

# Trading Spaces: Renovate, Relocate, or Do Nothing?

*On what information should you base this decision?*

BY LARRY BROOKS

You have been in your practice facility for many years. It has served you well, but recently things are not “working” as in the past. What is different? Has the practice grown in providers and/or patient volume (hopefully)? Has HIPAA affected the way you manage patients (certainly)? Have you added services (likely)? Maybe the answer lies in a combination of the above (probably). All you know is that your facility does not seem to accommodate your practice as well as in the past. The answer(s) of what to do about your facility – renovate, relocate, do nothing, etc. – is elusive because you are busy practicing medicine. It is hard to step back and take a meaningful, objective operational assessment of your practice to find out exactly what needs to be done.

This is the first in a two-part series on how to analyze your current practice – its operational systems, staffing model, and space – to determine if your present facility effectively supports your practice. This article will help uncover areas that may be adjusted to allow your practice to be more efficient, provide better patient care, and increase patient volume and revenue. The second article will focus on how to objectively evaluate the space options available to your practice.

## Practice Analysis

The process of analyzing a practice is similar to a patient office visit: you follow a logical series of steps to gather information, examine, and diagnose. Then, you design and implement a plan to achieve a desired result.

### Present Complaint or Goals and Objectives

The first step in analyzing a practice is to identify any and all present complaints and determine practice

goals and objectives. What would you like to see your practice do differently? What bothers you about your current practice? There are typically four basic areas where questions arise when practices start to discuss long-term goals and objectives:

• **Physician staffing:** *How many physicians should we plan for? Are we going to have both ophthalmologists and optometrists?* The number of physicians and

whether they are ophthalmologists or optometrists, in the group is the primary driver of space needs. Although ophthalmologists consume more space while seeing patients, they are not always in the office; on the other hand the optometrist consumes less space but normally consumes it every day?

• **Ancillary Services:** *Are we planning to have an Optical Shop? ASC? LASIK Suite?* The ancillary

services offered by the practice will also have a major impact on the spatial requirements of the practice. From how much display space for optical, to whether or not there will be a grinding lab, to how many cases we planning for the ASC and/or LASIK suite, these issues all play a role in the size and layout of the practice space.

• **The “work” schedule:** *Should we have evening and/or Saturday sessions? Should we consider a satellite office? How many more years do the senior physicians plan to work? Should there be space planned to allow a senior partner to slow down (non-surgical) and a new physician to be brought in to replace the senior partner?* Your weekly schedule will determine the number of physicians the facility needs to handle seeing patients at once. That schedule will need to be organized to normalize the physician demand on the facility.

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• **Likes and dislikes:** *What do you really like about your office? What don't you like?* Write down everything from the color of the wallpaper in the staff lounge, to the dimmer switch in the exam lane is hard to reach, to the fact you never seem to have a scribe available when you need one. Whatever you like or dislike should be compiled into a list. If any changes are going to be made, you want these items to figure into the equation.

## Examination and Diagnosis (Analysis of Practice)

To analyze the effectiveness of your current office, identify all users of the facility, their requirements, and the impact those requirements have on the overall organization of the facility. The three basic users of a practice are patients, physicians, and staff members.

Among these users, it is important to establish a hierarchy of needs on which to base operational decisions. In reality, the only reason patients and staff are at the practice is because of the physician. Thus, operational decisions should be made in the physician's best interest first. Because staff members work in the practice all day, every day, they should be considered next in the hierarchical decision-making tree. The last user to consider is the patient. This may seem contrary to some, but the logic is the patient makes the trip through the office systems once an office visit; the physicians and staff work in them all day, every day. Also remember, if the physicians and staff are as efficient as possible, they will have more quality professional time to spend with patients.

How do you determine if your current operational systems effectively support your physicians, staff, and patients? Since the physician is tops on the decision-making tree, start there. All physicians have their own personality and, therefore, their own "natural style" of managing patients. This natural style will generate a "natural patient-per-hour rate." This is the rate at which physicians would function if all negative influences (i.e., looking for a tech, not having a patient to see, getting questioned by the previous patient in the hall, etc.) were eliminated from their day. The total of the "natural rates" for all physicians in the office seeing patients will give you the information needed to effectively manage the flow of patients through the practice.

