Tracking Improvement

These benchmarks measure how efficient your practice is.

BY JON A. HULTMAN, DPM, MBA

For virtually every human endeavor—ranging from a simple game to complex business operations—participants seek benchmarks for setting standards whereby they can evaluate their performances. Because benchmarks convey only limited snapshots of important information, each should be considered in conjunction with others to form a more complete picture. Similar to the fact that taking x-ray views from different angles allows a more accurate interpretation of each individual film, the best overall interpretation of a medical practice's performance is gained through investigation of a combination of relevant benchmarks.

Medical practitioners and their staffs can achieve the greatest gains in performance by focusing on activities that render improvements in efficiency and productivity. To determine the effectiveness of their efforts, they must have benchmarks against which to measure both efficiency and productivity. A combination of the following six benchmarks is a good starting point for assessing a practice and measuring its performance: 1) profit increase relative to revenue increase, 2) the number of FTEs (full-time-equivalent) per doctor, 3) the collection ratio, 4) revenue, expense, and CPT codes billed, per visit, and 5) patient access and waiting times. These benchmarks are relatively easy to calculate using data readily available in most practices, and when examined together, they will provide a good assessment of how a practice is performing and where it can be improved. Let us take a look at each of these relevant benchmarks.

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Profit Increase Relative to Revenue Increase

Growth is the natural outcome for businesses that provide valuable products or services, and medical practices offer no exception. Doctors who are rendering quality care will develop good reputations with ever-increasing numbers of patients coming to their offices. Along with growth comes an increase in revenue; unfortunately, this is accompanied by both an increase in expenses and an increase in the complexity of "doing business". The percentage of any revenue increase that ultimately translates into profit is dependent on the practice's level of efficiency; an efficient practice will capture a greater percentage of revenue growth as profit than will an inefficient one. The ratio of profit increase to revenue increase is an easy statistic to calculate and track, and knowing this number will help

Continued on page 153

Tracking (from page 152)

doctors improve the performance of their practice.

A sure sign of inefficiency in a growing practice is revenue that is increasing at a higher rate than profit. An efficient practice will produce at least the same percentage increase in profit as it does in revenue. The superior, efficient practice can achieve a percentage increase in profit that is actually greater than its increase in revenue. It is possible to achieve this superior outcome through the opportunity of being able to spread an increasing volume of patient visits and services over stable fixed costs. While this outcome can result over years from organic growth, it can be achieved much more quickly through the merging of practices.

Suffice it to say, practices with superior levels of efficiency will be well positioned to convert a greater percentage of any growth into profit. Warren Buffett, one of the world's most astute investors, stated this concept well, "Great businesses make lousy investments if management cannot convert sales into profit. Managers of high-cost operations tend to find ways to continually add to overhead, whereas managers of low-cost operations are always finding ways to cut expenses."

FTE to Doctor Ratio

The FTE to doctor ratio of a practice tells us more about that practice than does the total amount of its staff salaries. Salaries vary greatly by region or physician choice, making comparisons amongst practices unreliable. Focus on the FTE ratio when evaluating efficiency and costs because payroll accounts for the highest percentage of office overhead in most medical practices. Ideally, a doctor needs to determine his/her optimum staffing ratio—one that will deliver the highest levels of productivity, treatment quality, and patient satisfaction—at the lowest cost. Reducing the FTE to doctor ratio is desirable only when it will not lower physician productivity, quality of care, or patient satisfaction.

Tracking a practice's internal collection ratio over time and individually tracking the collection ratio for each third-party payer are valuable exercises—especially for a practice whose volume is increasing.

The typical practice utilizes obsolete business processes, creating an environment in which, at any given point in time, 30% of the staff are idled waiting for something, and 25% are performing unnecessary tasks. This creates FTE ratios that are significantly high, with no corresponding benefit. The fact is that smaller FTE ratios can actually be consistent with higher levels of productivity, higher quality, and lower costs.

Typically, larger practices tend to have higher FTE ratios. Up to a point, higher ratios translate to higher productivity and greater earnings for the doctors. The "average" orthopedic practice may have an FTE to doctor ratio of 4.5; yet, this ratio can be as high as ten in several large orthopedic groups. In podiatric groups, there is a range in FTE/Dr ratios from 1.7 to 8.0. It is likely that neither the extremely high ratios, nor the extremely low ones, are optimal; however, it is safe to assume that the efficient benchmark for most group practices is much lower than their current ratio. Again, Warren Buffett has stated it well, "There is a right size staff for any business operation. For every dollar of sales, there is an appropriate level of expense."

Collection Ratio

The collection ratio reflects the efficiency and effectiveness of the entire billing process—from initial data entry, co-pay collection, and obtainment of treatment authorizations to submission of claims, follow-up, and final deposit of payment. Tracking a practice's internal collection ratio over time and individually tracking the collection ratio for each third-party payer are valuable exercises—especially for a practice whose volume is increasing. Increasing the collection ratio should be a high priority for every practice.

Obviously, every doctor would like to achieve a 100% collection ratio, but as we all know, this is unrealistic. Because each third-party payer uses its own fee schedule and rules for adjudicating claims, doctors often submit fees that are higher than those of the third party, knowing at the time of submission that much of this money cannot be collected and will have to be adjusted off at a later time. The result of this approach are inflated account receivables and artificially low collection ratios.

