## Addressing the Profession's

# Unsolved Problems and Mysteries

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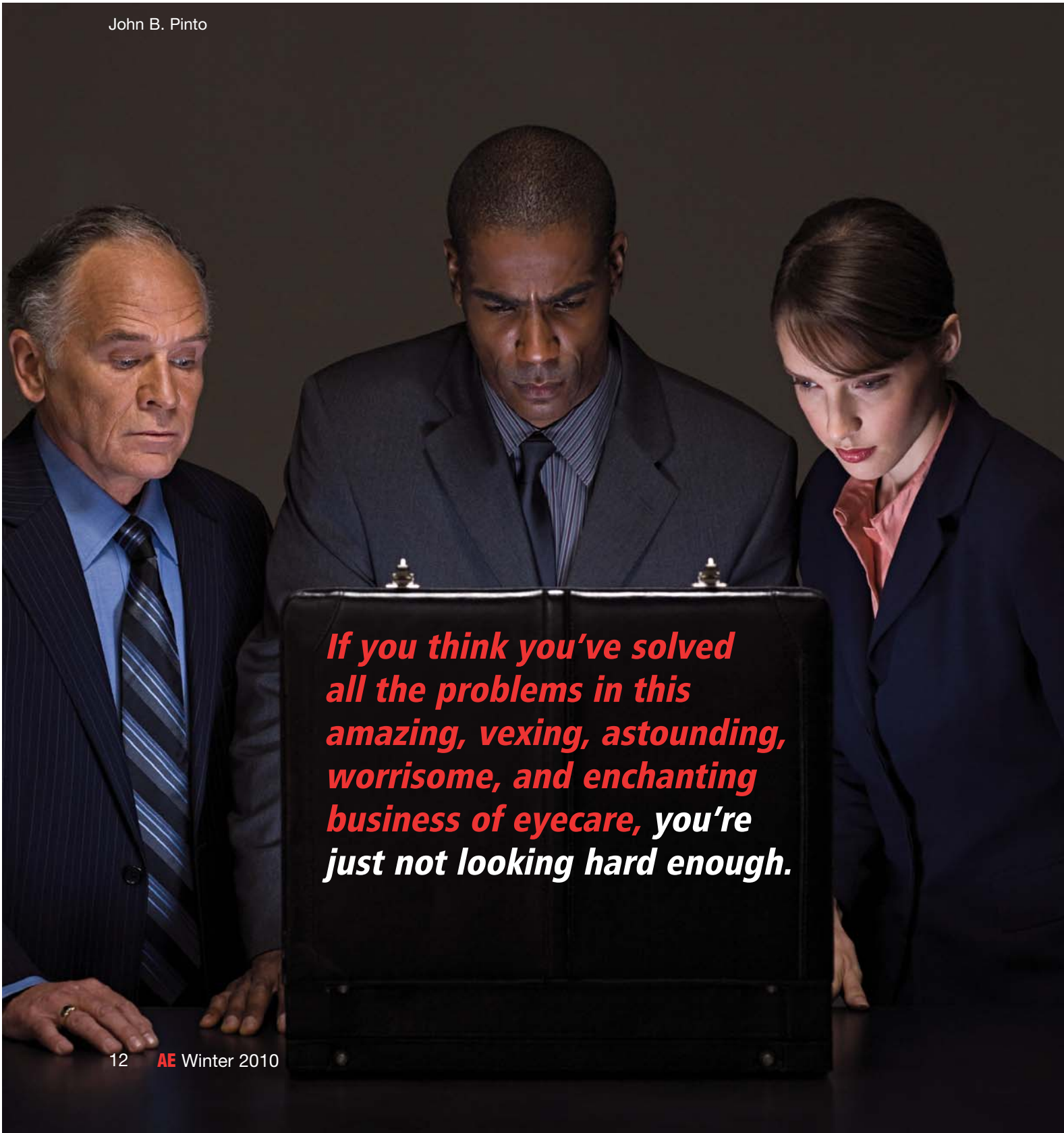

Any administrator reading this issue's column is guaranteed at least one chuckle. Two if you're paying attention.

