Introduction to Eye Care Economics

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INTRODUCTION TO EYE CARE ECONOMICS FOR OPTOMETRY STUDENTS
Preliminary Discussion – The Bottom Line

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I. Perceptions Surrounding Financial Success

When we discuss financial reimbursement for professional services, it can become very easy to get lost in rhetoric and to lose sight of the goals behind financial reimbursement in the marketplace. So, before we get too caught up in the academic nature of the subject, let us not forget this is about money, making a living, paying off debts, and providing for ourselves and our loved ones. Financial reimbursement is about financial success and the word "Profit."

The word "Profit" forms the basis of our discussion. Unfortunately, society conveys mixed messages about "Profit." The word is demonized by many, yet revered quietly by the same group. When talked about in public, "Profit" too often infers an element of greed. I am asking you for the sake of this discussion not to view financial success and the concept of "Profit" in negative terms. Rather, view this term positively, created from a mutually beneficial relationship between a service provider and a consumer. This mutually beneficial relationship is what we will refer to as ***true value*** in the marketplace.

II. Searching for True Value

The concept of true value in the marketplace can be put into a very simple equation. On one side of the equation you have the consumer without whom there would be no reason to provide services thus, no reason for a provider. The consumer has needs and wants and places value on them from both a personal and a financial point of view. A service provider has a similar situation. If needs, wants, and expectations are not balanced on both sides of this provider/consumer relationship, someone will exit the equation resulting in a valueless environment – one truly not conducive to business.

In the area of health care and specifically eye care, we refer to the provider/consumer relationship as the doctor/patient relationship. Probably in the early days of cash and carry marketplaces, the value-based paradigm was simple. However, this paradigm becomes somewhat complicated because wherever there is a successful provider/consumer relationship, there are always other people (third parties) trying to cash in on the benefits of the successful relationship. This is the nature of entrepreneurial business and although it is not necessarily a bad thing, it does require your attention so that you can manage somewhat complex situations that could threaten your long-term success.

A good example of these possibly complex situations is third parties encroachment upon the health care system. As previously discussed, we have gone from a health care system that thrived on the delivery of excessive care to a system that discourages care in an attempt to preserve the bottom line. However, as the economic system evolves, patients are realizing that third parties erode the

value of the doctor/patient relationship. As a result, patients are seeking other environments that fit their needs.

This change in environment will bring significant opportunities into the business world for doctors, patients, and third-party payers. To benefit from the opportunities of this shifting environment, you will have to take control of your own destiny. This will involve fueling your intellect and understanding of the marketplace and will allow you to protect yourself and your patients from those who would like to raid the marketplace with unbalanced value systems and inappropriate profit motives. It will require you as professionals to work together with your colleagues to develop appropriate eye care environments that patients perceive as valuable and beneficial.

III. Personal and Professional Decisions Consistent with Long-term Success

To achieve the balanced perspective that is commonly associated with long-term success, you must engage in some personal decision making. Basically, you have to answer three questions: 1) How important is money to you? 2) How important is your professional image and success to you? 3) How important is your personal life? Let's look at these one at a time.

A. Money

How important is money to you? Will the idea of making money totally consume you or do you think you can live without it? You must ask yourself these questions because the pursuit of financial success can consume you and play havoc with your professional standing and your personal life. The best advice I have at this stage is the following: those who think money is everything will have a rude awakening, and those who think money means nothing will be very disappointed. Everyone has to achieve a balance, finding this balance is another story.

B. Your Professional Image

How important is your professional image and success to you? Do you view them as only a means to an end or does your profession fuel your soul and enrich your life? These questions directly relate to the difference between "tech vs. doc" mentalities.

Many doctors will practice their profession like a "tech" just for the sake of making money so that they can do other things they deem more important. Others with the "doc" mentality practice optometry because the profession excites them and the interpersonal relationships with their patients are professionally rewarding. The industry accommodates both kinds of people. However, over a person's life the "doc" option seems much more sustainable.

C. Your Personal Life

How important is your personal life? You should consider three main parts of your personal life:

1. *Your Guiding Principles – Philosophical and Spiritual*

At some point in time everyone realizes the underlying philosophies that make them tick. The religious call this their spiritual base. The non-religious call this their philosophical base. Many people enter adulthood with little understanding of their guiding principles and left unattended, the lack of such understanding can be disastrous and leave people very vulnerable. I recommend you search for your guiding principles and nurture them. Remember, as you grow older your need for guiding principles will grow larger and when the chips are down, you will need them more than ever.

2. *Family*

How important is your family to you? For this particular component of your personal life I am excluding spouses and concentrating specifically on your children, parents, and extended family. Raising children and meeting the emotional needs of extended family can be very difficult. They require thought and time and if not attended to they can destroy your professional and personal life. Remember, when you are emotionally distressed, your patients know it.

3. *Spousal Relationship*

A long-term spousal relationship requires a great deal of commitment. In many ways, it is the most important relationship you will have in life. Problems with this relationship will destroy everything already discussed. Do not take this relationship lightly or make too many false assumptions. Remember, personal relationships require nurturing. They will cease to exist if left unattended.

Special Note:

Every one of these decisions will require time as well as emotional effort. Just as they can complement each other, they can also contradict each other. You need to have balance between the relationships without letting any one of them consume you. Your personal values will often guide your professional decisions. Understand that the opposite can also be true and for that reason our next discussion deals with the economic forces behind the optometric profession.

INTRODUCTION TO EYE CARE ECONOMICS FOR OPTOMETRY STUDENTS

Part I – A Historical Perspective

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I. Introduction

A number of factors drive the economics of every profession and business enterprise. Some of these factors can be controlled, others cannot. Understanding these factors, especially from a historical perspective, can help you see trends and make appropriate decisions for long- and short-term success, irrespective of your mode of practice.

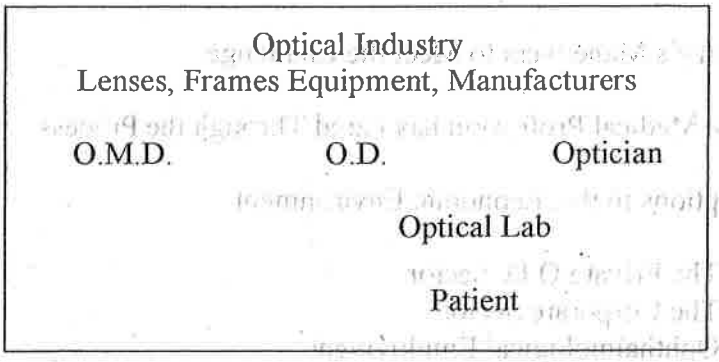
The present state of health care, optometry included, has been an evolutionary process and everyone has contributed to the present circumstances. Everyone has made errors in judgment – the government, employers, lawyers, insurance companies, patients, and doctors. As a result, the cost of medical care has become too high and our time of reckoning is now. Health care is going through economic upheaval – being analyzed from a strictly financial point of view – making the changing health care system a painful process for everyone. In addition, optometrists' incomes have decreased drastically in the last 25 years. Our next discussion will explain why optometrists' incomes have decreased and should also provide insight into our financial future.

This first section involves the historical perspective behind the factors and resultant concepts that allow us to understand this subject from a comprehensive perspective.

II. Historical Perspective

A. Optometric Niche

Optometry's success has been derived from a special niche that it has secured within the three (O's). The following diagram illustrates this niche:



The top level, Optical Industry, consists of lens manufacturers, equipment manufacturers, and frame manufacturers. Underneath lies the first O, O.M.D, the abbreviation for Ophthalmologist. The second O stands for O.D., Optometrist. The third O stands for the Optician. Traditionally, the three O's delivered eye care to patients. Historically, the O.M.D. supplied medical services, the Optician supplied optical services, and the O.D., in the middle, supplied comprehensive vision care, combining knowledge of the visual system (physiological optics) with the ability to prescribe lenses to better serve the individual needs of the patients. Note that the professional optical laboratory lies between the O.D., the Optician, and the patient and was originally the source of extremely high-quality optical materials.

B. Professionalization

After World War II (1945), optometry began to professionalize and the field increased its range of services, in those days called "scope", to deal more with total eye care. This included the detection of eye disease and servicing the visual needs of the patient. Professionalization occurred when the optometrist went from charging only for ophthalmic materials to also charging for eye exams. You must remember that this was an extremely difficult step for optometrists to take at that time. Unlike the medical profession, optometrists had to pay close attention to the prices the marketplace would support. This mentality carried over to today and has kept optometric services at bargain prices.

