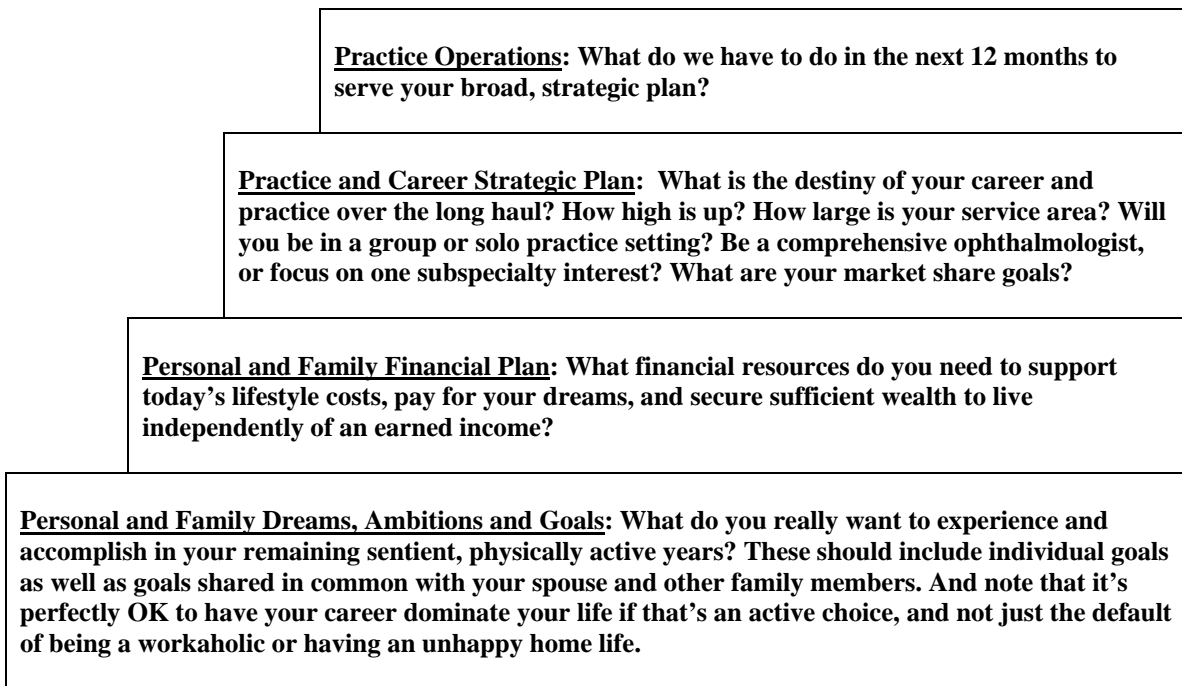


Chapter One: Doctors Control 90% of Clinical and Surgical Efficiency

“Show me the incentives, and I’ll show you the behavior,” goes the old line. After more than a quarter century of working with thousands of doctors, from new grads to Nobel laureates, I’ve learned that you can’t much help an unmotivated person. Even doctors with spectacular brains, rigorous training and abundant charm will fail to reach their potential without their dreams burning holes in their guts.

The most direct and helpful way to understand the impact of your personal dreams on your practice is to consider the following staircase diagram...just like a set of real stairs, when you’re climbing you should start at the *bottom* and work your way up:

(editing note: please insert an arrow going up the ladder...jp)



Here’s a practical example of how this staircase diagram works. Let’s say you’re 57 years old, and a higher-volume cataract surgeon. You’re in your second marriage, and raising your second family, with daughters who are seven and nine. Because you’re starting over again, money is a little tight; in fact, your net worth is only about \$300,000. You enjoy your practice—a lot—and have a compatible 5-surgeon partnership. But what you’ve always wanted is to go off on a medical mission trip for an extended sabbatical of three months. The path ahead is clear: you negotiate with your partners an arrangement whereby you each get a three-month sabbatical every five years...and you get to go first. Now, taking that much time off might actually cause your net worth to slip backward. But since you enjoy what you do, and since your youngest daughter is still going to be living at home for at least the next 11 years, and it’s going to take at least that long to build up your retirement and college education funds, you commit to work until you’re 68 or older, and take appropriate steps to remain healthy and vigorous. You visit an old classmate to

help step up your surgical pace, bring in a marketing coordinator to help find more cases for you to do, revise your template to see more patients per session and start looking around for another technician to accommodate expected patient volumes. The process started with personal goals, and wound up with practical tactics.

