

Applying Benchmarking to Physician Group Practices

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The challenges facing a chief executive officer/chief medical officer of a group practice have never been greater than they are today. Practice management has become increasingly complex and now calls for a range of skills beyond those usually available to any one person. Apart from the stresses of day-to-day operations, physician-managers and administrators are increasingly being confronted with questions such as: Where will the practice be tomorrow, next month, or even at the end of the year? What must the practice do to adapt to changing reimbursement patterns? What are the implications of changing demographics within the market area?

Given these types of question, there is pressure, on the one hand, to forge a long-term plan for the practice; on the other, there is concern with the immediate future. If the practice is not operating at peak effectiveness and efficiency, it will not have to worry about the future very much.

Some of the short-term issues that are worrying medical practice physicians and administrators today include:

- The operational effectiveness and efficiency of their practice
- Satisfaction levels of patients and referring physicians
- Organizational responsiveness to patients
- Effective billing and accounts receivable processes
- Clinical outcomes monitoring
- Compliance and accounting audits
- Marketing management

The challenge for today's physician-manager is to interweave these seemingly unrelated activities into a coherent plan that works for the group, its patients, its employees, and the countless other entities that interact daily with the group. This involves coordinating internal processes (like patient flow) with external processes (like marketing initiatives). To accomplish this, medical groups must have an integrated performance plan that takes into account the strategic goals and objectives of the group. It will not be possible to evaluate the success of the strategic plan if the practice is not able to monitor the incremental progress of the group over a given time frame.

There are certain critical indicators of success that are basic performance standards shared by the better performing medical groups. In these medical groups, the patient flow process was analyzed from the time the patient made the initial phone call for the appointment until the last piece of paper was filed in the medical record of the patient's chart. A critical element in the success model derived from this analysis was the satisfaction of the patient with the flow.

The typical medical group thinks in terms of designing systems that streamline internal processes. This "internal" flow issue is related to "external" expectations on the part of the patient. In the better performing practices, the level of patient satisfaction is given equal weight. Other factors identified as critical for superior patient satisfaction were: hours of operation,

scope of services provided by the group, quality of care provided by the physician and the staff; the quality of communication between the physician/staff and the patient; the quality of communication between the physician back to the referral source and to the insurance company; and the quality of patient education offered by the group.

The most direct way to evaluate the effectiveness of the practice's strategic plan is through a benchmarking system. Simply defined, a benchmark is an operating performance standard. It is an indicator of the relative strength or weakness of an organization at a departmental or cost accounting level. Typical benchmarks include such items as: number of days in accounts receivable, net fee-for-service collection percentage, new patient referrals, overhead percentage, and the ratio of full-time non-physician employees to full-time physicians. The only way to evaluate how well the practice is doing is through a comparison with some standard or benchmark.

Although it may be interesting to compare experiences with those of Dr. Smith in a different medical specialty with a different number of physicians operating in his facility, such comparisons are of limited value. A practice must compare its operations to physician groups in the same medical specialty and of comparable size. Then and only then can we meaningfully specify performance at the 25th, 50th, 75th or 90th percentile. Once that comparison is made, it is possible to state quantitatively that the practice is at a given point on the continuum and ranks in the specified percentile in terms of overall performance. This can be thought of as a monthly report card.

Benchmarks should only be considered a guide; the actual benchmarks used in your practice must be developed based on the size of the practice, practice location, and specialty. Any benchmark that you intend to use to measure the effectiveness of your practice must be:

- Clearly understood by the staff and the physicians in the practice;
- Agreed to by the group, the physicians and the employees;
- Data must be continually collected in an accurate, easy and consistent manner;
- The results of the benchmark must be communicated to the participants;
- When targets are met, celebrate and reward the success of the group's performance.

The benchmark system will generate baseline data that can be presented to the group to assist in its overall planning efforts. There can be no question about the effectiveness of the interventions called for in the strategic plan if there are clear benchmarks against which they can be compared.

Needless to say, all of the activities described above require access to the necessary data, and another characteristic of the best medical groups is that they have adequate access to information. Whether this was an inherent result of having better systems with greater capabilities or a result of maximizing current systems with third party products and training, the final result was the same: Quality data equates to better decisions.

Internal productivity reports and external benchmark survey data can also be used to provide meaningful feedback to physicians concerning their own level of productivity. Physicians can be paired with an "administrative partner", a nurse team leader or department manager to review

monthly reports. As a result, practicing physicians can remain well informed about their performance and the impact it has on the department, particular clinic site or the group as a whole. Ultimately, productivity will hinge on the ability to coordinate the range of internal processes with external considerations. Practices that fail to interface these “two sides of the coin” will be at a disadvantage in a competitive healthcare environment. Having a well thought out plan in place—and the ability to evaluate its effectiveness—is critical for the continued viability of any medical group.

If you are a multi-specialty group or a primary care group practice, administer the following self evaluation and see how you compare to your peers:

- Operating cost ratio as a percent of net revenue.....Less than or = 45%
- Days in AR (fee for service only).....Less than or = 70 days
- Same clinic net revenue growth.....Greater than or = 9%
- MD retention as % of net professional revenue.....Greater than or = 55%
- Net collection rate.....Greater than or =94%
- Staffing ratio per FTE Physician.....Less than or = 4.25