At the same time that optometry was professionalizing, the rest of the eye care industry began to evolve. Better ophthalmic equipment was being designed. Frame manufacturers realized the financial potential of style, as well as function, in frame design. Lens manufacturers decided that using plastic instead of glass could make them more money. As a result of these changes, costs of doing business began to rise, not only for goods, but also for labor.

The 60's evolved into the "heydays" for optometry, when 30-40% of what a practice grossed was taken home by the doctor. This began happening at the same time grocery businesses began transforming from "Mom and Pop" operations to large stores that operated on volume. The grocery business had gone from a 25% profit margin down to 10%, then 5%, and then 4% as volumes increased. So, optometry, by the mid-60's, had become quite attractive financially.

Unfortunately, competition set in, costs kept rising, overhead began to rise, and profitability began to slide. As with any business, people attempt cut costs to maintain profitability. In the eye care business, the first cost-cutting attempt happened within the optical industry. A young entrepreneur set up optical laboratories along the Texas border with Mexico. He obtained very cheap lenses and frames from the Pacific Rim for extremely cheap labor. He reproduced items that looked very close to the high-quality, high-cost American products that dominated the market at that time. California optometrists, as well as those in the rest of the country, began to order their lab work through these discount laboratories in Texas, bypassing their professional optical laboratories. The doctors substantially cut their lab bills and keep up their profitability.

This scenario led to an interesting maneuver by the Texas laboratory influence and represented the next major phase of optometric evolution – the recommercialization of eye care. I will call this next evolutionary phase the era of "Deprofessionalization."

C. Deprofessionalization

1. Recommercialization of Eye Care

The Texas commercial laboratories decided that it would be wise to move throughout the rest of the country, open local commercial entities to sell the glasses they produced in Texas for out-of-state doctors, and compete with local vendors. They could charge 50% less on the dollar, undercut local optometrists, and still make a handsome profit. This started the first really low cost eye care

throughout the country that later reached California. California was somewhat protected because it had laws against commercial practice where other areas of the country did not. This recommercialization, however, brought a lot of attention to the optical industry as a potentially profitable business. At that time large corporations within this country began to look at the optical business and set up specific organizations to compete with independent optometrists.

2. Corporate Raiders

The "corporatization" of optometry produced competition for the private sector by creating facilities managed by corporate entities. An example of these facilities would be Pearle Vision Centers, which originated as a buy-out by Searle Pharmaceuticals. Pearle wanted to control economic factors. They set up independent optical shops, incorporating their cut-rate laboratory work and controlling their optometrists and the optometrists' prescribing patterns. Eventually, they wanted to include ophthalmological care to create a single unit "One Stop Shopping Center." Cole National and Lenscrafters also fall into this category. This corporate structure really began in the late 60's and early 70's and only recently reached its full growth. Another example of companies controlling economic factors is Cole National's attempted financial relationship with the American Academy of Ophthalmology.

3. Third-Party Influences – Managed Care – Group-Directed Plans

Different types of corporate entities influenced and continue to influence the eye care field from the 70's to the present. These corporations' activities took the concept of controlling economic factors to new heights. We know it as the phrase "managed care." Managed care focuses on taking the care of patients out of the hands of the patient/doctor relationship and into the hands of a third party. These third-party corporations or institutions, arrange eye services to certain patient populations by signing up any doctor who wishes to provide care under the plan guidelines, or they may pre-select a limited number of providers. In any case, these are called provider "group-directed plans." Many of these corporations were insurance companies originally involved in the medical field that later decided to offer vision care as an option. The most common example of this is Kaiser, although many other examples exist in the marketplace.

An optometric response to these outside corporate influences was to form a corporate entity called VSP, or Vision Service Plan, a corporate structure that allows independent optometry to compete in the managed care marketplace.

I will discuss the specific roles of these corporate entities and institutions, such as the government, below. However, you must remember that competition among these entities in vying for employer contracts has led to a downward spiral of reimbursement rates in the eye care field, taking private sector net incomes from 40% of gross to as low as 10% of gross. I will discuss the more specific financial consequences of this in Part II of the Eye Care Economics series.

a. Socialization of Eye Care

The term "socialization" comes from governmental influence in the marketplace. In the late 50's and early 60's, the government decided it could afford to offer eye care to its indigent population. The deal went like this. They went to an independent optometrist and said, "If you will provide optical care to these people, we will pay you 90% of your normal and customary fees for an eye exam, and slightly less expensive materials (reduced fee-for-services)." The optometrists who did not have full patient schedules decided to take the government up on this offer. The government used a rather classic line, "Hey, you doctors aren't busy enough and we can get more people into your office."

But with time, reimbursement rates dropped dramatically. It became obvious that the doctor had to see more patients to make up for lost revenue from decreased reimbursement. Unfortunately, with higher volumes of people, doctors needed more staff, more space, and more equipment. Eventually doctors saw twice as many people for the same amount of money. Frustration followed. All third-party groups including those formed by independent optometry would later play this game, which I discuss below.

b. VSP (Vision Service Plan) and VSP-like Programs

VSP (Vision Service Plan), a California-based corporation was formed by optometrists, for optometrists, to enable them to compete in the managed care marketplace. VSP has been very successful with the idea of group-directed plans. VSP went out into the marketplace and sold vision care to unions and employee groups all over the state and the country. Other than Medi-Cal, VSP was optometry's first reduced fee-for-service group-directed plan. Over time, VSP's reduced fee-for-service has, in fact, kept California optometric reimbursement fees higher than the rest of the country for reasons that I will discuss later. The problem, however, is that due to VSP's success, others have entered into the marketplace trying to undercut VSP, causing a downward spiral in reimbursement rates.

Two economic forces are working simultaneously: the initial reduced reimbursement rate and the carving up of the marketplace with different reimbursement rates for different sectors, which can play havoc on a private sector practice. Table 4 in part II of this document on eye care economics illustrates what happens when demographics change rapidly within a community as a result of group-directed plans. Table 4 shows that if you accept the reimbursement rates of a particular plan, after a certain point you will be asked to provide care for nothing and, in fact, at a detriment to the practice. Many third-party plans have gone under and taken doctors with it, based on these principles.

c. Medical Insurance Programs/HMO's

Medical insurance plans, up until the last six or seven years, had not considered vision care a medical benefit and thus did not cover such services. They did, however, offer ophthalmological services for eye disease and excluded optometry from their panels. With Medicare accepting optometrists in the late 80's as eye care providers, theoretically on equal par with ophthalmologists, more insurance companies began to recognize optometric services in the area of ocular disease.

Vision plans have only become attractive recently with the huge influx of HMO's and employees' requests to provide vision coverage as part of medical plans. Medical insurance groups have little understanding of vision care. They often will not include O.D.'s on their panels because they deal only with ophthalmologists. Even worse, their reimbursement schedules are below the cost of doing business. HMO's do the same thing, but are now beginning to contract with VSP and other VSP-like organizations to carve out vision care at a substantial reduced fee-for-service. This has driven down optometric reimbursement rates even further. Recently, the situation began to turn around because patients complained of reduced levels of care provided in low reimbursement plans.

Health insurance organizations have taken fee reimbursement to a very creative level. Instead of paying a doctor for the services that he or she provides, they pay the doctor a certain amount of money per patient per month to take care of a whole population of patients, regardless of what services the doctor renders. This is called "capitation" and is prevalent in HMO's throughout the medical community and for ophthalmological eye health care. Thank goodness it has not been prevalent in vision care plans.

Essentially, we have moved from a fee-for-service system in the health care community that encouraged over utilization to a health care system where doctors are paid to under utilize, or ration, care to make a profit. Not surprisingly, care levels have dropped so drastically that finally patients are complaining. Hopefully there will be a turnaround and a happy medium achieved.

D. Optometry's Maneuvers to Meet the Challenge

When we look at the strategies that optometry has used to meet the challenges of change in economic climates and the forces behind that change, we must separate California from the rest of the country. Remember that during the professionalization phase, California put together laws to prevent negative corporate influences and the commercialization of private practice. Thus, all the forces that have caused reimbursement rates to spiral down took effect in the rest of the country before California.

