Screening fields, Auto-refractor/Keratometer, Optomap, Specular Microscope, Topography, Visual acuities, Color Vision, Stereopsis, Tonometry, History, Pupil evaluation, Entering of information into the phoropter and loading the information to increase the ease of access for the doctor and chairside assistant.

We then moved forward with the "vision analysis" portion of the examination. Again, as previously mentioned, as soon as I completed the refractive sequence, I moved away from the patient briefly while my chairside technician instilled the dilating drops onto the patients' ocular surface. Thus, the dilation had begun. I then moved on to the external exam, the anterior segment exam and the posterior pole exam, part of the "eye health" portion of the exam and then the "contact lens evaluation" portion of the exam. By the time I had completed those tasks and the discussion of our resulting data, the patient had many times dilated well enough to complete the peripheral retinal exam. *Once again preventing one encounter from becoming more than necessary as dictated by the contact lens evaluation and the number of fitting encounters required to achieve the optimum fit.*

If the patient was not sufficiently dilated, we prevented at least one extra touch/encounter from occurring and taking any more time than absolutely necessary by the earlier discussion of the case points and counseling the patient about what we expected to see in the peripheral retinal evaluation and explaining that if we did not see something different than we expected the follow-up encounter would not require more than a few minutes at most. Again, acknowledging respect for the patients' time.

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CLINICAL DATA TECH/SUPER TECH  
SPLIT APPROACH

*Let's define a*  
**SUPER TECH**

Clinical Assistant	Patient Advocate	Scribe
Patient Care Coordinator	Clinical Technician	Optician

The SuperTech meets the doctor as they leave one exam room, briefly discusses the next patient and enters the examination room with the doctor..

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**SUPERTECH**

- Record management (verification that the required testing has been completed and documented), all meaningful use documentation, entering all patient related data relayed by the doctor, assistance in the examination process with ophthalmic drop installation, assisting in some procedures, participating in the discussion of the patients' case, pre-appointing the next visit or visits. Also providing clinical summaries along with supporting educational videos (from You-Tube or All about Vision). Managing other education forums such as Eye Motion or Eyemaginations.
- Coordinating patient care with other doctors. Becoming the patient's advocate by providing the doctor's business card (including the doctor, by having them write their cell phone number on the card and assuring the patient of their availability in the cases of emergency or other questions).
- Presenting questions that were not asked during the examination to the doctor for clarification and making sure that the patient receives and understands the explanation from the doctor.
- Assuming the role of (cl technician/optician) by helping with cl education, fitting and dispensing or assisting the patient in the optical dispensary. (Including completion of the order and completion of the vision plan form or other third party care forms). Taking the patient payment (maintaining continuity of care for the patient and decreasing demand on the front desk).
- Finally, once again assuring the patient of the doctor and the staffs' availability with respect to further questions or emergent care.

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**WHAT ARE THE**  
*advantages?*

ADVANTAGES OF HAVING AN SUPER TECH IN THE EXAMINATION ROOM

- 1 Reduced risk of information loss during multiple handoffs.  
(Super Tech functions as an optician)
- 2 Increased staff self esteem.  
(Our staff loved being included in the case discussion)
- 3 Increased confidence in the staff with regard to the patient. The doctor should project obvious respect for the technician's opinion during the discussion of the case and the treatment plan recommendations.
- 4 Decreased workload for the doctor due to releasing data entry responsibilities.

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5 Increased efficiency during the examination process. Super Tech assists with any material or equipment the doctor needs, so no wasted motion.

6 Increased the time available for the doctor to discuss treatment options and recommendations.

7 Increased accuracy of documentation due to the assistant entering information during the examination. Super Tech is able to confirm the interpretation of the data while it is in the immediate thoughts of the doctor.

8 Increased ease of meeting documentation and dissemination of information requirements in the current health care environment.

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### WHAT ARE THE *disadvantages?*

- The staff may not have equal skills in all areas, especially the optical.
- Increase in the number of staff required for office operation.
- Possible increase in overhead created by additional staff.

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### HOW MUCH WILL IT *cost?*

INCREASE IN OVERHEAD COST FROM ADDITIONAL STAFF

- RESTRUCTURE**  
You may not need to increase your staff. Restructuring your workflow may provide the necessary staff time.
- TREATMENT PLAN ACCEPTANCE**  
Increased freedom to discuss treatment plans with the patient usually results in greater treatment plan acceptance.
- INCREASED PRODUCTIVITY**  
My collections increased 15% the first day that I introduced a Super Tech into our workflow. It increased by 25% per day by the end of the first week.

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*In the event that treatment plan acceptance does not increase...*  
 (NO WAY THIS IS HAPPENING)



INCREASE CAPACITY TO SEE MORE PATIENTS IN THE SAME AMOUNT OF TIME

GAIN TIME TO OFFER A NEW SERVICE

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Let's **take a moment** and visit just **one service** or **enhancement** of a **service you** already **provide**.

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*Blepharitis*  
 TREATING IN A STATE OF THE ART MANNER



- Do you separate the treatment plans into specific approaches to specific types? (Anterior vs. Posterior? Endotoxin vs. Pest Induced?)
- Have you written specific treatment protocols relative to type?

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After attending a lecture regarding the impact of Demodex Follicularum and Brevis on the lids and face. Along with the implications involving rosacea, ocular and facial, our practice invested in two microscopes.

We began implementation by writing treatment protocols for Demodex.

(Celestron LCD Deluxe Digital Microscope, model #44345. Recent price from B&H Photo-Video-Audio \$229.99)

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After implementation of our diagnosis and treatment protocols including the involvement of our clinical care assistant, our microscopes were paid for in four hours.

We had 100% treatment plan acceptance along with ecstatic patients and a supercharged staff. The technicians loved being involved in plating the slides, displaying the image under the microscope and being involved in the treatment

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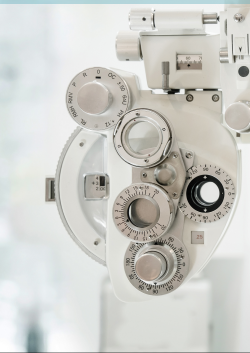
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**NEW TECHNOLOGIES**  
*introduced at an amazing rate*

- Improve existing treatment options
- Enhance our patient's immediate and future health.
- Many ways to enhance your patient's clinical experience and your practice income.



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*How many*  
**SUPER TECHS DO I NEED?**



If your patient load can support two employees:

- One can assume the role of doctor's Super Tech/Clinical Assistant/Patient Advocate.
- The other can oversee the reception area and the optical, in the case of walk-in traffic.

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*The importance of a*  
**WELL-MANAGED SCHEDULE**



Seeing 20 patients a day  
10 of them are comprehensive examinations

- **ONE** CLINICAL DATA TECH
- **TWO** SUPER TECHS
- **ONE** RECEPTIONIST/OPTICIAN

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*The importance of a*  
**WELL-MANAGED SCHEDULE**



Seeing 40 to 50 patients a day  
20 of them are comprehensive examinations

- **TWO** CLINICAL DATA TECH
- **THREE** SUPER TECHS
- **ONE** RECEPTIONIST/OPTICIAN
- **ONE** PERSON FLOATING BETWEEN THE OPTICAL AND THE CLINIC

You may also need an additional clinical data technician to perform special testing such as OCT, Visual Fields and Fundus Photos.

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## KEYS TO SUCCESS

- Engage your staff in the care discussion.
- Implement doctor-driven dispensing.
- Carefully considered workflow with respect to continuity of care.
- The most important person in the office is the patient.

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## THANK YOU!



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620.340.2255

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