Chapter Four: Selecting Appropriate Efficiency Benchmarks
and Managing to These Metrics

As the last chapter allowed you to see, there are numerous benchmarks to track efficiency; it's unlikely you're using all of them in your practice today. Nor should you—any more than you would perform the same battery of tests on every patient at every visit, which is an appropriate analogy. Managing, reduced to it's bare essentials, is just like medicine: gather the information, make decisions, and then implement. It's clearly a waste to gather reams of data each month on your practice unless the data are going to be used to make decisions and take action.

Let's first review a table with most of the potentially useful benchmarks, and then elaborate on which ones might be most useful for you to track based on your unique problems and opportunities. Please note that these benchmarks do not represent total industry averages, but performance levels that a striving practice should be able to reach with reasonable effort.

Practice Performance Benchmark	"Within Normal Limits" (All figures are for a general ophthalmology practice, except where noted)
Practice revenue growth rate (collections this year, minus collections for the prior year, divided by the collections for the prior year…eg: a practice that collected $1 million last year, and $1.1 million this year enjoyed a 10% growth rate)	3% to 5% should be the baseline goal, which means that in a slowly eroding fee environment, efficiency and productivity must materially exceed fee reductions to hit growth targets. Young and aggressive practices should aim at 10% growth rates; mature practices can do just fine with zero net revenue growth.
Practice market share (this figure is elusive, but can be crudely estimated as follows: multiply the total population of your service area by $100…divide the resulting figure into your annual collections…the figure you get, expressed as a percent, is your approximate market share. Eg: A practice in a market with 250,000 people is working in a universe of about $25 million in annual eye care spending…If this practice is generating $2.5 million in annual collections, it enjoys a 10% market share.)	This should be pro-rata or better to your share of the service area's provider base…if your practice has about 10% of the local eye doctors, you should enjoy a +/- 10% market share.
Profit margin (profits *before* any MD/DO salaries and draws, divided by total collections)	30% to 45% (can be 15% and still "normal" in an HMO-driven practice and as much as 70% in a high-volume LASIK, retinal or cataract referral center practice)
Cost per patient visit (add up total annual practice costs before all optical or contact lens costs, depreciation, MD/OD payroll, and any exceptional cost of sales such as PDT dye packs; divide by the number of patient visits per year)	$70 to $90 (you can see from this how accepting panel status with the wrong low-fee vision plans can kill profitability)
Staffing cost ratio (lay and OD staff payroll, benefits and taxes	25% to 32% (can be as low as

divided by total practice collections…in some settings, where ODs are cast more as fully-fledged practitioners than as surgeon-extenders, it can be more appropriate to count lay staff costs only…just be consistent in tracking monthly)	10% in a high-volume surgical practice and as high as 38% or more in a primary care oriented practice, or a practice in an adverse urban location)
Average lay staff costs per FTE (fully-burdened lay staff costs inclusive of wages, salaries, taxes and benefits divided by the number of FTEs)	+/-$35,000 (will be much higher in urban centers with higher average wages, and much lower in rural practices…also, some practices choose to hire a small number of top-flight staff, rather than the reverse)
Facilities cost ratio (rent or principle/interest payments, utilities, taxes and basic repairs divided by collections)	4-6% (can reasonably range to 10% or more when in a new facility that the practice is still growing into)
Patient visits per exam room hour (total patient visits for the year divided by the number of exam room-hours per year, which is calculated by taking the number of fully-equipped exam rooms times 2080 nominal hours available to see patients per year.)	0.7 to 1.1 is the typical range
Marketing cost ratio (creative, production, media, printing and other costs, but not internal marketing staff costs, divided by collections)	3-12% (rises to 20% or higher when launching new services such as elective plastics or LASIK) An old-line, established practice with no further growth aspirations can get by on 1% or 2%.
Cost per lead	Extremely wide-ranging. Global cost per lead (all marketing costs divided by all leads) should be at or under $150 for an established LASIK practice. Cost per advertised lead can approach $500 and be “normal.”
Annual collections per FTE staff member (divide collections by all non-MD FTEs)…[This can also be expressed as collections for lay staff payroll hour]	$110,000 to $130,000+ (up to twice this in retinal, LASIK and OD co-management practices). [Expressed as collections per FTE-hour, the figure is divided by 2080, with WNLs becoming $53 to $63+]
Tech efficiency ratio (tech total payroll hours divided by patient encounters)	0.6 to 0.8 (can be somewhat higher in a practice that delegates more care to lay staff, or a practice with trainees or a hub-spoke practice with lots of travel)
Reception staff efficiency ratio (check in/out staff total payroll	0.3 to 0.5 (this is highly