To determine the "natural rate" of each individual physician, a time and motion study should be performed to identify exactly how every minute of that physician's day seeing patients is spent. From this, you will be able

to determine what items can be eliminated, what items can be delegated to staff, and what items the physician must do because he/she is the doctor.

The following is an example of a time and motion study on a physician:

This chart illustrates the physician is seeing 3.63 pa-

Time and Motion Study				
Task	Time			
	Dr. Time	Delegated	Wasted	Elapsed
Patient Work-Up		5.25		5.25
Look for Tech			0.75	0.75
Dr. Phone Call	2.5			2.5
Patient Examination	7.5			7.5
Dictate Chart	1.5			1.5
Walk to Lab			1.5	1.5
Look for Chart			1.0	1.0
Talk to Patient in Hall			2.5	2.5
Patient Examination	5.25			5.25
Walk to Proc. Scheduler			1.1	1.1
Give Verbal Instructions		2.5		2.5
Dictate Chart	1.75			1.75
<b>Total</b>	<b>18.5</b>	<b>7.75</b>	<b>6.85</b>	<b>33.1</b>
<i>Patients Seen</i>	2.00			
<i>Actual PPH Rate</i>	3.63	<i>(Patients Seen / Elapsed Time)</i>		
<i>Potential PPH Rate</i>	6.49	<i>(Patients Seen / Dr. Time)</i>		

tients per hour. However, instituting a few changes to the operational systems to allow him/her to be more efficient could raise the patient-per-hour rate to 6.49. This can be achieved without changing the amount of time spent with patients. The practice and physician should be striving to reach the 6.49 "natural rate" figure.

Performing a similar time and motion study on staff supporting the physician can identify possible flaws in the staffing model or tasks assigned to those staff. For instance, is the tech who is assigned to load rooms and refract patients also assigned duties such as scheduling procedures, educating patients, or triaging patient calls? If so, there could be a conflict in the duties that staff member is trying to perform.

The number-one rule for staff (and the entire practice for that matter) should be to **always** have a "next" patient ready for the physician to see. By assigning staff conflicting responsibilities, they are bound to fail at one of them. The tech will get caught up in scheduling or educating a patient and not be able to prepare the next

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patient; or the receptionists will get caught up on the telephone and not be able to promptly check patients in and get them ready for the tech to escort to the exam lane, etc.

If the physician time and motion study determines there are times the physician does not have a patient to see, the next step is to continue backward on the chain of events that gets that patient to the physician to identify bottlenecks. Even if you find one bottleneck in the chain of events, there could be more further back. Follow the production chain of patient flow events back to the appointment schedule to make sure you discover all events that impact the process.

## Implementation Plan (Program Changes)

At this point in the process, you have determined goals and objectives of the practice, identified if your physicians and staff are efficient, and possibly identified changes that are needed to your operational and communication systems. Now you need to determine spatially what this means to your practice.

As mentioned in the introduction, part two of this article will evaluate the specific spatial options available to your practice – renovate, relocate, or do nothing. To do this you need to have quantified your space needs. This gets back to the goals of the practice: How many physicians should be planned for and how many of them do you need to plan for seeing patients at once? This is simply a function of the physician’s weekly schedule (not that many practice’s physicians schedules are simple). Below are examples of a practice’s: 1) current physician schedule, 2) the same schedule adjusted to normalize the physician demand on the facility, and 3) the same schedule expanded to project the future demand as physicians are added to the practice.

## Current Schedule

	M		T		W		TH		F		H-D/WK
	am	pm									
DR. A	O	O	O	O			O	O			6
DR. B	O	O			O	O			O	O	6
DR. C			O	O	O	O	O	O			6
DR. D	O	O					O	O	O	O	6
DR. E	O	O	O	O			O	O			6
	4	4	3	3	2	2	4	4	2	2	30

## Normalized Schedule

	M		T		W		TH		F		H-D/WK
	am	pm									
DR. A	O	O	O	O			O	O			6
DR. B	O	O			O	O			O	O	6
DR. C			O	O	O	O	O	O			6
DR. D	O	O					O	O	O	O	6
DR. E	O	O	O	O	O	O			O	O	6
	3	3	3	3	3	3	3	3	3	3	30

