Principles of Practice Transfer: Adding an Associate/Partner

CHAPTER 9

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Chapter 40 describes several "exit strategies" for optometric practices, but owners generally appreciate that there are basically two main options for practice transfer. The practice can be sold outright, or an associate can be brought in with the express intent to enter into a partnership and eventually own the practice when the senior doctor retires. As a best-case scenario, the associate-to-partner-toowner transition allows the greatest advantages for all concerned. This chapter examines this process and analyzes how it might be feasible for an existing practice to add an associate to assure the smooth transfer of the practice. This chapter also discusses tips and strategies for doctors seeking to find associate practice opportunities, along with suggestions for developing their own opportunities. The topics of practice sales and purchase contracts are covered in Chapter 8.

CAN THE PRACTICE AFFORD TO ADD AN ASSOCIATE?

For the owner of an optometric practice, the biggest concern when contemplating adding an associate is how it will affect their own income. How much will they have to sacrifice financially to be able to add the advantages an associate can bring to their practice? This is a legitimate question, but one where a number of misconceptions can skew the answer. One philosophy may be that the practice will need to be large enough and busy enough to add an associate without a significant impact on the existing doctor's income, but it may not need to be as large as some might think. Considering this philosophy, to successfully bring in a full-time associate, a minimum gross in excess of $500,000 is probably required. Smaller-sized practices will probably need to think about adding an associate on a part-time basis only, unless the owner is wishing to slow down and is prepared to accept a noticeable decrease in personal income.

Practitioners who have monitored their practices closely will be aware of the percentage of their gross receipts that is available to them as net income. For most practices, this will be in the 27% to 33% of gross revenue range, and for illustration purposes, 30% will be used as the figure for a normal optometric practice net income. Knowing this percentage for the practice and having monitored it over a number of years, there is a tendency for the practitioner to use 30% as the expected net income from an associate's activity as well. In fact, the net income from an associate's production will be in excess of 50%. The Williams Consulting Group uses 55% as the expected net from the associate. The reason for this higher effective net is that the office overhead (rent or mortgage, utilities, equipment, computers, and staff) is already being paid, regardless of whether an associate is added or not. The extra expenses related to the new doctor will be primarily laboratory costs, a small increase in office expenses and possibly a small portion for the increased staff costs needed to accommodate more patients and possibly increased hours.

Therefore, if an associate is paid $78,000, the gross income of the practice would need to increase by $142,000 ($142,000 × 55% = $78,000) for the associate's production to pay for himself or herself entirely, not the $260,000 that the familiar 30% net formula might suggest $260,000 × 30% = $78,000). Assume that the average revenue per patient (the gross income divided by number of full examinations) for the practice is $300; $142,000 divided by $300 yields 473, which is the added number of examinations needed to pay the associate's salary, if no other income streams are considered. That would amount to roughly nine extra patients a week. If the office can fill nine appointment slots per week for the associate, perhaps by expanding to more hours, adding weekend appointments, or by reducing the backlog of patients waiting to be seen, there will be no impact on the existing doctor's income. By adding additional services (discussed in the next section), the number of added examinations per week necessary to pay an associate salary will drop below nine and can easily be expected to be in the range of six to eight examinations.

While the prospect of sacrificing income to bring in an associate is for some a major concern, the reality is that it is less of an impact than might be expected. If the practice is busy, booked for several weeks in advance, and work hours have increased or services have been added, most practices who add an associate can come very close to paying for the additional costs in the very first year. In subsequent years, the increased growth provided by the expanded practice more than supports

itself, increasing the income to the original doctor and increasing the value of the practice.

In a study of the last 60 practice appraisals completed by one of the authors, in which tax returns or profit and loss statements were available for the year in which an associate was added, it was found that in all but four instances, within 18 months (average since it was not always known during which month an associate was hired and gross figures used were for the following complete tax year) gross income had exceeded a 20% increase. For a $500,000 practice this means $100,000 additional gross revenue and for an $800,000 practice an increase of $160,000. For all but one of these practices the increase in gross income for the following 12 months and after was no less than 10%. The result projecting this trend for 5 years (20% increase in first full year after bringing in an associate and 10% each year thereafter) would be for the $500,000 per year practice to now become an $875,000 per year practice and the $800,000 per year practice growing to $1.4 million. Considering the impact on net income for the senior practitioner, it would seem the initial investment in an associate would have made sense even if the senior doctor paid the entire $78,000 salary completely out of his or her own pocket. Not only did the senior doctor in these practices benefit from added net income, he or she benefited handsomely by the increased value of his or her practice equity.

