APERTURE

Associated Eye Care Partners

A UNIQUE APPROACH TO PRACTICE PRODUCTIVITIES PERFORMANCE ANALYTICS AND LEADERSHIP DECISION-MAKING

Since the dawn of the medical group practice, physician leaders and practice administrators have leaned on financial accounting data for most strategically and managerially important practice performance decisions. The reason why is unassailable; business success is quantified in terms of dollars and cents. The main challenge of relying on accounting data alone for critical decision-making is the conventions and logic of financial accounting and reporting, while useful and required, are not always sufficient. The reason is accounting conventions and reporting can leave a knowledge gulf between results and rational decision-making. Managerial decisions based upon financial accounting results alone require interpretation, interpolation, judgment, and wide tolerances for decision risk.

A simple illustration is useful here: The profitability of a medical practice is declining. The obvious question is, "why?" The solution set is multi-variate; in other words, at least a dozen factors can independently or interactively contribute to the observed "bottom line" deterioration. Examples of this potential solution set include provider productivity, payer mix, clinical programming, operating expense management, clinical services coding and documentation, revenue cycle management, competitor activities, and practice growth strategies, to name a few. What's more, misplaced attempts at problem resolution based upon insufficient or misleading information can make problems worse; attacking the right problem with the wrong assumptions puts the business and leadership at risk.

We have developed, and are recommending here, a new approach to managerial decision support: the adoption and applications of a disciplined approach to understanding the practical operating economics and productivities of the practice, while maintaining fidelity to financial accounting and reporting conventions.

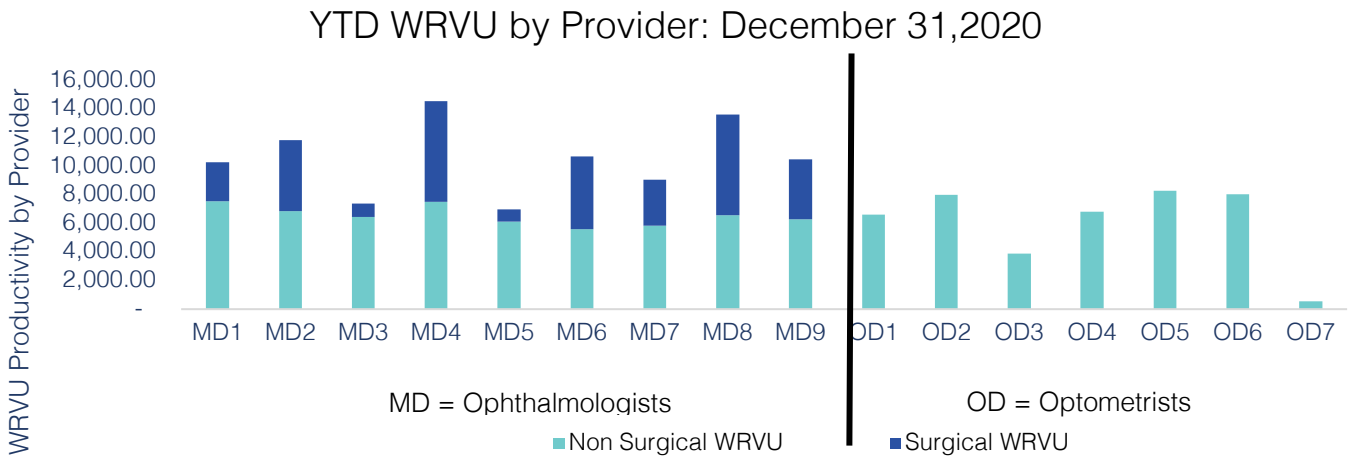
For example, operating economics are created by how the practice organizes and deploys practice resources, including provider productivity potential. The deployment of practice resources is influenced by leadership, guided by the mission, vision, values, philosophy, and strategy of how clinical care should be delivered to patient populations. The model described below makes use of data that are (or should be) available from electronic practice management information systems, including the electronic medical record.

