STAFFING CHALLENGES?

IT'S TIME FOR CAPITAL DEEPENING

Marc-François Bradley

It was an eye-opening summer in the job market. A city favorite—a burger and shake drive-thru—reduced hours of operations because they were short on their closing shift. I couldn't get a hotel room—not because they didn't have rooms, but because they didn't have staff to turn the rooms. Signage at my local McDonald's announced starting wages of $13/hour. Walmart is starting employees at $16.

Ophthalmology practice leaders around the country report similar stories and voice concerns about compensation within their own practices. Shannon Hunt, Office Manager, at Hillsboro Eye Clinic, explains it sometimes takes months to fill positions that would normally only take 1–2 weeks. "It has been extremely difficult to get call-backs from applicants for open positions," she says; things become even more challenging as "half our applicants don't show up for their interview, and those given positions may or may not show up for their first day of work." At the same time, pandemic-related workplace stress in healthcare has compounded the problem and increased burnout and attrition.

We know that if labor costs are high, firms will look to substitute capital for labor. For an ophthalmology practice this means investing in technology to boost productivity and substitute it for labor where possible.

Consider the example of planting a small orchard. You could hire laborers to dig holes or rent equipment to do it. You'd evaluate if laborers could be found—and compare costs of paying laborers versus buying equipment. The *capital-to-labor ratio* is the ratio of dollars you spend on capital to the dollars you spend on labor for the same output—say, planting twenty-five apple trees.

In an ophthalmology practice, labor inputs are more complex, with some more suitable to capital investment than others. Each part of the value chain in delivering patient care should be evaluated for its labor and capital input alternatives. While robots can't replace surgeons, software tools can augment scheduling capacity. Here, we focus on evaluating your capital-to-labor ratio in scheduling activities within the practice.

CAPITAL DEEPENING

As you look to control payroll costs and address staffing shortages for your scheduling department, consider your capital-to-labor ratio

by assessing the following monthly costs and outputs:

- Capital: What do you spend on software for reminders, recall, and other online scheduling tools?
- Capital: What percent of your practice management system monthly costs can you allocate to scheduling activities?
- Labor: What is your total payroll cost for schedulers?
- Output: How many patient appointments are completed?

For a given output, your capital-to-labor ratio is the total of your monthly capital costs divided by your monthly labor costs. Now consider rising labor costs. Do you decrease output by using less labor? Or do you invest in capital to maintain production without increasing staffing payroll?

This is the concept of capital deepening: adding more capital to the mix of inputs to maintain or grow your outputs. Guido Piquet, Chief Operations Officer at Mann Eye Institute in Houston, Texas, for example, explains that "given our growth objectives, we were confronted with the challenge of adding to staff in a difficult labor market or investing in technology to augment our scheduling capacity."

It may be time to deepen your capital investment in operations. On average, ophthalmology practices need one scheduler for each 500 appointments/month.[1] Assuming an average national wage for schedulers of $16.44/hour with two weeks' paid vacation and six holidays, this means that the average labor cost of scheduling is $5.50/appointment. This may differ from the labor cost for every appointment kept, as patient rescheduling means staff inevitably schedules far more appointments in a month than are physically possible.

Your scheduling-labor-cost-per-appointment-held becomes a critical number as you look at capital investment alternatives.

SCHEDULING COMPONENTS

Schedulers typically

- Take calls from patients to schedule or reschedule appointments.
- Contact referred patients to get them scheduled.
- May contact patients to remind them of upcoming appointments.
- Follow up on recalls.
- Chase down no-shows.

Many software tools exist as aids or replacements for scheduler staff time. These range from reminder systems sending patients email, text, and voice messages to online scheduling systems for use by patients or referring doctors.

Now look at your existing investments in scheduling technology relative to the number of appointments held. Determine your per-appointment capital costs. A typical five-doctor practice seeing 2,000 patients per month might allocate $600/month (40% of its $1,500 monthly practice management system bill) for scheduling plus $400/month for an appointment reminder system for a monthly capital scheduling cost of $1,000. A kiosk check-in, patient portal, or other patient engagement technology might add an additional $500/month. Together, this might mean $0.75/appointment in capital costs.[2]

LOOKING TO GROWTH

The above exercise allows us to view a practice's growth opportunities. Assume you have the doctor availability, exam lanes, etc., and you want to grow but you realize you can't schedule more appointments with your existing schedulers. Consider the marginal cost of additional appointments in terms of possible additional capital and labor costs.

Based on the above analysis and assumptions, an additional scheduler could allow you to schedule another 500 appointments per month at a cost of $5.50/appointment, but what if adding online tools for patients to self-schedule will only cost you an additional $1.00/appointment for the same number of appointments (i.e., if all 500 decide to schedule online)? The calculation can be adjusted based on your projection of patient adoption; still, this is a big difference.

Even as local hourly wages continue to rise you will be prepared. You will look at your options and recognize the opportunity for capital deepening within your practice. *AE*

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NOTES

[1] Data from seventeen individual ophthalmology practice leaders who responded to a survey I conducted in summer of 2021 in preparation of this article.

[2] The assumption here is that the software and the human both will book an entire 500 more appointments per month. If fewer than 500 book appointments online, capital cost per appointment will rise, but it will remain a cheaper option if more than 100 patients book online.

Marc-François Bradley (800.608.6017 ext. 101; mbradley@sophrona.com) is president of Sophrona Solutions, Inc., North Oaks, Minn.