

What Is Your Practice's Efficiency Rating?

Larry R. Brooks, AIA, and Tim Griffin, AIA

Practices are always comparing themselves to other practices through national benchmarks, using that comparison as a barometer of how they are performing. Although national benchmarks and comparisons to other practices have their place, they shouldn't be looked at as the sole de-

terminant of how well a practice is operating.

No two practices are the same, nor are the patient populations that they serve. Different doctors prefer different ways to practice medicine; different doctors have different levels of access to varying resources. Look at the doctors within your own group. More

than likely they do not all see patients the same or see patients at the same rate.

We were in a practice recently discussing patient volumes and numbers of lanes. One doctor commented, "Dr. X in a different practice has a busy practice and we have more lanes than he does." The question I had for him is this: What is "busy"? Is a 40-patient, half-day session "busy"? That depends on the doctor and the resources that doctor uses. This doctor thought that because Dr. X *seemed* busy, that doctor was seeing more patients than he was seeing. But looking busy is not always equal to being busy or handling higher patient volumes.

So how do you know how well you are doing? Base your answer on how well the doctors use their time for seeing patients. Determine an efficiency rating that can be compared to other doctors. The efficiency rating is based on the amount of time the doctor spends effectively practicing medicine, meaning performing functions that only the doctor can do for the patient, versus the overall time he/she is in the practice seeing patients. Two doctors with an efficiency rating of 90% may see a different number of patients; the goal is not to get all doctors

Dr. Birdie			
Task	Timing		Total
	Start time	End time	
Find next patient	8:25:30 AM	8:26:00 AM	0:00:30
Review medical record	8:26:00 AM	8:28:23 AM	0:02:23
Exam - Patient 1	8:28:23 AM	8:35:59 AM	0:07:36
Look for staff to get information	8:35:59 AM	8:37:14 AM	0:01:15
Exam - Patient 1	8:37:14 AM	8:39:19 AM	0:02:05
Dictate note/ mark encounter form	8:39:19 AM	8:40:42 AM	0:01:23
Walk	8:40:42 AM	8:41:05 AM	0:00:23
Talk in hall w/ patient leaving	8:41:05 AM	8:41:58 AM	0:00:53
No patient ready	8:41:58 AM	8:45:20 AM	0:03:22

Figure 1

Dr. Birdie						
Task	Timing		Distribution			Total
	Start time	End time	Practice	Staff	Lost	
Find next patient	8:25:30 AM	8:26:00 AM		0:00:30		0:00:30
Review medical record	8:26:00 AM	8:28:23 AM	0:02:23			0:02:23
Exam - Patient 1	8:28:23 AM	8:35:59 AM	0:07:36			0:07:36
Look for staff to get information	8:35:59 AM	8:37:14 AM		0:01:15		0:01:15
Exam - Patient 1	8:37:14 AM	8:39:19 AM	0:02:05			0:02:05
Dictate note/ mark encounter form	8:39:19 AM	8:40:42 AM	0:01:23			0:01:23
Walk	8:40:42 AM	8:41:05 AM			0:00:23	0:00:23
Talk in hall w/ patient leaving	8:41:05 AM	8:41:58 AM			0:00:53	0:00:53
No patient ready	8:41:58 AM	8:45:20 AM			0:03:22	0:03:22

Figure 2

Practice Watch Study Summary

Doctor	Timing		Distribution			Total Time	Efficiency %
	Start time	End time	Practice	Staff	Lost		
Dr. Birdie	8:10:00 AM	12:08:00 PM	3:22:18	0:24:59	0:10:43	3:58:00	85.00%
Dr. Eaglin	8:05:00 AM	11:52:00 AM	3:28:50	0:12:43	0:05:27	3:47:00	92.00%
Dr. Par	8:18:00 AM	12:25:00 PM	2:47:58	0:31:37	0:47:25	4:07:00	68.00%
Dr. Bogey	1:44:00 PM	6:33:00 PM	2:01:23	0:50:17	1:57:20	4:49:00	47.00%
Percentage of Total Time			69.98%	11.95%	18.07%	100.00%	

Figure 3

The efficiency rating is based on the amount of time the doctor spends effectively practicing medicine, meaning performing functions that only the doctor can do for the patient, versus the overall time s/he is in the practice seeing patients.

to see the same number of patients, but to utilize their time as wisely as possible.

To develop such a rating requires observing as the doctor sees patients and time-tracking every task s/he performs. Make a record of tasks, the duration of the tasks, and the number of patients seen during the timings. This should be done over several hours to get a good sampling of patient types and enough data to understand how the doctor's time is being consumed. Figure 1 is a sample of a study we performed using proprietary timing software.

The sampling in Figure 1, approximately 20 minutes of a doctor's day, illustrates the tasks or events that occurred during a patient visit. Some of these events require a doctor, some do not. It is those things that do not that lower the doctor's efficiency rating, leaving him/her with less time to care for patients.