1. Out-of-State Strategies

Outside the state of California, the first portion of optometric fees that came under attack was for the eye exam. Eye exams traditionally done at $75.00 dropped as low as $15.00-$20.00. In those states where exam fees fell lowest, the underwriters of eye care allowed optometrists to have normal and customary fees for glasses. Thus, material cost fees stood high and exam fees very low, but the average of the two remained equal to California, which I will discuss later. As competition began on material fees, doctors had to find another area to shift cost toward in order to stay viable. This shift in cost probably drove the entire transition to ocular therapeutics. Optometrists who were in fact trained to take care of a large portion of ocular disease became licensed to do so. They could then shift cost into the medical field that had very high reimbursement fees in the early years of optometric medical eye care. Currently, reimbursement fees for medical procedures have also plummeted, leaving very few avenues out for profitability.

A very important point to mention is that with such pressures on reduced reimbursement, care would eventually suffer. In most places in the United States an eye exam takes approximately 15 minutes, similar to the amount of time needed to care for an eye disease case, and both are considered "patient visits." A classic example would be that a doctor doing primary eye care in the "old days" might do 15 eye exams a day. When they switched to medical procedures, they would see as many as 15 eye exams a day and 15 medical procedures a day, or 30 patient visits.

2. California Strategies

Anti-commercial laws protected California, but eventually legislative maneuvers through HMOs circumvented those laws and therefore allowed California to become a large HMO State. Eventually, all the forces that first attacked the rest of the country reached California with some limitations.

VSP is probably responsible for keeping optometry afloat in California. VSP paid the doctors high exam fees for his or her services, but reduced fee-for-service in the optical area. Unfortunately, the success of VSP and the long-term strategies to keep corporate optometry from the state allowed optometrists to acquire a false sense of security. Now that all these forces have come to California, doctors worry about what is happening to their reimbursement rates.

In addition, VSP has always encouraged the use of quality independent optometric laboratories that have high quality production and labor costs. In the rest of the country, doctors moved to doing their own in-house laboratory work to cut costs. Prior to the VSP Regional Network Plan, California was not allowed to have in-house laboratories. However, you have to remember that many practices in California are 75% standard VSP, which means that all your lab work must go to either the VSP laboratory or a VSP-qualified lab and cannot be done in-house. If reimbursement rates continue to plummet, in-house laboratories will be mandatory in order to survive.

3. Consolidation

When looking at these strategies to maintain viability within the marketplace, we see increased volumes of patients and decreasing lab bills. A third strategy has to be consolidation. Eventually, it will be very difficult for one doctor to survive as an entity. Overhead will eventually prevent him or her from competing. Shared overhead and partnership have to be reconsidered as an avenue of survival within the present health care marketplace. Many pitfalls and misconceptions exist regarding these different avenues of consolidation. You must take a great deal of time to study them to understand which is the best for you.

E. How the Medical Profession has Fared through the Process

You have to remember that medicine, up until about 5 to 7 years ago, remained basically unaffected by forces in the marketplace. The more procedures medical professionals did, the more money they made, and when they felt that their services were worth more money, they raised their fees. Insurance companies would pay them their customary fees and pass the cost to the consumer. Unfortunately, the system ran out of money and the insurance companies took it out on the doctor first, the hospital second, and the patient third. Doctors worked harder and longer hours for 50% less income than they had made just 7 years prior. Hospitals struggled and huge hospital corporations took over the marketplace. Doctors became employees of large corporations, both in staff models where all physicians were housed in one unit, and in non-staff models where independent medical groups contracted services. In ophthalmology, incomes have dropped 50% in many cases. Ophthalmologists are being encouraged to practice optometry in order to make ends meet and for this reason we are seeing more ophthalmologists in groups with their own dispensaries.

In some ways, managed care has improved optometric relationships with medicine. Optometrists are relied on more of the time to provide services previously rendered only by their ophthalmological colleagues who have priced themselves out of the market.

F. Your Options in this Economic Environment

The evolution of eye care has led to a very interesting business environment. You must use your knowledge and review what some of your options are upon graduation. Below you will find a summary list of those options.

1. The Private O.D. Sector

The private practicing O.D., whether as individuals or in groups still make up over 50% of the patient care environments that exist. Just like in all other industries, some professional and some not so professional opportunities exist. This sector of eye care has gone relatively untapped by young graduates and most of the eye care economics information that I have provided is to encourage you to understand this sector, thus increasing your options and opportunities.

2. Corporate Sector

This sector can be divided into two sections: the thoroughly commercial sector such as Frame and Lens, and the semi-professional sector such as Pearle and Lenscrafters. Remember, in this environment you are an employee that has to meet the demands of the corporate structure within a specified patient-care environment.

3. Ophthalmological Employment

Working for ophthalmology as an optometrist offers you a number of opportunities:

a. Solo Practice

Solo ophthalmologists still exist and increasing numbers of them realize that optometric skills are very valuable, especially since more of them deal with optical products.

b. Group Practice

Many ophthalmologists group together into small or very large facilities and find optometric skills valuable. I like to call many of these environments, "the high rise environment," with an ophthalmologist's office on the first floor, an optometrist's office on the second floor, a surgery center on the third floor, and an optical dispensary on the fourth floor.

4. Hospital-based Environments

Some hospital-based environments will employ ophthalmologists and optometrists to provide eye care. However, in this environment you have to follow institutional guidelines. This sector also includes both ophthalmology and optometry.

5. Government Opportunities

Even though the government outsources Medicare and Medicaid eye care to the above-mentioned eye care environments, it also finances its own institutions through schools and government hospitals, such as the Veteran Administration Hospitals and Military Interdisciplinary Centers. Indian Health Services and Military base clinics may also be included.

Special Note: I stress the importance of understanding that each of the above environments vary drastically in several areas. First, they are funded very differently and unfortunately, economic pressures may dictate not only the quantity of eye care that doctors provide but also the quality. Also, each setting plays to a different audience and it is very important that you get some kind of feeling for how the audiences differ in each setting. Ultimately, you want to find that audience or patient base where they appreciate the care that you give, and you enjoy caring for their visual needs under the guidelines of a

specific setting. At this point our discussions of the decisions that you have to make professionally and personally become important and ultimately influence what short- and long-term employment you desire.

G. Conclusion

I have provided a great deal of information in this brief introduction to eye care economics. If nothing else, it points out that the days of being well paid simply because you have a degree are gone. You can no longer acquire high income, with little or no business knowledge. Everyone must be a student of business in order to have long-term employment potential. Everyone must understand what drives the acquisition of an eye care dollar and to recognize a good economic situation.

INTRODUCTION TO EYE CARE ECONOMICS FOR OPTOMETRY STUDENTS
Part II – The Nuts and Bolts of Optometric Practice Economics

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Content Outline

I. Optometric Practice Fundamentals

In our introductory comments on eye care economics we discussed that if the professionalization of optometry and the economic gains made in the late 60's and early 70's held true today, incomes for optometrists would be upwards of $185,000 per year in equivalent dollars. This erosion of income occurred in many places in society, although some were hit harder than others. In many ways, we have returned to a more realistic economic environment. Table 1, entitled Optometric Practice Fundamentals, illustrates what has happened to the "$100,000 practice of the 70's" and the demographics of such a practice today. The terms down the left-hand side of the table and defined below are important and deserve special attention for future reference.