Description of the Model

The model uses the work relative value unit (WRVU) as a mainstay of the applied analytics platform. The WRVU is a standardized unit of professional services effort output. It is applicable across medical services professionals, and is recognized domestically and internationally by medical practice leaders and administrators. It is easy to mine from electronic practice management systems and electronic health records. The WRVU lends well to descriptive and inferential statistical methods applications and analytics and makes for a common language bridge between clinicians, who produce WRVUs, and administrators who manage medical practice performance, practice productivity, and financial performance.

The fundamentals of the model described below applies the WRVU through defined analytics in two ways: (1) descriptively, as arrayed distributions of WRVU across key categories of practice performance, and (2) as the foundation for various higher-order analyses to answer questions relating to the productivity of the practice determined "as a function of" the WRVUs provided. Examples are provided to answer several useful practice performance questions that are not easily answered from conventional financial reporting. Analytics examples are made available from a comprehensive, medical-surgical eye practice serving multiple locations with general and sub-specialized providers. Ten useful sample model questions are addressed below with graphic representations of the model "in-action."

Figure 1. YTD WRVU by Provider



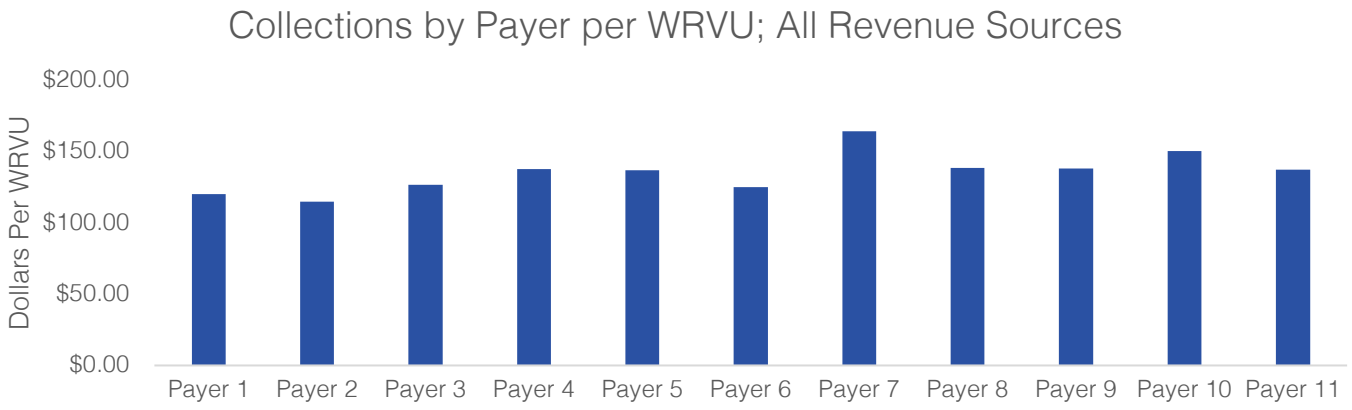
This graphic demonstrates a simple display of WRVU productivity, by provider, with ophthalmologists and optometrists arrayed for comparison. Medical and surgical WRVUs are provided for ophthalmologists. Optometrists do not generate surgical WRVUs.

Question #1: How is WRVU productivity distributed, per provider, for a defined accounting period?

Productivity Observation: WRVU productivity differs markedly within and between provider groups.

Key Leadership Question(s): 1) What causes wide variation between providers within clinician categories, and 2) are there abilities to narrow variation toward high levels of average provider productivity within and between groups?

