THE FIRST TIMER’S GUIDE TO STRATEGIC PLANNING

What is a strategic plan and why should we have one? Certainly both valid questions!

With the myriad of rules, regulations and hoops to jump through, today’s modern medical practice needs to have a really good grasp on what they intend to do and how they intend to do it. Having a strategic plan for the practice gives the owners great confidence in the fact that they have developed a series of strategies that will enable them to control more of their own destiny than the average medical practice. In fact, it will almost guarantee them a greater prospect for success than a large majority of their colleagues and competitors.

In general, organizations do not usually start out with a strategic plan. In the case of medical practices, this is particularly true. Traditionally a medical practice is started by a young physician, fresh out of training who has very little, if any, business experience and who will resort to hiring a manager who may or may not have the knowledge required to formulate a strategic plan for this newly founded medical practice. Over time, the practice will grow and the business operations side of the practice will evolve.

In today’s medical business climate, the need for operational strategies planning is an absolute requirement, not a “nice thing to do when we have the time!” Strategic planning should be at the very top of the list of items on the “to do list” for the practice. The physicians and managerial staff must become very involved in the strategic planning processes as early as possible in the existence of the practice.

One of the very first questions that should be considered by the organization is, “Why should we do this?” This is a great question, and is deserving of a response which we will undertake within the framework of this essay. Quite often the following comment is made concerning the practice,” we have gotten along just fine without doing this, and we simply do not have the time to sit down and assume such an undertaking.” At first glance, this may appear to be true. The problem however, is that without a strategic plan for the practice, one can never be sure that “we are getting along just fine!” In order to make that assumption, there needs to be a scoreboard of sorts, and without goals, guidelines and benchmarks, it is impossible to tell, for those are the entries on the scoreboard of practice management. One could assume that if all the bills are paid in a timely fashion and the physician is happy with the amount of money that is left over as a satisfactory income, then all is well. The real challenge comes in attempting to manage all of this without a plan. It is rather like going somewhere without a map or in the digital age, a GPS!

WE’RE GOING TO PHILADELPHIA….

If one were to start out on a journey, would it not be wise to get some information on how to get there prior to departing? Wives will be the first to tell us that the husbands refuse to stop and ask for directions. One might think that problem was a prime factor that led to the invention of the GPS! Now, husbands don’t have to stop and ask, and they have electronic toys to play with in addition! Without a mechanism to provide guidance, how would we ever get to our destination? As importantly, how would we know when we arrived? Illogical as it would seem to start out for Philadelphia without a map or a GPS or at the very least a set of written instructions, many physician practices attempt year after year to run a multi-million dollar business without even the least of these. Most likely, it is not because they are against asking for directions, but rather don’t realize that there are very explicit directions available for this task. Unlike the resorting to the roadmaps of yesterday, we are in an age where things are changing with lightning speeds and require a host of helper information to keep up with the changes. Most physicians can easily see that with all the new drugs, diseases, and surgical techniques and tools it is paramount for them to keep up with reading journals, attending courses, investigating new procedures and networking with colleagues. Couple this with patient treatment, surgical time, some reasonable attempt at a family life, maybe even a little time for a hobby or entertainment, and there is not much in the way of time left over for business study and planning. As such, this activity generally goes lacking and the result is a less than stellar outcome for the business side of the practice. This leads to inefficiencies in
the operations side of the practice, which puts more and more pressure on the providers and management to produce very elusive profits.

Many physicians enjoy a certain amount of freedom in having an independent practice and subsequently do not engage in strategic planning because they are unwilling to place themselves in what they view as a position from which they cannot deviate. In actuality, nothing could be further from the truth. By having a well thought out strategic plan, they could enjoy a good bit more free time than they presently have and most likely a better income in addition. In addition, they can now be comfortable with the idea that they can change strategies as circumstances dictate. In any case, they would know where they were operationally at all times and would not suffer from the dilemma of wondering how it would all come out at the end of the month or year as the case may be. One only has to receive the bit of bad news from the accountant about how much additionally they will owe in taxes at the end of this fiscal year to appreciate the value of how having good information is important.

Once, a physician commented about his practice that “they did not perform strategic planning because the providers did not do well at this planning thing.” An interesting approach. On the trip to Philadelphia, what does one do if they encounter a construction crew working on the highway? Logic would tell you that you follow the detour signs or the instructions of the flagman to get around the area of construction and get back on the proper highway once again. The same is said of the strategic plan. This is a dynamic document that is always subject to change. We never plan on having a flat tire, but we always carry a spare tire with us on the trip. We don’t carry a spare transmission in our car because it is highly unlikely that our transmission will fail. One could rationalize that with the quality of tires today, it is not necessary to carry a spare. Because of the low cost of carrying a spare tire, it is generally considered to be an acceptable cost vs risk situation. This rationale is the same that is used in formulating procedures in a strategic plan for the practice. The idea is to look at the situations that can and do arise in the everyday operation of the practice and develop strategies that will either protect the practice, enhance the growth capability or defeat some of the various negative options that can occur.

It is also important to note the difference between a strategic plan and a contingency plan. There are some who would argue that these are synonymous, and to some degree there are similarities. The basic difference is that the strategic plan deals with the how to’s of managing the events that we feel sure are going to happen vs the contingency plan’s approach to dealing with emergencies, disaster, and the like. We will leave the contingency plan to another time.

