Benchmarking: Can the Numbers Lead You Astray?

Take time for careful analysis when drawing conclusions from benchmarking.

By Maureen Waddle and Derek Preece

It is encouraging to see the use of benchmarking and goal-setting increasing in ophthalmic practices across the country. Many practices have discovered the value benchmarking brings to improving performance. It is a generally accepted business axiom: That which is measured improves. However, after completing a few strategic planning sessions where similar situations existed (albeit thousands of miles apart), we thought it might be valuable to use a case study to explore the use of benchmarks to develop a plan of action. This study, based on an amalgam of several practices with similar characteristics, will show that the "numbers" sometimes can point toward one course of action when the practice might be better served taking another.

The Situation and the Numbers

The primary concern of the physicians: *We are overstaffed. (Note:* This is one of the most common concerns we hear as consultants.) Practice status:

- Located in a metropolitan area (at least 1.5 million)
- Four to 10 partners
- Additional employed MDs and ODs
- Multiple office locations
- At least one surgery center
- At least one partner older than 55 and beginning to slow down his work pace.
- Has added new doctors over the past four years.
- Revenues growing year over year.
- Office visits growing year over year.
- Expenses growing about the same pace year over year.

Staffing Benchmarks		
Description	**Case Study (four years of data)**	**Healthy Range** (1)
Full-time equivalent staff per FTE MDs	8 – 9.5	6 - 8
Revenue per FTE staff member	$105,000-$125,000	$110,000-160,000
Staff overhead ratio (net collections divided by gross staff wages)	36 – 40%	20 – 26%

(1) Healthy ranges are established by informal tracking at BSM Consulting for more than 20 years. The healthy ranges typically fall between the 25th percentile and 75th percentile of all practices.

What conclusions would you make based on the information thus far? Knowing that the partners believe the practice is overstaffed, and given the benchmarks, the natural tendency would be to chart a plan for a reduction in work force. However, if we continue to peel back the layers, the priority for implementing such a reduction might change. Step into the shoes of this practice administrator and think about two key questions: 1) What additional information might I want to review to confirm this course of action? 2) How does this course of action impact our ability to achieve our strategic plan?

Additional Information About the Dollars

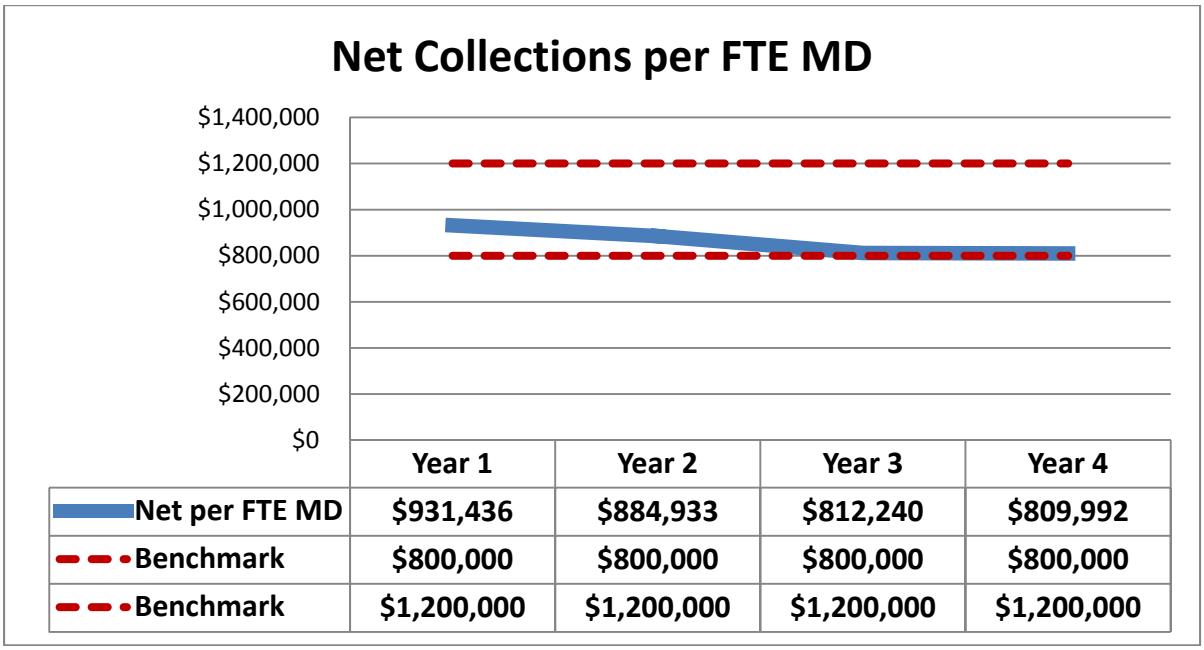
It is always important to remember when calculating statistics and business ratios that two numbers affect the result: the numerator and the denominator. Therefore, begin by analyzing both the numbers and where they originated. I always like to start at the top with the revenues. In this case a couple of key circumstances were occurring:

