USE BENCHMARKING TO BE A BETTER MANAGER

Steve Robinson, FASOA, COE

According to Wikipedia, benchmarks were originally horizontal lines that were cut or chiseled into stone in order to position pieces of steel that were used to support leveling rods, which in turn were used for the purposes of supporting devices to help measure the height above sea level of a known point of land. All vertical measurements in topography are compared to sea level. By creating another known point at a particular elevation, a standard was recognized as a basis for yet other elevation measurements. The strategic placement of these benchmarks gave the world a means of correctly measuring elevations above sea level.

BENCHMARK

a. a point of reference from which measurements may be made
b. something that serves as a standard by which others may be measured or judged

So, how does that relate to my practice? The term "benchmark" later became a label for any data point that was measured relative to some standard. Problem is…. we sometimes have difficulty in determining the "standard!" For instance, we normally measure the aged accounts receivable of our practice against some "standard." In a normal medical practice, the percentage of the total accounts receivable that are current (under 30 days old) should be 45–60%. For years, though, the basis for those numbers has been a great argument. At any point in time, those numbers can and do fluctuate a good 15%. If the numbers fluctuate, how can they represent a benchmark?

In the truest sense of the word, they do not. This set of numbers, however, does represent a very good "ballpark" measurement based on a lot of different practice reports that have formed a statistically significant data sample. It thus becomes a very helpful "benchmark."

Let's talk about a benchmark that perhaps is more critical for our particular practice: Overhead.

TO EACH HIS OR HER OWN

Overhead is an item of interest for everyone, and unfortunately has wide variability. For that reason, this particular benchmark is much more accurate for us when measured on an individual basis. That is, what is the overhead in our particular practice when compared to the measurement of that same information during another period of time? In this way, the benchmark becomes our own and is clearly not indicative of what is going on in other practices. Obviously, the overhead of a large retina practice in Manhattan could differ dramatically from that of a pediatric ophthalmology practice in Kansas. This is one of

those measurements that fits into the category of "to each, his or her own!"

Just what is included in the category of overhead? What are some of the more commonly accepted "benchmarks" that are included in overhead? What does it take to do business in the marketplace?

ITEMS TO TRACK

Rent, salaries, utilities, insurance, legal and accounting costs (otherwise known as professional fees), and advertising are but a few of the items that can make up overhead.

There are others, and most of them can be found in the expense categories shown on the monthly profit and loss statements. A word of caution here…just because an item is listed as an expense does not necessarily guarantee that it should be a benchmark. In fact, just because it is listed as an expense category only means that this is where the accountant placed it. Unfortunately, accountants don't always design the layout of profit and loss statements to make them a good management tool. Many times, for example, items such as cost of goods sold in the practice are found erroneously nestled in the overhead category. Even though your medical practice is on a "cash" accounting system, cost of goods sold should not be considered a part of overhead.

Physicians' salaries and bonuses are yet another example of expenses that should not be considered a part of overhead. A pertinent question is, are you tracking the items that would be considered benchmarks for an ophthalmology practice? Further, what are you using for comparison?

One thing is for sure: if you have not tracked the data previously, you are going to have a very difficult time in knowing when something has changed. Suddenly, you may find yourself in a severe cash flow crunch without being able to understand how you got there. So, where do you start? The answer is perhaps to go back in time for a few years and construct the tracking of various data points to be able to understand what should be expected.

"NON-FINANCIAL" BENCHMARKS

Financial numbers such as overhead are not the only items that should be tracked and compared. Items such as the total number of patient visits, the percentage of your patient visits that are new patients, refractions issued, and cataract surgeries performed are also a few of the very important items that should be measured. If the number of new patients to your practice has traditionally grown at 5% per year over the last 5 years, for example, and you suddenly find that the growth rate is 2%, you can deduce that something is amiss. Question is, what has impacted this number? If you did not know your growth rate before, when would you know that you have been impacted? Obviously, the sooner you learn the new growth rate, the better your chances of rectifying the problem.

Great care must be taken in determining your tracking points and comparing them to the proper standards. For instance, if you use the sum of the codes 92002 and 92004 against the total of patients seen, would this give you an accurate representation of the number of new patient visits? The answer is perhaps. If the physicians were to change their coding procedures and move away from the 92 series of codes to the 99 series of codes in order to secure better reimbursements, the practice could see the same number of patient visits, but a completely different percentage would appear and the benchmarks would no longer be of value.

For this reason alone, it is imperative the administrator and the providers converse regularly about what is occurring in the practice and how it is being measured.

APPLES TO APPLES

In short, in order to have valid benchmarks, one must always compare like information. This is sometimes very difficult. It is of extreme importance that the choice of the items measured really does give information that is valid and valuable.

Practices sometimes get caught up in minutia. While measuring the number of ballpoint pens purchased by the practice is important, for instance, the value of this measurement pales by comparison to the dollars that are possibly being lost due to improper coding or theft.

Measuring of traditional benchmarks is of the utmost importance. One should take the time to list all of the data points or benchmarks that you presently track in the practice and attempt to see how these may be affected by any changes in the way that you deliver your services. It may be very difficult to make that determination initially, but over time, you should constantly evaluate which items should be tracked.

Comparisons to national data are certainly good ways to see if your practice is "on track," but great care must be taken to see that the comparisons are always "apples to apples." Comparisons to your own historical numbers give you the best information. For instance, your rent might be 4% of your total overhead, and that might compare to 8% for your neighbor or 1% for the practice across town. If your rent numbers are consistently 4% and suddenly you find yourself at 10%, this will obviously have an impact on your bottom line profit.

The key is to determine the benchmarks to track, based on the value of the information to your practice management. In short, always ask, how will this knowledge help me to manage? *AE*

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Steve Robinson, FASOA, COE (423-316-3934; steve@srr2.com), is senior consultant at S&R Consultants, Chattanooga, Tenn.