Figure 2. Collections by Payer per WRVU; All Revenue Sources



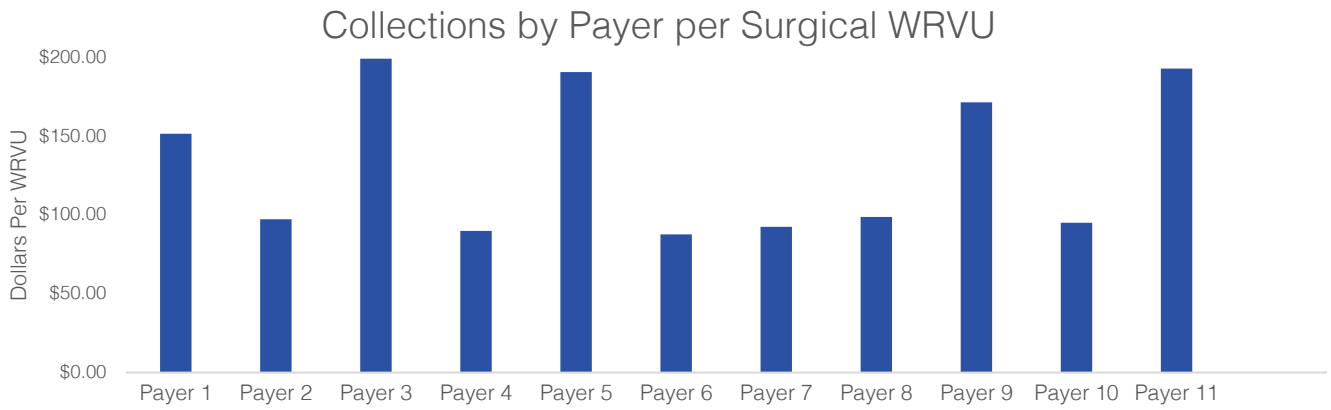
This graphic shows collections per WRVU distribution across all third-party payers.

Question #2: "How is provider work effort distributed across the practice payer mix?"

Productivity Observation: Allocation of provider capacity to payer type affects operating revenue and financial productivity.

Key Leadership Questions(s): Can payer mix be positively shifted by changes in market positioning strategies?

Figure 3. Collections by Payer per Surgical WRVU



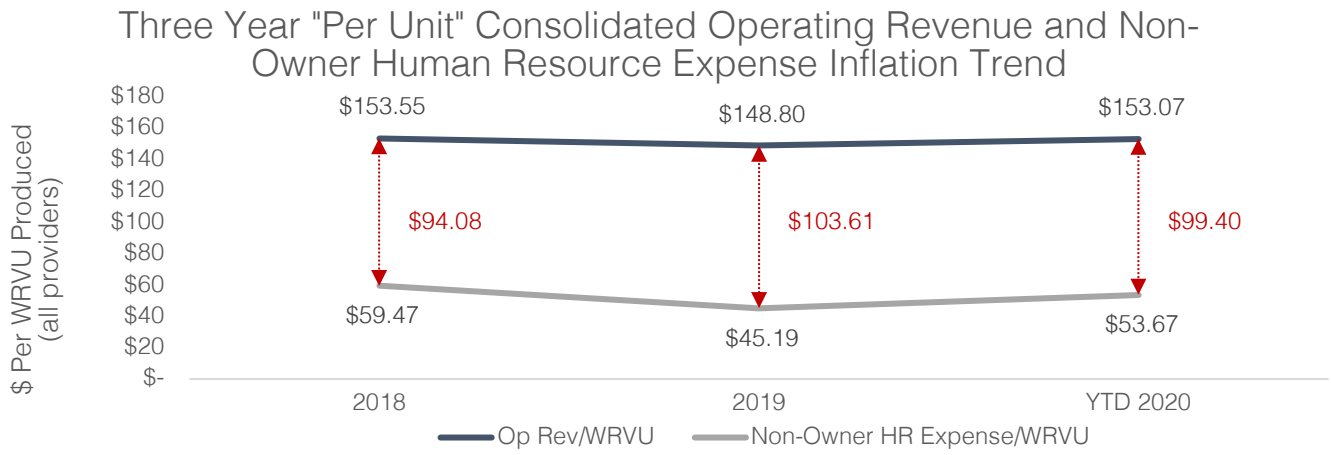
The graphic shows the financial realization rate per surgical WRVU billed to all payers, including governmental.

Question #3: "What is the average revenue realization rate, per surgical WRVU, by payer?"

Productivity Observation: Surgical revenue productivity, per WRVU, varies markedly across payers.

Key Leadership Question(s): 1) Are adjustments to the pricing of the surgical services practical, 2) are specific payers likely to disproportionately exert downward pressures on reimbursements, and 3) can the practice leaders positively affect operating productivities and financial performance of surgical services as payer pressures continue?