## Projected Future Schedule

	M		T		W		TH		F		H-D/WK
	am	pm									
DR. A	O	O	O	O			O	O			6
DR. B	O	O			O	O			O	O	6
DR. C			O	O	O	O	O	O			6
DR. D	O	O					O	O	O	O	6
DR. E	O	O	O	O	O	O			O	O	6
	3	3	3	3	3	3	3	3	3	3	30
DR. F	O	O			O	O	O	O			6
DR. G	O	O	O	O					O	O	6
DR. H			O	O			O	O	O	O	6
	2	2	2	2	1	1	2	2	2	2	18
	5	5	5	5	4	4	5	5	5	5	48

H-D/WK = Half-Day Sessions per Week

The important point to gain from these examples is that the normalized schedule allows the physicians the same amount of clinical access each week as does the current schedule, a total of 30 half-day sessions. Therefore, both schedules allow the practice the same chance at generating the same revenue. The difference is the normalized schedule never has more than three physicians working at once, while the current schedule has sessions with four physicians at once. This means a practice with a normalized schedule could build and staff a smaller facility than a practice with the current schedule with peaks and valleys in the number of physicians in the office seeing patients at once.

The projected future schedule allows the practice to know how many physicians seeing patients at once it needs to include in its plan. The spatial needs of the practice should be based on this information and knowledge. For example, this practice should use five-physicians-at-once as the number to project out its future space needs. The practice must also understand how much space each

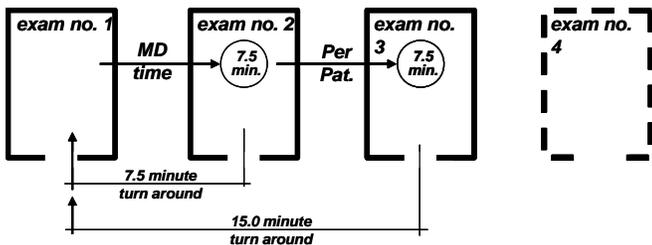
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physician requires. This relates back to a physician’s “natural rate.”

The patient-per-hour rate of the physician and the length of time it takes to ready a lane with another patient once that physician exits that lane (referred to as turn-around time) determines the number of exam lanes (called an Exam Module) a physician requires. The typical turn around time for a ophthalmology practice is 8 to 10 minutes. This gives the tech time to follow up with the patient, the patient time to exit the lane, and the tech time to clean the lane and get another patient in the lane for the physician. The following example illustrates the need for a physician seeing eight patients per hour.



The example above (eight patients per hour and a 8 to 10 minute turn-around time) illustrates that three exam rooms should be sufficient. However, because these times are averages and there likely will be peaks and valleys to the rate of patients seen, the practice may want to plan four exam rooms for this physician.

This diagram determines how many exam lanes the physician needs, but has not addressed the lanes required by the techs if refracting is delegated. The number of lanes required is determined by multiplying the number of patients per hour needing to be refracted times the number of minutes per average refraction and dividing by 60 minutes/hour. This number also gives you the number of techs required to just refract.

The next step is to begin determining square footage numbers based on the number of physicians in the practice, the number of physicians seeing patients at once,

Sample Partial Space Program			
Description	Sq. Ft.	Qty.	Area
<b>RECEPTION LOBBY</b>			
3 MD x 10 pat/hr + 2 OD x 6 pat/hr			
= 42 patients/hour			
x 2.5 tag-a-long factor = 105 people/hr			
- 9 MD Lanes - 4 OD Lanes			
- 8 Tech Lanes - 10 subwait seats			
= 74 seats	20	74	1,480
Toilet(s)	56	2	112
<b>Sub Total</b>			<b>1,592</b>
<b>CLINIC</b>			
<b>MD Exam Module</b>			
Physician Lanes	114	3	342
Tech Lanes	114	2	228
MD Station	36	1	36
Tech Station	48	2	96
# of Examination Modules		3	
<b>Sub Total</b>			<b>2,106</b>
<b>OD Exam Module</b>			
Physician Lanes	114	2	228
Tech Lane	114	1	114
OD Station	36	1	36
Tech Station	48	1	48
# of Examination Modules		2	
<b>Sub Total</b>			<b>852</b>

the rate at which those physicians see patients, and the services to be provided. Below is an illustration of a partial space program. The spatial program being developed also needs to project the need for parking and land.

## The Next Step

Treating your operations and facility as a patient, you have gathered the history and present complaint on the patient, examined the patient, made your diagnosis, and devised a treatment plan. Now — and only now — are you ready to determine the best alternative to implement the treatment plan. Part 2 of this article will help you decide which “space” option is right for your practice.

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