

The Productive PT

Increasing your productivity does not always mean working harder. Sometimes, it means working better.

the current environment in which we practice is rapidly changing and very unstable. Many of the paradigms upon which we built our careers and professional development are being challenged by forces such as cost containment, managed care, and utilization management. Although interest in increasing our productivity has always been present to some degree, these current environmental forces are placing an unprecedented emphasis on productivity levels.

What is "Productivity?"

Simply put, being more productive means getting more work done or getting the same amount of work done in a shorter period of time. It refers to efficiency.

There are a number of ways in which a clinician could get more work done. The two most common ways are to work harder or to do the work differently. In situations in which there previously was not enough work to do but the work demand has now increased, working harder may be all that is needed. The more frequent concern for clinicians, however, is increasing productivity in situations in which they already are busy.

The key to increasing productivity in a busy situation is to avoid *just working harder*. Changes to be gained from working harder usually are limited by the ability of the staff to avoid burnout and fatigue. In a busy clinic, the key to increasing already high pro-

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ductivity is to change the manner in which the work is done. And that means changing the systems that are used to accomplish the work.

Redesigning the Systems

All clinics have a number of operating systems in place, some of which are more likely than others to interfere with productivity. Those systems most likely to have an impact on efficient operation of the clinic can be categorized into three areas: staff interface systems, hygiene systems, and clinical systems.

Staff interface systems, or interpersonal interfaces, include those activities in which there is a need to exchange information or integrate the work of diverse team members. In the clinic, examples of these are management-staff communication, clinician-

clinician interaction, and clinician-support staff interfaces. Management-staff communication includes such things as staff meetings, performance planning and appraisal, and payroll and human resource management activities. Clinician-clinician interaction includes development of joint treatment plans, discussion of patient coverage, and sharing of available clinical resources. Clinician-support staff interfaces occur when there is a need to delegate clinical care to an aide or PTA, schedule changes, or oversee and supervise the work of support staff.

Each of these interfaces represents a system that may be efficient or may actually interfere with efficient delivery of care.

Hygiene systems, so-called because these systems are needed to keep your work environment healthy, represent work processes that are essential for the ongoing success of the practice, but that do not directly involve the treatment of patients. The most common hygiene systems are documentation systems, patient and staff scheduling systems, and routine housekeeping and facility maintenance.

If they are inefficient, each of these systems can have a negative impact on the ability of the clinicians to deliver care in your clinic. Having perfectly efficient hygiene systems will not ensure high clinical productivity, but it will ensure that these systems do not interfere with clinical care. Because these

hygiene systems are necessary but not sufficient for high clinical efficiency, they are easy to overlook as causes of low productivity. Additionally, each of these systems can require a great deal of energy and effort to maintain. (For example, few clinicians have not felt the stress that accompanies a sizeable backlog of incomplete patient charts.)

Clinical systems have the most significant impact on overall productivity. These systems are numerous and include:

- use of support personnel for clinical care,
- access to clinical tools and instruments,
- individual clinician judgment and efficiency of patient assessment and treatment planning,
- individual clinician treatment skills,
- systems used to evaluate patient outcomes, and
- systems to transfer knowledge, skill and responsibility to patients and their care partners.

These are the systems that are the most difficult to change, because they represent the thing closest to the heart of our profession: patient care. Changing these systems can be the most threatening, and many clinicians find it difficult not to be resistant to suggestions in these areas. This resistance is easily understood, but it still can interfere with improving our practice.

The Relationship of Quality to Productivity

There is no doubt that there is a point at which increased volume of work leads to decreased results for any individual clinician. In this situation, there is an inverse relationship between productivity and quality. This is especially true when the clinician attempts to increase efficiency without changing work systems. However, when systems are revised and processes are improved, it is very likely that increases in volume and efficiency will be accompanied by increases in quality.