Figure 4. Three Year "Per Unit" Consolidated Operating Revenue and Non-Owner Human Resource Expense Inflation Trend



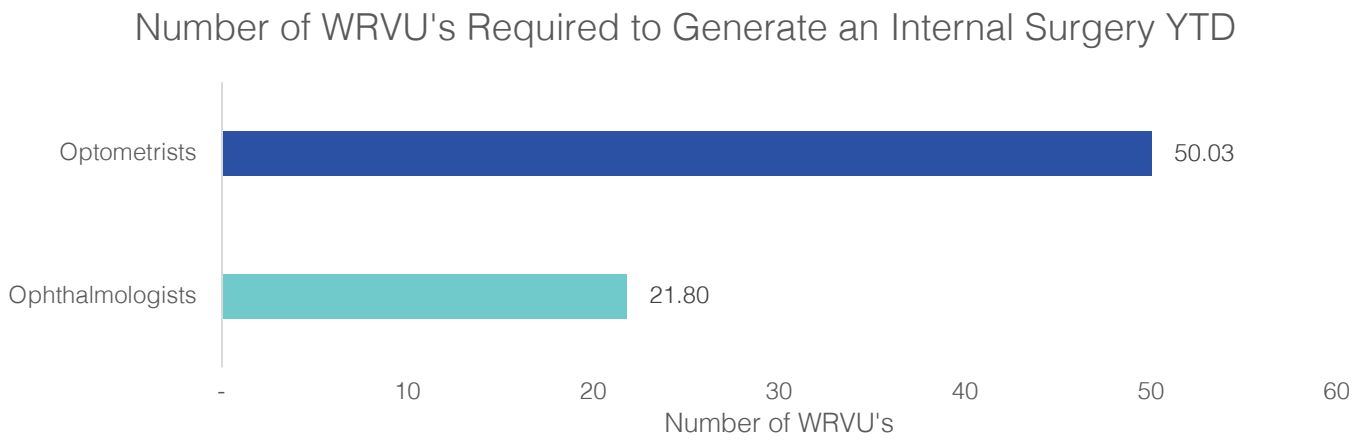
This graphic compares, for three points in time, trend lines for weighted average reimbursement, per WRVU, compared with average non-provider human resource expense, per WRVU, for the same period, comparing two operating inflation rate trend lines.

Question #4: "How is reimbursement per average WRVU trending as compared with average non-owner human resource expense per WRVU?"

Productivity Observation: Operating revenue per WRVU can operate independently of human resource expense.

Key Leadership Question(s): What is the likelihood that the "per-unit" human resource inflation trajectory will out-pace the "per-unit" reimbursement rate inflation trajectories for the practice, and what can be done to manage this trend through practice productivities improvements?

Figure 5. Number of WRVU's Required to Generate an Internal Surgery YTD



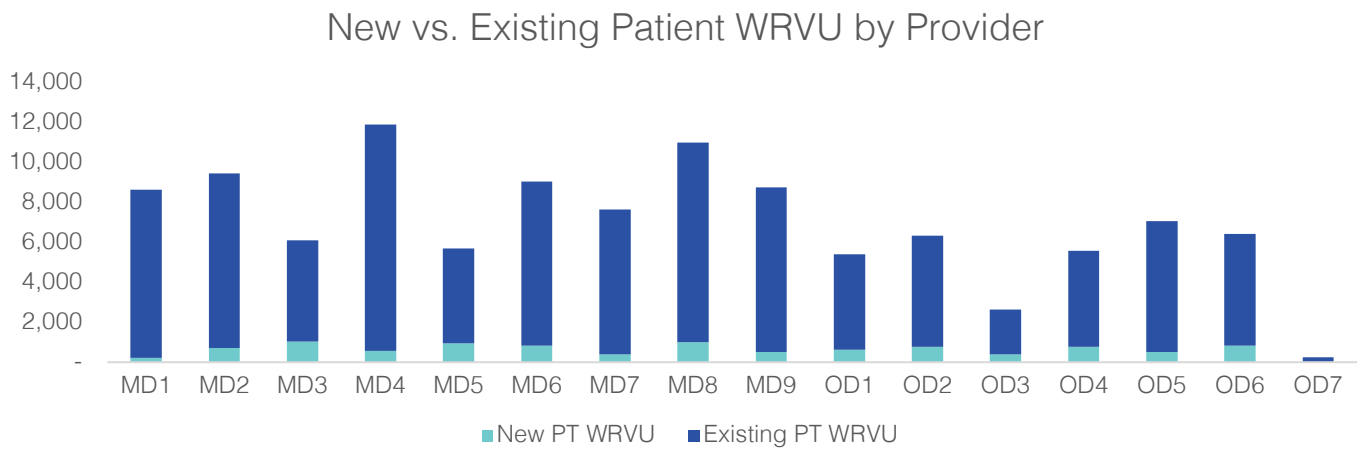
This graphic demonstrates the number of WRVUs required to produce a surgery; optometrist rates and ophthalmologists' rates are compared.