Because each doctor has a different "retail" fee schedule, it is not possible to directly compare collection ratios among practices other than as "reality checks". While it is revealing to know how you are doing relative to other practices in your specialty, the goal is to improve your own collection ratio. To accomplish this, it is essential that you be able to track your own progress, explain any fluctuations, and measure results as you implement changes directed at improving this process. Today, many practices utilize fee schedules with fees that are 2.5 times the Medicare rate. If this were the standard for a practice, and it actually collected 40% of its total charges, its collection ratio would essentially be 100%.

One consistency is that the collection ratio for an inefficient billing process is typically at least eight percentage points below where it should be. Ideally, we should strive to collect 100% of what we are allowed to collect. A good starting point for accomplishing this is to set a goal of achieving a collection rate that is at least eight percentage points higher than a practice's historical rate.

One benchmark that correlates well with the collection ratio is the length of time that money remains

Continued on page 154

Tracking (from page 153)

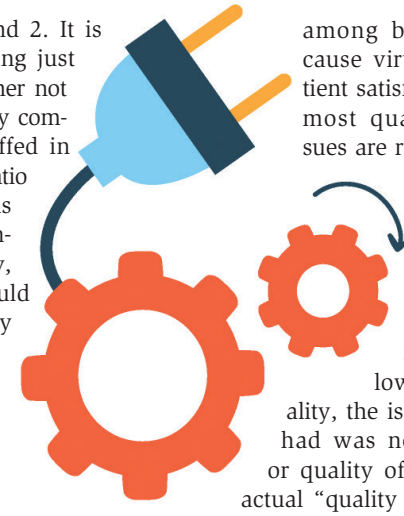
in accounts receivable. Faster money collection always translates to a higher collection ratio. Collecting cash (co-pays, deductibles, non-covered services, and the patient's portion of the insurance), entering billing data on the day of service, making fewer mistakes, submitting claims to third parties more quickly, and following up immediately on under-payments all speed the collection process and translate to higher collection ratios. Money that sits in receivables for a long period of time becomes far less collectable than money that is collected on the date of service or within the first 30 days following a visit.

Revenue, Expense, and CPT Codes Billed, per Visit

Most practices use standard financial statements to monitor total practice revenue and expenses. While these give an indication of productivity and efficiency, they become even more useful when considered relative to patient volume. This can be accomplished easily by dividing total revenue or expenses by total patient volume, thus expressing these amounts as revenue, or cost, per patient.

An increase in patient volume is likely to increase total costs, but the relevant cost benchmark is whether the cost per visit—not merely total costs—is increasing or decreasing. The goal should be to *decrease cost per visit.* This can be done either by actually reducing total costs (e.g., through a reduction in FTEs per doctor) or by *relatively* reducing costs (i.e., spreading a greater patient volume over the same number of FTEs and available office space). Future medical practices based on collaborative models will have significant opportunities for creating per patient cost reductions.

The average number of services, pre-visit, provided by podiatric practices—as measured by the ratio of CPTs billed per visit—is around 2. It is likely that practices billing just one CPT per visit are either not following up on secondary complaints, or are understaffed in the clinical area. If your ratio of CPTs billed per visit is below 2, this is a good indication that productivity, and hence, revenue, could be increased significantly by hiring another FTE to assist in the clinical area of the practice.



Patient Access and Waiting Time

The factor in the operations of a medical practice that most directly correlates with high quality treatment and patient satisfaction is short patient wait times. Richard J. Schonberger, author of *Building a Chain of Customers,* states, "If there was one single measure of quality, especially quality of service, waiting time (or lack of it) is probably it." Patients want faster access to practices, and they dislike waiting at the office once they arrive. They are even willing to pay more for short waits and quick access as evidenced by the success of many "concierge" practices.

A clearly superior practice is one that can provide same day access, has short patient waits, and has an efficient FTE to doctor ratio.

It is difficult to reduce waiting time, and it cannot be reduced without first being able to accurately measure and monitor it. Today's software can be used in helping to set benchmarks through the accurate measure of "wait times." This can be accomplished by electronically "tagging" patients at critical times—when they arrive at the office, when they are moved to treatment rooms, and when they check out. This tracking data provides a breakdown and "count" of the patient's total waiting time and is, therefore, useful for pinpointing the areas at which office processes break down.

The measure of waiting time is key to understanding the interrelationships among benchmarks because virtually every patient satisfaction issue and most quality-of-care issues are related to waiting time. Remember when the Veteran's Administration was being reported in the news as having low quality? In reality, the issue that patients had was not with doctors or quality of their care. The actual "quality problems" were the difficulties patients experienced when attempting to gain access for examination and treatment and the long waits they faced upon arrival at the VA. If access to your practice is delayed a number of days for new, non-urgent patients, and patients are facing long waits when they arrive for treatment, it may be time to consider adding an associate or a physician extender.

A clearly superior practice is one that can provide same day access, has short patient waits, and has an efficient FTE to doctor ratio. One with a high FTE/Dr. ratio, delayed access, and long patient waits is not translating its large number of FTEs into higher quality. When we compare the revenue and costs, per visit, we get an even more complete picture. The superior practice (the one with fewer FTEs *and* shorter waits) will be creating more profit, per visit. This may be accomplished by being more productive (higher revenue per visit), more efficient (lower costs per visit) or, ideally, both (the extreme, superior practice). Tracking these benchmarks and setting the bar high will set your practice on a course capable of delivering the best care, most profitably. **PM**

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