I was called the other day by a senior-level manager—one of your peers—who said, after he had described his basic practice setting, "This job is getting a little boring. I've solved all of our problems. There's nothing of real importance left to do or fix. I'm starting to feel stale, just plodding along one day after another. What should I do?"

My glib answer? Try to find a time machine. Go back in history and see how humanity has often said, "That's it, there's nothing left to discover or invent."

Here's one of the first places you could go in your time-travel machine. It's 1843, Washington, D.C. The commissioner of the Patent Office, Henry L. Ellsworth, is reporting to Congress and says, "The advancement of the arts, from year to year, taxes our credulity and seems to presage the arrival of that period when human improvement must end."

Thankfully, we're not nearly finished trying to figure out how to run even the smallest ophthalmology practices, much less the big ones. Your career as an administrator is safe. Here are seven major problems we are going to have to figure out, either in the four walls of your personal practice or collaborating as a profession-at-large.

**Can we break the "$50 Speed Barrier?"** When you add up all practice expenses (before doctor wages and the cost of goods sold) and divide by the number of patient visits, it takes about $70 to $90 in the typical general ophthalmology practice to transit a single encounter. That works out swell when the average revenue yield per patient visit is $150 or more—the typical figure today. But as we look down the road to potentially lower fees, we have to learn how to transit more patients with a finite basket of costly resources, while continuing to add more self-paid value to patients and more revenue to the top line of the practice.

**How can we fairly, objectively measure and communicate our individual or institutional outcomes for cataract surgery?** How can we do so in a way that allows our surgeons to learn and make faster improvements in care, so that our patients and payers choose *our* surgeons over others who are less skilled? Pro ball players have collectable cards with all of their stats: runs, hits, errors, batting averages. What would you put on your doctors' "surgeon cards"?

**How far can we go in rationally apportioning patient care work between clerks, techs, optometrists, and ophthalmologists?** When I ask the average eye surgeon what portion of the work is spent doing optometric-level care, the answer is typically, "One-third." You get the same answer when you ask optometrists how much tech-level work they do or techs how much clerical work they do. These answers are not good for either professional satisfaction or economic efficiency. We should learn how to do better today, and we MUST learn how to do so in the future.

**The perfect provider compensation model has yet to be derived.** Or the perfect practice valuation formulary. Or the perfect buy-in and buy-out model. Or the perfect associate provider employment contract. Small flaws and wide fissures abound in almost every practice. We can do better.

**The demand for ophthalmic care is going up 5% per year.** The ranks of ophthalmology are growing about 1% per year (and many younger docs practice far less intensely than their forebears). Although we all worry about a looming revenue crisis today, the REAL crisis looming is how we're going to care for the swelling bulge of baby boomer eyecare patients. A pretty worthy problem to solve for your practice, much less your country.

**How can we make doctors happier?** Some ophthalmologists I know are depressed. An even larger number don't enjoy the level of happiness one might expect to find in such accomplished, successful people. A psychologist colleague, Dr. Craig Piso, and I just finished a study of surgeon happiness (full results will be shared and discussed at the 2010 ASOA meeting in Boston). Not surprisingly, one of the most profound correlates to happiness involves money, but not *how much* you make. The happiest doctors appear to be those who are either well-disciplined enough or well-counseled enough to live on a smaller percentage of what they make. Help your doctors figure that one out, and everybody wins.

**How big should your practice get?** There are well-recognized economies of scale when your solo practice takes on additional doctors. But this breaks down—and can become a frank diseconomy of scale—beyond about six to eight surgeons. A 20-doctor practice feels—and is—at least 10 times more complex and tough to run than a 10-doctor practice. Once you reach the roughly eight-doctor threshold, should you stop, push forward, or devolve back to a more manageable core enterprise?

As I hope this warm-up list shows, if you think you've solved all the problems in this amazing, vexing, astounding, worrisome, and enchanting business of eyecare, you're just not looking hard enough. AE

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