Chapter Three: How Efficient Are You, Really? A 100-Point Self Assessment

Medicine is, by its nature, reductionist. Eye surgeons everywhere enjoy reducing complex, nuanced data into a simple up or down score so they can proclaim living tissue as healthy or unhealthy. Some surgeons like it even better when they can apply a score to their practices and match their performance against colleagues. I've developed the following scoring system to help you grasp how well you and your team are doing.

A 100-Point Scoring System For Efficiency in a General Ophthalmology Practice

Please note that for consistency the following conventions are applied:

- This scoring system is best applied to general practices only. That can mean anything from a modest primary care and dispensing-oriented practice to a higher volume cataract or refractive surgery practice.
- One "FTE" is a "full-time equivalent"…a doctor or lay staff member working 40 or more hours per week. A tech working 20 hours a week would be 0.5 FTE.
- When counting patient visits, count the number of patients *seen by a doctor* only, whether for a paid or unpaid exam…don't under-count by omitting post-op appointments…don't over-count by adding in special testing—a patient who comes in for a complete eye exam and a visual field test should be counted as just *one* visit.
- For the sake of convention, a payroll hour is counted for every paid hour, whether worked or not. A staff member working full time will typically generate 52 weeks x 40 hours = 2080 payroll hours per year, although after vacations and personal leave, 120 hours or more each year may not be for time actually worked.
- Unless otherwise stated, we are examining the core, clinical dimension of your practice, not the optical dispensary or the surgical center

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1. Passive Income From Ancillary Services

The introduction of ancillary facilities—special testing, optical, ambulatory surgery center—generates passive income for the owners, while potentially improving patient convenience and quality of care. Give your practice the correct number of points based on your status today:

- 5 Points…."Our practice has vigorously moved into providing ancillary services; we do virtually all available special testing in-house, operate our own optical shop/s, and own one or more ASCs"
- 3 Points…."Our practice has moved into providing ancillary services; we have two of the following three services in-house: special testing, optical shop/s, an ASC"
- 1 Point…."Our practice has so far introduced one or none of these ancillary services"

2. Profit Margins

There is considerable confusion about how to measure the profit margin of a practice, and where that margin should properly be to lie within acceptable ranges. The most appropriate convention in most settings is to consider profits to be those cash-basis funds available to pay for physician (MD or DO) salaries, draws, bonuses, payroll taxes, health and other insurance benefits and officer entitlements. When calculating cash-basis profit margins, omit the cost of depreciation.

Thus, a practice generating $1 million in collections, and having $500,000 in expenses (before the above-described physician costs, and before depreciation), would have a 50% profit margin.

- 5 Points…If your core, general ophthalmology practice has a profit margin exceeding 45%
- 3 Points…If your practice has a profit margin between 30% and 45%
- 1 Point…If your practice has a profit margin below 30%

[Note: margins can be 15% and still "normal" in an urban, HMO-driven practice and as much as 70% in a high-volume LASIK, retinal or cataract referral center practice…this wide-ranging metric is highly dependent on your practice's service mix and location.)

3. Facility Utilization

You can tell when you step foot in any clinic facility just how intensely it's being used. Unfortunately, even the busiest practices have considerable down time when the doctors are in surgery, in satellite offices, or away from the practice altogether. You can smooth out the peaks and valleys with visiting subspecialists and part-time optometric coverage…even using your office during evening and weekend hours. A useful metric of how intensely your office's clinical space is being used is to calculate the number of patient visits you are moving through an exam lane in an hour. This is simply derived by taking the total patient visits for the year and dividing this figure by the number of exam room-hours per year (which is calculated by taking the number of fully-equipped exam rooms times 2080 nominal hours available to see patients per year.) A practice with four exam rooms would have 8320 room-hours per year. If that practice saw 7000 visits per year, it would be driving 0.84 visits per exam room, per hour.)

- 5 Points…. Over 1.1 patient visits per room-hour
- 3 Points…Between 0.7 and 1.1 patient visits per room-hour
- 1 Point… Under 0.7 patient visits per room-hour

4. Facility Costs

Some doctors practice in palaces, some get by working in the pits. Each, within reason, has a cost and a benefit. You can't expect to build a successful refractive surgery or elective plastics practice on the cheap…but neither can you cash flow a bread-and-butter cataract practice with marble flooring, French impressionist paintings and fresh flowers in every room. Facilities costs are best gauged as a percentage of practice collections. Add up annual rent or principle/interest payments, plus utilities, taxes and basic repairs and divide this figure by annual collections.