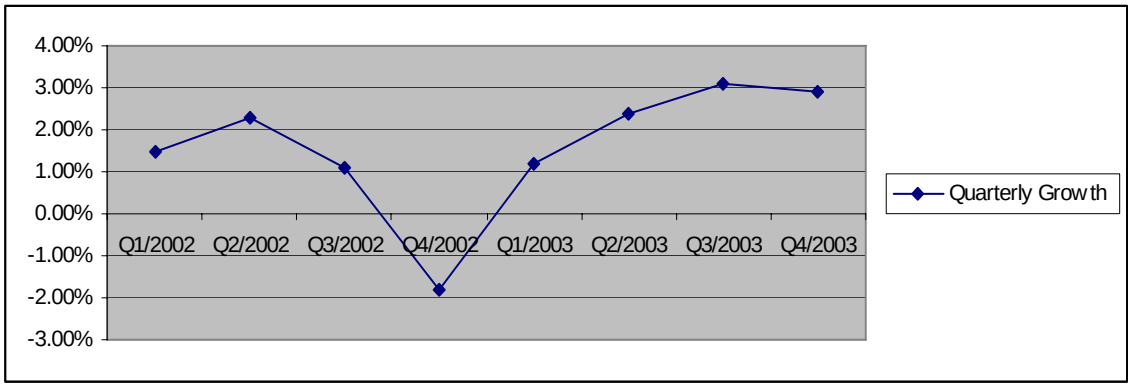
hours divided by patient encounters)	influenced by the payer mix of the practice, and where charge posting duties reside)
A/R ratio (this month's ending A/R divided by the average monthly gross unadjusted charges over the past three months)	1.3-1.8 (note that this can vary widely based on service mix, patient base, and fee schedule)
Gross collection ratio (collections divided by total charges)	50%-85% (varies depending on *both* fee schedule and accounts management efficiency)
Net collection ratio (collections divided by allowable charges)	95+%
Patient accounts staff efficiency-I: annual collections divided by department FTEs (all staff doing posting, charging, collections, etc.)	$800,000 to $1.2 million
Patient accounts staff efficiency-II: billing department payroll hours (all staff doing posting, charging, collections, etc.) divided by additive product of the total patient visits and the total surgical cases	+/- 0.3 hours
Optical sales ratio (Optical sales divided by all other medical and surgical sales, excluding any ASC revenue)	15%-25%
Optical cost of goods sold or "COGS" (frame, lens and lab costs divided by total optical sales)	30-40% (can be higher with premium stock)
Optical staff efficiency: total annual optical sales divided by number of dispensing opticians (omitting the lab staff)	$200,000+
Optical sales per patient visit	$15-60 (very dependent on the style of practice and mix of surgical vs. general care)
Collections per average patient encounter (monthly total collections divided by monthly total patient visits, inclusive of post-op visits); also referred to as the "average ticket"	$125-$175 (Can be much higher in surgically-dominated centers…can range to $450+ in retinal practices)
New patient ratio (new patients divided by total patient visits)	10%-20% Younger offices will obviously have a much higher ratio of new patients. Higher percentages than this baseline for an established practice may indicate poor continuity of care and recall protocols, which should be audited for gaps before spending on external marketing.
Patient visits per physician and optometrist per day	35-80 per physician 20-30 or more per optometrist
Patient visits per physician and optometrist per month	Optimally lies at 550+ per physician and 300+ per optometrist, but can range 10-20% lower, especially in subspecialty practices.
Percent of allotted schedule template that is filled…that is, if	100% is obviously optimal, but