ARE PRACTICE GOALS NECESSARY?

If the decision is made to formulate a strategic plan, is it necessary to develop practice goals? There is an old axiom that says “it is not whether you win or lose, it is how you play the game.” That sounds good, but it is not borne out by reality. If you go into any sports arena in the U.S., one of the things that you almost always discover is the existence of a scoreboard. In examining these scoreboards, one rarely finds a statement displayed on it that tells you how the game is being played. You will, however, find the scores. While we may not wish to admit it, life in the business world is all about keeping score. Businesses are particularly good at reporting these scores. In the field of ophthalmology, we keep score by looking at the refractive error for a patient and then attempting to get that set of numbers as near to perfect as we can.

If we start out with a patient who has a best corrected visual acuity of 20/100 because of their cataracts, we remove those cataracts, replace the original lens with artificial lenses in the form of IOLs that are specifically manufactured with qualities that will attempt to enhance the patient’s vision and correct it to 20/20 or better. What was the goal?

The goal was to achieve patient vision as near to perfect as was possible. Businesses should be run the same way. If there are specific goals set forth for the business side of the medical practice, everyone can always know at any given time the degree of success for the practice.

WHAT SHOULD WE USE AS PRACTICE GOALS?

Much like the football scoreboard, we could look at first downs, time left in the period, which period we are in, etc. But
the really important thing in this instance is who is ahead and by how much. Similarly, we can look at things like how many patients we have seen, what is our average ticket in terms of charge, what is our percentage of charges collected, how many cataracts have we performed, etc., etc. So what is the really important thing for us to see about the ophthalmology practice? It is commonly believed that there are two that are more important than the rest:

1. What is the degree of customer satisfaction?
2. What is the amount of profit after all expenses are paid?

If the degree of patient satisfaction is acceptable, then we have achieved one of the most important goals. Secondly, have we made any money in return for our efforts? If this goal is not achieved, it will not matter what the degree of our patient satisfaction, we will not be around to achieve our primary goal. One could argue that there are more important things in life than money, and that is true. At the end of the day, you must have earned some money, or you will not be able to enjoy any of those other things. Where do we get the information to determine how we measure up?

Benchmarking is a very necessary part of determining what to measure and how to place those numbers on a scale that is relative. As a solo practitioner, would a benchmark of seeing 500 patients per day be realistic? The answer should be obvious. Quality would seriously deteriorate even if this were remotely possible. Would an average practice profit net of expenses at around $300 per patient be possible? The answer to this one is yes, most definitely, but the caveat here is that this is entirely dependent on your business model.

We have already seen what the two most important goals for a medical practice should be. In the case of patient satisfaction and quality of care, the control is left with the providers. In terms of the profitability, the identity of the responsible person is less clear.

Generally, the burden is placed upon the shoulders of the practice manager or administrator. The responsibilities and the capabilities of practice management persons vary widely.

While some have a complete grasp of the situations that confront the operations side of a medical practice, others have only the key to the front door, a title and limited managerial knowledge. The difference between these two extremes is immense, and the likelihood of profitability under the leadership of the manager with the lesser degree of knowledge is questionable at best. Perhaps one of the goals of the strategic plan would be to enhance the education of the manager(s). Every dollar spent in this effort should be considered a long term investment and the benefits will be reaped many times over. Of course, it would then follow that the subsequent education of all of the staff would bring about a similar benefit to the owner(s.) This knowledge by the employee now enhances our ability to observe a much broader range of potential problems.

A knowledgeable work force will also watch for those potential “dragons” that can and will get us into a great deal of trouble, left unattended.

If we are to have goals, how can we judge if they are realistic? Much of this is determined by what is occurring in the practice, presently. The process of using benchmarks is always an advisable, no...make that absolutely essential for the practice. The best benchmarks are those from your own organization, but it is a valid idea to use those from other practices as well. It is important to compare apples to apples. As an example, your solo practice provider sees an average of 31 patients per day for each day of office production that (s)he performs. Using a benchmark of 31, the practice plans for the future. If the practice wishes to increase this number, what will be the basis? Rather than picking a number randomly, we could look at other providers in similar practices for guidance. Let’s say that Dr. X from another practice in a similar socio-economic area sees 57 patients per day and Dr. Y from another practice sees 37 patients per day. Which would be the more appropriate set of data to consider using as a Benchmark? Consider this, you have one assistant in your practice and Dr. X has a scribe and two technicians assisting him and Dr. Y has the same number of personnel as you, but the assistant has been with him for much longer than your assistant. What changes would you have to encounter in your practice staffing in order to increase your production? If we know Dr. X and Dr. Y, this information might be readily available, but given the idea that we may not, then there is a wealth of information available from organizations such as the American Society of Cataract and Refractive Surgeons, the American Academy of Ophthalmology, as well as others, that could be used to assist the physician in setting relevant goals for the practice.
and developing strategies to achieve them.

**YOU DON’T UNDERSTAND, OUR PRACTICE IS DIFFERENT!**

This is probably the most widely believed myth about practices that could have ever existed. To a very small degree, there is truth here, but for the most part, the supposition is simply not true. When one boils down the similarities and differences among practices of comparable size, it does not take very long to determine that the statement has little or no merit. The differences are most likely philosophical, but the basics, the reasons for existence and the two main goals, are the same. Many physicians and consequently their personnel believe that the practice is so unique that few, if any, of the universally accepted ideas which are the backbone of strategic planning, will be applicable to their practice. This, in turn, presents a case against the idea of strategic planning.

