

# A New Benchmark—Your “Ophthalmic Resource Utilization Score”

John B. Pinto

**“Efficiency is doing things right; effectiveness is doing the right things.”**

*Peter Drucker*

**“There can be economy only where there is efficiency.”**

*Benjamin Disraeli*

**A**s the administrator of your practice, the first line of your job description could read “Resource Allocation Authority.” What resources do you have at your command to serve your patients?

- Providers
- Lay staff
- Clinical and surgical facilities
- Technology
- Reputation
- Relationships
- Internal and external expertise
- And finally...Time (which is no longer on your side)

## Shift: From coarse thinking to granularity

In years past, you could leave a lot of your potential resources lying fallow, because profit margins were so high. Twenty years ago, when one could easily bring 50% to the bottom line in an anterior segment practice, few really cared if there was an

extra staffer at the front desk, or if we ordered so many extra medical supplies that some of them went out of date before they could be used.

In the present and soon-to-come environment, that all changes. You not only need to think coarsely in terms of “Do we have an extra worker we don’t really need?” but more granularly: “Can I send Mary home an hour early and bring \$17 to the bottom line?”

As a practice manager, you may relish this new granular accountability. Indeed, if you came from tighter sectors of the economy—retail or restaurants or hospitality—you’re probably saying, “What took ophthalmology so long to catch up?”

## Augment your benchmarking

Most of you reading this are probably already benchmarking at least a few key indicators. Perhaps you have a formal dashboard of statistics you share with your physician or board every month or quarter. Here’s a possible augmenta-

tion to the benchmarking you already perform...a gross composite core of what percentage of your key resources you are actually using. This is a simple, fast way to objectively answer the question: “Are we doing all that we can with all that we have?”

There are just three segments to this composite “Ophthalmic Resource Utilization Score” or ORUS. Taken together, these three segments are not only the most important...they are also the most costly, consuming 70% or more of every dollar you collect. Each of these three segments is couched in terms of what percentage of the maximum patient throughput it is achieving.

**Provider utilization segment.** Every ophthalmologist and optometrist has a personal capacity to see patients. I have MD clients, for example, who personally see more than 1,000 visits per month—and others who gasp at anything above 350 visits. How many patients a physician can see depends on a number of factors, but can be reduced to this simple formulary:

- A general/geriatric or corneal ophthalmic provider is at 100% of nominal capacity at 550 visits (including post-ops; not including surgery or tech-only visits) per month.
- A plastics, retinal, glaucoma, or pediatric MD provider is at 100% at 450 visits per month.

- An optometrist, in the typical mid-level provider role, can comfortably see 350 visits per month<sup>1</sup>.

Let's say your practice has one general ophthalmologist, one retinal specialist, and two ODs named Smith, Jones, Davis, and Edwards, respectively. Make a table like this:

Doctor	Average Monthly Patient Visits	Maximum Potential Monthly Patient Visits
Smith	500	550
Jones	375	450
Davis	450	350
Edwards	275	350
Total	1600	1700

Next, you can simply calculate what percent of nominal capacity your providers, as a cohort, provide by dividing their actual volume (1600) by their potential volume (1700): 94%.

**Lay staff utilization segment.** There are several ways to measure lay staff efficiency. These include

- Overall lay staff payroll hours per patient visit
- Tech, reception, or billing staff per patient visit
- Staffing costs as a percent of collections
- Annual collections per Full Time Equivalent (FTE) staffer in the practice

For the purpose of this ORUS scoring system, we'll use a quite-close proxy for overall lay staffing efficiency...the number of "man-hours" per patient visit. You calculate this simply. Determine the average monthly core lay staff payroll hours the practice pays for—this can be readily determined from most payroll report forms. Omit surgical, optical, and

contact lens staff. Divide the resulting hours by the average monthly patient visits in your practice.

In eyecare, the high-water mark for this metric is 3.0 lay staff hours per patient visit<sup>2</sup>...any higher and you are drowning in staff. A reasonable target in all segments except retina is 2.3 hours. In a pure retina practice, 2.6 hours is reasonable. In a hybrid practice, perhaps 2.5 hours. (It's interesting to know that it takes Toyota about 30 man-hours to build a car.)

So let's imagine our sample practice above (the one with 4 providers and 1600 visits per month) has 4480 lay staff payroll hours per month...that would be nearly 26 staffers (4480 divided by 173 hours in the average month). What's their efficiency score for this segment? Simple. First divide 4480 lay staff hours by 1600 visits to get 2.8 staff hours per visit. Then (realizing that this is a mixed general-retinal practice, and should have about 2.5 staff hours per visit) make the following calculation to get the efficiency percent:

- With 4480 staff hours, they should be able to see 1792 patients per month (4480 / 2.5 = 1792)
- But they actually only see 1600 visits
- So we divide 1600 by 1792, and get an efficiency percent of 89%

**Facility utilization segment.** Last, we calculate facility utilization. How should that be done? Again, we resort to indexing patient visits...this time, the relationship between exam rooms and examinations.

In the typical general practice it takes one room-hour to transit a patient visit. A practice like the one we are holding up as an example, with 1600 visits per month, requires 9.2 exam rooms (1600 visits divided by 173 hours in the average month.)

But imagine that Smith & Jones Eye actually has 12 exam rooms. How many room-hours do they have? And how do we calculate their utilization rate? Simple: 12 exam rooms times 173 hours in the average month makes for 2076 room-hours. And they really only need

1600 room-hours. So we divide 1600 by 2076 and get 77%. (Note: There is not enough facility utilization difference between general practices and subspecialty practices to worry about...we simply use the metric of one exam room hour being needed per visit.)

### Adding it up

The composite score in this example of Smith & Jones Eye is the average of the three utilization scores:

$$(94\% + 89\% + 77\%) / 3 = 87\%$$

Said another way, Smith & Jones Eye is working at about 87% of its overall potential capacity. What should they be at? That's entirely up to Smith & Jones, of course. But speaking economically, practice profitability improves the closer you can get to 100%.

Try this "ORUS Score" out in your own practice. If your score is lower than you would like, you have two options to improve...to shed capacity or boost patient visits. **AE**

### Notes

<sup>1</sup>The benchmarks cited in this article come from J. Pinto & Associates proprietary benchmarking studies performed in the course of client service. Data have been gathered longitudinally for more than 20 years and have been cited in various publications throughout that time period.

<sup>2</sup> See note 1.



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