Question #5: "What is the surgical yield rate produced, per WRVU produced, by employed optometrists and Ophthalmologists?"

Productivity Observation: Internal surgery referrals per WRVU for optometrists and ophthalmologists demonstrate a predictable demand pattern.

Key Leadership Question(s): If optometrists are relied upon to deliver surgical cases, what is the ideal number of this class of provider for the practice, and 2) are there reasons to better manage the case-mix between optometrists and ophthalmologists to produce the required number of surgical cases for the practice?

Figure 6. New vs. Existing Patient WRVU by Provider



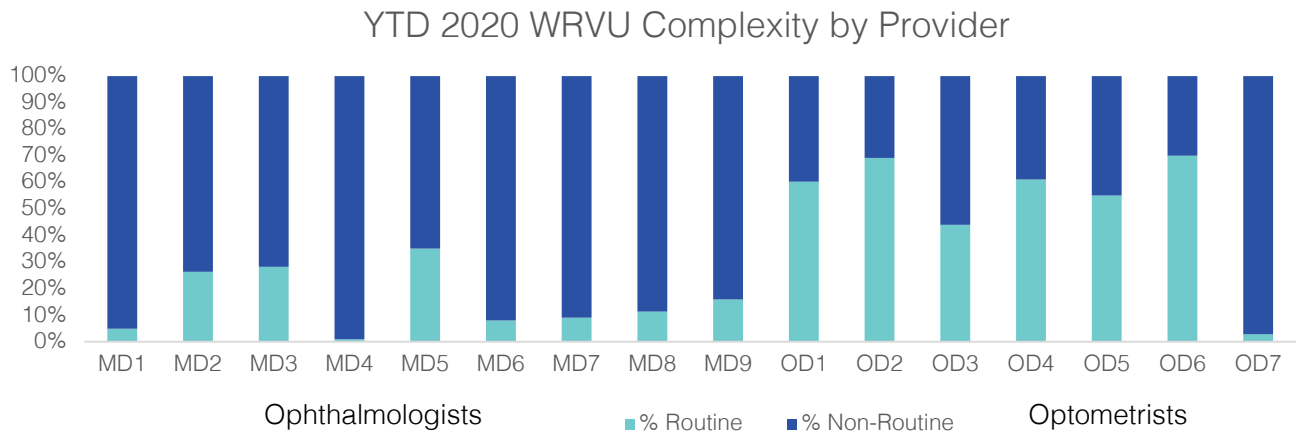
This graphic demonstrates new patient WRVUs proportions allocable to all optometrists and ophthalmologists.

Question #6: "What proportion of provider work effort is allocable to new patients, optometrists and ophthalmologists?"

Productivity Observation: Capacity for new patients is limited across providers.

Key Leadership Question(s): Is access for new patients sufficient by provider and for the practice overall?

Figure 7. YTD 2020 WRVU Complexity by Provider



This graphic demonstrates, per provider, WRVU complexity distributions; medical routine, medical complex, and surgical/ procedural for ophthalmologists and optometrists.