Regardless of the impact on net income and practice value, there are a number of other benefits the practice enjoys by adding an associate.

BENEFITS OF AN ASSOCIATE FOR THE SENIOR DOCTOR

Adding an associate to maintain and then increase the growth of a practice can be a benefit financially in a relatively short period of time. The prospect of now having a workable exit strategy is also of considerable worth. By knowing the practice transfer is arranged so that when the desire to either slow down or stop working arrives, the first owner gains a large sense of security and peace of mind. The practice is set to continue on after he or she retires, and the practice transfer and purchase are assured at the maximum value. The associate-to-partner-to-owner transition is the most desirable of all exit strategies and the most flexible. It allows a timeline to be established, so that retirement can be well planned. If the senior partner wishes to ease into retirement, that should be possible. On the other hand, if they wish to retire fully at a certain age, the process of bringing in another associate is begun by the previous associate.

Having an associate provides security in the event of a serious illness or a period of disability that the first doctor may experience. Without an associate, this would cause a significant loss of income and decrease the value of the practice if the office were left unattended for an extended period of time. This added security is valuable and needs to be factored into the associate's ultimate added contribution value.

Since the associate will generally be younger, the practice will be able to attract younger patients. The average patient age increases with the age of the practitioner. A younger associate will be involved in different community, school, and social groups, thus interacting with a younger population. Being able to attract young mothers will allow the practice to continue to grow because they generally control the appointments for the entire family. A younger patient base will also be expected to lead to more income from contact lenses and provide more sports vision-related opportunities. The associate also allows the opportunity to bring a higher percentage of new patients into the office. This percentage tends to drop over time as a practice matures since they accumulate a large number of established patients. As the waiting time to be seen for an appointment increases, the established patient who knows the value of the practice may be willing to wait, but a new patient is less likely to wait 3 or 4 weeks to be seen. Many practitioners tend to boast about how far in advance they are booked—this is not good patient service and is a sign of inadequate planning for practice growth and transition. The associate allows these patients to be seen much sooner and helps stimulate practice growth and assures the future of the practice by keeping more new patients coming through the door. Additionally, the senior doctor needs to assess how computer literate he or she really is and whether a transition to electronic medical records (EMR) and the importation of other technology into the practice will be a comfortable transition. Recent graduates tend to be extremely computer literate and such a transition for them would not present many roadblocks, as might exist for the senior doctor proceeding on his or her own.

Finally, having an associate should invigorate the practice. Both the established doctor and the staff can be stimulated by the energy the new associate should bring. Introducing new ideas, new technology, and new enthusiasm into the practice will create an atmosphere of change and innovation that should be noticed by patients. Providing enhanced services and adding new instrumentation can elevate the level of care provided and also increase the pride and enthusiasm of the office, as well as leading to more satisfaction and enjoyment in practicing for the senior doctor. It is difficult to put a dollar value on the intangibles of attitude and satisfaction changes but clearly need to be considered when calculating how an associate adds value to the office.

WHAT DO DOCTORS SAY ABOUT THE EXPERIENCE OF ADDING AN ASSOCIATE?

In 2002, doctors in Indiana were surveyed for their attitudes and experiences with regard to adding associates. Some of the key findings of this survey, published in 2003 by the Indiana Optometric Association, are listed in Box 9-1. These questions were answered by doctors who had added an associate, and the responses are certainly informative.

Note that a large majority of these optometrists who brought in an associate did not suffer a loss in their personal income even in the first year. They received all of the advantages discussed at no cost. Because the practice growth has been boosted, they will in fact soon be making more money, or perhaps the same amount of money but enjoying more free time. They benefited by all of this, and the practice transition at maximum value is ensured as well.

BOX 9-1

Adding an Associate: Experience of Established ODs

83% of the associates went on to enter into partnerships.
80% of established ODs did not experience a drop in their income in the first year.
100% reported being glad they added an associate.
50% wanted to decrease their time in the office (and did) and 50% remained full–time ODs.
67% based the associates pay at least partly on production.
34% of the associates added a new service or specialty to the practice.
Average practice growth before associate: 12%
Average growth after associate: 34%

From Indiana Optometric Association: *Associateship: The future of your practice and you,* Indianapolis, 2003.