**ISN’T STRATEGIC PLANNING FOR LARGE PRACTICES?**

To the solo practitioner, the 5 person practice is large, to the 3 person practice, the 50 person practice is huge and some of our academic institutions have hundreds of providers. How large is large? It is true that larger practice are more likely to have made some effort at strategic planning and perhaps they have been very successful in formulating a plan, but size does not guarantee that the plan is effective or reasonable. No matter how large the vehicle, the distance and direction to the goal is all the same. There may be some mitigating factors that will have to be dealt with, but the goals will still be pretty much the same.

**S.W.O.T.**

This is not the name of one of the new television shows in the fall lineup, but rather an acronym for the Strengths, Weaknesses, Opportunities and Threats that are to be considered in the formation of the strategic plan. A very realistic discussion and assessment of each of these areas must be undertaken in any Strategic Plan formulation. Owners and management must know the correct answers to each of these, and the plan would then encompass what actions will be undertaken to offset or take advantage of each of these items. For instance, if one of the attributes of the practice is that it has a superb location, then that would be listed as a strength. On the other hand, if the location was not very good, perhaps a lack of parking, run down neighborhood, housed in a facility that was no longer large enough to accommodate the practice, etc., the location would be listed as a weakness. Opportunities could be things that had not yet been adopted as a part of the practice. Lack of an optical facility, or their own ambulatory surgery center, not yet utilizing premium intraocular implants, etc., are good examples of opportunities that would be areas to be considered as potential growth areas for the practice.

There could be other types of opportunities such as the purchase of auto-refractive equipment, other test and measurement devices, or even the opportunity of renovating the office space to make it more friendly, modern and inviting for the patients. Threats would be those things that are or might occur that would have a detrimental effect on the practice. Competition moving in across the street, provider unhappy in the practice and threatening to move out and go into business alone or join another group, etc. All of these and many more should be looked at carefully and realistically. In the case of those negative things, the idea would be to consider what impact would this have on the practice if it did occur? On those that are considered to be positive, the idea would be to plan on how to be exploit this opportunity or truth about the practice. Should we be marketing this particular positive attribute? How would we best do that?

There is always the challenge or perhaps group of challenges that surround the idea of practice expansion. For instance, if it is determined that there is growth potential or that the practice has more demand that it has supply, will we bring in another provider? If so, will that provider be another MD or would an OD be the best approach? If we
decide to bring in that provider, what will we have to do logistically to support the provider? What changes in staffing will be necessary?

**HELP! I’VE FALLEN DOWN AND I CAN’T GET UP!**

This is a line from an old television commercial for one of the small personal paging devices which are sold for use by people who live alone and might have need for assistance and perhaps are unable to summon that help. The devices are designed for use by people who might have a limited means of getting assistance. What is the device or idea that the practice will use in the event of a similar situation? Rarely do practices have a plan of this nature in place.

We ride elevators all the time without a thought as to what we would do if the door does not open. They are so dependable, we never think about the possibility that this might happen.

What do you do if the elevator door doesn’t open? What is our plan? The thought that we should have a plan for something of this nature may amuse many, however, someone thought it had merit. If you notice, there are alarm buttons and in many cases, telephones in the elevators that we ride. The elevators may be very dependable, but it is still a good idea to have a plan. When something goes wrong, we need to have designed a response process.

Should we have a bailout plan? All military aircraft carry parachutes.

There is an obvious reason for this process and the parachutes are a response to the idea that things may not go as we had hoped. There is also the rescue effort: after we get safely on the ground with our parachute, we are not completely out of trouble. We do not know exactly where we are, and we have no means of transportation to take us to our final destination, so what do we do next? These and many more things should be considered in our formulation of the strategic plan. The plan is not just about our response to emergency situations, it is about determining why we are here, what we are going to do regarding staying here, and how we intend to operate given certain circumstances.

**HOW DO WE GO ABOUT DEVELOPING A STRATEGIC PLAN? WE MADE THE DECISION....WHAT DO WE DO NEXT? THE RETREAT:**

The process of formulating a strategic plan is best achieved without the normal pressures of the everyday operation of the practice. Generally, a location away from the practice, at a time that allows little interruption, with an environment that allows the freedom to speak our mind works quite well. The choice of the time and place for this very important event should be made with great care. The formulation of a strategic plan is a process that has huge implications for both the future of the practice and the individual practitioners, management and staff members, alike. Input at all levels is extremely beneficial to formulate a successful plan. This process should not be hastily attempted. Doing so is most likely to bring about results that will be unacceptable. The utilization of an outside person to facilitate the retreat not only deserves a strong recommendation, it is a downright necessity! This facilitator should be chosen with care. They should have extensive experience in leading a retreat of this nature, and they should be given the necessary authority to run the meeting. This retreat should be carefully structured and planned to the highest degree. Following this direction gives the organization the greatest possibility for success. Extensive notes should be taken for future reference so that the information shared is not just filed away in someone’s memory bank, but will become the basis for our eventual strategic plan. Trust NOTHING to memory, write it all down....multiple times!