in a doctor's half-day session allots 30 visits, what percentage of these slots are actually filled each day?	with
No-show rates (the percentage of a day's scheduled appointments, after prior reminder calls have been placed who do not show up that day for their appointment) A clinic with 100 filled appointments, and 10 missing patients that day would have a 10% no-show rate…this figure should be averaged over time.)	5% or under is optimal in a general practice. Rates hit 10-15% in pediatric offices. Rates are typically twice as high when automated calling systems are used instead of live callers.
Profit per surgeon-hour	A key metric. Wide ranging…may be as little as $50 or over $600 This is one of many dimensions of efficiency where ratio analysis is often best applied as an internal standard, rather than trying to match external benchmarks.
Surgical yield (total patient visits divided by the number of major surgical cases…better used as an internal reference than comparing to external benchmarks)	Highly variable depending on practice mix; 15-30 is WNL in a typical cataract practice; often under 10 in a comanagement center.
YAG ratio (YAGs divided by cataracts)	35% and falling with new lens materials

Whew! That's 31 different "dials" you could potentially put up on your "dashboard" to see how things are going in your practice. Do you have the time and attention to look at all of them, all the time? Probably not. I would rather that you take the same approach to watching the numbers of your practice that you take toward driving your car, glancing periodically at the dashboard for signs of trouble.

When you're driving, you spend most of your time looking out on the road. You might glance at your dashboard instruments a few times a minute. If you're conscientious, you check the oil dipstick and coolant level every few hundred miles. And you take the car in for professional service every few thousand miles.

It's the same thing with your practice. If your practice is young, and your real interest is simply raw growth, it might be helpful to focus on your growth rate. At the end of every calendar quarter, compare your collections for that quarter to collections from the same 3-month period in the prior year. You may find it helpful to graph this data, which might look something like this:



If your practice is more mature, and you're really at the stage of fine-tuning and profit optimization, you might decide to focus in a more balanced way on both revenue enhancement and cost-containment. An example of the latter would be to examine staffing cost ratios monthly, with an eye toward seeing these drop or at least stabilize.

Irrespective of the vintage or development stage of your practice, you should also ideally track the following revenue and volume performance figures graphically each month or each quarter using Excel or a similar spreadsheeting/graphing program:

1. A four-line graph showing month-ending accounts receivable, gross charges, collections and expenses before physician draws and depreciation
2. A two-line graph showing new patients and total patients.
3. A graph showing the number of new patient as a percent of total patient visits
4. A graph showing the average collections per patient visit
5. A two-line graph showing cataract cases and YAGs
6. A surgical density graph, showing the number of total patient visits divided by the number of major surgical cases
7. A YAG rate graph (YAGs divided by cataracts)
8. If you perform LASIK, a three-line graph showing patient leads, consultations and surgical cases…along with companion graphs showing the primary conversion rate (from lead to consult) and the secondary conversion rate (from consult to surgery)
9. Optical graphs, showing the total monthly sales, along with sales per patient visit
10. In addition, as discussed in the coaching chapter later in this section, it may be very useful to graph individual doctor performance with three graphs: month-by-month collections, month-by-month patient visits, and a third graph showing the average collections per patient visit. For each of these graphs, be sure to label each provider's personal goals

Amidst all these finite metrics, don't be afraid to score the *subjective* performance of the practice, too. It can be very helpful, in a joint meeting between managers and owners, to assign a letter grade to the overall operational performance of the practice or it's individual departments. Here's a sample of a report card from one client office, the "Smith" Eye Clinic as it was, is and should be:

	Dr. Smith	Office Manager	Marketing Manager	Billing Manager
Our grade one year ago:	C	C	D+	C+
Our grade today:	C	B-	C+	B-
Our grade a year from now should be:	B+	A-	B+	A

Even though this measure of practice operations is purely subjective, it forces management and owners to discuss their respective opinions and brainstorm agreed goals. As you can see from this, Dr. Smith has a lower opinion of the operational integrity of the practice than his senior staff, and this composite report card helped us all agree on more specific goals and expectations.

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