ADDING SERVICES OR SPECIALTY PRACTICES TO AFFORD AN ASSOCIATE

A portion of the increased income needed to support an associate can come from expanded services. The easiest of these might be expanded hours. Offering early morning or evening hours may be attractive to a number of patients. The same may be true for weekend appointments. In addition, there may be services or testing not offered by the practice that the associate could add or provide. In addition to providing increased income, these enhanced service areas also contribute to the reputation and overall standing of the practice in general. By adding one or two of these additional services, the cost of paying for an associate from existing net income can be reduced significantly. These might include the following.

Pediatrics If the practice is not actively seeking pediatric patients, this area could be added. With a relatively low cost to prepare the office for young patients, from infants to young children, additional examinations can be scheduled and more importantly, perhaps new families may become loyal patients. The associate can visit and maintain communication with pediatricians and nurses in the community, explaining that he or she is willing and prepared to see their pediatric patients. If the practice is not offering free screenings for infants under the age of 1, the associate will have the time in their schedule to offer this service. New parents are very impressed and appreciative of such offers and can become strong advocates for the new doctor. Parents, grandparents, and siblings often become new patients, as well (see Chapter 29).

Contact Lenses

Although nearly all practices provide contact lens services, the majority could expand services in this area. The new associate may have the time and interest to promote presbyopic contact lens fittings. They may also have the skills and interest to tackle the more challenging irregular cornea complications, such as keratoconus, or postsurgical patients. Both multifocal and irregular cornea cases command higher professional fees than more routine contact lens fittings, so even limited numbers can add up to a noticeable benefit for the bottom line. Finally, if overnight corneal reshaping is not offered, the new associate could bring this service to the practice as well. With fees typically in excess of $1,000 per patient, this area of contact lens practice can quickly contribute to offsetting the added cost of the associate (see Chapter 30).

Postsurgical Co-Management

If co-management services are not being provided or not heavily promoted, a new associate will likely feel very comfortable contributing this service. Co-management of cataract patients is fairly common and a number of practices co-manage refractive surgery cases. Most, however, do not actively promote these services well. If they are not being offered, as few as 2 or 3 cataract patients and 2 or 3 refractive surgery patients seen a month can add $25,000 in professional fees to the yearly gross, with most going directly to net income (see Chapter 29).

Medical Management

Practices that are not currently treating glaucoma are prime candidates to add this service for patients through an associate. There have been estimates that a busy average optometric practice might detect or at least suspect glaucoma in 4 or 5 patients a month. Keeping them in the office for the monitoring, evaluation, and subsequent treatment, if needed, can provide a large new billing area. Even providing the care for just 3 new glaucoma patients a month can add $20,000 to the yearly gross. These patients then need continuing care year after year, with the fees generated for continuing patients only a little lower than the first year testing and visits. If there is sufficient demand, additional equipment may need to be added to provide state-of-the-art care. This added technology eventually will more than pay for itself and elevates the level of patient care, as well as the level of pride and satisfaction on the part of the doctor. Recent graduates are well trained and are licensed to provide these services.

As the population ages and the baby boomers become older, the number of patients needing care for macular degeneration and diabetic eye complications will significantly increase. With a number of instruments available to test for, monitor, and possibly predict macular pigment changes and very early macular edema, the need for more frequent monitoring will be increasing. Adding an associate comfortable with this new technology and the management of these diseases may be a big boon for the practice financially.

Dry eye is a very common ocular problem, especially prevalent with the aging population and with female patients. Typically, when believed to be relatively mild or not very symptomatic, either nothing is done or artificial tears alone might

be recommended. The vast majority of patients are then left to treat themselves by trying to choose from shelf after shelf of tear products in the drug store. A much more effective and appropriate approach would be to look and question more for dry eye syndrome symptoms, return the patient for extended testing and diagnosis of their specific condition, and then institute a detailed course of therapy. Providing this enhanced care not only benefits the patient, but the visits and testing are rightfully billed to their medical insurance, increasing practice income.