Essentially, the facilitator will guide the participants through the process of determining why the practice exists, assist the attendees in arriving at a statement of purpose and the formulation of a mission statement. The facilitator would then move the group through the process of examining the strengths, weaknesses, opportunities and threats that exist. This is most commonly referred to as the “SWOT” analysis. Each of the items in these categories should be examined and discussed thoroughly in an effort to insure that each strength, weakness, etc., has been correctly identified and
listed. Initially, identification of these is the most important. At this stage, they should not be looked upon as “problems” or items of greatness. It is sufficient to have a consensus as to what these are.

Later in the process, we will discuss how to utilize, overcome, change, etc. each of them. This is by no means an easy task, and will require considerable effort by the group.

The very first item on the list has to do with identifying why we are here. This may seem overly simplistic, but it may come as a surprise to learn that there are a great many practices in existence who do not know the answer to this very important, but fundamental question. Most would say that the reason for existence is to provide excellence in patient care for the citizens in the community, or words to this effect, and while that sounds very noble, there are a lot of things that are left out of this statement. While noticeably absent, the matter of finance has to be brought into this thought process. Is it relevant for the practice to charge for services rendered? Is a profit to be made? What about the size of the profit? Who will share in these profits? One can quickly see that only the tip of the iceberg is showing. As we explore these items, they lead to more questions. In turn, each of these must be addressed. Once this process comes full circle, we can become more comfortable with the final, stated reason for our existence. We then proceed to determining our goals in support of the above reasons for existence and how we intend to achieve those goals. A word of caution here against having too much minutia explored.

To begin, we are creating a “sketch.” From that “sketch” we will develop a “blueprint” and from that “blueprint,” we will build a practice. Our strategic plan will be the blueprint and “spec book” for the practice and its efforts.

Architects will quickly tell you that great buildings don’t just happen. It takes months and sometimes years of planning to produce what we would like to think is the final building plan. (It won’t be the final...it will be amended as we build!) Along with the blueprints is another document that is voluminous. It is called the list of specifications or “spec book.” This becomes the bible of the project. Every time there is a question about how something is supposed to be built, constructed, colored, bent, wired or piped, the “spec book” is the document that is used to answer the question. There will be times when that document has to be amended as well. In the case of the building project, a final “as built” set of prints and specifications are produced to document exactly what has occurred and how we built the building. Unlike a construction project, the practice operation continues on for long periods of time. In the case of a strategic plan for the medical practice, we continue to evaluate, update and amend as needed as the practice continues to operate over time. This strategic plan is truly a dynamic document.

**THE DOCUMENT**

Once the initial strategic plan document is compiled, each of the participants in the retreat should take the document and read it very carefully, making notes regarding any questions that they may have. All participants should be given a deadline to complete their evaluation of the document, taking careful notes of any questions they may have. After that time period has elapsed, the group should meet and discuss the questions that have been noted. The final working document should then be edited and produced for everyone and the owner physicians will sign off on this final copy to signify their commitment to the plan. As we go through this process, one of the very important items is to determine the tools that we will have in place to insure that we utilize the strategic plan. All too often, the groups may develop a propensity to wander as they go through their day to day existence. This is most especially true of groups with a very high degree of “entrepreneurial spirit!” Great care should be taken to always bring new ideas to the strategic plan and see if they are a “fit” for the practice. There will be times when new technologies and new ideas or opportunities will be discovered, and should be heavily considered even though they may not have been a part of the strategic plan. For instance, our original plan may have not considered that we would move the practice to another location or open a satellite operation. Suddenly, we find that a new expressway is being built, and the property upon which the practice is located is going to be taken by the government and a new location for the practice will have to be acquired. How will we approach this dilemma? Clearly, we have little choice in the matter as to whether the move will occur, and we are now confronted with a complete change we had not anticipated when the plan was formulated. What to do?
Simultaneously, we should begin the planning process for this move and look very carefully at what part of the strategic plan needs to be amended. Perhaps the present location of the practice was listed as a strength. How would we go about dealing with this, as one of our strengths is about to disappear? Of course, it may have been listed as a weakness. Could this be just the answer that we need? One can quickly see that the plan should always be consulted and perhaps amended. The strategic plan is just this...it is about our strategies to succeed. It cannot take every possible event into account. After consideration, an opportunity that is not deemed a good “fit” for the practice should not be pursued at this time. Perhaps, at a later date, this idea would be appropriate. Caution should be exercised so that a logical rather than an emotional commitment is made. There is always the option to place new ideas on hold until more information is available. The key is not to put them all on hold or you may find your surgeons still practicing medicine with outmoded technology or techniques!

WHAT PERIOD OF TIME SHOULD THE PLAN COVER?

Should a strategic plan be made for a particular segment of time? Should the plan be for one year at a time or three years or five years or more? Actually, the answer to all of these is yes. As earlier stated, the plan can be reviewed and changed if necessary over time. Just formulating the plan is not enough. That would be much like buying a book and never reading it. The plan should be reviewed at least annually and determination made as to whether all of it is still relevant. Interestingly enough, what may have been a strength last year could turn into a weakness this year. The group that is involved in this process should always approach the task with an open mind. There should never be any “sacred cows” in the plan! It is wise to formulate a plan that would list the strategies that we are going to implement during the next 12 months. We should also look at what a longer term plan might be. This is where the 3 year and 5 year items would be shown. For instance, our strategy for the next 12 months might include the feasibility study for building a new ambulatory surgery center. Assuming the study leaned toward the idea being feasible, during the ensuing 24 months, we might incorporate a search for an architect, consideration for a consulting firm and the beginning of the process of looking for short and long term financing. Always remember the plan is dynamic. If it becomes static, you may as well dismiss the idea of having a strategic plan.

