

You're Wasting Your Time

Increasing efficiency in the refractive practice.

BY SHAREEF MAHDAVI



Most of what has been written on refractive surgery has focused on making the practice (surgeon, staff, marketing) more effective. Given the size of refractive surgery's opportunity and the relatively low penetration thus far relative to the market's potential, focusing on effectiveness makes sense. That is, we need to explore ways to make refractive surgery more attractive to more of the population. Of equal value to a practice's effectiveness is the concept of practice efficiency. In a practice that focuses on improving quality in everything it does, being efficient in daily activities carries as much weight.

OF EFFICIENCY AND EFFECTIVENESS

Back in the 1920s, the concept of efficiency entered the workplace courtesy of Frederick Taylor, the father of scientific management, who did the first time and motion studies for Henry Ford. Taylor's work was instrumental in helping realize mass production as the automobile company pioneered the assembly line concept for manufacturing. Thus, efficiency was born. Beginning in the 1950s, the greatest management thinker of the 20th century, Peter Drucker, helped businesses understand the difference between efficiency and effectiveness. *Efficiency*, said Drucker, was "doing things right." *Effectiveness*, by contrast, was "doing the right things." It is the combination of both that makes for the most potent managerial style and produces the best business results.

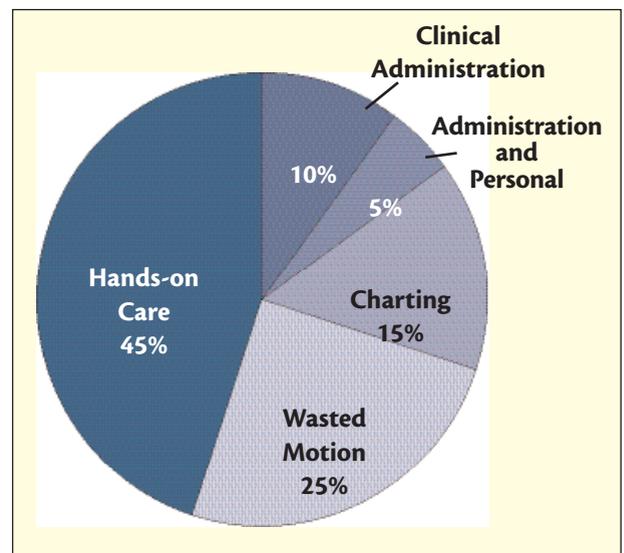
A good example of this one-two punch is the way in which Southwest Airlines assigns seats and boards passengers. Rather than the airline's preassigning specific seats, passengers check in and receive a boarding card labeled A, B, or C, and then line up to board by group. It's a highly effective approach in that it creates an incentive for passengers to arrive early for their flights (ie, doing the right things). It's highly efficient as well; Southwest's passengers board planes faster than anyone

else's, and its aircraft turnaround takes 20 minutes or less (ie, doing things right).

Also, the airline's check-in process has been the subject of continuous improvement. First came its self-check-in kiosks, which were much faster for passengers with no bags to check. Then came Internet check-in. Now, the company is working on the ability to check in from your cell phone. Each incremental improvement is guided by the principal question, "how can we make the process better and easier for our customers?"

EFFICIENCY IN THE MEDICAL PRACTICE

This same question needs to be applied to refractive (and for that matter, all ophthalmic and medical) practices, particularly when it comes to efficiency. It's a vital question because of a very simple fact that is looming over all of healthcare: as the population ages, patients' demand for services will increase. Government spending



(Courtesy of the International Council for Quality Care.)

Figure 1. Studies on time management illustrate how the average physician's time is spent each day. (Reprinted with permission from Korneluk G.¹)

on healthcare will increase, but at a much slower rate. This gap means that payment per work unit will decline, period. In order to recoup these losses, physicians will need to become more efficient.

Does increased efficiency mean a decrease in service? Not at all, according to Greg Korneluk, Chairman of the International Council for Quality Care (ICQC) and author of the book, *Physician Success Secrets: How the Best Get Better*¹ (available at www.physicianstrategycollege.com). Korneluk sees a golden opportunity for physicians who focus on improving their entire system so that quality gets better at the point of service between provider and patient. Contrary to popular notions, efficiency means spending more time delivering care, not less. According to research by the International Council for Quality Care, the typical doctor spends less than half his time on hands-on care with patients. As Figure 1 shows, fully one-fourth of a doctor's time is spent on wasted motion that adds no value to the practice or the patient's experience. Korneluk's data indicate that 18.5 minutes per hour are wasted. That's 1.5 hours per day!

What does wasted time mean to you? A small but powerful example can be found in the simple act of washing hands between patients. Turning the faucet on and off takes 3 seconds. With a primary doctor's time valued at \$180 to \$200 per hour (much higher for surgeons), at 20 patients per day and \$3 per minute, that translates to \$72,000 over a 30-year career. How do you remedy this? Save \$72,000 by installing a \$240 automatic faucet that turns on once you put your hands beneath it. Yes, it's three times more expensive than the \$80 one with handles, but the return on investment is there ... all day long.

The opportunity for improvement is even more significant for those physicians who offer self-pay or private-pay procedures, as do refractive (and now, cataract) surgeons. Self-pay procedures create the opportunity for practices to become less dependent on the system by shifting the mix of revenue away from third-party payors in favor of direct payment from your patients, who become your customers as well as recipients of your care. At the same time, these types of procedures require physicians to improve their levels of service to become competitive with real-world purchases vying for that same discretionary income (eg, Hawaiian vacation, kitchen remodeling, etc).

A peek into any refractive practice affords ample opportunity to examine efficiency (or the lack of it) in action. The number and layout of examination rooms, the number and type of staff, and patient scheduling are three major determinants of efficiency. Korneluk believes many physicians mistakenly minimize their

investment in this area, confusing saving money with being more efficient (see the earlier example on the faucet). Actually, physicians become less efficient by doing tasks that they should delegate and behaving redundantly in areas such as dictation and charting. Korneluk strongly advocates a return to a pod system, which creates a team for each physician that includes the doctor, a nurse, and an administrator and has its own dedicated phones and charts. Prime examples of how to increase efficiency (and service to your patients) can be found in staffing (hiring an additional nurse or technician) and space (using four to five examination rooms per doctor, not three). The leverage that can be attained here in achieving higher levels of revenue and net income (as well as increased staff and customer satisfaction) have been well documented and, especially for refractive surgeons, cannot be overstated.

TAKING STOCK

In the context of Drucker's definitions, doing things right in the refractive practice should be a clearly stated priority. As the head of the practice, the surgeon must establish an environment that allows for the highest level of quality at the point of service between provider (doctor/staff) and patient (customer). How many of you can say you're doing things right and doing the right things in your practice? Equally important, how do you know?

When you reflect on your typical day in the clinic or surgical suite, you can begin to visualize areas where you can improve efficiency: dictation, chart review, patient scheduling, callbacks, visits from sales representatives ... the list goes on. I hope that you will pause, reflect, and even start to keep track of those wasted moments that keep you busy but not productive. Feedback from some of you who have already read Korneluk's book has been overwhelmingly positive. I highly recommend *Physician Success Secrets* as a resource for any physician who is serious about improving the quality of his practice. Reading it is definitely a good investment of your time! ■

Shareef Mahdavi of SM² Consulting (Pleasanton, CA) offers more than 20 years of experience to help improve the marketing efforts of medical device manufacturers and providers. He may be reached via his Web site, www.sm2consulting.com.

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1. Korneluk G. *Physician Success Secrets: How the Best Get Better*. International Council for Quality Care: Boca Raton, FL; 2004.