Benchmarking for Ophthalmology Practices

Benchmarking is an effective way of identifying and prioritizing areas in which you can improve your practice.

By Maureen Waddle and Derek Preece

Most practices are diligent in gathering and measuring financial data and important statistical information. Some practices then compare their results with published benchmarks so that they understand how they measure up to similar offices. The truly successful practices take an additional step and use that information to develop strategic plans and make better business decisions, propelling them into greater success.

The benchmarks presented here are derived from formal and informal tracking of ophthalmology practice trends that BSM Consulting and its consultants have conducted for more than 20 years. We have also used industry sources to corroborate and validate these measures. The table shown on page 3 generally includes the 25th and 75th percentiles for the various benchmarks, a range we consider to be "healthy" for most comprehensive ophthalmology practices. Of course, for some benchmarks, a practice may be very pleased to be higher than this healthy range; in other cases, an office that finds itself below the 25th percentile may be delighted in its good fortune.

The main objective of benchmarking is to identify and prioritize potential areas of improvement. For long-term success, practice improvement must be a continuous process.

Benchmark Cautions and Caveats

Before exploring specific benchmarks, it is important to understand some caveats so that these benchmarks are used appropriately in your practice:

• Avoid overreacting to monthly fluctuations. There are many reasons numbers will spike or dip in a month. Rather than panicking over a temporary blip, it is important to look at trends over time before making any rash decisions.

• Avoid the belief that your practice must find a way to get into the "healthy ranges" shown. Each practice has unique circumstances that must be taken into account when comparing its results to the benchmarks.

• Compare apples to apples. Take time to understand clearly the definitions and formulas for calculating the benchmarks and to make sure your calculations are equivalent to those shown in the table.

• Use more than one benchmark to diagnose the health of your practice. Most benchmarks give only a limited view of one facet of an office, and using several related measures can enhance your understanding of your practice's true situation.

• Remember that each ratio is the result of dividing two numbers. Therefore, changing the ratio can be achieved by impacting either the numerator or the denominator. Often, practice managers focus on only one way to improve the ratios – for example by decreasing employee expenses to reduce staff payroll ratio. However, increasing revenues is probably a less painful way to bring that measure into the healthy range.

• When preparing your practice's data, adjust for one-time occurrences or unusual financial arrangements. For example, if your practice pays above-market rent because the doctor also owns the building, use fair market values to adjust your rent expenses.

Use Benchmarks to Improve Performance

Many practices have discovered the value benchmarking brings to improving performance. A successful quality improvement initiative normally entails four essential elements:

First, management and ownership must agree on realistic goals for the practice.

Second, accurate and timely information must be gathered. Reliance on faulty data inevitably will result in faulty decisions.

Third, the information assembled must be analyzed and a diagnosis of the practice's most critical needs for improvement developed. This diagnosis should include a plan for actions the practice will implement to advance towards its goals.

Fourth, the action steps identified in the practice's plan must be pursued vigorously and tenaciously.

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These four steps, when carefully applied and repeated in a cycle of continuous improvement, will help the practice make significant, positive changes.

Conclusion

It is important to understand that, due to the varied nature of ophthalmology practices, any comparison to benchmarks must be viewed in the context of individual practice circumstances. Service mix, patient demographics, local market competition, and other factors will greatly influence how a practice compares to established benchmarks. Negative variation from the healthy ranges does not necessarily mean the practice must immediately change, and a positive variation should not be seen as a license for complacency. The main objective of benchmarking is to identify and prioritize potential areas of improvement. For long-term success, practice improvement must be a continuous process.

For more information, contact BSM Consulting at 1-800-832-0609.

Please see a list of ophthalmology-specific benchmarks on the following page.

Table 1: Ophthalmology Practice Benchmarking				
	Performance Indicator	How to Calculate - Formula	General/Comprehensive Benchmark Range 25th - 75th Percentile	Retina Benchmark Range 25th - 75th Percentile
Billing Measures	A/R Aging Analysis 0-30 Days 31-60 Days 61-90 Days 91-120 Days 120+ Days	Total accounts receivable for each day range divided by total accounts receivable.	 55% - 75% 8% - 18% 3% - 9% 2% - 6% 4% - 17%	 55% - 75% 8% - 18% 3% - 9% 2% - 6% 4% - 17%
	Net Collection Ratio	Net collections divided by adjusted charges (expected collections).	95% - 99%	95% - 99%
	Days Sales Outstanding	Adjusted AR balance divided by average daily collections.	20 - 40 Days	20 - 40 Days
Productivity Measures	Net Collections per FTE MD	Net collections (professional fees less refunds and collections from injectable drugs) divided by the number of FTE MDs.	$800,000 - $1,300,000	$1,000,000 - $1,600,000
	Patient Visits per FTE MD	Patient visits divided by number of FTE MDs. Patient visits include eye codes, E&M codes, and no-charge exams.	4,000 - 7,000	3,600 - 5,600
	Net Collections per Patient Visit	Net collections divided by patient visits.	$175 - $250	$230 - $465
	New Patient Ratio	Total new patient visits divided by the sum of new and established patient visits (excludes no-charge visits).	15% - 25%	10% - 18%
	Cataract Surgery Yield	Total patient visits divided by cataract surgeries performed.	15 - 25	Not Applicable
Staff Efficiency	FTE Staff per FTE MD/OD	FTE Staff divided by FTE MD/OD	4.0 - 8.0	6.0 - 8.0
	Net Collections per FTE Staff	Net Collections divided by FTE Staff	$140,000 - $200,000	$145,000 - $205,000
Overhead Management	Operating Expense Ratio	Total operating expenses (before provider compensation) divided by net collections.	50% - 70%	50% - 70%
	Facility Expense Ratio	Rent and other facility expenses divided by net collections.	6% - 8%	6% - 8%
	Staff Payroll Ratio	Gross non-physician payroll divided by net collections.	20% - 26%	16% - 26%
	Burdened Staff Payroll Ratio	Gross non-physician payroll plus benefits and taxes divided by net collections.	26% - 32%	22% - 32%
	Marketing Expense Ratio	Marketing expenses divided by net collections.	2% - 5%	1% - 3%