DO WE FOLLOW THE PLAN AT ALL COSTS?

The short answer is NO! We have already discussed the idea that circumstances change, and we should be fully prepared to change with them. The important thing to consider is that the changes need to be made based on fact, rather than emotion. Many times it is very difficult to perform in this manner. There are times when entrepreneurial surgeons will develop tunnel vision about a particular procedure or piece of equipment or location. When this occurs, the duty of the rest of the group is to examine the facts in a very methodical manner. One of the first items of interest for the group should be the costs and revenue projections for an idea, a process or a location. These numbers can have a resounding affect on the principals of an organization. Suddenly, something that was very attractive based on emotional attachment, can now find it is an orphan when the monetary issues are examined.

KEEPING SCORE

This is something that we must address in the strategic plan. We must have a way of measuring things, and we must record the information so that we can make reasonable decisions. Making business decisions for the practice without adequate data is a recipe for disaster. Keeping score is absolutely essential. What do we measure? Are benchmarks important to us? What benchmarks should we look for?
THE NEW PARADIGM

Here are three items that could cause us to make some serious changes to our strategies:

1. We outgrew our facilities. Our patient volume grew to such an extent that we have much more demand than we can supply. Further, if we had more providers to meet the supply, there is no place for them to work. Clearly, if we had not been tracking our production growth, this problem could have caught us completely unaware.

2. Competition from another city has moved into the area and is taking patients from our practice to such an extent that we are suffering serious financial repercussions. Of course, this is just the reverse of the first situation. Again, data tracking is paramount to our ability to make decisions.

3. There is something new on the horizon. Medicare has suddenly decided to cut reimbursements by 27% and there is no negotiating away from that point. Sixty-five percent of our total volume come from Medicare, and this move by the federal government will cost us an absolute minimum of 17.6% of our total revenue.

QUESTION...WHAT DO WE DO?

It is doubtful that any of these three extremes would be addressed in your strategic plan, but any of these would have such an impact on the practice that it would cause us to immediately look at what sort of strategies would be needed to deal with the problem. If no strategy existed, we should develop one and implement it. Benchmarking data would extremely helpful to us in developing and implementing these new strategies. The most important data to benchmark is the historical data of the practice.

It is interesting to know what the industry as a whole is doing, and it is interesting to know what a similar practice in another city is doing, but none of those is as important as your own.

If the information has been recorded consistently, decisions utilizing this data can be made with greater confidence.

SUCCESSION PLANNING

One of the most difficult items that any practice addresses is succession planning. Most physicians want to practice as long as is feasible. The question is...when is it no longer feasible for the physician to continue in practice? Who is being impacted? Most older physicians will make the statement to their colleagues, “I’ll give you plenty of notice.” This is not always the case. There are times when they have difficulties far outside their control and when these occur, the practice is placed in a very precarious position. For instance, what does the practice do when one of the three hard working providers suddenly dies of cardiac arrest? How does the practice plan for such an event? This conversation among the providers invokes a lot of emotion. Making the preliminary decision as to when and how provider changes will be made is of great importance to all concerned. There should be strategies in the plan for dealing with these issues.

RECRUITING A NEW PROVIDER

The process of succession planning brings many challenges to the practice, not the least of which is the recruitment of a “replacement.” This is not a quick or easy process and should be well thought out and planned. This is very definitely something that should be in the strategic plan. There is some thought that it should be in the contingency plan for the practice, and this is probably appropriate for an emergency situation. The emergency approach would be somewhat different than the planned recruitment. The planned recruitment would be more associated with strategic planning.
WHEN DO WE HAVE ALL THE BASES COVERED?

Check the scoreboard. What do the numbers tell us? The plan is never complete. The strategic plan for a medical practice is a constantly moving target or set of targets.

The idea behind the strategic planning process is that we constantly need to re-evaluate everything in the practice. We can never be satisfied with the status quo. The world is changing everyday and we need to be prepared to change with it.

Remember, the strategic plan is an identification of the attributes and shortfalls of the practice and an objective statement of purpose. After that, a well thought out listing of the various strategies that we think we need to implement regarding these three.

It is not a daily operations guide. It is not a practice policy manual. It is the practice plan that will enable the group to grow, adapt and prosper over time by addressing possibilities and being prepared for them.

HOW DO WE IMPLEMENT THE PLAN?

Once the plan is formulated, how do we go about implementing it? Once the document is put together and agreed upon by the owner(s,) the plan should be put in motion. Start with whatever was considered to be the most important item, and begin to implement the various ideas that were listed. If the stumbling blocks are too great, then back up and have another look at it. You can work on multiple parts of the plan simultaneously. One does not have to be completed before another is begun. However, caution is given about getting too many “irons in the fire” at the same time! This can lead to many problems. One of the keys is to avoid over obligating the management and staff. They need to work at a comfortable pace, but this pace should allow them time to complete all of the items they presently have open.

As each of the strategies is worked and the pieces of the puzzle start to fall into place, great care must be exercised to work towards excellence in everything that is undertaken. There is no room for mediocrity. Plan the work and work the plan! Insure that everything is done with a high degree of excellence. Celebrate the accomplishments! Even the small ones.