Once these data are gathered, the next step is to categorize the events. Three categories we use are **Practice**, **Staff**, and **Lost**, defined as follows:

Practice—Events that **only the doctor** can or should do for the patient. Events consuming the doctor's time that would be included in this category are things such as

- Performing the exam

- Reviewing the medical record
- Taking calls from other doctors

Staff—These events **do not require the doctor**; they can be delegated to support staff or technology, but the doctor is performing them. These would be such things as

- Noting the chart (which could be done by a scribe)
- Searching for a next patient (which efficient communication systems would eliminate)
- Getting samples
- Retrieving equipment

Lost—These events generate **no benefit** to the patient or practice. Events that would be included in this category include

- Not having a patient ready to see
- Escorting a patient out
- Long walks to and from remote lanes/procedure/diagnostic rooms
- Being caught by patients/ reps/ staff in the hall for non-patient-related issues

As mentioned previously, no two doctors or practices are alike. Some practices will consider certain events **Practice** while other practices will consider them **Staff**. Getting samples is an example; some of our physician clients believe this is a portion of the visit they *must* perform. They have a myriad of reasons why they must give out the sample, and we do not believe

it is up to anyone who is not a doctor to tell doctors how they should practice medicine. We do, however, think consultants and administrators should educate the doctors on how much of their time is being consumed on these events so they can decide whether or not they want to continue engaging in these events.

To show your doctors how their time is being consumed, gather the timing information and put it into a spreadsheet format (Figure 2).

The chart now contains the three **Practice**, **Staff**, and **Lost** categories and the time allocated appropriately. Once the allocation of time has been finalized with input from you, your staff, and the doctor, an efficiency rating for the doctor can be developed (divide "practice time" by "total time"). Figure 3 is an example of an assessment for a four-doctor group.

This Practice Watch Study Summary illustrates that the doctors in this practice range from 42% to 92% efficient in the use of their time. The overall practice efficiency rating is 69.98%.

Note that the chart has nothing to do with how long the doctors spend with the patient practicing medicine or the number of patients they see; instead, it shows events that are consuming their time that do not require the doctor's training, knowledge, and experience. The amount of time the doctor believes s/he needs to handle a patient visit is up to the doctor. What the efficiency percentages above indicate is only how well each doctor utilizes time spent seeing patients. As a consultant or administrator, that is all that you can demonstrate.

continued on page 59

Especially in these times of creative revenue generation, even an extra \$20,000 to \$40,000 per year in refraction collections is well worth the time it takes to implement a solid and consistent collections policy.

plaining that they are getting ready to refract the patient and why that refraction is important to the patient's care. Upon check-out, patients again hear from our patient registration specialist about how they received a special test that day and why we need to collect for that refraction upon leaving the clinic. For the most part, this three-step approach works well and we receive very few complaints. Granted, we refined this process over time—in the beginning we quietly had patients sign the consent form with no further explanation, then had to deal with the frustrated phone calls later. The multi-step communication approach has worked well in decreasing confusion and easing the minds of those left paying for refractions out-of-pocket.

Best Practice #2: Develop a Collections Policy

Suppose your communication strategy is in place. What is your practice's refraction collections policy? This gets even trickier as every office will develop a policy based on the individual nuances within its own patient base. Again, I can only share what is working well within our practice, but our chosen policies are supported by research about best practices from around the country.

For starters, we collect for refractions at the time of service for all Medicare patients. Since Medicare universally denies coverage for refractions, this one is pretty much a "gimme." For our commercially covered patients, we explored a few different approaches and finally determined that the method resulting in the fewest insurance refunds and the

highest collections rate is to bill refraction charges directly to the patient's commercial carrier. Some commercial payers cover refractions, some don't, and some appear to decide coverage depending on what day of the week it is. If the plan does not cover the refraction, the cost is then billed to the patient. Although charge amounts can vary from practice to practice, the Centers for Medicare and Medicaid Services (CMS) does assign a value to CPT 92015 of approximately \$56 (2007).

This value continues to fluctuate from year to year, but practices can feel comfortable using CMS guidelines to justify charges that are comparable to other practices within their geographic areas. Commercial plans covering refractions will already have a set allowable fee, so individual practice contracts should be reviewed to determine what those payment

continued from page 57

This same type of time study can be performed on all staff who handle patients during their visit, such as receptionists, technicians, surgery schedulers, and check-out staff. Performing this type of study on these positions will not only help you to realize how their time is being consumed, but also to identify reasons for logjams in the movement of patients through your facility—which ties back to doctors having no patient ready to examine, which, as we've already seen, detracts from having an efficient practice. **AE**

amounts will be.

For those patients having both a primary and secondary insurance plan we let the primary plan establish which route we'll take. If the primary plan is Medicare, we collect for the refraction at time of service, as a lot of secondaries will follow the primary plan's denial. For these patients we do, however, still submit the refraction code to both Medicare and the commercial secondary so the denial (or payment for that matter) is a part of the patient's billing record. In the rare instances these plans actually pay for a refraction when we had previously collected payment from the patient, we simply refund the patient and call it a day.

Whether your office collects for refractions up front, submits all charges to insurance, or adopts a hybrid approach, charging and collecting for refractions should become commonplace within your practice. Especially in these times of creative revenue generation, even an extra \$20,000 to \$40,000 per year in refraction collections is well worth the time it takes to implement a solid and consistent collections policy. **AE**



Ashlie Lefko, MBA (843-797-3676; alefko@carolinacataract.com), supervises business operations at Carolina Cataract & Laser Center, Ladson, S.C.



Larry Brooks and Tim Griffin, architects and co-founders of Practice Flow Solutions (678-935-7911; help@PracticeFlowSolutions.com), specialize in improving flow patterns and the productivity of medical practices.