- ***Gross:*** Total economic production of the practice
- ***Lab:*** Total laboratory expenses for materials provided to the patient
- ***Overhead:*** Operating expenses of the practice
- ***Net:*** Doctor's income
- ***Patients/day:*** Number of patients seen per day (# of exam units/day)
- ***Number of days/week:*** Number of days worked in a week
- ***# of Weeks:*** Number of weeks worked in a year
- ***# of Doctors:*** Number of doctors working in the practice
- ***# of Staff:*** Personnel other than the doctor
- ***Office:*** Square footage of the office
- ***# of Exam Rooms:*** Number of examination rooms
- ***Total Patients:*** Total number of patient exams, either new or returning, seen in one year
- ***Percent Private:*** Percent of total patients who are private paying patients
- ***Percent Vision Service Plan (VSP):*** Percent of total patients who use VSP
- ***Percent Medicare:*** Percent of total patients who use Medicare
- ***Percent of other insurance seen:*** Percent of total patients who use other accepted third-party plans
- ***Rx rate:*** How many of the total number of patients receive prescription eye wear
- ***Time/Exam:*** Amount of time taken to do a general eye exam
- ***Gross per patient:*** Gross revenues per patient (this is an average that includes the Rx rate) For example, if everyone got an exam and glasses, the gross per patient could be quite high, but because only 75% of the patients were prescribed, the gross per patient goes down.
- ***Gross Margin (net per patient):*** The total amount charged to the patient minus the lab expense – pays for overhead and doctor's income
- ***Income per patient for doc:*** The net value to the doctor for each patient, after deducting lab and overhead expenses
- ***Overhead per patient:*** Total overhead divided by the number of patients
- ***Gross Margin/30 minutes:*** Money produced free of lab bill for every 30 minutes of office time
- ***Gross Margin/15 minutes:*** Money produced free of lab bill for every 15 minutes of office time
- ***Income per day:*** Doctor income per day
- ***Overhead (OH) per day:*** Total overhead for the practice per day

A. Table 1 Description

Three columns appear in Table 1: 1971, Projected, and Reality. The first column represents a 1971 practice at full capacity. The second column projects numbers for today's equivalent practice. The third column represents the "real numbers" for today's practice to show what kinds of changes have taken place. Compare the demographics in Column 2 and 3. Parentheses on the table denote special changes in patients per day, total patients seen, and the amount of time for an exam. The "Reality" column, or column 3, shows specific items that we should pay particular attention to:

1. Percentiles of the practice – gross, net, overhead
2. The increase in number of exam rooms (an increasing number of patients required an increase in the number of exam rooms)
3. Private pay schedules versus third-party influenced pay schedules
4. The percentage change in the practice statistics at the bottom of the column – gross margins per unit time, income, and overhead per day

We especially need to consider "Exam Time." Note that the amount of time spent on an eye exam was cut in half because doctors saw twice the number of patients 25 years later than they saw in the 70's. That number over the last 5-7 years has grown by 30%. Please also note that if doctors become more efficient, young doctors have fewer patients to see. The increase in doctor efficiencies diluted the tremendous increase in patients expected in the 70's.

B. Gross per Patient

In the "Reality" column, the gross per patient is $185.18, a number somewhat weakened by third-party reimbursement rates, a subject we will discusses later when we discuss varying reimbursements. Remember that the gross value per patient includes the total amount of money generated per patient including the Rx factor (for a population of patients).

C. Gross Margin per Patient

The number $138.88 corresponds to the gross margin per patient in the "Reality" column and represents the total amount of money left to distribute to the practice after subtracting any lab bills. The director of the practice determines the dispersal of that money.

The next two numbers ($41.66 and $97.22) indicate the income to the doctor per patient and the overhead of the practice per patient respectively. Pay attention to the fact that for every half-hour the practice has to generate at least $97.22 to cover all expenses, not including the doctor's salary. So, when a patient misses their appointment, the doctor must tap into his or her income to pay for that $97.22.

D. Gross Margin/30 Minutes; Gross Margin/15 Minutes

The gross margins for both time periods illustrate how much money is being generated during an eye exam and how much money needs to be generated if a patient comes in for an emergency, removal of a foreign entity, flashes and floaters, or red eye rather than an

eye exam. This gives you an idea of how much reimbursement must be generated for eye health-related emergencies to equal what you would generally make through normal eye exams, otherwise know as the optical equivalency factor.

5. Income per Day and Overhead per Day

Imagine you take off one day of work as a young associate, not only do you lose $416.60 of income, but the senior doctor has to reach into his or her pocket for the approximately $1,000 necessary to cover the practice overhead on that particular day. These numbers provide insight into why doctors neglect taking vacations. This figure becomes very important when you, as an associate, practice on a day when the senior doctor takes off – someone still needs to cover the overhead. Who? The answer, you.

II. Patient Visit/Optical Equivalency Factor

Table 2 shows how to calculate the gross margin for any unit of time in an office. More specifically, how much money do you generate after removing the optical component? If you see a patient who does not require optical care, you have some way to compare the fee structures per unit time. Notice the sequence:

Step 1: The gross minus the lab bill per year equals the gross margin (GM) per year
Step 2: The gross margin per year divided by the number of patients examined per year will give you the gross margin per patient
Step 3: Divide the gross margin per patient over the amount of time that it takes to examine an average patient, either 1 hour, a half-hour, or 15 minutes, whichever you deem appropriate – a patient visit is usually considered 15 minutes

Table 2 provides two examples for you:

Example 1: A $300,000 practice with a gross margin of $225,000, where 1500 patients are seen per year, and a patient is seen every hour. The gross margin per unit time is $150.00 per hour or $37.50 per 15 minutes.

Example 2: A $600,000 practice with a gross margin of $450,000, where 3,000 patients are seen per year, and a patient is seen every half-hour. The gross margin per unit time is $150.00 per 30 minutes or $75.00 for 15 minutes.

Which practice would want therapeutics if the average therapeutic reimbursement rate for large numbers of ocular health problems seen by optometrists was $50.00 for every 15 minutes of diagnostic and treatment time? Clearly the first practice would choose to have optical therapeutics. High volume optical practices, which have an endless supply of optical patients, do not want to be bothered with therapeutics. However, when the optical pool begins to dry up, these practices immediately shift to therapeutics.

Table 3 lists some important questions that you should consider regarding what we have discussed.

III. Changing Economic Reimbursement Demographics

Table 4 shows the effects of changing financial demographics on individual income and the need for increasing patient volume to cover this income loss. Five different patient populations span across the top of the table. Each population has 4 patient subsets with 500 patients each. You can see these populations mathematically by looking to the right of Section I. It shows 500 patients in each subset for a total of 2,000 patients. As you move across the populations, column 1 in each population represents the gross generated by each subset in thousands. The second column represents the gross per patient. So, in population 1, each subset produces $100,000 worth of gross and the patient average equals $200.00 per patient.

Notice the change in 1 of the subsets in population 2 from a standard fee to a reduced fee. This subset represents a 30% decrease in reimbursement leading to $70,000 worth of gross revenues and $140.00 per patient. Note that population 3 has 2 subsets at standard fees and 2 subsets at the reduced fee. Population 4 has 3 of the subsets now at the reduced fee of $140.00 per patient, and population 5 has only 1 subset at the standard fee, 2 subsets at a reduced fee of $140.00, and 1 subset at $98.00 per patient, which represents another 30% decrease in reimbursement.

Section II shows you how the practices that serve each of these populations break down. (All numbers in Section II are in thousands). Line 1 shows the gross of the different practice populations, $400,000, $370,000, $340,000, $310,000, and $289,000 respectively. The second line represents the lab bills, which are 25% of the gross value in each population. The third line represents overhead (OH), which remains constant for our populations because facility and staff remain constant. ***Line 4 represents the decreasing net income of a doctor whose practice transforms from population 1 to population 5 over time.*** In other words, in an environment ravaged by managed care and reduced fee-for-service plans, you can go from a $100,000 income to a $16,750 income over a period of 5 years. The question becomes, "What can you do about it?"

Section III illustrates on Line 1 the decrease in net for the doctor at each population level, again in thousands. Lines 2, 3, and 4 indicate the gross per patient and corresponding ***gross margins*** per patient provided by each patient in each of the subset types. With this kind of information, you can calculate how many more patients out of Subset type 1 or Subset type 2 (SS1, SS2) you need to see to make up income losses.

Section IV indicates the patient statistical increases from SS1 that you would need to match the net loss. There are several statistical categories:

1. The total number of patients necessary to match income
2. The percent increase of patients in that population needed to match income
3. The resultant increase in patients per day
4. The percent increase in patients per day, which is an overall view that shows a need for higher productivity

In the last column in Section IV, note that you would have to increase your patient load by .71 patients a day in population 2 with SS1 type patients to make up for lost revenue. When you get to population 4, you have to increase your patient load 2.25 patients a day (20%). By the time you get to population 5, you have to see 2.9 patients a day at a 29% increase with SS1 type patients. The problem is getting extra private patients (SS1). These kinds of increases in patient

volumes from SS1 would be very difficult. Section V offers a more likely scenario. In another case, let's say SS1 were private pay patients, SS2 were VSP, and SS3 were Government payment patients. Section V shows how many patients you would need out of the SS2 (reduced fee-for-service patients) to make up income. Note that across the table for Section V, you have to increase your patient volumes from SS2 by 40% to cover for lost income. This increases the total patient per day production significantly. The last box in Sections V illustrates what happens when SS3 reduced fee-for-service patients have to make up for all the lost income in population 5. You can see that there would have to be a 56% increase in total patient load to restore revenues.