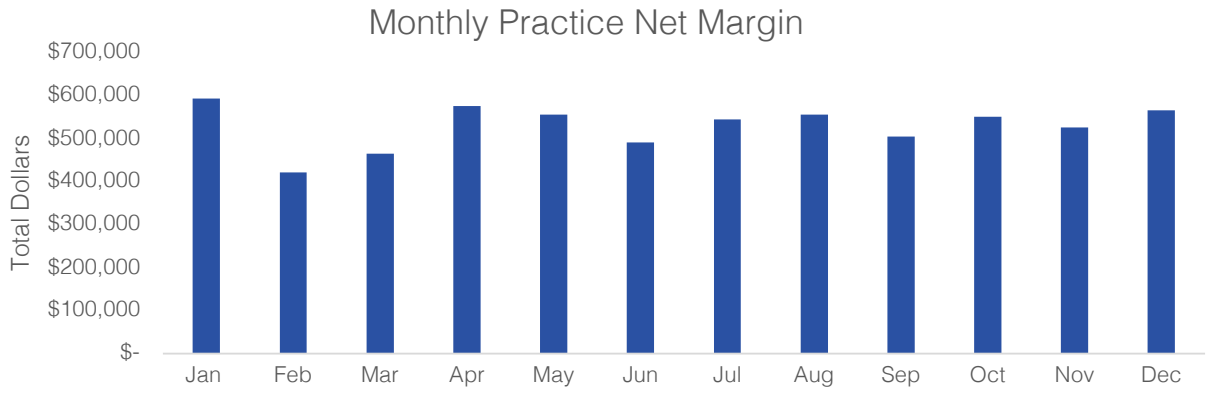
Question #7: "How are optometrists and ophthalmologists allocating their clinical time as defined by clinical complexity?"

Productivity Observation: A higher proportion of the more complex patients are being directed by the schedulers to ophthalmologists, with more of the routine patients directed to optometrists.

Key Leadership Question(s): Can patient clinical complexity be better managed for the patient and practice?

In a private practice setting, especially with business models that integrate medical, surgical, optical and optometric services, owners should understand how their business model design yields financial returns as a function of the work effort they produce. Such analyses serve as an indicator of the financial productivity of the chosen business model design. A principal goal of business model design is the financial yield of every WRVU produced by practice owners.

Figure 8. Monthly Practice Net Margin



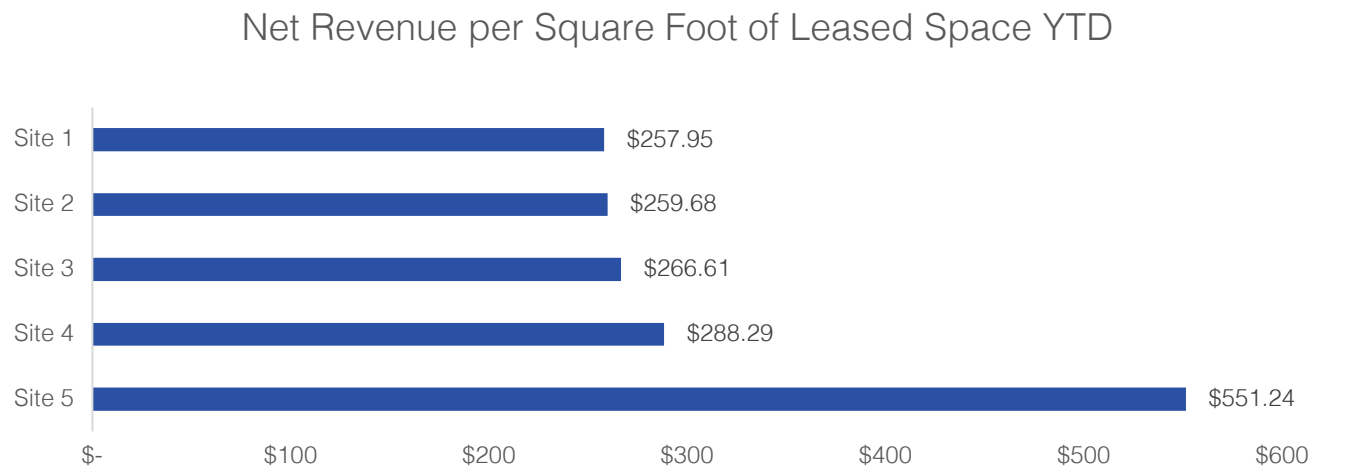
This graphic demonstrates a monthly display of net practice margin (the owner compensation pool) available to practice owners per WRVU produced by owners; a monthly display for twelve months.