Just as no consensus definition of acceptable productivity exists in physical therapy, no universally accepted definition of high-quality care has yet emerged. However, one working definition that suits our needs here could be as follows:

“High-quality care is efficient, accountable, and likely to provide the desired outcomes.”

In other words, high-quality care is quick and cost-effective—and it works. If “productivity” describes efficiency, “high quality” describes effectiveness. This definition is derived from the patient’s perspective, meaning that the focus is on the outcome. The process to achieve that outcome is very important, but only because it leads to the desired outcome.

How a PT personally defines high-quality physical therapy can have a significant impact on his or her clinical practices and attitude toward productivity improvement. A PT who agrees with the definition of high quality above would be likely to focus on the factors of care that allow him or her to increase productivity.

Many PTs, however, define high-quality care from the clinician’s perspective. When asked, these PTs might define high quality with phrases like, “High-quality care means I spend at least 30 or 45 minutes one-on-one with each patient,” or “High-quality care means that care is given only by a PT, not a support staff member.” These definitions ignore the impact of therapy on the patient. They look at the process, not the outcome, of therapy. They also can limit the manner in which the clinician analyzes systems for possible productivity enhancement.

The Productive Therapist: Two Portraits

To develop into clinicians who are optimally efficient and effective, we must all work to analyze and redesign the systems that are outlined above. However, we must also recognize that we will need to analyze certain aspects of ourselves. We will need to analyze (and possibly redesign) our attitudes and beliefs about productivity and quality and our individual clinical behaviors (see sidebar, opposite). We will then need to work to develop skills to improve our productivity without sacrificing quality.

Consider the characteristics of the following two “composite PTs,” drawn from observation and interaction with PTs in a variety of clinical settings. Are any of these behaviors familiar to you?

“Quality is my middle name” Quincy:

- Always schedules a minimum of 45 minutes one-on-one for each patient treatment, longer for evaluations.
- Rarely utilizes assistive personnel because “I really need to assess the patient’s response to each treatment myself, so I can adjust as needed.” Has tried utilizing an aide in the past, but it “just didn’t work out.”
- Is constantly behind in notes and letters to referrers and third-party payers. Prefers to handwrite notes. Is resistant to using standardization techniques for routine notes because they are “unprofessional.”
- Is constantly frustrated by frequent treatment interruptions due to phones, peer questions, and general commotion in the clinic.
- Frequently is unable to schedule as many patients as desired because of all the patient cancellations and “no-shows.” Is frustrated by lack of patient attendance and has even tried to allow patients to alter schedule with each visit to make it more convenient for the patient.
- Is dedicated to patient education so that patient can learn how to follow through with treatment. Each patient is instructed individually.
- Despises any attempt to monitor his productivity. Frequently tells his boss, “All you really care about are numbers. My patients deserve my best.”

Productive Pat:

- Decides on a visit-to-visit basis how much time each patient will need one-on-one. Blocks out 30 minutes for evaluations and continues to evaluate with each visit as needed.
- When not sure which treatment technique to use or when faced with a choice of equally clinically acceptable treatments, tries the one that is quickest and least expensive. Evaluates the patient’s response to that treatment before trying something else.
- Delegates routine or repetitive care to support personnel. Communicates well with aides and technicians to get sufficient feedback on patient response and progression.

- Dictates notes and evaluations before leaving the patient. Uses standardized forms and dictation scripts to expedite routine notes. Explains to patient that the documentation is a necessary part of his care. Asks patient to correct any information that he might dictate that is not completely accurate.
- Identifies for staff and peers which situations warrant interrupting him. Limits his interruptions list to only a few situations that can't wait until he is more available. Blocks out a short period of time first thing in the day and right after lunch to return calls and catch up. Lets important people know when his call back times are so they can try to be available.
- Schedules his patients in regular time slots. Explains to each patient the importance of attending each session. Questions all patients after a missed session. Reminds patients that he is there to help them but that he must also be available and on time for his other patients.
- Is dedicated to patient education. Uses standardized handouts, audiovisuals, and group sessions to communicate effectively with his patients. Coordinates groups with other therapists who may need to teach patients with similar needs.
- Continually asks peers for suggestions on how he can better organize his day and be more efficient so he can focus more of his time on patient care. Tries to incorporate their suggestions into his routine, if only on a trial basis.
- Works to improve his productivity, but is very aware of what impact increased volume may have on the quality of his performance. Works as a member of the staff on the outcomes assessment task force to compare his results with others in the clinic and at other clinics. Frequently tells himself, "My patients deserve my best."