In all of these numbers, Section V reveals the bottom line. If doctors take on 25% of their practices at a 30% reduced fee-for-service rate, they must increase the volume of their practices from 7-10% to compensate. If they accept 50% of their practices in that reduced fee-for-service category, they must increase their volumes by 15-20%. If, in the end, they have to finally accept 75% of their practices in reduced fee-for-service, they may have to increase their patient base by 22.5-30%. Remember that once you pass an increase of 15% in patient volume, you will usually have to get new staff, overheads will rise, and net begins to drop further.

Frequently when young associates join a practice, they are asked to see patients from a subset that has reduced fees-for-service. Close scrutiny of the math involved allows you to know how many extra patients you would have to see in a category to equal the productivity of the doctor's regular patient set. This happens often with Medi-Cal. Remember, you would probably have to see twice as many patients in subset 3 for the same productivity as subset 1. It would be realistic that if the senior doctor saw 10 patients per day out of subset 1 types, you may have to see 20 per day of subset 3 to make the same income. However, remember when you see patients for reduced fee-for-service, it frees the senior doctor to see patients for full fee-for-service. That has a benefit for both of you when you are trying to cover overhead.

IV. Optometric Reimbursement Analysis

The composite table in Table 5 shows you how reimbursements for different plans vary. You have to understand a few basic assumptions. First, the patient mix was the same for all plans; that is, out of 10 patients, 4 receive single vision lenses, 4 receive bifocals, and 2 receive trifocals with a 100% prescription rate. For the sake of simplicity, the frame factors in these tables reflect a retail cost X2 plus $37. As you know, most fees run from 2X to 3X cost in order to cover optical overheads.

Also, you will see lab fees at the top of Table 5 next to material cost. For single vision, you will see two numbers, one is the regular price that you pay for private. The bottom number equals the discounted price for plans – the same for BFL's, TFL's and PAL's.

Roman numerals I-IV designate each plan. Column 2 indicates each plan's gross margins for exam and lenses. Column 3 represents the lens weighted factor. Basically, a lens weighted factor is calculated by multiplying the gross margin of single vision X4, bifocals X4, and trifocals X2. Add it all up and divide by 10. This gives you a weighted factor for lenses. Column 4 shows the entire cost of an exam, lenses, and a $40.00 wholesale frame. Column 5 shows what happens if you used an in-plan frame, a frame the plan allows. Column 6 shows you average extras, including PAL's, per patient as a factor. Note that the cost for some private fees would include $87.00 for an exam and a lens weighted factor of $78.64 combined with the frame. This totals

$240.84 gross margin, with $40.87 for extras.

Then, in Column II, Plan I shows a $60.80 lens weighted factor with a $73.93 exam, leaving you with $168.85 for a $40.00 frame. In this case, the plan included a $40.00 frame, which means Column 5 equals the same amount of money, but you have a $35.49 extra value, which means a cap exists on how much you can charge for extras.

In Roman numeral III represents Plan II. You can see a significant drop in the lens weighted factor and when you are allowed to use a $40.00 wholesale frame, you are capped at the amount that you can charge the patient. Then in column 5 you can see that if the patient uses the in-plan frame the gross margin decreases dramatically in addition to being capped on extras.

Plan 3 (Roman IV) shows some increase allowed in the expensive frame category, but when an in-plan frame was used, the gross margin decreased, again with a $37.00 increased for extras. Roman numeral V represents typical government plans in column 4 when the patient pays for their own frames. In column 5, when a patient uses an in-plan frame, the gross margin drops to $77.29 with no extras allowed.

V. Conclusion

What can all these numbers do for anyone? First of all, they give you an idea of what you need to evaluate any plan coming over your desk. You must assess the gross margins for single vision, bifocals, or trifocals, including PAL's and all extras. This information can be graphed out on paper and made quite simple. With these numbers you can calculate what gross margins you would obtain, given a certain patient mix, a certain number of patients per day, and certain plan types. For example, what if you were hired to see only the government patients in Section V? You would know that your gross margin would be somewhere around $77.00. Depending upon the age of the patients and whether you saw 20 per day, you would have some idea of what income you generated for your services. You, of course, could then negotiate what income you should receive from such work. This type of analysis will be reserved for the next section in the series.

Special Note: Specifics of how to set up a spreadsheet of this information will be supplied later in an appendix to this section.

TABLE 1
OPTOMETRIC PRACTICE FUNDAMENTALS

Terms	1971		Projected		Reality	
Gross	$100,000	100%	$400,000	100%	$400,000	100%
Lab	$25,000	25%	$100,000	25%	$100,000	25%
Overhead (OH)	$30,000	30%	$120,000	30%	$210,000	52%
Net	$45,000	45%	$180,000	45%	$90,000	23%
Patients/Day	5 to 6		10 to 12		10 to 12	
# of Days/Week	4.5		4.5		4.5	
# of Weeks	48		48		48	
# of Doctors	1		1		1	
# of Staff	2		2		4	
Square Feet	750 -1000		750 -1000		1000 -1250	
# of Exam Rooms	1		1		2	
Total Patients/Year	1080		1080 (2160)		2160	
% Private	70%		75%		15%	
% VSP	25%		25%		50%	
% Medi-Care					10%	
% Other Insurance					25%	
Rx Rate	90%		90%		80%	
Exam Time	1 hour		1 hour (1/2 hour)		1/2 hour	
Gross/Patient					185.18	
Gross Margin (GM)					138.88	
Income to Doctor/Patient					41.66	
Overhead (OH)/Day					97.22	
Gross Margin/30 minutes					138.88	
Gross Margin/15 minutes					69.44	
Income/Day for Doctor					416.6	
Overhead/Day					972.22	

TABLE 2

PATIENT VISIT/OPTICAL EQUIVALENCY CONCEPTS

1. Gross - Lab = Gross Margin/Year (GM)
   Year

2. Gross Margin = GM/Patient
   Total # of Patients (Per Year)

3. GM/Patient or GM/Patient (Patient visit) = Optical Equivalency Factor (OEF)/15 min.
   Time for each exam 15 minutes

EXAMPLE I

	Gross	$300,000	8 patients/day
1.	Lab	- $75,000	4 days/week Works 187.5 days/year
	GM/Year	$225,000	1 hour/exam
			1500 patients/year

2. $225,000/1500 = $150.00/patient = NOI patient average

3. $150/1 hour per exam = $150.00/1 hour or $37.50/15 minutes

*If a patient takes 15 minutes to treat for an eye disease, you must charge $37.50/15 minutes to equal office optical rates.

EXAMPLE II

	Gross	$600,000	15 patients/day
1.	Lab	- $150,000	4 day/week Works 187.5 days/year
	GM/Year	$450,000	30 minutes/exam
			3000 patient/year

2. $450,000/3000 = $150.00/patient

3. $150.00/30 minutes per exam = $150.00/30 minutes = $75.00/15 minutes (OEF)

So, which practice would want TPA given the present medical reimbursement rates?

TABLE 3

QUESTIONS INVOLVING PART I AND PART II OF EYE CARE ECONOMICS

A. **Q:** In an $800,000 practice, what is the gross margin per patient for 15 minutes if the doctor(s) see 4,320 patients per year and have a lab bill of $200,000?

A: $138.88 per 15 minutes

B. **Q:** Which practice, the $400,000 or the $800,000 practice, wants TPA certification?

A: $400,000

C. **Q:** For a $400,000 practice, what would happen if you found a cheap lab with a 10% decrease in lab cost? How would it effect your income? See Table I, Reality column.

A: $9,000 increase

D. **Q:** If VSP pays 70% of private fees for a 50% private and 50% VSP practice, what would happen to the doctor's income if he or she went to 75% VSP?