Here's another example. You're 52 years old, a higher-volume cataract surgeon, and a one-third partner in a group practice in upstate New York. After 20 years as an ophthalmologist you're finding that you just are not that interested in the profession, at the same time that you and your spouse discover a passion for scuba diving. All your kids are grown and out on their own. You run the numbers and discover that with a couple more years of hard work you'll be safely over your financial finish line, with some cushion to spare. The path ahead is clear: you announce to your partners your intent to leave in 36 months, allowing them to find a partner-track physician and arrange an orderly transition. You spend the next several vacations not only diving, but exploring possible seaside retirement communities to move to after three years have passed. You rebalance your investment portfolio for safety, even at the cost of percentile returns. And you kick your surgical efforts into high gear to capture a last bundle of retirement dollars. You find these cases by going through the charts of patients seen in the last three years who have been lost to followup due to your practice's poor recall system, and you compare the best-correct pre-operative visually acuity of your cataract patients to that of your partners, and find that you're unnecessarily delaying needed surgery.

By following this staircase approach, I find that ophthalmologists become more conscious of their real control over profits and more responsible within their practices for the success of the overall organization. That seems obvious, of course, but is rarely owned up to at the start by doctors with faltering practices who seek out advice. They see that the numbers are faltering because of market difficulties or staff deficits; they don't see at first that they could be the key to most improvements.

It's possible—and instructive—to get a little more obsessive about the math as applied to this staircase approach to career and life management. Let's imagine this:

1. An examination of your life's goals and a bit of financial planning yields the conclusion that you need another \$50,000 in net after-tax income each year to meet all of your needs.
2. After state and federal tax effects, you determine that this comes to about \$85,000 in pre-tax practice profits.
3. Your solo practice currently yields \$140 per patient visit, and you operate at a 35% profit margin. Because most of your costs are fixed, you determine that you'll enjoy a 70% profit margin on the next incremental business.
4. You run the numbers, and determine that if you see another 869 typical patients a year, you're going to make just over your \$85,000 pre-tax profit goal.
5. You currently work 49 weeks a year, and see patients 4 days a week. This means you need to see an average of 4.4 extra patients a day, or about 18 patients a week. You change the appointment template accordingly, and give yourself a pay raise in five easy steps. (Or maybe six, if you're stumped on WHERE those extra 869 patients a year are going to come from.)

The same math obviously works in reverse, if you decide that to meet your personal goals you need more free time, not more income.

As I described in the book CashFlow, the math of sustaining practice profits in a falling fee environment works better when you try to increase income rather than decrease expenses. Let's say you see an average of 35 patients per day, 3½ days a week, 48 weeks a year, and have an

average ticket of \$150 per patient visit...and run a practice with a 60% overhead. You'll make about \$350,000 a year. With this common scenario, if there's a net fee reduction of just 5%, and all expenses stay the same, you'll be taking a 12% pay cut. If expenses also go up at the typical 3%, you'll take a 17% net pay cut in one year alone.

To make up for these impacts, you would need to see about another 7% more patients, or 2½ patients per day. This productivity gain is a lot more likely to be accomplished than the 8% cost savings it would take to yield the same profit restoration. Getting rid of 8% of your costs in a single year would be equivalent to lopping off one full-time staff member in a solo practice, or nearly all of the marketing or facility costs. You simply can't keep that up year-on-year. The best, most practical, reasonably sustainable way to slay the fee reduction dragon is with increased personal productivity.

* * *

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 detail rep or stockbroker. 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.

Many 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 or stock car racing.