Make certain the staff understands what you are attempting to do and why. Having them on your side is mandatory. They don’t need to be a counterproductive influence in the practice.
RETREAT PLANNING FORM

1. WHERE IS THE RETREAT TO BE HELD?

2. WHO WILL ATTEND THE RETREAT?

3. HOW LONG WILL THE RETREAT LAST?

4. WHO WILL BE THE RETREAT FACILITATOR?

5. WHAT IS THE LEVEL OF THIS PERSON’S EXPERIENCE?

6. WHO WILL BE RESPONSIBLE FOR WRITING THE RETREAT AGENDA?

7. WILL THIS BE AN OVERNITE STAY?

8. WHO WILL TAKE CARE OF THE LOGISTICAL PLAN FOR THE RETREAT?

9. IMPORTANT TO NOTE THAT EVERYONE SHOULD BRING SOMETHING AWAY FROM THE RETREAT. THIS DOES NOT HAVE TO BE THE FINISHED DOCUMENT, BUT IT SHOULD HAVE A LOT OF DATA THAT WILL BE USED IN THE FINISHED DOCUMENT.

10. IT IS EXTREMELY IMPORTANT THAT ALL FEEL AS THOUGH THEY WERE INVOLVED. THIS CAN ONLY OCCUR IF THEY ARE!

11. ABSOLUTELY NO ALCOHOL SHOULD BE ALLOWED DURING THIS MEETING. MODEST AMOUNTS DURING DINNER AFTER THE BUSINESS PORTION OF THE DAY, BUT NOT BEFORE.

NOTES:

- RETREAT SHOULD BE HELD IN CASUAL ATMOSPHERE...IT IS OK TO HAVE FUN DOING THIS!
• Attendees should be encouraged to dress casually, but modestly.
• Retreat should be the central focus of the meeting, not the thing we may have a go at after the golf game or the tennis match.
• Personnel should be encouraged to speak out on things about which they are passionate.
• Personnel should be encouraged to ask questions.
• Personnel should feel the freedom to participate and not feel as though they cannot speak their mind.
• It is not necessary for every person in the practice to attend the retreat.
• It is necessary for all managing staff to attend the retreat.
• All personnel attending should participate.
• All personnel that are attending should be given a copy of the benchmarking information that has been prepared beforehand. These personnel should study the information very carefully so as to be able to discuss the data in the meeting.
• Develop some “ice breakers” to get things started.
DEVELOPING THE PRACTICE’ MISSION STATEMENT

Everyone should write this out and be prepared to present and defend it to the group
(If you have more than 10 people present, divide them into teams of 4 or 5 and let each of the teams prepare the
information for presentation and defense to the group)

1. Who are we?

2. Why do we exist?

3. What is it that we are going to achieve?

4. Over what period of time will we achieve this?

5. Why do we want to achieve this?

6. This is our mission statement:

Caution, is this a statement that everyone in the practice can read, memorize and say back to anyone in a short period
of time. Do we really believe this? This statement should be something that every person in the practice is prepared to
support and defend. If they cannot, or will not, then it is either the wrong mission statement or they are the wrong
people for the organization. Commitment to this has to be unavailing.
SWOT ANALYSIS
(STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS)

Before beginning this portion of the exercise, a complete financial and operations report is in order. This does not have to be given at the level of detail that identifies the level of income of every provider, but it should show the revenue by department, expenses by department (in general), the gross profit of the practice, the details of how many patients are being seen, how many and what type of surgeries are being performed, what services are being performed, what level of sales exists by department, etc. Without some idea as to what is taking place, there can be no plan for growth. As the numbers are presented, the growth or lack thereof should be presented over a specific time period. (I.e: past 3 years, past 10 years, etc.) Of course, you do not have access to your competition’s numbers, so it is difficult to compare yourself to the competition from a detailed perspective. Comparisons here would be more from an appearance situation. On occasion, tax information is available that will give you some insight into what the competition does. This possibility should be investigated and the information obtained if it is available.

NOTE: Before beginning to identify these, make sure that you are doing so from a position of fact, not emotion. All too often, we determine things to be strengths that are not. The information in these items needs to be stated by unanimous consent. If there is any doubt, your facilitator should be able to help you identify those that are realistic and those that are not. There is nothing sacred here. We are after the truth. Let’s make sure that is what we get.

THESE ARE THE STRENGTHS OF OUR ORGANIZATION:

THESE ARE THE WEAKNESSES OF OUR ORGANIZATION:

THESE ARE THE OPPORTUNITIES FOR OUR ORGANIZATION:

THESE ARE THREATS TO OUR ORGANIZATION:

Here are some items that would be of major importance to us at this point.

What is our financial status? Assets vs Liabilities? These are not just about finance. For instance, all of the principal providers (owners) in the practice being near retirement is not an asset, etc., etc. What is our competitive status? How many competitors, where are they located? What do they do that we do not or will not do? What do we do that they either cannot or will not do? We really need to think outside the box for this exercise.

Your facilitator should be able to get your “juices flowing” in this segment.

We need to determine how we can improve on any numbers that are presented. We also need to look at the patients’ perception of our practice and how we can improve on that perception. Some items that would be of interest are the number of new patients that we get on an annual basis. Note that nationally, about 20% of your practice “turns over” every year.