- First, there was an addition of at least one new service to what had historically been a cataract surgical practice. This is usually either retina or oculoplastic services — with product sales. Grouping dissimilar services into a benchmark that is based on general services is probably not the right thing to do. Whenever possible, measure service lines separately.

- Second, another common reporting problem was occurring: The injection medications and products sold somewhat artificially inflate the revenues. This is because the expense for those items is much greater than other overhead expenses — nearly 100 percent of the revenue, in the case of Avastin® and Lucentis® . This is not unlike retail businesses, where we learn to subtract out cost of goods sold before reaching a revenue number for use in calculating benchmarks. This will give a more accurate measure of revenue trend of actual physician services. In one case, a practice which thought had achieved a 22 percent growth in revenue was actually closer to 10 percent. The overhead ratio quickly returned to within normal range as well.

The other key note is that new doctors do not enter the practice and immediately match pace with the veteran providers. When the top-line revenue continues to increase, it gives us a sense of security. Keep in mind that new doctors entering the practice need time to ramp up into the healthy range. Therefore, another key indicator you would want to look at would be revenue per full-time equivalent M.D. And, if you recall from the practice situation, we have some doctors who are in the practice who have begun to slow down (a month off at a time, one week off per month, or one or two days off per week). This reduces both the numerator and the denominator.

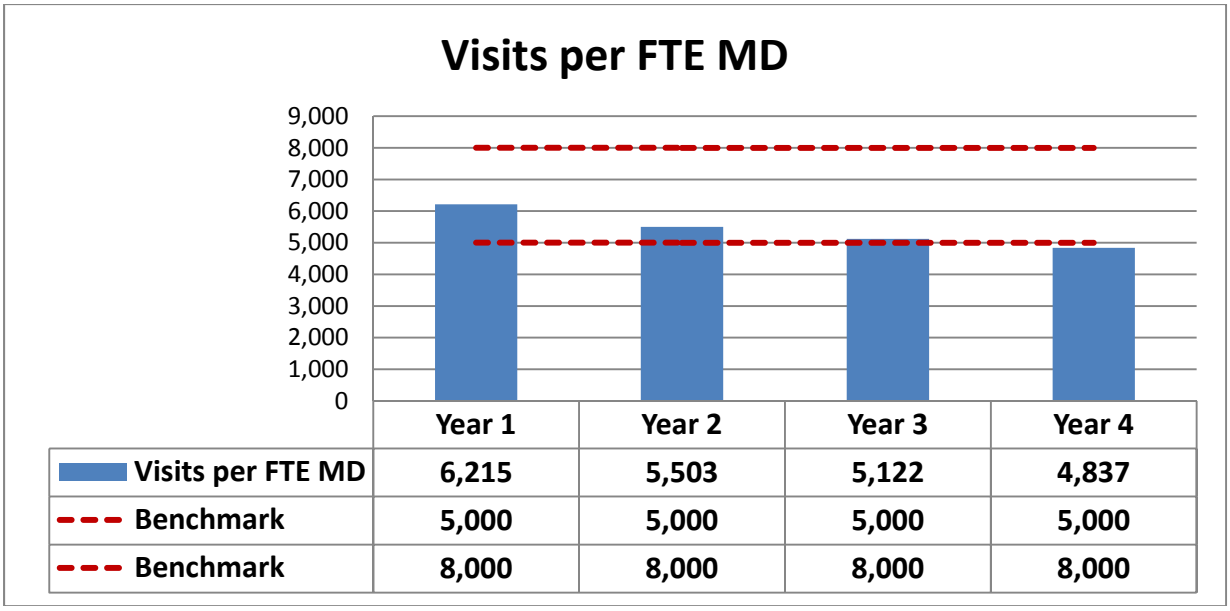
After subtracting out the anomalies and comparing apples to apples, we see the following trend, which is important in considering your plan of action. Even though total revenues are increasing, the practice is not as efficient as it used be in generating those revenues:



	Year 1	Year 2	Year 3	Year 4
Net per FTE MD	$931,436	$884,933	$812,240	$809,992
Benchmark	$800,000	$800,000	$800,000	$800,000
Benchmark	$1,200,000	$1,200,000	$1,200,000	$1,200,000

Additional Productivity Information

With many large practices, each with tens of thousands of patient visits annually, it is easy to lose sight of the details because the total numbers are increasing. Like the revenue growth in these practices, there was a growth in overall office visits. However, when you put it into a benchmark formula, you begin to see what is truly happening with the trend: The growth of the full-time equivalent doctors (the denominator) is greater than the growth in total office visits (the numerator). Like the graph above, we find a downward trend.



	Year 1	Year 2	Year 3	Year 4
Visits per FTE MD	6,215	5,503	5,122	4,837
Benchmark	5,000	5,000	5,000	5,000
Benchmark	8,000	8,000	8,000	8,000

Capacity Analysis

Since we are seeing a trend in inefficiency, there is one more analysis to conduct. It is actually a problem we are seeing more and more with practices that have physicians nearing retirement who have begun to slow down. Because it is hard to keep good staff, and few staff members want to work only part-time, you often will see in larger practices with multiple practitioners in the slow-down phase that staff members are busy on days all practitioners are seeing patients, and have nearly nothing to do one or two days a week. A capacity analysis in this combination of practices almost always revealed that the main office was functioning somewhere around 70 percent capacity with outer offices around 50 percent. Finding the right mix of providers willing to mix and match schedules in order to ensure operation at full capacity is probably one of the biggest challenges operation managers face today.

The Vision of the Practice

The long-term strategic view for these practices is to serve their community for many years to come. This sometimes results in a little squeeze on the take-home pay of the partners as established practitioners phase out and new physicians grow. Careful planning for those phases (and avoiding too much overlapping occurring at the same time) is critical. Careful planning — including a financial impact analysis — had not occurred in these circumstances. In any case, looking at the number of techs per physician during clinic, the practice needed those people who were in place. Covering multiple offices also frequently requires a slight increase in full-time equivalent staff. If the strategic plan calls for multiple locations, then a feasibility analysis should have been prepared in advance so the partners would know what to expect as new offices open and do not immediately hit capacity. To reduce the work force at this critical juncture might affect revenues and exacerbate the problem. Reduced revenues, even with reduced expenses, the staffing benchmarks probably will not improve. This then becomes a series of

strategic questions: Given the current capacity measures, are we confident that we will be able to build volume and revenue in those locations? Do we need to evaluate the closing of a location? What will the financial impact of our actions be, not only on the practice but also on the surgery center?

Has your conclusion about the plan of action changed? While it is always good to keep tight reins on staffing expenses, the real problem appears to be a revenue problem resulting from inefficient use of assets: space, staff, and physicians. While the work force and its organization might represent an important action item, we suggest that finding opportunities to increase revenue and improve operating efficiencies might be higher on the priority list.

Disciplined Approach

Practices that are disciplined in their approach may still head the wrong way once in a while, but it certainly occurs far less frequently. We have several helpful mantras we use to evaluate practices:

- Know exactly where the numbers are coming from and how an action will impact the numerator and the denominator.
- Never make a quick decision when looking at benchmarks.
- Always consider all the benchmarks of a practice before charting a course of action.
- Make sure you are comparing apples to apples to uncover the real trends.
- Remember to consider your strategic vision and weigh that with the analysis of the numbers.