

Increasing Office Throughput In Physician-Only Practices: Experiences of a Model Practice

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Abstract: This physician-only model practice has physicians who earn between 1.5 and 2.5 times the national average for comprehensive ophthalmologists while taking 6 to 12 weeks off annually and maintaining a near 40 hour workweek. This is accomplished through the use of very simple office processes that minimize the need for coordination and optimize time and motion principles facilitating patient flow through the office. The practice also benefits from investing in staff training and by paying its staff well. This results in a flexible labor pool with minimal turnover that is very effective and has low aggregate costs despite that fact that individual staff members are well paid.

I. MARKET AND PRACTICE DESCRIPTION

There are some highly efficient and productive comprehensive ophthalmic practices that do not utilize ophthalmic technicians or optometrists to assist in examining their patients. While these practices typically see fewer patients per day and have lower surgical volumes, they benefit from lower practice overhead expenses. Such operations are often solo practitioners in very competitive, large urban areas with high labor costs and rents. Other examples of this type of practice are those that lack the patient volume needed to justify clinical assistance such as new practices and practices whose partners are nearing retirement. Patient socioeconomic levels or managed care penetration have minimal impact on the effectiveness of this practice model.

As a case study, this is a group of four comprehensive ophthalmologists with a highly efficient and productive practice who do not use technicians or optometrists. Approximately 11% of the population in the practice's area is over 65 and the population has a very diverse racial and ethnic mix. The area also has a high level of managed care penetration. Their patient mix is 45-50% traditional Medicare, 20-25% managed care and 5-8% Medicaid.

The practice was started in 1946. The practice focus is comprehensive ophthalmology with emphasis on cataract surgery and oculoplastics. The practice does no refractive surgery and does not co-manage with optometrists. The group refers to sub-specialists for all glaucoma filtering procedures and retina cases requiring further evaluation and treatment. Only one of the ophthalmologists fits contact lenses. They have an optical dispensary which sells 150-200 glasses per month.

They have one technician for the whole practice who only performs diagnostic tests (automated perimetry, OCT and IOL calculations). In addition, the office has an office manager, three receptionists, three billers, one surgery scheduler and a part-time clerk for a total of nine plus employees (2.35 FTE employees/MD). There are no scribes or other technicians. Their optical dispensary employs two licensed opticians and is run as a separate business entity. The office is approximately 3600 square feet with six fully equipped examination rooms (no work-up lane) and optical dispensary. It is located in an ophthalmology only medical office building with four other offices of ophthalmic sub-specialists and next to their physician-owned ophthalmic ambulatory surgery center. These buildings are across the street from a large hospital.

II. WHY IS THIS A MODEL PRACTICE?

The busier physicians in the practice average six to seven patients per hour including one to two refractions. These are the more senior partners with more glaucoma and established patients who generally require less exam time. Usually two comprehensive office visits and four shorter visits are scheduled each hour. The other physicians average four to five patients per hour. Each physician uses two exam rooms and there is a maximum of three doctors in the office each day. The surgical volume (mostly cataracts, oculoplastics and non-refractive lasers) varies from 275 to 625 cases **per doctor** annually. Each physician works three full days (8am to 4:30-5pm) in the office with 30 minutes for lunch and $\frac{1}{2}$ to $\frac{3}{4}$ day in surgery (depending on volume) per week. Physicians take 6-12 weeks of vacation and educational leave annually. Despite working less than 4 days a week, physician net incomes are 1.5 to 2.5 times the national average for general ophthalmologists. An analysis of RVUs¹ per hour for one physician in the group showed that the physician was generating 7.6 RVUs per hour.

III. PATIENT FLOW DESCRIPTION: WHAT WORKS WELL

The office layout and flow maximizes time-motion principles with minimal distances from waiting room(s) to reception desk to exam rooms and back. In fact, the physicians typically call the patient from the waiting room to the exam room themselves. The physician directs the patient into the open exam room and then goes into the other exam room where there is a patient waiting. The ophthalmologist takes the history, examines the patient including refraction (no auto-refractor) and records the findings in the medical record. The physician describes the clinical findings to the patient during each step of the examination to reduce the time needed for post exam discussion. After the exam, the patient is escorted by the physician to the reception desk to schedule any necessary follow-up. A form (includes charges, diagnosis, follow-up appointment and tests) that the physician fills out during the exam is given to staff at the reception desk

and facilitates an efficient hand off. The physician then calls the next patient from the waiting room and the process repeats itself.

The office utilizes many color-coded check-off forms (e.g., exams, referral letters, surgery scheduling, prescriptions, operative reports, etc.) to maximize efficiencies. The practice has looked at three electronic health record programs, but found them to be slow, cumbersome and not cost-effective at this time. However, they are planning to upgrade their practice management software and add computer terminals in each exam room to facilitate prescription refills and billing activities.

The physicians are working at a fairly fast pace but are not exhausted at the end of the day. The two senior physicians (ages 62 and 68) continue to enjoy the practice and wish to continue working into their seventies, but with less surgery and more time off. The two younger physicians (ages 32 and 38) are very pleased with the growth of their practices and incomes.

Some things that enhance patient flow and productivity:

1. Using color-coded check-off forms for exams, referral letters, surgery scheduling, prescriptions, operative reports, etc.
2. Keeping the optical dispensary, office and phones open during lunch by staggering the lunch breaks of receptionists and opticians.
3. Training the employees to multitask.
4. Having the physicians step outside the lane to take outside patient calls even though they are with patients because this eliminates “phone tag” when they try to reach them later.
5. Having the physician describe the clinical findings to the patient during each step of the exam not just at the end.
6. Designing the office layout and flow to minimize the distances from waiting room to reception desk to exam room and back.
7. Using the AAO patient education pamphlets and videos to convey information to patients.
8. Writing all the drug prescriptions for your glaucoma patients at their first office visit of the year.

9. Maintaining a **hardworking and experienced** staff with low turnover by paying them well and providing good benefits (average length of employment of present staff is 19 years).
10. The practice rigorously analyzes investments (e.g., EHR systems, diagnostic equipment, additional personnel) to ensure that reasonable financial and non-financial goals can be realistically achieved.

This practice model results in low labor costs (fewer employees) and maximum utilization of the office space translating into low practice overhead expenses. This practice is able to see up to seven patients per hour without the aid of technicians or optometrists. They admit that their busier physicians are “maxed out” and will need the assistance of technician/OD to see more patients and meet the future demands of the baby boomer population. Thus, the main challenges would be to find and train the ophthalmic technicians they may need in the future and create more exam rooms to accommodate them. Also, to find the “perfect” electronic medical record software that would actually enhance the efficiency of the practice rather than the opposite.

IV. CONCLUSION

There are solo and group practices that are very productive and generate high net incomes without the aid of technicians and/or optometrists. These offices are tightly managed with hardworking physicians and staff and have well designed spaces. With well organized policies and procedures in place, these practices can achieve high levels of patient satisfaction and volumes with minimal clinical assistance. However, this practice will have a difficult time seeing more patients without the physicians working more hours and/or adding technicians/optometrists and increasing the number of exam rooms.

¹. RVU analysis is for the exam codes performed in clinic only and does not include tests done by the technicians. The full 2008 RVU is used, not just the Work RVU.