E. **Q:** What if 50% of your VSP patients had a 30% decrease in reimbursement? What would be the effect on your income? (Example: VSP/RNP)

F. **Q:** If you no longer prescribed glasses or contact lenses, how many patients must you see to keep your income even? ***How many VSP patients must you see to keep your income even?***

G. **Q:** For B & C above, how many more VSP patients must you see to keep your income even?

TABLE 4
EFFECTS OF CHANGING DEMOGRAPHICS ON INCOME AND PATIENT VOLUME

		SB	Population 1		Population 2		Population 3		Population 4		Population 5	
			G/S	G/P	G/S	G/P	G/S	G/P	G/S	G/P	G/S	G/P
I	# of Patients in Subset	500	100	200	100	200	100	200	100	200	100	200
	# of Patients in Subset	500	100	200	100	200	100	200	70	140	70	140
	# of Patients in Subset	500	100	200	100	200	70	140	70	140	70	140
	# of Patients in Subset	500	100	200	70	140	70	140	70	140	49	98
II	Practice Gross		400		370		340		310		289	
	Lab Bill		100		925		85		775		775	
	Overhead (OH)		200		200		200		200		200	
	Net		100		78.5		55		32.5		16.75	
III	Decrease in Net		0		21.5		45		67.5		83.75	
	Subset Type 1		150 G/P		200 GM/P							
	Subset Type 2		105 G/P		140 GM/P							
	Subset Type 3		74.5 G/P		98 GM/P							
IV	# of Patients from SS1 to Match Net (assume Pop 1 @ 10 P/D productivity)		#		143.3		300		450		558	
			%		9.5%		30		90%		116%	
			P/D		0.71		1.5		2.25		2.9	
			% P/D		0.66%		7.1%		22.5%		29%	
V	# of Patients from SS@ to Match Net		#		204.7		428.5		642.8		1124	
			%		40.9%		42.8%		42.8%		224%	
			P/D		1.0		2.1%		3.2%		5.6%	
			% P/D		10%		21%		32%		56%	

KEY:
Gross/Subset (G/S)
Gross/Patient (G/P)
Gross Margin/Patient (GM/P)
Patient Subset (SB)
Patients/Day (P/D

TABLE 5

FEE ANALYSIS OF DIFFERENT CONTRACTS

Material Cost: SVL 14.40/11.75; BFL 28.40/20.14; TFL 38.00/27.80; PAL 74.00

1	2	3	4	5	6
PLAN #	Gross Margin for Exam & Lenses	Lens Weighted Factor	Frame @ $40 Added to Exam + Col. 3	Frame In-Plan Allowance Added to Exam + Col. 3	PAL & Extra Factors
I	Exam 87.00				
	SVL 54.00				
Private	BFL 91.60	78.64			
	TFL 102.00				
			240.84	240.84	40.87
II	Exam 73.95				
	SVL 48.40				
Plan I	BFL 64.40	60.80			
	TFL 78.40				
			168.85	168.85	35.49
III	Exam 45.00				
	SVL 23.75				
Plan II	BFL 38.35	35.98			
	TFL 53.70				
			130.76	110.78	24.32
IV	Exam 45.00				
	SVL 22.25	34.80			
Plan III	BFL 36.85				
	TFL 52.50				
			140.15	105.31	37.60
V	Exam 41.00				
	SVL 21.54				
Government	BFL 31.80	30.08	146.28	77.29	Not Allowed
	TFL 43.76				
	TFL 53.70				

INTRODUCTION TO EYE CARE ECONOMICS

Part III – Finding a Private Sector Job and Keeping It

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Content Outline

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- A. Excess Factor
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- C. Reimbursement Factor as a Function of Practice Demographics
- D. Optical Factor (Lab Factor)
- E. Facility Factor
- F. Owner/Older Partner Attitude

II. Methods to Calculate and Increase Your Value in the Optometric Marketplace

INTRODUCTION TO EYE CARE ECONOMICS
Part III – Finding a Private Sector Job and Keeping It

By A. Lee Scaief, O.D., M.S.
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I. Identifying Worthwhile Private Sector Job Opportunities

Over the last 10 or more years, most of the job opportunities in optometry have come from the institutional corporate and ophthalmological environments. The private sector of optometry has not found a good way to help young licentiates gain experience. It can be very costly for established doctors to employ young licentiates. Some statistical data suggests that after working in corporate, ophthalmological, hospital-based, and government sectors for about five years, some doctors want to migrate back into the private sector for long-term employment. But there still remains a problem in how to make this transformation. As a result, private sector associateships and partnerships have a particularly bad reputation.

Nevertheless, tremendous job opportunities exist in the private sector of optometric care. Unfortunately, most people don't know how to identify a good opportunity for a short-term gain or long-term potential. This section provides a simple technique, originating from conversation and observation, to recognize a valuable private sector job opportunity. But please note even though this section concentrates on the private sector of optometry, it also applies to other eye care environments. Therefore, this section should be of value to all new licentiates.

Below six steps outline the process of successful private practice. The first three identify short-term opportunities the last three recognize long-term potential.

1. Excess Factor
2. Access Factor
3. Reimbursement Factor as a Function of Practice Demographics
4. Optical Factor
5. Facility Factor
6. Owner/Older Partner Attitude

Please note Owner/Older Partner Attitude should not to be taken lightly. These steps are not listed in the order of their importance. In fact, for long-term associations, Owner/Older Partner Attitude is the most important.

However, getting information regarding a private practice is not an easy matter and requires some subtlety. It would certainly be inappropriate to ask doctors what their gross and net are or if they are looking for a partner. Most of the information that you need can come from very casual conversation with either a doctor or a staff person. The specifics of such conversations are mentioned below.

A. Excess Factor

The most important thing that you need to know about a potential job opportunity is whether a practice has any excess patients around for you to examine. If no patients exist for you to see, you will not get a job. This excess factor, more commonly referred to as backlog, consists of knowing three things:

1. Number of days the doctor is booked in advance (how long people wait to be seen)
2. Number of exams generally seen per day
3. Number of days worked in a week

You could obtain this information from an office staff member by asking, "How long do patients have to wait to get an appointment?" You can also find out how many days the doctor is booked in advance by knowing how many patients the doctor sees in a day and how many days a week he or she works. If a doctor sees 10 patients a day and works 4 days a week and the next opening is one week away, you know 40 patients are waiting to be seen.

This backlog of 40 patients (or whatever the number is) creates the pool of patients by which you will derive your employment. Unfortunately, the number alone will not provide you with solid employment, which we will discuss more in-depth in relation to reimbursement factor. You must know the type of patients waiting to be seen because different types of patients have different types of switch rates (who will switch to the younger doctor based on how long they have to wait). Private patients do not switch very often. Third-party patients will switch according to their third-party plan type. For example, VSP patients switch less often than Medi-Cal patients and new patients are more likely to switch than returning patients. You must have the ability to estimate the switch ratio based on the type of patients waiting and how long they have to wait to be seen. For example, if patients have to wait 1 week, most Medi-Cal patients will switch, 10-20% of VSP patients will switch, and most likely no private patients will switch unless they have an emergency.

Let's take an example of a totally Medi-Cal practice. The doctor works 5 days a week, sees 20 patients a day, is booked up 2 weeks in advance, and has 200 patients waiting to be seen. If the doctor has room in his or her office, you will have plenty of patients to see.
Another example would be a 100% VSP practice. The doctor works 4 days a week, sees 15 patients a day, is booked 1 week in advance, and has 60 patients waiting to be seen. At a 20% switch rate, you could have access to and see about 12 patients a week. That could mean one day a week for you to work. But remember you will need access. If the senior doctor is not working and the office is open, you have a perfect opportunity to access to the workplace and see patients.

Of course, a 100% private pay practice where the doctor is booked a week in advance will provide you with the least amount of opportunity. Most likely no one will switch, but as we will discuss later on increasing your value within a practice, this environment can be profitable to both you and the older doctor.

2. Access Factor

We can think of access factor as "room factor." In other words, does the practice have room for you to practice? You have to ask yourself, "how many days a week does the doctor work and/or, does the doctor have extra rooms where I can practice?" Some doctors have two rooms but only use the second room 10-30% of the time. Given the backlog switch rate, this would provide you an opportunity to practice and better utilize the doctor's second room. Unfortunately, many doctors only have one exam room. This means that the doctor has to take off a day of work to provide you an opportunity to see patients. You could also work days that the office normally stays closed – Saturdays and evenings, etc. Tremendous opportunity exists for you if you know how to maneuver yourself. You also have to consider staffing because anytime you add extra staff hours, the cost of paying them comes out of the associate's income. Either existing staff will

have to stay around to help you (which they may not want to do) or the doctor will have to hire additional staff to accommodate your presence.

An example will help illustrate this point. A doctor finishes work at 4 p.m. He or she can arrange to have enthusiastic, willing staff members stay until 8:00 p.m. If the demographics of the doctor's practice show that people would take advantage of evening hours, you could examine a patient every 45 minutes from 4:00 p.m. to 8:00 p.m., about 5 patients. If reimbursements from those patients were high enough, you would only need one patient a day to pay for the extra staff. The other patients would derive income for both you and the facility. We will discuss this more in-depth later.

