

## **Avoid These Doctor-Driven Practice Efficiency Killers**

By John B. Pinto

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On the most hectic, late-week clinic afternoons, every manager and practice owner laments the human factor that trips up the best intentions for an efficient flow of patients. If only we could hire RoboDocs and support them with RoboTechs and RoboClerks, the management of an ophthalmic practice would simplify vastly.

But we're a long way from that level of automation, and by the time we get there robot workers will have probably unionized and we'll face a whole new set of management headaches. For now, we'll have to satisfy ourselves with getting the frail human units we're stuck with working as well as they can.

As you begin work to develop a more efficient practice, it helps to vanquish the large and small "efficiency killers" found in every organization. Some of these are occult—others are out in plain sight.

Doctors are the most visible culprits, and are their own largest source of inefficiency in most of the practices I visit. The most immediate improvements are truly at the provider's command. Let's consider the simple, obvious dimension of practice efficiency: "At what time does the doctor arrive in the office?" In the overwhelming majority of cases, a clinic with excessive patient waiting time can be remarkably improved simply by having doctors arrive 10 minutes or more before the time of the first scheduled patient appointment. Use the extra office time for a brief standup meeting with support staff to review the day's (or half-day's) schedule. Think like a quarterback, calling out the "plays" and anticipating the tough spots. Then, if you have sufficient exam rooms, dive in with your team, starting a short patient or two before being fed patients who have been worked up for you.

If you try doing this (rather than excusing yourself to a private office while your staff work up the first patients of the day, or worse, arriving only after the rooms are all filled) you'll discover several benefits. You'll find that staff are more punctual in their arrival time in the office—it's a little embarrassing to come in after the boss has arrived. You'll find that staff appreciate spending just a few extra minutes with you and having the benefit of your leadership. And you'll discover that by starting the day *ahead* of schedule, it's harder to get *behind* as the session proceeds along.

Once your clinic is in session, stay on the floor and resist the temptation to wander off for a chat with your administrator, friendly rep or stock broker. It's a real temptation, in the face of a no-show patient, or unexpected lulls to tell your staff, "I'll be back in just a few minutes—I'm just going to make one call." Of course, this is code for, "I'm going to go play on the computer until all of my lights are flashing and you've asked me twice to get back to work." If you must depart, tell your lead tech. Get her tacit permission, declare precisely how long you will be away, and where you can be found. Then, keep your promise. If a little extra discipline is necessary, set a countdown timer to go off in your pocket or on your wrist when it's time to be back on the floor.

A few doctors have no problem arriving in clinic and sticking around, but they do find it difficult moving from one room to the next due to excess socializing with patients. This can grind your

clinic down to a crawl. How much social time is too much? That's entirely up to you, obviously. But consider the hard costs. The typical surgeon, with let's say \$400,000 in annual overhead, has about 75600 clinic minutes per year to see patients in the office. (That's 48 weeks, times 3.5 clinic days per week, times 7.5 hours per day, times 60 minutes per hour.) Doing the math, we get \$5.29 *PER MINUTE* as the cost to sit and socialize with patients when you could be starting the next encounter. Clearly, there is an irreducible percentage of each patient encounter which must be apportioned to developing rapport and a relationship with the patient. But the patient's eye, whose structure and function you're there in the room to assess and improve, really doesn't care if you spend an extra five minutes (remember, that's about \$26.45) chatting about trout fishing.

Of course, it could be you'd like to get more efficient with every other part of the practice so you can spend even *MORE* time with patients—and that's terrific. Presumably, if you're reading this, you're open to the possibility that you may not be as efficient as you'd like. How you spend the extra time you save is up to you.

In my experience, a very few doctors are hampered to some degree in their office pace due to clinical insecurity and a resulting hesitancy to diagnose and treat. Some of this is perfectly normal—healthy, really—in a new career. In contrast, some of the most intelligent surgeons I've met through the years are able to devour crowded patient days with an efficiency that is a wonder to behold. The apex of the clinical and surgical efficiency pyramid is populated with doctors who cunningly manage to see 80 or more general ophthalmology encounters per day...make each patient happy...and win the grudging respect of their peers for the quality of their care.

Other doctors, including less-endowed or less-experienced minds, sometimes point to such hyper-doctors and proclaim them incompetent or believe they short-change patients. And to be sure, some doctors with mere raw throughput are short-changing their patients. But I would urge you to seek out and observe such high-volume clinics in action, in person, before casting the first stone.

Some doctors arrive on time, stay on time, and stay on the clinical task at hand, but their efficiency is retarded by insufficient delegation to optometrists, techs and other staff. Ask yourself a few questions. Of all the patients you saw last week, what percentage could have been seen by a competent optometrist? The typical answer from clients is 30% or more. Then ask, of all the direct interaction you had with patients last week, how much more could have been delegated to your technical staff? A bit more of the history taking? The refraction? The intra-ocular pressure check? The dilation decision and drops? Writing in the chart? Routine patient education? Delegating even one more task to an appropriately supervised and trainable lay staff member will free up time for you to either serve additional patients, or spend more quality time with the patients you have.

Some doctors lose time and efficiency doing more for patients than is obliged by third party payers or needed to give the patient excellent service and a great experience in the clinic. Remember that the reimbursement world we are moving toward is a little like the world of modern commercial airline service, where you will be rewarded for providing a *sufficiency* of service rather than an abundance.

This is clearly a very sensitive area. Some few ophthalmologists feel that the standard of care they want to give every patient includes a blood pressure reading and a broad discussion of their general medical status. Most doctors cut corners. A few cut not only the corners but the middle, too. In the interest of efficiency, performing any task not *absolutely* required to assess and treat the patient, and meet billing standards, should be thought of as an uncompensated gift of service

to the patient. Most providers are realistic today and understand that they can only be as generous as their practice's financial position will allow.

Some practice efficiency killers take place off the clinic floor, and are simply a matter of poor business and personal life husbandry. For example, some doctors have difficulty with boundaries on their time. They are unable to prioritize requests on their time and find it impossible to say "No" when appropriate to patients, staff, colleagues and vendors. Often, what appears to be procrastination is simply over-commitment.

Be sure you're putting major time into major practice issues. It may seem business-like and efficient to limit meetings to a fixed time-span, or only allow a small number of meetings each month, but this can actually be inefficient in the long-run if you cut short discussions that will eventually save time and motion.

A common trap of managers and doctor-owners alike is to focus excess time on responding to perceived external elements, including competitors, rather than working to improve each of the hundreds of internal moving parts that in aggregate will have a much larger impact on performance. For example, it's much more effective and profitable (if boring) to tighten recall and continuity of care procedures than to fine-tune your advertising campaign to do battle with the doctor next door.

Finally, some doctor inefficiencies are the result of poor physical or mental conditioning, a tempo dulled by substance abuse, or simply a lack of sleep. I recall a client who presented with what looked like a simple case of mid-life career burnout. He arrived late, dragged through each clinic day, and went home a little more exhausted with each passing day of the week. Beyond the usual crescendo of life stresses that hits most of us at some point in our fourth decade, it turned out that this doctor merely had sleep apnea. His office efficiency and his mood both improved markedly with treatment of this underlying cause. The most efficient doctors I know maintain disciplined dietary and exercise regimes.

If your practice is measurably inefficient in volumetric or economic terms, or simply *feels* a little pallid, look first to the core of the practice, to the doctors, and then work outward from there.

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