Question #8: "What are the results for the financial margin yield for practice owners per WRVU produced by owners?"

Productivity Observation: Owner compensation pool varies based upon several factors, including organizational strategy, clinical services mix, provider mix, the ratio of non-owner providers to owner providers, and how clinical case mix is distributed across providers in the practice.

Key Leadership Question(s): 1) What practice design opportunities will improve the financial returns on the partners' efforts, and 2) how will options affect the mission, strategy and required resource investments.

Figure 9. Net Revenue per Square Foot of Leased Spaced YTD



This graphic demonstrates, for a defined period of time, operating revenue produced per square foot of useable clinical space.

Question #9: "What is the state of the productivity of leased clinical space?"

Productivity Observation: WRVU productivity, per square foot, differs per location. The most productive use of leased clinical space is where all three clinical model revenue streams are aggregated; clinic, ASC, and optical products sales.

Key Leadership Question(s): 1) What is the potential to utilize the fixed asset cost structure more productively, 2) what is the potential to add more WRVU productivity from the existing providers, 3) will the facilities fixed asset base accommodate additional providers, and 4) how should future facilities be designed to optimize the fixed asset cost structure?

Inferential Analyses Example (understanding where to invest practice resources)

Question #10: Which operating revenue streams are most available for profitability improvements? In other words, what can the practice do to most enhance the financial performance of the practice without wholesale changes in the business model? The practice revenue structure is composed of three integrated businesses; medical, surgical, and eyewear product sales.

Productivity Observations: Analysis of the relationship between the three practice revenue streams demonstrates that increases in eyewear product sales, with the current level of clinic visits held constant at existing levels, will demonstrably increase returns to owners with little or no investments required except for cost of goods sold.

Key Leadership Question(s): How can eyewear product sales be improved while ensuring that patients are offered clinically required and ethically appropriate options?

Summarizing the Value of the Model for Physician and Medical Practice Professional Professionals

The model demonstrations provided here represent a sample of the range of decision analytics available from the model. As presented, the model is recommended for use with the tried-and-true methods of financial accounting and reporting. The advantages of using both models together are numerous, including providing clear guidance on how practice clinical and business model productivities affect financial performance, how strategic decisions affect practice productivities and financial performance, how practice investments affect practice productivities and financial performance, and explanations of how operating revenue and expense inflation trends, per unit of service produced, portend future financial performance. The model also serves as a communication bridge between clinical and administrative leaders in the practice by providing understandable illustrations of how clinical models and programs convert units of provider productivities to financial performance and accounting reports.

Observations on the Model from the Perspective of a Physician Leader

As physician leaders, we are schooled in treating a patient first and managing a business second. When we are faced with negative financial performance as described above, a common reaction is "analysis paralysis," the collection of increasing amounts of data with the hope that the solution will eventually reveal itself. Unfortunately, when the problem is as multifactorial as it typically is, the solution will not reveal itself by collecting the data from the financial reports we instinctually turn to.

The key to developing a deeper understanding of the factors causing the financial performance problems is understanding how the work that is creating the revenue is being performed. Without this information, the resultant data will always be incomplete. Fortunately, the WRVU was created to keep track of provider effort. However, most practices do not use it to its fullest potential, instead using it only in the submission of charges. By mining WRVU information that the practice is already collecting and applying performance analytics to them, practice managers and physician leaders can more easily reallocate provider resources to improve financial performance.

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Associated Eye Care Partners

Associated Eye Care Partners (AECP) is a practice development company that delivers management services, strategic capital, and expertise to grow and develop independent, high-performing eye care practices in partnership with their physicians. Associated Eye Care Partners was founded by the physician owners of Associated Eye Care - an adult and pediatric eye care group with nearly 50 years of sustained growth, and the owners of Castling Partners - a premier health service advisory and management firm.

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