- 5 Points….Under 4%
- 3 Points…Between 4% and 6%
- 1 Point… Over 6%

5. Marketing Costs

Your practice's marketing cost ratio is calculating by adding up annual creative, production, media, printing and other costs (but not internal marketing staff costs) and dividing this figure by annual practice collections.

- 5 Points….Under 2%
- 3 Points…Between 2% and 5%
- 1 Point… Over 5%

[Note: Marketing costs should appropriately rise to 20% or higher when launching new services such as elective plastics or refractive surgery. An old-line, established practice with no further growth aspirations can get by on 1% or 2%. "Efficient" practices are not those that starve critical departments of needed resources. If you desire growth, your practice would be much more efficient spending 5% of collections on marketing and growing 8% a year, than spending 1% on marketing and growing 3% a year.]

6. Staffing Costs –I: Collections per FTE

A very coarse measure of labor productivity in your practice is the amount of annual collections per FTE lay staff member. Simply divide collections by all non-provider FTEs. A practice with $1 million in annual collections and nine FTEs would have about $111,000 in collections per FTE per year.

- 5 Points….Over $130,000 in annual collections per FTE per year
- 3 Points…Between $110,000 and $130,000
- 1 Point… Under $110,000

[Note: Labor productivity can be twice these norms or more in a retinal or refractive surgery practice, or in a practice biased toward OD co-management.]

7. Staffing Costs –II: Costs as a Percent of Collections

A second way to measure staffing costs is to divide lay and OD staff payroll, benefits and taxes by total practice collections…in some settings, where a larger number of ODs are cast more as fully-fledged practitioners than as surgeon-extenders, it can be more appropriate to count lay staff costs only…just be consistent in the way you track this each month.

- 5 Points….Under 25%
- 3 Points…Between 25% and 32%
- 1 Point… Over 32%

[Note: This figure can be as low as 10% in a high-volume surgical practice and as high as 38% or more in a primary care oriented practice, or a practice in an adverse urban location.]

8. Staffing Costs –III: Reception Staff

The reception and check-out staffing levels needed to cover a general practice are subject to several variables, including the mix of patients and what jobs reside in reception vs. a separate billing department. A higher volume of established instead of new patients, or a market with a low managed care penetrance and fewer pre-authorizations, will reduce workloads for front desk staff. Workloads go up when check-out staff are tasked with posting charges.

- 5 Points….Under 0.3 check-in/check-out staff payroll hours per patient visit
- 3 Points….0.3 to 0.5 check-in/check-out staff payroll hours per patient visit
- 1 Point…. Over 0.5 check-in/check-out staff payroll hours per patient visit

9. Staffing Costs –IV: Patient Accounts Efficiency

All the practice efficiency in the world is for naught if the doctors and the entire lay team aren't working together to make sure the practice is paid everything it's owed for services rendered. First, the doctor or scribe has to nominate the correct codes on the superbill. Clerks then have to accurately and completely transcribe the charges, submit claims and followup with payers and patients. The point value for this area of the practice are higher, given the importance of each of these steps. Choose the number of points that come closest to your current performance:

- 10 points…"We audit often and widely to make sure that <u>everything</u> the doctor has done is appropriate and is noted in the chart, on the superbill, and on the claims we submit. We routinely collect in excess of 95% of the allowable charges"
- 5 points…"While we don't audit frequently, we turn up very little when we do audit. We are probably collecting about 90% to 95% of what might be possible if we were a little more careful in this area."
- 1 point…"We don't really audit at all, except on the rare occasions when we're spot-checked by a visiting billing consultant. We are probably collecting less than 90% of what might be possible if we were a lot more careful in this area."

10. Staffing Costs –V: Billing/Patient Accounts Staff

There are at least two key measurements of labor productivity in this area of your practice. First, the annual collections divided by the number of billing department FTEs (counting all lay staff, wherever they may work, doing posting, charging and collections work.) Second, the billing department annual payroll hours (all staff doing posting, charging, collections, etc.) divided by the total annual number of paid and unpaid transactions in the practice (the total surgical cases plus the total patient visits.)

- 5 Points….If collections per FTE-year in billing is over $1.2 million, and there are under 0.3 billing staff payroll hours per transaction
- 3 Points….If collections per FTE-year is between $800,000 and $1.2 million, and there are between 0.3 and 0.4 billing staff payroll hours per transaction
- 1 Point… If collections per FTE-year in billing is under $800,000, and there are over 0.4 billing staff payroll hours per transaction

11. Staffing Costs –V1: Technical Staff

Some ophthalmologists like to work with little or no technical support and do everything themselves. Others like to have at least a couple of idle staff at their command, and delegate patient care and education avidly.