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 percentage of doctors are hampered 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 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 doing so. 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 at the clinical tasks 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 trained and supervised lay staff member will free up time for you to either serve additional patients, or spend more quality time with the patients you have.

I've had a number of clients through the years who arrive on-time, even early to surgery, but who are chronically late to clinic. Of course, this is a vicious cycle, because if you arrive late, you tend to spend more time with patients to make an apology for your tardiness, which makes you run

even farther behind as the session proceeds. This can be a signal that your clinic life is no longer satisfying, which can have several causes. You may simply be bored with routine clinical work—get techs, optometrists and junior associates to handle this for you. You may no longer enjoy your colleagues or your office manager—work on improving these relationships, or replacing any offending parties. In the last decade, a major source of lost passion has been falling fees—the only solution to this is to come to terms with the new reality, and to become efficient and productive enough to off-set the difference.

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 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.

In a group practice, it's extremely helpful for the providers to formally chart out the agreed care pathways for the most common presenting conditions. This can have several benefits:

- By sharing each other's approaches to working up and treating patients, you'll find subtle—even major—differences. If you can agree on the one best way, you'll improve care. And even if you don't agree on everything, by discussing your differences, you'll increase doctor-to-doctor respect in the practice.
- You may find that different clinical approaches not only have different clinical outcomes, but different coding or other financial outcomes. An examination of these differences may lead you to opportunities for greater profitability, which should be pursued so long as they don't adversely impact the quality of care or lead to compliance irregularities.
- Support staff, and particularly technical staff, will become much more effective if the doctors in a group are on the same page with care pathways, and staff are not forced to memorize conflicting work-up or testing protocols.

Here's another way that doctors kill their own clinics: They disengage from the details of the practice. They don't come to staff meetings. They don't participate in staff training or the preparation of training materials. Remarkably, when they complain about the quality of their technical staff, and I ask, "How often do you observe your techs during their patient work-ups?" the answer is commonly, "Gosh, I've never done that." Practices don't work well when the lay staff whirl in one orbit, and the doctor are on a different planet altogether. Owning a practice and being a kind of "parent" to your team, is a little like not spending enough time with your kids at home—they'll both suffer from your neglect.

You don't have to figure this out on your own. Ask your staff often, formally during meetings and informally in the hall: "What could I be doing more, less or differently to do a better job here? What would you like me to start doing? Stop doing? Continue doing?" And then listen carefully to their answers. They may simply ask you to complete the superbills faster and with more accuracy. They may want you to teach them how to save time in refracting, which will only help the team. And be sure to pay them back for their honest answers. As the great American

humorist Will Rogers said, “As long as you live, you’ll never find a method as effective in getting through to another person as making that person feel important.”

Be sure to guard yourself from inadvertent “shoplifters” of your time. These are staff who seek to ingratiate themselves with you through fun but irrelevant banter on the clinic floor when you’re trying to get down the hall to see the next patient. Drug and equipment reps, without appropriate boundaries on their interruptions, can rob you of precious time...appoint such visits during non-productive time (before and after clinic and surgery, during lunch hours) or delegate your administrator or head tech to screen all but the most essential visits.

Another time thief is the patient who always has one more question to ask. If you’re not immune to this, it helps to have a scribe in the room, and then when the last question is asked, bow out gracefully, saying, “You know, that’s a great question—Margaret here will tell you all about that, and we have a brochure you can read.” As Dr. Shields presents in his excellent chapter in Section II, you may find it helpful to employ a countdown timer as an external source of discipline. Or to nominate one of your staff as a kind of human alarm clock, to substitute for any time discipline you may lack. External discipline can take lots of other forms. In bottom line terms, it may pay to apply novel tactics to help you shift gears and stay on time.

At the same time, be sure to cut yourself appropriate slack. If your patients are older, sicker, slower, fatter or less conversant in English than average, your practice may have an irreducibly lagging tempo that you’ll have to live with. You may find that there’s no substitute for adding a few hours to each work week if you want to increase practice success.

Some doctor-driven 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 to 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 money, 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, sleep and exercise regimes...and they’re not afraid to go see the doctor when they’re the ones who need healing.

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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