They move away, die, become disenchanted and leave, transfer out of the area, have a different insurance plan for which you are not a provider, etc. The list gets to be really long! If your practice does not get at least 20% of its patients as new patients each year, then it is probably not growing. Of course, if this is a new practice, the “new patient” numbers will be much higher than an established practice. This and many other situations are why great caution should
be used in the comparison of your practice numbers or “benchmarks” to those of other practices. It is OK to compare your practice to others, but your own numbers from year to year are the most important benchmarks for you to consider.

Listed below are a number of the benchmarks which are generally accepted in Ophthalmology. The means by which they are calculated is also shown. The practice should consider using many (if not all) of these in preparation for your strategic planning session. This will require a great deal of preparation time prior to the meeting by one or more staff and management personnel.

**Benchmark Categories and Calculation formulae**

**used to derive benchmarks for your practice**

NOTE: Not all of these may apply to your practice, as you may or may not have OD’s or Optical operations within the practice.

**Section 1. Financial Receipts and Income**

**Professional clinical collections per FTE Ophthalmologist (MD/DO)**

\[
\text{[Total Ophthalmologist (MD/DO) Clinical Net Revenue]} ÷ \text{[total number of FTE Ophthalmologists (MDs/DOs)]}
\]

**Professional clinical collections per FTE Optometrist (OD)**

\[
\text{[Total Optometrist (OD) Clinical Net Revenue]} ÷ \text{[total number of FTE Optometrists (ODs)]}
\]

**Clinical revenue per encounter for Ophthalmologist (MD/DO)**

\[
\text{[Total Ophthalmologist (MD/DO) Clinical Net Revenue]} ÷ \text{[Total Ophthalmologist (MD/DO) Encounters]}
\]

**Clinical revenue per encounter for Optometrist (OD)**

\[
\text{[Total Optometrist (OD) Clinical Net Revenue]} ÷ \text{[Total Optometrist (OD) Encounters]}
\]

**Practice Net Collections per FTE staff member**

\[
\text{[Total Clinical Net Revenue]} ÷ \text{[total number of FTE staff]}
\]

**Practice Net Collections per FTE billing office staffer**

\[
\text{[Total Clinical Net Revenue]} ÷ \text{[total number of FTE billing staff]}
\]

**Section 2. Financial Costs and Expenses**

**Clinic Operating Expenses per encounter by entire practice**

\[
\text{[Total Clinic Operating Expenses]} ÷ \text{[Total Encounters for All Providers]}
\]

**Clinical operating expenses as a % of net collections (Overhead Ratio)**

\[
\text{[Total clinical operating expenses]} ÷ \text{[total clinical net revenues]}
\]

**Non MD/DO/OD Clinical Staff cost per encounter**

\[
\text{[Total Non-MD/DO/OD Clinical Staff Cost]} ÷ \text{[Total Encounters for All Providers]}
\]

**Front office staff cost per encounter**

\[
\text{[Total Front Office Staff Cost]} ÷ \text{[Total Encounters for All Providers]}
\]

**Total staff wage and benefit cost as a % of net collections**

\[
\text{[Total Staff Cost]} ÷ \text{[Total Clinical Net Revenue]}
\]

**Total front office wage and benefit cost as a % of net collections**

\[
\text{[Total Front Office Staff Cost]} ÷ \text{[Total Clinical Net Revenue]}
\]
Total Billing Staff wage and benefit cost as a % of net collections

\[
\frac{\text{Total Billing Staff Cost}}{\text{Total Clinical Net Revenue}}
\]

Total Non-MD/DO/OD Clinical Staff wage and benefit costs as a % of net collections

\[
\frac{\text{Total Non-MD/DO/OD Clinical Staff Cost}}{\text{Total Clinical Net Revenue}}
\]

Section 3. Staffing Levels

Number FTE Optometrists (ODs) per FTE Ophthalmologist (MD/DO)

\[
\frac{\text{[total number of FTE optometrists (ODs)]}}{\text{[total number of FTE Ophthalmologists (MDs/DOs)]}}
\]

Number FTE front office staff per FTE MD/DO/OD

\[
\frac{\text{[total number of FTE front office staff]}}{\left(\text{[total number of FTE Ophthalmologists (MDs/DOs)]} + \text{[total number of FTE Optometrists (ODs)]}\right)}
\]

Number FTE non MD/DO/OD clinical staff per FTE MD/DO/OD

\[
\frac{\text{[total number of FTE non MD/DO/OD clinical staff]}}{\left(\text{[total number of FTE Ophthalmologists (MDs/DOs)]} + \text{[total number of FTE Optometrists (ODs)]}\right)}
\]

Number FTE staff per FTE MD/DO

\[
\frac{\text{[Total Number of FTE Staff]}}{\text{[total number of FTE Ophthalmologists (MDs/DOs)]}}
\]

Number FTE staff per FTE Provider

\[
\frac{\text{[Total Number of FTE Staff]}}{\left(\text{[total number of FTE MD/DO/OD Ophthalmologists (MDs/DOs)]} + \text{[total number of FTE Optometrists (ODs)]}\right)}
\]

Section 4. Accounts Receivable Management

Total Days Clinical A/R Outstanding

\[
\frac{\text{[total $ clinical A/R]}}{\left(\text{[total gross charges for fiscal year]} \div 365\right)}
\]

Percentage Clinical A/R in "Current"

\[
\frac{\text{[Total $ Clinical A/R 0-30 days]}}{\text{[Total $ Clinical A/R]}}
\]