Although Pat and Quincy are composites, they are representations of real people. They may even work in your clinic. If so, you've seen them work within your existing systems.

You may have seen Quincy struggle with delegating treatment to support staff (clinical systems), keeping up with documentation requirements (hygiene systems), or getting to

meetings on time (staff interface systems).

You may have seen Pat work his patient schedule like a pro (hygiene systems), communicate with the front office at a very high level (staff interface systems), or navigate critical pathways with grace and elegance (clinical systems).

Both Pat and Quincy are good clinicians, and both have worked hard to become proficient and respected therapists. They both receive high satisfaction scores from patient surveys. Both feel stress at times in the clinic because they are busy.

Pat and Quincy have about the same amount of experience. They work in the same clinic. Based on what their outcome studies tell them, they have similar success rates. Pat just sees more patients and, therefore, bills for more services than Quincy does. If you had to hire one of them, who would it be?

Can You Become a Productive Therapist?

The concept of increasing your productivity is very personal and sometimes threatening to many clinicians. It requires a thorough examination of systems within your clinic and within yourself. We all are comfortable to varying degrees with the *status quo*. Change requires risk and energy expenditure.

Factors in the current health care environment may necessitate change. Regardless of whether we initiate the change or change is forced upon us, efforts to improve productivity must not mean that we sacrifice the quality of our service.

How, then, do you become more productive? Avoid just working harder; the results probably won't last long, and it may lead to burnout. Focus on the factors related to productivity. Analyze and redesign systems as needed. Accept the challenge to examine your attitudes, beliefs, and behaviors, and eliminate those that are preventing you from accomplishing all the things you want to do.



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Myths and Misconceptions About Productivity and Quality

Myth: Increasing productivity must lead to a decrease in quality.

Fact: Quality will only decrease when productivity is increased if you don't redesign the systems you use in your practice. This is especially true as you develop new attitudes, beliefs, and skills to improve both productivity and quality.

Myth: To increase productivity, you must work harder.

Fact: Although learning new skills and redesigning systems is hard work, the key to increasing your productivity without reducing the quality of your care is not to just work harder. System redesign is the key.

Myth: Quality is improved by ensuring that each patient receives at least a set amount of the PT's time (eg, 45 minutes).

Fact: Patients have different needs. The amount of time needed to help the patient progress must be determined individually by a qualified PT. Evaluating the quality of care based on how much time is spent with the PT assumes that a PT-centered philosophy is best. Patient-centered philosophies focus on what works for the patients, not on the PT.

Myth: Using support staff to provide clinical care will automatically make you more productive.

Fact: In many cases, using support staff will make you more productive, assuming that you are an effective supervisor and know how to delegate well. However, ineffective delegation and poor supervision skills can lead to inefficient care and decreased quality and productivity.

Myth: Developing and using advanced clinical techniques will promote the quickest and most complete patient outcome.

Fact: Developing a wide variety of clinical techniques is always a good idea. But they will only increase your productivity and improve your quality if you are selective in their use and constantly evaluate their effectiveness. You must know when to use each of the techniques you have learned. Using more advanced or time-consuming techniques than are necessary is wasteful and can increase the cost of your care to your patients.

Myth: "Good hands" are the most important characteristics of effective clinicians.

Fact: Manual techniques are just one tool you have at your disposal as a clinician. The most important characteristic of effective clinicians is the discriminating use of any tool, based on clinical judgment and careful analysis of research data and previous patient outcomes.