Similar to the management of dry eye, patients with ocular allergy problems are often not handled as seriously as they might. Diagnosing, providing patient education, prescribing medications, and returning the patient to monitor the effectiveness of the treatment should be a much more common mode of practice. It is quite possible the new associate will be inclined to provide medical eye care in an enhanced manner, thus adding to the level of care and the overall services provided by the practice.

Sports Vision

There are a large number of patients who take their leisure time very seriously. Golfers, fishermen, or softball players are examples of persons who spend a great deal of money on the enjoyment of their sport. How willing might they be for anything that benefits their ability to perform those activities? In addition, young patients are participating and performing in various sports in record numbers. Anything that contributes to their performance is eagerly sought. Adding sports vision as a specialty area to the practice can add to the services and be an attractive draw for patients to the practice (see Chapter 29).

Low Vision

With an aging population, the need for low-vision services will surely continue to increase. Life expectancy is increasing each decade and with older age, decreased vision will be even more prevalent. Providing low-vision services and aids, from high adds and magnification lenses to elaborate, computerized systems, is a great service to the patient and can keep them in the practice and serve as another revenue stream. Since many of these low-vision patients will be suffering from macular degeneration, adding instrumentation to test for early macular pigment loss or using scanning lasers to measure macular thickness may offer opportunities to enhance vision performance and reduce the impact of macular degeneration (see Chapter 29).

GENDER ISSUES

Although this may seem an unusual topic when discussing practice transition, it bears some brief comment. The large majority of optometrists in practice who will have associate opportunities to offer younger doctors will be male. If they assumed the practice of another doctor when they started, it is a near certainty that it was a male who passed the practice on to them. As of 2009, the doctor seeking an associate position is now just as likely to be a male as a female. Within the not-too-distant future, the pool of potential associates will likely be a majority of females. It is very important that the established doctor be open to all potential future partners. When the picture of optometry has been formed by overwhelmingly male images, it may be natural and more comfortable for doctors to seek a male associate. Optometric educators and external rotation site doctors can offer assurance that doing so would eliminate the opportunity to add many outstanding doctors to a practice. Optometrists should be aware of these natural tendencies and be careful not to limit their opportunity of adding the best associate possible.

THOUGHTS FOR OPTOMETRISTS SEEKING TO FIND AN ASSOCIATESHIP POSITION

Surveys of new graduates continually show that the majority desire to have some form of ownership in an optometric practice. Some will find practices to associate with by responding to practice listings on various placement services. Many, however, will need to be more proactive in finding an ideal practice opportunity. There are a good number of practices that could benefit by having an associate. Either they are busy and fully booked, or the owner is approaching a time when retirement is being contemplated. Although they should be seeking an associate to grow their practice and assure a smooth practice transfer, it is easy to get caught up in the busy day-to-day details and to continue doing things as usual. It takes a definite effort to begin the process of finding an associate. Therefore the younger doctor may very well have to plant the seed and drive the process, which can lead to developing an associate relationship.

One of the first aspects of the process is to identify locations and communities that would be attractive and acceptable to establish residence. In more than half the cases, an associate leaves the practice before ever becoming a partner or owner. A fair number of these situations result from compatibility or financial issues, but it is not uncommon for the new doctor to realize that the community is not really where they want to live. It might have seemed an attractive place to live, but if it is too far removed from family members or does not provide the things needed for happiness outside the office, its location may well create enough problems to doom a prospective partnership. Finding the “perfect” practice opportunity in a location that does not provide ultimate family happiness will not often be fruitful.

Industry sales representatives may be helpful in identifying practices that may benefit from adding another doctor. Contact lens company representatives in the area can be contacted through the national toll-free numbers. Local finishing laboratory and frame salespersons will also be excellent resources because they see many practices every day, know which waiting rooms are always full, and know which practitioners might be approaching retirement age. Helping a new doctor find a successful opportunity will likely be repaid by a lasting loyalty from that new doctor.

