

# Ophthalmology Times<sup>®</sup>

All the Clinical News in Sight

AUGUST 15, 2007  
www.ophtalmologytimes.com

## Practice Management

### Reconstruction

## Changing practices for increased productivity

Physicians can find and eliminate the constraints on their new or existing practices

By Christina Phillis  
Associate Editor

**San Diego**—“Any way you want it, that’s the way you need it” may apply to relationships, but letting a physician run his or her practice any way he or she wants it could decrease productivity.

The concept that changing the physician’s style increases productivity could be the solution to some practice’s problems.

Concepts like this started to develop in the early 1980s at Medical Design International (MDI), Atlanta, where Larry R. Brooks, partner and senior medical planning consultant, puts these theories into practice. *Since publication of this article Larry has co-founded Practice Flow Solutions and is no longer with MDI.* At the annual meeting of the American Society of Ophthalmic Administrators, Brooks spoke about “The Four Ss to Control Production in the Practice: Style, Staffing, Systems, and Space,” giving physicians a different perspective when designing new practices and changing existing ones.

**‘Everything the techs or the doctors need [should] be in a nice, compact area.’**

**Larry R. Brooks**

Currently Principal of  
Practice Flow Solutions

“As [Richard Haines, company founder] started designing medical facilities, he started realizing that physicians were either more or less productive depending on how he laid out the space,” Brooks said. “And then he started realizing that space wasn’t the only input that had control over production.”

### Take-Home Message

The four Ss to control production in the practice—style, staffing, systems, and space—if done right, can make a practice run more smoothly. Constraints on a practice can affect its output negatively and should be the focus, rather than resources. Once constraints are identified and eliminated, practices can start increasing their output.

### Taking a different perspective

Various groups measure production differently. For example, Electronic Health Records looks at production based on charge per visit while the Medical Group Management Association looks at income generation.

“Today when you hear the word production, what I am talking about is the Practice Flow Solutions definition, which is physician hourly output,” Brooks said. “What we have found is if you look at the hourly output of all of the physicians at your practice, at once it’s going to tell you a lot about how to design your new facility or how to organize your current one.”

The constraints on a practice can affect this output negatively and should be the focus, rather than resources. According to Brooks, the physician should become the constraint that controls production, not other factors.

Practices that realize their productivity is based on the amount of patients seen per hour can start moving forward. Goals such as reaching the net income, which was accomplished by lowering expenses, can now be reached by increasing physician output.

### Style

The first step to increasing productivity is figuring out the style of the physician and eliminating what holds him or her back. Brooks

**When a physician or technician spends time walking to get to the patient information he or she needs, this is ... an ineffective system of communication.**

gave the example of one physician who always walked patients to the check-out desk because he felt it was a good way to bond with them. However, Brooks found that by not walking every patient to the check-out desk, this physician was able to see two more patients per hour.

Observations like this one can be identified in a time-motion study, which monitors the physician during a 2-hour time block. Watching the physician throughout the day can be used to determine the existing patient volume and help figure out the physician’s natural rate of seeing patients. Brooks advises determining an average of 10 2-hour sessions.

The time-motion study findings are divided into three categories: effective time, time that can be delegated, and wasted time. Effective time is time spent doing tasks that only the physician can carry out, such as examining the patient or making calls to other physicians.

“We’re not Star Trek so we can’t use teleportation, so doctors are going to have to walk from one room to the next, but at the same time you want doctors to be able to come out of the exam room and go straight to the next patient with no downtime,” Brooks said. “If you are able to do that then you are maximizing their capacity.”

Time that can be delegated to another staff member and wasted time, such as the physi-

## Focal Point

**A 2-hour time-motion study done for about 10 sessions can help you determine the natural rate of a physician in your practice.**

cian standing in the hallway waiting for a technician, is time that needs to be decreased. Once these data are gathered, figure out methods to increase effective time, according to Brooks.

### Staffing

Next in the process is changing the way the staff works. How well the staff does its job can be just as important when it comes to increasing the natural rate of the physician. The main focus is working with staff members who work directly with the physician, such as check-in clerks and greeters.

The check-in desk should be a place where the patient spends no more than 4 minutes, Brooks said. Eliminating the sign-in sheet is one way to decrease the amount of time a patient spends at the check-in desk.

