

How to Hold the Line on Clinic Costs, Without Suffering From “Practice Anorexia”

By John B. Pinto

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As this column goes to press, the slated 4.4% Medicare fee reduction has been rescinded, and Part-B-dependent ophthalmic practices throughout the land have put plans for radical downsizing and cost-containment back up on the shelf.

These plans have included staff cutbacks, salary revisions, cancelled equipment orders, deferred maintenance and shelved facility development...a little fat to be sure, but because of the depth of the slated cuts, a lot more meat than in years past.

Although the heat's off for the balance of this year, it's important to continue to harness the anxiety and cost-containment jitters you and your staff felt just a few months ago, and use these feelings to stimulate an examination of where you could reasonably pare costs.

At the same time, it's important to not take your company over the edge into "practice anorexia," where cuts are so severe that the profits you intended to boost actually go backwards.

Both older and younger doctors are more likely than mid-career surgeons to cry out for cost-cutting. For older doctors, cutting costs is a natural response in the board room to the winding-down phase of their professional life--they want to trim costs in anticipation of falling personal outputs (even if they're part of a robust group practice, they'll still typically vote for more cost containment.) For younger surgeons, at the opposite pole of their career, their natural instinct about cutting back costs comes from a recent personal life of relative penny pinching through their training years, and a lack of appreciation for normal business costs.

It's important to consider the big picture when containing costs. Of course, cost containment is not a business *goal*...it's a business *tactic*, put into service to achieve the goal of enhancing profits. Cutting business costs for the Scottish satisfaction of mere thrift is like washing your hands between patients because you like the smell of the soap. That's a nice by-product of hygiene, but has nothing to do with the clinical goal of infection control.

Try to be consistent from year-to-year with your approach to cost containment. I've observed in larger groups, as well as the smallest solo practices, that surgeon-owners tend to move in wide swings, from excess liberality in perceived good years, to excess parsimony in years that are even a little bit off the mark. Administrators, accountants and practice advisors should provide an important buffering and dampening role to prevent this kind of over-reaction. This role includes preparing budgets and benchmarking reports, and forecasting the impact of proposed new investments.

In some of the most difficult situations I encounter, owners can have unrealistic expectations about practice profitability. If you've been in practice for a couple of decades or more, it's easy to remember when even sloppy managers could wring out 50+% profit margins.

Although none of us are particularly happy about the current average profits, we all have to live with the new reality, and aim for the best results now possible. In this new era, it's entirely normal for an urban or suburban general ophthalmology practice to have a 30% to 40% profit margin. The profit margins today in rural practices can still be 40% to 50% and sometimes much higher because there are fewer competitors, lower costs and higher rates of untreated pathology (not to mention bonus payments from Medicare if the service area is declared "under-served.") Profit margins in costly urban hubs and managed care hotbeds rarely exceed 35%.

Let's explore a few reasonable areas to attempt cost cutting today. Here are some of the common opportunities I see in my travels around the country:

1. **Selective Lay Staff Pay Cuts...**As difficult as it may be to contemplate, the time may be approaching when it will be reasonable to reexamine the wages of staff--especially long-term employees--who have been elevated above local pay ranges, or whose performance has fallen below their relative contributions to the practice. The starting point for this is a local salary survey.
2. **Reducing Overtime...**Even the most ethical staff, given an opportunity, will evidence the human tendency to allow work to fill the allotted time. And if you leniently allow ad lib overtime, many staff will find a way to take it. Make it a policy that all overtime has to be pre-approved by a partner doctor, department manager or the administrator.
3. **Selectively Reducing Staff Hours...**Many practices preserve a 40-hour work week on the assumption that staff really need that much time to get their job done, or would leave the practice if they didn't get a full week's wages. These assumptions are not always correct. Start by asking for volunteers for a 32- or 36-hour work-week. The next time you need to replace a full-time employee, ask yourself if two part-time staff would work as well, thereby saving benefits costs.
4. **Removing Excess Staff...**It's beyond the scope of this column to set out all of the benchmarks for determining if your practice staffing levels are excessive, but here are a few key metrics:
 - Total lay staffing costs (wages, taxes, benefits) should be at or under 32%.
 - Total tech paid hours divided by total patient visits should be at or under 1.0 in most general ophthalmology practices.
 - Total reception/medical records/dictation staff paid hours divided by total patient visits should be at or under 0.5.
 - Total patient accounts/insurance/billing/collections staff paid hours divided by total patient visits should be at or under 0.35 in most general ophthalmology practices.
 - Annual professional fee collections divided by lay staff FTEs (full-time equivalents...a staff member working 40 hours per week is 1.0 FTE) should be above \$110,000 in most general ophthalmology practices.
 - Annual optical collections divided by dispensing optician FTEs should be at or above \$200,000 in most settings.
5. **Renegotiate Your Leases...**Depending upon occupancy rates in your service area, you may be able to drive a harder bargain in the next contract cycle, or at least extract a couple of free month's rent or few extra dollars for tenant improvements.