Once a potential practice that might support an associate and that is located in a desired location or community has been identified,, the next step is to establish contact with the practice owner. A letter should be sent that states how you

were referred to them and your interest in discussing possible opportunities in the area. This letter would not necessarily be specific for an opportunity in that office but might approach it as seeking the doctor's input on the topic as a person knowledgeable about eye care needs in the area. This letter might be followed by a telephone call within a week or 2 of sending the letter. The goal is to arrange a time to meet them and open communications. The standard response may be that they themselves have no opportunity, but the visit and possibly follow-up contacts and information may plant the seed. Pointing out the benefits a new associate can bring, highlighting any special skills or services that might be added, and educating the practitioner on how an associate might be afforded will lead to serious consideration by most doctors. The tipping point may be when they give serious consideration to the need for an "exit strategy," and they think ahead about how to best transfer their practice, so referring them to the information contained in Chapter 40 might be helpful.

This process may take up to several years to become fruitful. There will be times when a practice is very promising, but because of either volume or space limitations, the doctor decides he or she cannot bring in an associate on a full-time basis. These situations may eventually result in a very successful relationship. When the opportunity is attractive enough, finding a way to begin working in the practice on a part-time basis and supplementing that income with employment elsewhere is an excellent road to take. There have been a number of instances in which practices in two separate communities within driving distance could benefit from part-time help. After a few years of splitting time in both, the younger doctor then chooses which opportunity to join as a full-time associate. The help the younger doctor had provided in growing the other practice may make it possible for them to be able to bring in a full-time associate as well. There are many excellent practice opportunities that may require starting with part-time employment. Again, the new doctor may need to instigate the process, but the option of building an opportunity should not be overlooked.

COMPENSATION OPTIONS FOR ASSOCIATE PRACTICE

In most situations where an associate is added to a practice with the understanding from the outset that partnership is the goal, there will be an introductory or trial period identified. This is most often 1 year but could range from 6 months to 2 years. This period allows both sides to evaluate if the association will be positive and if all involved, including doctors and their families, will be happy.

Fixed Salary

The salary could be a yearly or a per-day or per-hour rate. A fixed salary allows both parties to know exactly what to expect and to be able to plan based on a guaranteed rate. It also eliminates the fear an associate, whose pay is based on production, might have as to the expected volume. The disadvantage of a fixed salary is that with a fixed salary or rate per day or hour, there may be little incentive or motivation for the associate to help grow the practice. Similarly, implementing cost-effective or cost-saving strategies or demonstrating an interest in increasing efficiency or working at faster rates to see more patients does not benefit the associate on a set rate compensation plan. The assumption is that an associate who is looking forward to ownership will have an interest in "thinking like an owner" from the start but that would not be the case in every instance.

Variable Salary or Compensation Based on Production

A variable salary based on production is generally stated as an agreed-on percentage of the gross production by the associate. Remembering that in many circumstances, the associate's net will be around 50% even when the overall practice net is 30%, an arrangement of paying the associate 25% to 35% of their gross production would still benefit the owner. It could also be arranged to pay one percentage for professional fees and a lower one for materials fees generated. This plan would give the associate great motivation to see as many patients as possible and to bring in new patients to the office while removing the risk on the part of the owner of having to pay for a nonproductive associate. The disadvantage of a variable salary is that there is no guarantee to the associate. They may not be in control of the appointments, and in fact, the staff may be loyal to the owner and fill their schedule first, at the expense of the associate. The practice may not be busy enough or attract enough patients to earn a wage sufficient for the associate. If there is an associate in the practice who is leaving and a new associate is taking his or her place, there is a track record of activity and an ability to better estimate the expected income, which would somewhat lessen the disadvantage.

Fixed Salary with a Bonus Based on Production

A fixed salary with a bonus is an attempt to combine the advantages of each of the first two methods while lessening the disadvantages. With an annual guaranteed rate, the associate can know they will have a livable wage. With a portion of their compensation based on production, the owner knows the associate has an incentive to work hard and to contribute to growing the practice and attracting new patients. There is not much of an incentive for the owner to keep themselves fully booked while the associate is not busy because if the associate's production bonus is reached, the owner typically benefits as well from the increased income. Therefore the senior doctor may be more likely to attempt to level the load or even take more time off than they might be under a straight production plan.

Combined Salary, Production, and Ownership Plan

This compensation method can be structured in a variety of ways. It is again an attempt to combine the best parts of the first methods mentioned, while lessening the impact of the disadvantages of each. It also incorporates recognition that

ownership should be a factor in the compensation formula, as well as a method that can be continued once an associate begins to assume increasing ownership. A salary portion can be set, then an amount is based on production, and finally a portion of the compensation is based on ownership.

