# Drowning in Data

## It's a matter of separating key metrics and less key metrics.

BY MARK TERRY



It is possible to collect and analyze data on almost anything going on in your podiatric medical practice. You may not need to or want to, of course. You can measure the length of time your staff spends on a patient phone call, but that's only useful if it's causing a problem and there's something you could do about it. Each patient call likely varies depending on the issue being raised. But it's possible that certain staff members spend too much time chatting with patients, which could potentially be a waste of time or, on the other hand, could just be part of good patient care and customer service.

Dr. Wishnie

This article isn't about phone calls, but about considering some less-common metrics that can give insight into your practice. It will also touch on some of the most important metrics podiatric practices should analyze on a regular basis.

Peter Wishnie, DPM (Piscataway and Hillsborough, NJ), says, "We try to measure everything. For example, at one point, more of our diabetes shoes were being returned than normal. Why? We wanted to track that to see why they were being returned and to implement strategies to fix it if it was fixable. It costs the practice business and money every time you return shoes. It has a trickle-down effect."

> **"We try to measure everything."**
> **—Wishnie**

### Dollar per Hour

One topic that gets discussed often is a podiatric practice's optimal staffing ratio. The general rule-of-thumb is two-and-a-half staff for each physician. As with many benchmarks, there are a lot of factors that go into whether this is an accurate number. It depends on the type of practice. It also depends on whether you do the billing yourself, someone in your practice does the billing, or if you hire it out. It depends on the number of patients you see and what types of procedures you perform, and how many ancillary-type services you might offer, anywhere from selling orthotics to offering laser procedures.

Rem Jackson, CEO/Owner of Top Practices (Las Vegas), thinks a better metric is dollars per hour. "How many dollars does the practice generate every hour that it's open and seeing patients? You can come to a point where you can't afford a bigger staff and the only real way you're going to grow is by utilizing your staff, having them do as much as is humanly and legally possible for them to do."

Meaning, as a physician, you

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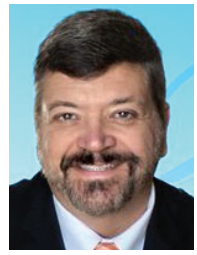
want to focus on performing duties only you can do by law or by your training, degree, certifications, and licensures. Everything else should be done by other people.

In terms of dollars per hour for the practice, as an example, Jackson has calculated that some of his top practice members bring in $550 for every hour they're open. "But doctors that really start to utilize their staff and consider them to be, quote-unquote 'producers,' can make upwards of $1,200 an hour."



Rem Jackson

**What's Your Overhead?**

What's your overhead and is it appropriate to your revenue? Podiatry practice overhead runs about 60% to 65% of collections. That's a figure that, according to the Medical Group Management Association (MGMA), has been increasing since at least 2001, and appears to be running up to 70% in more recent surveys across all medical practices.

One definition of overhead is any revenue that doesn't go into your pocket. According to MGMA, the following are common overhead in the average medical practice:

- Total support staff costs (salary and benefits)
- Medical/surgical supplies
- Facility (building rent or mortgage plus occupancy)
- Building depreciation
- Information technology (IT), such as EHR, billing system, servers, internet, practice management software, telephone system, etc.
- Clinical laboratory (in some cases)
- Radiology/imaging
- Furniture and equipment (often leased or paid off via a loan)
- Furniture and equipment depreciation
- Administrative supplies and services (postage, forms, printer ink, paper, etc.)
- Professional liability/malpractice insurance
- Billing and collections purchased services
- Other insurance premiums
- Outside professional fees (legal, accounting, consulting, etc.)
- Marketing and advertising
- Other ancillary services, such as cleaning expenses
- Miscellaneous operating costs

**In terms of dollars per hour for the practice, as an example, Rem Jackson has calculated that some of his top practice members bring in $550 for every hour they're open.**

If you want to calculate your percentage of overhead, you use the following equation:

*Total operating expenses (minus provider salaries and benefits)/total collections = actual overhead*

If you want to assume a benchmark, MGMA finds 60% is typical, so the calculation is:

*Revenue X 0.60 = benchmark overhead*

In most practices, the biggest expenditures are staff, medical supplies, and facility expenses.

Luckily, it's easier to cut expenses than to increase revenue. This is at least partly where certain benchmarks can come into play. Generally, when it comes to reducing medical

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FIGURE 1

## 12 Tips for Reducing Medical Practice Overhead

The American Academy of Family Practitioners (AAFP) developed a comprehensive 12-step plan for cutting medical practice overhead. Here are 12 tips they suggest:

1. Review the practice's staffing needs and adjust number of staff if necessary.
2. Evaluate and systematize staff pay and benefits.
3. Shop for savings in health insurance.
4. Review your retirement plan for possible savings.
5. Assess your sick leave, vacation and overtime policy and adjust if necessary.
6. Review your practice's lease and other lease contracts.
7. Evaluate and optimize ordering and handling of supplies.
8. Examine the cost-effectiveness of outside services.
9. Consider ways to economize on postage and telephone costs.
10. Analyze practice advertising for waste and effectiveness.
11. Evaluate and eliminate causes of patient refunds.