Percentage Clinical A/R in "31-60 days"

\[
\frac{\text{[Total $ clinical A/R 31-60 days]}}{\text{[Total $ clinical A/R]}}
\]

Percentage Clinical A/R in "61-90 days"

\[
\frac{\text{[Total $ clinical A/R 61-90 days]}}{\text{[Total $ clinical A/R]}}
\]

Percentage Clinical A/R in "91-120 days"

\[
\frac{\text{[Total $ clinical A/R 91-120 days]}}{\text{[Total $ clinical A/R]}}
\]

Percentage Clinical A/R in "121+ days"

\[
\frac{\text{[Total $ clinical A/R 121+ days]}}{\text{[Total $ clinical A/R]}}
\]

Section 5. Throughput and Productivity

Total encounters per FTE Ophthalmologist (MD/DO)

\[
\frac{\text{[Total Ophthalmologist (MD/DO) Encounters]}}{\text{[total number of FTE Ophthalmologists (MDs/DOs)]}}
\]

Total encounters per FTE Optometrist (OD)

\[
\frac{\text{[Total Optometrist (OD) Encounters]}}{\text{[total number of FTE Optometrists (ODs)]}}
\]
New patient encounters as a % of total encounters by entire practice
\[\frac{\text{Total New Patient Encounters}}{\text{Total Encounters for All Providers}}\]

Encounters per FTE Non- MD/DO/OD Clinical Staff
\[\frac{\text{Total Encounters for All Providers}}{\text{total number of FTE non MD/DO/OD clinical staff}}\]

Encounters per FTE Front office staff
\[\frac{\text{Total Encounters for All Providers}}{\text{total number of FTE front office staff}}\]

Section 6. Facility

Total clinic facility expenses as a % of total net collections
\[\frac{\text{Total Clinic Facility Expenses}}{\text{Total Clinical Net Revenue}}\]

Section 7. Bottom Line

Net clinical compensation per FTE Ophthalmologist (MD/DO)
\[\frac{\text{total ophthalmologist (MD/DO) clinical compensation}}{\text{total number of FTE Ophthalmologists (MDs/DOs)}}\]

Net clinical compensation per FTE Optometrist (OD)
\[\frac{\text{total Optometrist (OD) clinical compensation}}{\text{total number of FTE Optometrists (ODs)}}\]

Net clinical compensation per FTE owner
\[\frac{\text{total owner compensation from Clinical Operations}}{\text{total number of FTE owners}}\]

Section 8. Optical Benchmarks

Optical collections per FTE MD/DO/OD
\[\frac{\text{Total Optical Net Collections}}{\text{total number of FTE Ophthalmologists (MDs/DOs)} + \text{total number of FTE Optometrists (ODs)}}\]

Optical collections per FTE Optician
\[\frac{\text{Total Optical Net Collections}}{\text{total number FTE opticians}}\]

Optical collections per practice encounter
\[\frac{\text{Total Optical Net Collections}}{\text{Total Encounters for All Providers}}\]

Optical cost of goods sold as % of Net Optical Collections
\[\frac{\text{total optical cost of goods (COG)}}{\text{Total Optical Net Collections}}\]

Optical Operating Expenses as % of Net Optical Collections
\[\frac{\text{Total Optical Operating Expenses}}{\text{Total Optical Net Collections}}\]

Optical Rx capture rate (not all practices capture refractions in the same manner)
\[\frac{\text{Total number of optical sales}}{\text{Total number of refractions (92015)}}\]

Average revenue per sale
\[\frac{\text{Total Optical Net Collections}}{\text{total number of optical sales}}\]

Average cost per sale
\[\frac{\text{[total optical cost of goods (COG)]} + \text{Total Optical Operating Expenses}}{\text{total number of optical sales}}\]

Average net profit per sale
\[\frac{\text{Total Optical Net Profit or Loss}}{\text{total number of optical sales}}\]
Total Optical Net Profit or Loss
\[(\text{total optical net collections}) - (\text{total optical cost of goods (COG)} + \text{total optical operating expenses})\]

IMPORTANT NOTE: These numbers should be reviewed by the owner(s) prior to divulging them with the balance of the staff.

Once the benchmarking data has been discussed, targets should be determined and recorded as potential goals for the coming year.

These numbers should be tracked very carefully to determine the progress the practice is or is not making toward goal achievement.

A simple form that lists the achieved number and the target number for next year can then be produced. If desired, the necessary strategies for attaining this goal (bullet points) can be included.

As the goals are being determined, the necessary strategies for achieving these goals should be discussed. These should include any financial investments by the practice that are necessary for the successful attainment of the stated goals.

Goals may take other forms than just the numerical quantities shown in the examples, i.e.: if you desire to extend your outreach into a neighboring community, then the acquisition of a location from which to operate within that area will be needed. Will the strategy be to buy land and build, lease a location, work with another practice such as an od office where you can rent space, etc.

The implementation of these strategies will then become goals for various groups within the practice to achieve. A goal of this type may be one of the strategies used for the attainment of a higher number of patient encounters or increased surgeries for the practice.

Periodic management meetings should be held to discuss the practice progress – these meetings should include a determination as to what impediments are keeping the practice from obtaining their desired growth goals or strategy implementation.

This will most probably be a completely new approach to the management of your practice. It is not an end, but a beginning. The rest is the journey.