3. Reimbursement Factor as a Function of Practice Demographics

What clientele a practice serves has a great deal to do with the quantity of work an associate will have and how much pay he or she will receive. Private paying patients tend to bring the highest revenues, but remain the least likely to switch to a younger doctor. Patients with VSP, the most common third-party program in California, have reduced fee-for-service rates, but remain more likely to switch than private pay. Medi-Cal patients, as mentioned, have the lowest reimbursement rates, but very few loyalties to specific doctors. A young associate must consider private versus third-party reimbursement, the age of the patients (the older the patient, the less likely they will switch), and the problems that the patient population has in deciding if he or she will have work of not.

For example, patients will eye disease have less loyalty to a specific doctor because they just want the problem attended to by a professional. Binocular vision patients tend not to want to switch because of the complexity of their problems. Contact lens patients, depending upon whether they are in a commercial or professional environment, often remain unwilling to switch. You need to understand that whoever pays the bill (private vs. third-party plans) determines whether you will have patients to see and how much you will get paid for seeing them. You might ask a staff person, "Do you have a lot of VSP patients?" or, "Does the doctor see a lot of Medicare patients?" These few examples illustrate the kind of questions that can illicit demographic patterns from practices.

The above three factors will allow you to identify whether a practice has the room to pay an associate or employee on a part-time basis. So, how do you calculate the value of your work so that it benefits you, the doctor, and the practice? This is a subject of another discussion. However, the next three factors, 4, 5 and 6, will help you evaluate the potential for a more long-term relationship.

4. Optical Factor (Lab Factor)

Optical products that generate most of the income to pay for running a business come from a number of sources. Examples of these sources are independent optical laboratories of both high and low quality, corporate labs set up to service their own clientele, and government facilities designed to serve a certain patient population (i.e. the prison system). Each one of these has different economic realities. Each of them will have a certain quality associated with a certain price to match the fabrication of the hardware.

You need to know what kind of laboratory an office uses. A low quality lab will allow for inflated nets, but low quality products. Very high quality labs will put some cap on earning potential. Corporate labs, such as the labs belonging to VSP, also have their advantages and disadvantages. It benefits you to know the quality produced by certain lab work. Also, you should know if particular offices do in-house lab work. Certain unique financial considerations exist if they do have in-house labs. An in-house lab can maintain quality in single-vision work, increasing profitability. Multifocals are much more difficult to make in-house. If, however, a practice is ready for an in-house lab, and you know how to and enjoy doing that type of work, you have increased value to a private setting.

5. Facility Factor

If you simply look around and office and make a few observations, you can determine the overhead of the environment and its affect on income. You should consider the following list:

1. Number of staff per number of doctors
2. Square footage of the office: do you see room for growth?
3. Number of exam rooms
4. Is the facility owned or rented?
5. Is the equipment up-to-date?
6. Is the ophthalmic area attractive in order to maximize optical profitability?
7. Is the contact lens section efficient enough to be profitable, in respect to inventory and staffing?

In California, the staff ratios are usually 3-4 staff per full-time doc. Two 2-room practices, of course, have a much higher potential for growth and affiliation with younger doctors. Renting or buying a facility affects the net and can become inflated if hidden in the Profit and Loss Statement. Technology changes and equipment needs constant upgrading. Offices need to have an attractive ophthalmic area in this world of high competition. Remember, when you assess these items look at them in their present state but also look at how they could change with your input.

6. Owner/Older Doctor Attitude Towards Working with Other Doctors

Some doctors should only work by themselves. Optometrists, unfortunately, tend to be very individualistic. So, you must assess whether a potential long-term associate is a team player and capable of working with another doctor. Also, you need to know if they can handle working with young doctors. Most importantly, you need to know the doctor's attitudes towards buy/sell agreements. You may have the greatest opportunity in the world, but if the doctor's attitude regarding buy/sell agreements is unrealistic, you will end up paying severely in the end. We will discuss the concepts behind buy/sell agreements later in this series, but in closing, be careful not only of the doctor's attitude, but also his or her staff's attitudes. If you make the doctor uneasy you can still manage, but if the staff does not support you, you are history. We will discuss this more when dealing with interpersonal effectiveness in a partnership environment.

Special Note: One of the major reasons for even having this discussion in identifying a potential work environment was to help you understand that you have options. Take a ruler and draw a 50-mile radius around where they live and find 5 doctors who may have the resources and inclination to hire you in a

mutually beneficial relationship. Most young O.D.'s do not take the time to search. However, jobs exist and they may pay reasonably well. Not only will you get a great deal of experience, but bets are that with 1 of the 5 doctors you will have some business chemistry and a potential long-term association. Don't forget – productive half days can be as lucrative as unproductive full days. Once you fully understand reimbursement rates and the type of patients you will serve, you will have room to negotiate your salary, and we plan to teach you those rules.

II. Methods to Calculate and Increase Your Value in the Optometric Marketplace

If I begin applying certain prescription rates to the gross margins of private and reduced fee-for-service plans in Part II of this series, Table 5, I can come up with some simplified gross margins per patient for three different plans. For the sake of simplicity, at 80% prescription rates, you could have a gross margin for private pay patients at $200.00 per patient, a VSP standard plan at $150.00 per patient, and an even less attractive plan (Plan #3) at $100.00 per patient. The use of these numbers can reveal important information. If you found a doctor who had enough private patients backlogged that he or she could provide you 1 day a week of work seeing 5 private patients per day, your net gross margin for the day, after lab, would be $1,000.

Naturally you should ask, "How much should I be paid?" An unrealistic answer would be $1,000. Remember, in our previous scenario of the realistic practice in Part II, overheads are $1,000 per day. So, in many ways, you just barely covered overhead if you worked alone that day. A more realistic look at this scenario would be to make it mutually beneficial between you and the doctor. For example, you cover $500.00 of his or her overhead that day and you take $500 home. A nice salary, I have to admit. But remember, he or she may have to employ extra staff just to cover you while you work during the day he or she is gone, so, in reality, there should be some money for the doctor, some for you, and some for the staff. This $1,000 could easily be divided three ways and most people would be quite happy. Remember, by working you dive into the senior doctor's backlog and allow him or her to derive income from patients he or she does not have the time to see. It also allows the staff to benefit from your presence and $333 a day to see 5 patients is not a bad wage for you. Unfortunately, it seldom turns out this way. The equations are generally weighed in the direction of the owner and his or her staff and in reality for this type of scenario, $250.00 a day for you would be reasonable.

Young licentiates often do not capitalize on some of the value they actually have as young people:

1. You really shouldn't mind seeing the less efficient patient for the sake of having experience.
2. You should naturally attract a younger clientele if you stay around long enough.
3. Your contact lens knowledge should allow you to see patients who have lower reimbursements and allow the older doctor to see more profitable clientele.
4. If you are smart, you will align yourself with the staff and be willing to do anything they do in order to help the facility. A young doctor with an ego who is not willing to help the staff in the office only creates animosity. I guarantee you this situation will not last long.
5. Also, a licentiate can teach the staff a lot of the things that the older doctor does not have the time to teach. So, having good training techniques for certain optometric duties are of value to the practice.
6. Remember also, if you understand EM Coding, which at this stage you do not, you are

a tremendous value to the practice. You can make seeing ocular disease patients more profitable by seeing cases that older doctors are less likely to want to see and knowing how to bill for those services.

The scenario changes quite readily if on the day you worked you saw 5 Plan #3 type patients at $100.00 of gross margin per patient. Your gross margin for the day would be $500.00. Remember that the overhead costs $1,000 per day. Also remember that you could consider it fair pay if half of the money goes to the doctor and the staff. In addition, keep in mind that there tends to be some bias to the owner and in this particular case, so some of you would probably make $175.00 to $200.00 per day. I want to remind you that some of this bias comes from the fact that new licentiates have a very high "redo rate" and sometimes the associate situation is more inconvenient for staff, patient, and owner.

You can see that if you had a Medi-Cal situation with a gross margin of $60.00, 5 patients would only create $300.00 gross margin. It would take quite a few Medi-Cal patients to get your income up to $250.00-$300.00 a day. In many Medi-Cal settings, doctors see 20 patients a day to make $300.00 a day.

