Creating Headroom for Growth

Cost cutting is not always the best answer.

BY SHAREEF MAHDAVI

Quick—what's the eight-letter name of the monster haunting most physicians? If you guessed o-v-e-r-h-e-a-d, you're right. Typically, overhead is described similarly to a sci-fi monster: it shows up at the worst times, is difficult to control, and never goes away. Strategies for taming this beast were not included on your MCATs or found anywhere during your residency. Instead, most doctors get on-the-job training for controlling overhead and quickly become frustrated about what approach is best. After long struggles, that frustration often becomes resignation in the form of cost cutting.

Cost cutting becomes a perpetual game of trying to minimize overhead. Sometimes this method is appropriate, but not always. Although the pressure of keeping costs under control is ever present, cutting past the fat and into muscle tissue is a recipe for disaster. If taken too far, cutting costs will hamper your ability to provide responsive and timely service to your patients.

WHERE DO YOU STAND?

I assume that you are collecting financial data and monitoring your fixed expenses as a percentage of your practice's revenue. If not, you are at significant risk for a financial meltdown, and you need to institute a system to track and monitor this ratio. For most medical practices, 50% to 60% of collections is a good benchmark for overhead. In ophthalmic surgical practices, this percentage tends to be a little higher, depending on their geography and amount of on-site surgical equipment. If you have a handle on your overhead percentage, please read on. If not, please put this down and call your accountant.

Most physicians take the negative approach to overhead: they strive to reduce costs as a means of lowering their ratio of expenses to revenue. Another means of decreasin overhead is to increase revenue. Those of you who closely watch overhead know that your ratio is affected more by changes in revenue than by individual cost items. So, which is the more effective approach?

STRUCTURING OVERHEAD

A Means, Not an End

First, it helps to think of overhead differently. As professed by practice management authority Greg Korneluk, Chairman of the International Council for Quality Care (ICQC; Boca Raton, FL), "overhead is the means to providing value, not an end." This distinction is important because it helps you think of overhead as an *investment* rather than an *expense*. This redefinition should help you move away from resignation and toward proactive action in how you approach and manage overhead.

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In a medical practice, overhead should be used to maximize your time. (That's a far cry from viewing overhead as something that should always be reduced.) Staff, space, and equipment all have a singular purpose: to maximize the doctor's productivity. Korneluk says it so well in his book, *Physician Success Secrets: How the Best Get Better*,[1] that I deem it a golden rule: *Every nickel that's spent in your practice should relate to improving your productivity and that of your staff.*

At Nordstrom department stores, a perennial example of business management, there are only two kinds of employees: those who serve the customer and those who support those on the "front line." You should apply a similar rule to your practice's expenses: "Does this cost help us directly improve quality at the point of service, or does it help support the delivery of that quality?" If the item does not satisfy either objective, you should

seriously question adding it to your overhead.

In addition to equipment, this rule may be applied to staff and space, which are often the two biggest line items in the fixed-expense portion of a practice's budget. Again, physicians' typical knee-jerk reaction is to reduce staff and space to save costs. The ICQC has collected sufficient data to show that the long-taught mantra of starting out with three examination rooms and one nurse causes the doctor to "hit the wall" at 18 patients. Adding a fourth room means increasing capacity for the doctor by 33%, and adding one technician or nurse allows him more time to use that space. The operational leverage (an MBA term that means creating incremental revenue and income) is significant, especially for the ophthalmic practice, which has an increasing array of self-pay services available to patients. However, it requires the careful monitoring of costs and an open mind as to how to control them. If this solution is so obvious, then why is it not routinely taught to doctors during residency?

The Korneluk Concept

Korneluk teaches a more advanced concept of cost structuring that has to do with the intraday variability in overhead. As Figure 1 shows, most businesspeople are conditioned to think of overhead as a fixed percentage for the quarter or year, shown at 55%. In reality, your overhead rate starts out each day extremely high and comes down every hour that patients are seen and revenue is booked. At 8:00 AM, overhead is more like 200% of revenue. Sometime during the afternoon (let's select 4:00 PM), overhead is covered and drops to 5% of revenue. This structure represents the variable cost of treating each additional patient once fixed expenses are met. Therefore, from 4:00 PM on, your profit margin increases to 95% of revenue!

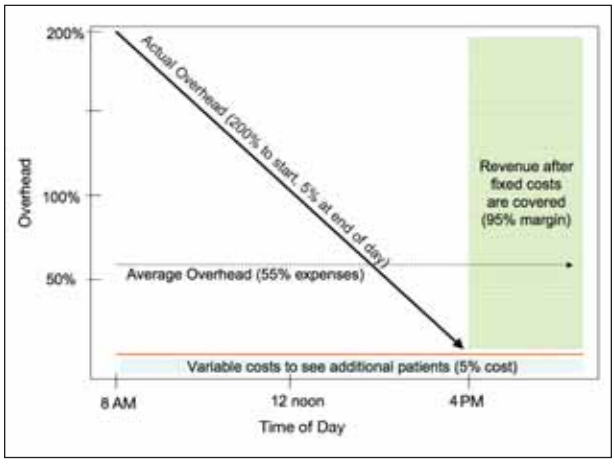

Figure 1. Most practices tend to view overhead as a fixed cost that remains constant throughout the day. In reality, overhead starts out very high in the morning and comes down every hour as patient revenue is booked. A modern approach to overhead would strive to increase revenue later in the day, when fixed costs have been covered and incremental revenue generates higher margins to the practice. (Concept adapted from the International Council for Quality Care.)

This concept is closer to reality than is calculating your average overhead during a month, quarter, or year. It should be motivation enough to re-examine how you have structured your staff's bonuses. Are their incentives aligned to increase productivity using the modern view of overhead as described by Korneluk, or are they married to the traditional view? Steven Leavitt and Stephen Dubner, authors of *Freakonomics: A Rogue Economist Explores the Hidden Side of Everything,*[2] demonstrate in their book that just about everyone in society responds to incentives. Workers in an ophthalmic practice are no exception. In the traditional view of overhead, staff members often respond to scheduling gaps in ways that counteract productivity and magically create their own bonus system. A missed appointment becomes time for a coffee break. A light schedule means closing the office early that day. A late-afternoon telephone caller is told there's no available appointment that day. Such staff responses change dramatically in a system where everyone is rewarded for maximizing productivity each day and everyone shares in the success when revenue reaches into the 95% margin arena.

CREATING MORE HEADROOM

Next month, I will continue this topic and discuss how to be smarter when hiring staff, planning space, and improving systems that give you and your practice the headroom to grow. In the meantime, to those of you who want advice in this area, I recommend the 2-day Physician Strategy College that the ICQC offers each month (a schedule is available at http://www.physicianstrategycollege.com). The ICQC's novel approach to overhead is one of many new concepts you will learn to help increase the quality of your practice where it matters most—at the point of service between you and your patients. ■

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1. Korneluk, G. *Physician Success Secrets: How the Best Get Better.* Boca Raton, FL: International Council for Quality Care; 2004.
2. Levitt SD, Dubner SJ. *Freakonomics: A Rogue Economist Explores the Hidden Side of Everything.* New York, NY: HarperCollins Publishers Inc.; 2005.