For example, a practice has decided to allocate the profits into three different pools: ownership, salary, and production. A predetermined portion of the net will be placed into each of these pools, for example, the ownership pool will get 15%, salary pool 45%, and the production pool 40%. The practice net income is $300,000, the owner owns 100% of the practice, the owner produced 45%, and the associate produced 55% (the owner is taking more days off and more vacation time, while the associate is working more hours).

Ownership pool: 15% of $300,000 = $45,000
Owner: $45,000 × 100% = $45,000
Associate: $45,000 × 0% = $0
Salary pool: 45% of 300,000 = $135,000
Owner: $135,000 × 50% = $67,500
Associate: $135,000 × 50% = $67,500
Production pool: 40% × $300,000 = $120,000
Owner: $120,000 × 45% = $54,000
Associate: $120,000 × 55% = $66,000
Owner's compensation: $45,000 + $67,500 + $54,000 = $166,500
Associate's compensation: $67,500 + $66,000 = $133,500

Once the associate begins to purchase into the practice, they would participate in the ownership pool. Other options for partnership practices are to eliminate the salary pool and have ownership and production pools only. The percentages chosen are open for negotiation between the parties, but using formulas similar to this allows the total compensation to reward ownership, to reward the person who might be working harder or more hours, and if there is not a proven track record of income, to be able to assure a basic salary for the new associate.

Miscellaneous Compensation Formulas

There are many variations on compensation formulas, as well as a number of other methods. A primarily production-based plan can be adjusted to take into consideration the cost of goods. If one practitioner is generating mainly professional fee income with little or no cost of goods, this might be a more fair arrangement. There are plans that might apply certain quality measures to the formula such as patient satisfaction surveys or record reviews for key quality measures. In general, for an associate just joining a practice with the anticipation of assuming some level of ownership in the next 1 to 2 years, these methods would be the main compensation arrangements.

Initial Guarantee and Transition to Partner Salary

One of the authors highly recommends that senior and junior doctors explore the following scenario that provides the initial guarantee that a new associate desires and encourages transition from an associate to a partner. In this scenario, the associate is guaranteed an initial fixed salary. Each subsequent year it would be reduced by 20%, but simultaneously the associate would receive a 10% share of equity (either as a buy-in or as compensation for initially accepting a reduced salary). This would entitle the associate to an additional 10% of the net income distribution for each year as well. The end result after 5 years is no salary but 50% distribution of the net income (Table 9-1).

TABLE 9-1

Conversion of Associate Salary to a Division of Net Income Based on Equity Owned

Year	Compensation as a Percentage of Salary	Compensation as a Percentage of Net Income
1	100%	0
2	80%	10%
3	60%	20%
4	40%	30%
5	20%	40%
6	0	50%

CONCLUSION

Fantastic opportunities exist for the recent graduate or for those seeking to change their mode of practice to one of independent practice. Unfortunately, this is not the message that graduates from some schools hear. To present a balanced perspective for students, clinical instructors must have had that experience and be appropriate role models. Such a role model or mentor cannot be those whose only mode of practice is as an employed optometrist such as by an optometry school, a health maintenance organization (HMO), a corporation, an ophthalmologist, or another optometrist (unless on a partnership/ownership track). In a recent survey, it was found that as many as 92% of clinical instructors are in modes of practice *other than* independent private practice and only 5% of externship sites are independent practices. At some schools, less than 20% of optometry graduates go directly into some form of private practice with a partnership/ownership track. The following three reasons are given for this increasing trend:

1. The changing demographics of the optometric student population who may be less likely to possess entrepreneurial skills necessary for success in independent practice.
2. Higher student debt levels (exceeding $135,000 on average nationally), which are thought by some to limit mode of practice options upon graduation.
3. A lack of role models and mentors among clinical faculty who are or have been personally successful in independent private practice.

Entrepreneurial skills can be learned. Debt, when invested wisely, is not a roadblock—quite the opposite. There is no better investment (other than our health) than in our education. Education opens doors rather than closing doors.

The opportunities for independent practice are certainly available for those who seek them out. The changing demographics of the patient population, as well as for the providers who care for their health, are changing in a very favorable way for optometry.

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