- 5 Points….Under 0.6 tech payroll hours per patient visit
- 3 Points….0.6 to 0.9 tech payroll hours per patient visit
- 1 Point…. Over 0.9 tech payroll hours per patient visit

[Note: The demand for technical support increases when the practice has some labor productivity lost to travel between offices, or when there are a number of junior/trainee techs on the payroll. Beware excessive cuts in tech staffing, lest patient satisfaction and care quality decrease.]

12. Staffing Costs –VII: Optical Staff

Dispensing optical staff efficiency can be measured broadly by taking the total annual optical sales divided by the number of dispensing optician FTEs (omitting any lab or reception staff)

- 5 Points….Over $200,000 in annual sales per FTE
- 3 Points…. $180,000 to $200,000 in annual sales per FTE
- 1 Point…. Under $180,000 in annual sales per FTE

13. Optical Sales Ratio – I: Sales as a Percent of Practice Revenue

Divide the annual optical sales (just frame and lens…omit contacts and low vision aids) by the total of all other medical and surgical collections (excluding any ASC revenue.)

- 5 Points….Over 25%
- 3 Points…. 15% to 25%
- 1 Point…. Under 15%

14. Optical Sales Ratio – II: Sales per Patient Visit

Divide the annual optical sales by the number of total patient visits for the year. Note that this figure will skew smaller in geriatric practices that operate their optical as a small-time boutique as a convenience to patients…and larger in practices with a younger or more affluent patient base.

- 5 Points….Over $50
- 3 Points…. $15 to $50
- 1 Point…. Under $15

15. Clinical Sales Ratio

Collections per average patient encounter (monthly total collections for the clinic only, omitting optical and ASC collections) divided by monthly total patient visits, inclusive of post-op visits); also referred to as the "average ticket" $125-$175

- 5 Points….Over $175
- 3 Points…. $125 to $175
- 1 Point…. Under $125

[Note: Can be much higher in surgically-dominated centers…can range to $450+ in retinal practices]

16. Patient Volumes per Provider – I: Daily Volumes

Raw patient visits per physician and per optometrist are a core driver of practice profits. And the incremental gains in patient volume are critical, given the fixed costs of running a clinic. Generating just a few extra exams a day can lead to a six-figure gain in practice profitability

- 5 Points….Physicians see over 45 patients per day; optometrists see over 25 patients per day
- 3 Points…. Physicians see 35-45 patients per day; optometrists see 18-25 patients per day
- 1 Point…. Physicians see under 35 patients per day; optometrists see under 18 patients per day

17. Patient Volumes per Provider – II: Monthly Volumes

Patient visits per physician and optometrist per month, given the foregoing measure of doctor productivity per day, is simply a measure of how many days the doctor is willing to spend in clinic each month, and how intensely he or she is willing to work on those days.

- 5 Points….Physicians see over 525 patients per month; optometrists see over 350 patients per month
- 3 Points…. Physicians see 450 to 525 patients per day; optometrists see 275 to 350 patients per month
- 1 Point…. Physicians see under 450 patients month; optometrists see under 275 patients per month

18. Profit per Physician-hour

This is a key—perhaps *the key*—measure of practitioner efficiency and financial success. Divide the number of hours you work each year into the practice's available profit from ALL sources—optical, ASC, and clinical practice. A doctor working 45 hours a week, 48 weeks out of the year, and with $375,000 in annual profits would be generating $173.61 in profit per hour.

- 5 Points….Over $200 per hour
- 3 Points…. $100 to $200 per hour
- 1 Point…. Under $100 per hour

19. Surgical Yield

Financially efficient practices tend to have a much more favorable surgical yield than other practices. Ranges and scoring shown are for a typical cataract-biased practice.

- 5 Points….Under 15 patient visits per major surgical case
- 3 Points…. 15 to 25 patient visits per major surgical case
- 1 Point…. Over 25 patient visits per major surgical case

[Note: This is one of many dimensions of efficiency where ratio analysis is often best applied as an internal standard, rather than trying to match external benchmarks.]

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Now add up your total score. Just as fine wines are graded by professional tasters on a 1-100 scale…and no wines to speak of ever make a perfect score…you shouldn't judge yourself harshly if your score today sits at well below 90 or 80 or even 70 points. Instead, use this objective scale to periodically measure improvement in your overall efficiency score, and to highlight those areas needing the most improvement. The higher your score is, the better control you'll gain in an environment where fees are being challenged annually by payers, and where practice costs are poised to run up in the years ahead.

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