“In the practices I’ve seen that have this really down pat, when the patient walks in there are enough receptionists that there is no delay; they immediately check them in, they copy the insurance card, whatever they need,” Brooks said. “There is no need for a sign-in sheet because receptionists take care of patients immediately.”

Another problem is technicians walking back and forth to obtain patient information or find out which patient is next.

“Everything the techs or the doctors need [should] be in a nice, compact area,” Brooks said. “Because if you are able to limit the amount of walking your techs and doctors are doing their rate will naturally rise.”

When a physician or technician spends time walking to get to the patient information he or she needs, this is considered an ineffective system of communication. Time spent walking should be either decreased or eliminated. Light signaling and electronic processing are effective ways to eliminate walking. The lighting system enables the physician to look at the light above the door to find the next patient.

“It’s better than phones, it’s better than flag systems—you push a button and it automatically puts it in the queue,” said Brooks. This prevents the physician from walking to the technician or to the check-in desk.

Brooks suggested using printers in practices that still use paper charts.

“[Practices] send the super bill to a printer that is sitting at the tech station,” Brooks said. “That’s the non-walking, non-verbal way to let that tech know the next person is there.”

The other system, electronic processing, is effective because the technician or physician just has to look at a screen. Nevertheless, Brooks prefers the printer method. The paper sitting in the printer has more urgency than the passive screen of an EMR system, according to Brooks.

Patient flow is one system in a practice that seems to be uncontrollable.

“If you can be able to have the patient come out of the exam room door and know how to get out of your facility without asking or being directed, that’s the best scenario for you, but typically they have to go out the same way they came in,” Brooks said. Patients don’t really recognize signs but they do recognize space, such as different coloring or certain lighting levels, according to Brooks. Higher ceilings at the check out and lower ceilings as you get farther back help them get a feeling for the space around them.

### Space

When it comes to space, higher ceilings come into play, but not as much as how the exam lanes or rooms are laid out. The number of physicians you have needs to be a factor, as well as how many physicians you plan to add to your practice down the road.

“For instance, if you have four doctors seeing patients in your building at once and they have four lanes apiece, you have 16 exam lanes. If those 16 exam lanes are all wrapped around a corridor all on the same side of the hallway, the doctor will be walking as far as he or she has to walk to get to those four lanes, whereas if I took those four lanes and put them across the hall from each other, I just reduced the walking, and the doctor’s production will rise,” Brooks said.

Future “toy rooms” are what Brooks calls rooms that are put into a practice to plan for future additions, such as new equipment or new physicians, and can be used as storage in the mean time. When planning for rooms, Brooks said, remember to add another 30% of space for circulation, which can be useful when meeting handicap codes that require extra space in the halls and bathrooms.

Private rooms added because of the physician’s preferences should be as far away from the exam rooms as possible so there is less temptation to go into those rooms. It’s just an-

**‘There is no need for a sign-in sheet because receptionists take care of patients immediately.’**

**Larry R. Brooks**

other way for effective time to increase while wasted time decreases.

### Guidelines

“For every square foot of building you have, you’re going to have about 2 square feet of parking and you’re also going to have about another 3 square feet of setbacks, green space, landscaping, retention ponds, and what not,” Brooks said. “For every square foot of building, you need about 6 square feet of land.”

The squarer the shape of the land and building the better, because this reduces the amount of time spent walking. The building should never be twice as long as it is wide. If the building already has this layout, solve the problem by putting all of the non-patient offices at one end to shorten the effective length of the building, according to Brooks.

### Efficiency

Landlords may tell you that their building is efficient.

“What they mean by efficiency is the ratio of gross square footage of that building to the net rentable square footage,” Brooks said. “If a building is 85% efficient, as they would term it, this means they are going to be able to rent 85% of that building to practices.”

Be careful when looking at suites where the elevator is in the middle of the building. There is no good way to divide the halves of this kind of building into a good square shape. When constructing a new building, offset these core factors to the side, according to Brooks.

“The rentable square footage is your usable square footage multiplied times a factor to pay for all these core elements, these hallways, stairs, elevators, lobbies, and all that,” Brooks said. **OT**

© Reprinted from Ophthalmology Times, August 15, 2007  
AN ADVANSTAR PUBLICATION Printed in U.S.A.



Larry R. Brooks, AIA Principal  
Practice Flow Solutions  
brooks@PracticeFlowSolutions.com  
direct line 678.983.0229  
www.PracticeFlowSolutions.com