6. Live With the Facilities You Have, Instead of Moving to a Larger Office...Are you contemplating a move? Do you *really* need the extra space? Here's a gross screening metric: Take your total number of equipped exam rooms, and multiply by 2080 (the number of nominal work hours in a year). Divide this number into the total number of patient encounters you transit in a year (including post-ops). The resulting figure should be *around* 1.0 patient visits per exam room hour. If your number is 0.5, you may only be using your facilities at 50% or less of potential intensity. Even for a small solo practice, the disruption and patient confusion of moving to new office facilities will transiently reduce patient volumes by 5% or more.
7. Reduce Associate Provider Compensation...It's common for me to examine a practice and see that MD or OD associates are being paid well above normal rates. Medical ophthalmologist and optometrist base wages above about \$150,000 should be examined for bilateral fairness. Although the base wages for associate surgeons in every general and subspecialty category have been bid up sharply in the past few years, look at your contracts and local averages for opportunities to save costs.

While these and many other appropriate areas for cost-cutting are still to be found in even the best-run practices, there are numerous areas where you should think twice before cutting. Here are some common examples of damaging cost containment.

1. Across-the-Board Lay Staff Pay Cuts...Doing this in any situation other than a frank business emergency will lead to resentment and defection among your best staff, leaving your practice with only the weakest members of the team. It may seem counterintuitive, but it's far better to cull two or three weak staffers than to punish everyone equally.
2. Grinding Vendors to the Point of Resentment...Whether it's your cleaning service, your accountant, or the most sophisticated clinical product rep, excessive efforts to cut costs will likely rebound. (By the same token, don't be shy about collaborating with vendors on how unnecessary costs can be spared. Can you reduce cleaning to every-other day? Have your staff take some tasks over?)
3. Staying in Office Space That is Limiting Growth...There's no gain in turning your practice into the business equivalent of a root-bound bonsai tree. At typical facility costs and patient revenues, it takes just one or two extra patient visits a month to pay for another 100 square feet of office space. If by moving to larger quarters and gaining 1000 square feet of space you can see just 3 or 4 extra patients a day, you'll be dollars ahead. (Unless you work on the Upper East Side, in which case you might need to see an extra 10 patients a day!)
4. Reducing Optical Stock to the Point That Customer Service Falts...The typical break point is that you need about 800 frames on display to lend the impression to patients, "Wow, there's a lot to choose from here. I'm sure I'll find something." With fewer than 500 frames on display, the patient will typically be thinking, "Hmm, not much here. Maybe we should go to Lenscrafters or Walmart."
5. Deferring Needed Equipment or Maintenance...To be an effective, efficient eye surgeon today you have to be surrounded by a complex array of gadgetry. To forego such equipment, or to let it molder into disrepair, will reduce both your profitability and your sense of professional accomplishment.

6. Excessive Cuts to Marketing...As marketing executives everywhere know, the industry maxim during recessions is, "Last to know, first to go." When the going gets tough, even highly experienced CEOs of the largest companies can take an overly short-term view and slash marketing costs, so it's no surprise that surgeons will do the same thing. It's perfectly reasonable to continuously evaluate every marketing execution for its cost and benefit to your practice. But while you're trimming, try to avoid chopping down the tree.
7. Cost Containment Spirals...The pattern is all too common: Patient volumes flutter...you downsize by one receptionist...this leads to faltering appointing and recalls, and a further drop in patients...you cut back on marketing...fewer patients hear about you...surgical volumes fall...you close down a satellite and fire two techs...and so on. Remember that in the largely fixed-cost business of eye care, profit enhancement is more often a matter of boosting revenue than containing costs.

In the future, in the typical practice setting, every 1% cut in Medicare revenue will result in a roughly 1.5% drop in net doctor salaries...nearly twice this reduction if commercial carriers continue to index their allowable payments to Medicare. And that's before figuring in typical inflation rates for labor, facility, and most other practice costs. A 5% Medicare fee cut, combined with a 3% increase in the cost of doing business, leads to a 12% drop in take-home pay for the typical practitioner.

If we do indeed encounter such an era of upward spiraling costs and falling fees, only the most adroit practice managers and owners will be able to preserve gratifying levels of profitability.

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