FIGURE 2

**National Benchmarks for Days in A/R**

| Percentage of Claims | Days in A/R |
|---|---|
| 52% | 0-30 |
| 16% | 30-60 |
| 7% | 60-90 |
| 5.5% | 90-120 |
| 17.7% | 120+ |

**Source:** Medical Group Management Association (MGMA)

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practice overhead, there are three options:

1) Increase productivity ("get more bang for the buck")

2) Cut costs ("get the same bang for fewer bucks")

3) Improve business efficiency ("get more bucks for the bang")

[See Figure 1 for more tips for reducing medical practice overhead].

The balance point for reducing overhead is to not negatively affect productivity or patient care (or morale, for that matter; running lean is one thing, but cut-to-the-bone-and-then-some is another). Also, some expenses increase productivity, so investing in certain things—some IT, certain staff, etc., may improve efficiency and cost-effectiveness, at least in the long run.

**The 4 Most Important Metrics**

Some metrics, such as determining your optimal staffing ratio and your overhead percentage, probably don't need to be done all that often—maybe a once-a-year review, maybe even less. Others should be ongoing, such as quarterly. Here are the four biggest business metrics involved in your practice's revenue cycle.

***1) Days in A/R.*** How long does it take to get your average claim paid? Most practices should aim for below 50 days to get a claim paid. If your days in A/R number is greater than 50, you have a possible bottleneck somewhere in the system. The formula for days in A/R is: (total A/R divided by gross annual charges) X 360.

***2) Accounts Receivable report (A/R).*** Most billing software places outstanding revenue in divided time categories. National benchmarks that you can measure against are found in Figure 2.

***3) Claim rejection rate.*** Claim rejection rate refers to claims that have been rejected immediately by the clearinghouse on the front end. It may be because of simple demographic errors, claim data error, missing diagnosis, etc. Claim rejection rates should normally be lower than 4%.

***4) Denial rates.*** Claim denials are claims that have been accepted by the clearinghouse but have been denied by the insurance company. Claim rejection rates should be below 8%. A very serious issue related to denials is that 50-60% of all denials are never worked to adjudication—basically lost revenue.

**If your days in A/R number is greater than 50, you have a possible bottleneck somewhere in the system.**

**You Want More?**

Again, anything can be measured. Not everything is worth measuring. Not everything is worth measuring all the time, but many things might be measured if you're seeing a problem and need to determine what's causing it. That said, having looked at the four top key indicators, here's a look at another top eight used in medical practices, which have some overlap with the four top key indicators.

***#1. Monthly charges.*** The number of bills for service your practice makes.

***#2. Monthly collections.*** How much money you receive, as opposed to how much you're actually owed.

***#3. New patients.*** Analyze for trends associated with marketing efforts.

***#4. Total patient visits.*** Total number of visits isn't always a key number, but it is important, especially the ratio of new patients to existing patients.

***#5. Accounts receivable (AR).*** Accounts receivable is the outstanding monies owed to the practice. This is also a measure of how long claims are overdue. Generally, claims over 90 days should be less than 20% of total AR, hopefully a lot less. It is important to know "days in AR," or the average number of days it takes to collect the payments due to the practice.

***#6. Per visit value (PVV).*** Sometimes called revenue per visit (RPV), it refers to how much money you bring in per visit. This is calculated by collections divided by total patient visits.

***#7. Net collection ratio.*** This is [(Collections + Contractual Obligations) divided by (Charges)] X 100. Once you properly adjust accounts according to contractually obligated write-offs, you can calculate your net collection ratio. The optimal net collection ratio is greater than 93%.

***#8. First-pass denial rate.*** This shows what percent of claims are not getting billed out correctly. For example, it costs about $25 to rework a claim that has been denied. With a first-pass denial rate (FPDR) of 20%, with 20,000 claims and a 20% FPDR, that equals 4,000 denials. 4000 denials X $25 is $100,000. Ideally the FPDR should be less than 5%.

**Knowledge Versus Wisdom**

The world, it has been noted, is overwhelmed by a flood of data. What to do with it all? Is it even possible? Is it, as the expression goes,

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like trying to drink from a fire hose? Quite possibly.

But your practice management software should be able to help, and noting which data to collect and to analyze (and then, of course, do something about what the data is telling you), should help decide which data is the most useful to you. But the data itself is vital. As efficiency guru Peter Drucker noted, "If you can't measure it, you can't improve it."

Or going further back, in Arthur Conan Doyle's "The Adventure of the Copper Beeches," Sherlock Holmes says, "Data!data!data! I can't make bricks without clay."

At its most basic, you can't make your practice more effective, more efficient, or more profitable if you don't know how effective, efficient, or profitable it is. And to do that, you need to have data, the correct data, and analyze it. Then you have to make plans based on what you're observing, implement them, and analyze the resulting data to determine if the plan is creating the desired outcome. Annoying, isn't it? Collect all this data, then you have to figure out what to do with it.

**You can't make your practice more effective, more efficient, or more profitable if you don't know how effective, efficient, or profitable it is.**

My own favorite quote on this comes from *Star Wars: Episode III—Revenge of the Sith*. In it, Obi-Wan Kenobi visits an old friend in his diner on Coruscant, asking about some information he has found, but which he doesn't understand. After answering Obi-Wan's question, Dexter Jettster says, "I should think that you Jedi would have more respect for the difference between knowledge and wisdom." **PM**

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