The contact lens practices where young associates can do contact lens work also create a sticky situation. Many people assume that the gross margin for contact lenses stays relatively high when, in fact, it remains relatively low, as low as $100.00 a patient when including time and materials. You must remember that if a young licentiate does work that has less reimbursement potential, it allows the other doctor the time to do more highly productive work. This adds value to the associate and can certainly become a bargaining tool. If you were to see 5 contact lens patients at $100.00 gross margin and in the same time slot the other doctor was able to see 5 private patients at $200.00 gross margins, you have value to the doctor and the practice.

Interestingly, some people mention that they work for an ophthalmologist and see 24 patients a day as a glorified tech and make $300.00 a day. Can you imagine if the ophthalmological facility also had an optical shop so that all the patients that you saw also had optical care? I do not think it takes much figuring to realize that you are grossly underpaid. However, if you work for an ophthalmologist who has no optical, the game is certainly different. Remember, if you took glasses away in a general practice of optometry with a 20% net, 50% overhead, and 30% lab bill, you would almost have to triple your patient load in order to just break even. Therefore, in an ophthalmological environment with no optical, you have somewhat less value unless at the same time you are freeing the doctor up to generate more surgery, and that is a whole other matter.

I have a final point to make that very few people have taken advantage of and yet it is probably the most important point I can bring up. Many doctors don't have a high enough backlog to do the traditional associate format and so they figure they are not able to make even the slightest move in that direction. If you adhere to the following format and find a doctor in the position described above and with whom you would love to work, try the following option.

Let's say the doctor sees 10 patients a day at $150.00 gross margin per patient. He or she is a full service doctor and basically sees 1 patient every 45 minutes. What if you approached this doctor and asked if he or she would like to divide the eye exams in half one day, where he or she does all the general optometry procedures and you do all the general ophthalmology work. That is, he or she does all the case history and refractive exam work and you do all the ophthalmoscopy, slit lamp, and health consultation. Often, in doing this, he or she can increase his or her patient load

on that day by 3 or more extra patients. At $150.00 gross margin there would be a total of $450.00. You are certainly worth $200.00 a day and it will still allow the doctor to take $250.00 home. This is fairly close to a 50/50 split and would certainly get you in the door and provide a mutually beneficial relationship.

This example has some distinct advantages:

1. Patients still approach the same staff, having been seen and controlled by the senior doctor. They don't have to deal with another personality. They like that.
2. If the doctor phones the patients to see if they liked the new exam procedure and the patients said it was OK, you should be fired because you must generate enthusiasm. However, if the patients loved it and felt that you provided a worthwhile service that the old doctor hadn't, you are now an asset. Phone calls like that can easily tell a doctor if an associate is worthwhile early in the relationship, not 3 years later.

Associateships where you are working one day a week by yourself versus working with the senior doctor have very different outcomes. In the former scenario where you are seeing 5 patients a day to make your $200.00 one day a week, you are exposed to 5 patients a week for say 50 weeks (250 patients). In the latter, mutually beneficial scenario, you see 13 patients a day to earn your $200.00, a total of 650 patients in 50 weeks. Remember exposure means that when a patient comes back and they like you, they are more likely to switch. Therefore, if you stay at a practice for awhile, your growth curve will be much faster than with the old scenario.

Finally, private practice takes cultivation. It is seldom an 8-5 job. Being involved in helping everyone in a private practice is very important, even with cleaning up. If you can, be an active member in the community in some way – buy things in your community and pay with a check, eat in local restaurants, and be a member in community clubs where you like the activities. These are all avenues of exposure. Exposure is the road to success. For those people who are interested in this technique, we can discuss it in more detail at a future time if requested.

volumes from SS1 would be very difficult. Section V offers a more likely scenario. In another case, let's say SS1 were private pay patients, SS2 were VSP, and SS3 were Government payment patients. Section V shows how many patients you would need out of the SS2 (reduced fee-for-service patients) to make up income. Note that across the table for Section V, you have to increase your patient volumes from SS2 by 40% to cover for lost income. This increases the total patient per day production significantly. The last box in Sections V illustrates what happens when SS3 reduced fee-for-service patients have to make up for all the lost income in population 5. You can see that there would have to be a 56% increase in total patient load to restore revenues.

In all of these numbers, Section V reveals the bottom line. If doctors take on 25% of their practices at a 30% reduced fee-for-service rate, they must increase the volume of their practices from 7-10% to compensate. If they accept 50% of their practices in that reduced fee-for-service category, they must increase their volumes by 15-20%. If, in the end, they have to finally accept 75% of their practices in reduced fee-for-service, they may have to increase their patient base by 22.5-30%. Remember that once you pass an increase of 15% in patient volume, you will usually have to get new staff, overheads will rise, and net begins to drop further.

Frequently when young associates join a practice, they are asked to see patients from a subset that has reduced fees-for-service. Close scrutiny of the math involved allows you to know how many extra patients you would have to see in a category to equal the productivity of the doctor's regular patient set. This happens often with Medi-Cal. Remember, you would probably have to see twice as many patients in subset 3 for the same productivity as subset 1. It would be realistic that if the senior doctor saw 10 patients per day out of subset 1 types, you may have to see 20 per day of subset 3 to make the same income. However, remember when you see patients for reduced fee-for-service, it frees the senior doctor to see patients for full fee-for-service. That has a benefit for both of you when you are trying to cover overhead.

IV. OPTOMETRIC REIMBURSEMENT ANALYSIS

The composite table in Table 5 shows you how reimbursements for different plans vary. You have to understand a few basic assumptions. First, the patient mix was the same for all plans; that is, out of 10 patients, 4 receive single vision lenses, 4 receive bifocals, and 2 receive trifocals with a 100% prescription rate. For the sake of simplicity, the frame factors in these tables reflect a retail cost X2 plus $37. As you know, most fees run from 2X to 3X cost in order to cover optical overheads.

Also, you will see lab fees at the top of Table 5 next to material cost. For single vision, you will see two numbers, one is the regular price that you pay for private. The bottom number equals the discounted price for plans – the same for BFL's, TFL's and PAL's.

Roman numerals I-IV designate each plan. Column 2 indicates each plan's gross margins for exam and lenses. Column 3 represents the lens weighted factor. Basically, a lens weighted factor is calculated by multiplying the gross margin of single vision X4, bifocals X4, and trifocals X2. Add it all up and divide by 10. This gives you a weighted factor for lenses. Column 4 shows the entire cost of an exam, lenses, and a $40.00 wholesale frame. Column 5 shows what happens if you used an in-plan frame, a frame the plan allows. Column 6 shows you average extras, including PAL's, per patient as a factor. Note that the cost for some private fees would include $87.00 for an exam and a lens weighted factor of $78.64 combined with the frame. This totals

$240.84 gross margin, with $40.87 for extras.

Then, in Column II, Plan I shows a $60.80 lens weighted factor with a $73.93 exam, leaving you with $168.85 for a $40.00 frame. In this case, the plan included a $40.00 frame, which means Column 5 equals the same amount of money, but you have a $35.49 extra value, which means a cap exists on how much you can charge for extras.

In Roman numeral III represents Plan II. You can see a significant drop in the lens weighted factor and when you are allowed to use a $40.00 wholesale frame, you are capped at the amount that you can charge the patient. Then in column 5 you can see that if the patient uses the in-plan frame the gross margin decreases dramatically in addition to being capped on extras.

Plan 3 (Roman IV) shows some increase allowed in the expensive frame category, but when an in-plan frame was used, the gross margin decreased, again with a $37.00 increased for extras. Roman numeral V represents typical government plans in column 4 when the patient pays for their own frames. In column 5, when a patient uses an in-plan frame, the gross margin drops to $77.29 with no extras allowed.

VII. Conclusion

What can all these numbers do for anyone? First of all, they give you an idea of what you need to evaluate any plan coming over your desk. You must assess the gross margins for single vision, bifocals, or trifocals, including PAL's and all extras. This information can be graphed out on paper and made quite simple. With these numbers you can calculate what gross margins you would obtain, given a certain patient mix, a certain number of patients per day, and certain plan types. For example, what if you were hired to see only the government patients in Section V? You would know that your gross margin would be somewhere around $77.00. Depending upon the age of the patients and whether you saw 20 per day, you would have some idea of what income you generated for your services. You, of course, could then negotiate what income you should receive from such work. This type of analysis will be reserved for the next section in the series.

Special Note: Specifics of how to set up a spreadsheet of this information will be supplied later in an appendix to this section.