

ACMPE Paper, October 2002

Benchmark reporting: A key to practice improvement

By Gary Lewins, FACMPE

This exploratory paper is submitted in partial fulfillment of the requirements for the election to Fellow status in the American College of Medical Practice Executives.

This manuscript was prepared as part of meeting various recognition criteria as set forth and may be changed from time to time by the American College of the Medical Practice Executives (ACMPE). The experiences, thought, ideas and opinions set forth are solely those of the author. They do not reflect any position on the part of ACMPE with respect to their completeness, correctness or accuracy of the paper's contents, for example, on points of law or accountancy in effect at the time of or subsequent to the date of paper completion.

Summary

What do automobiles, baseball and golf have in common? They all use recognized benchmarks to judge performance. EPA miles per gallon, earned run average and par are recognized measures of performance. Other examples of benchmarks are everywhere.

The benefits of benchmark performance comparisons have largely been untapped in healthcare. Currently, there is significant pressure on healthcare to improve performance and quality. Using a best practices benchmark process offers a powerful tool to accomplish these improvement goals.

Increasingly, managed care companies and large local employers are presenting providers with performance information. If your organization has not developed and analyzed the data, they will be at a significant disadvantage. Government and consumer organizations are developing more healthcare performance information. Providers will need to develop and monitor benchmark comparisons in order to

be competitive.

The development of key indicator benchmarks is an effective way to facilitate planning and the management function. Steps to establish a benchmark program and to identify sources of benchmark performance information will be covered in the following sections. Additionally, the paper will show an example of practical ways to apply the internal benchmark process to improve operations.

Benchmark Defined

Webster's Dictionary defines benchmark as: "a standard by which something can be measured or judged." Performance measurement systems are the curb on the road to guide organizational performance. Benchmarking is the means of comparing operations (usually a specific business process) with the performance of others; best practices are the best way to perform a business process. Universal benchmarking compares a company's results with high performers, regardless of their industry, size, geography, or products. Companies frequently find breakthrough ideas for business improvement outside of their industry. In the process of gathering quantitative benchmark data, project leaders also seek to identify best practices and as a result, the two techniques complement each other. When used together they provide the "why" behind the numbers. This turns data into actionable knowledge.

Benefits of Benchmarking

In his book *In Search of Excellence* Tom Peters wrote, "You cannot manage what you do not measure." A benchmark process provides a structured approach to data gathering and analysis. This helps management focus on developing optimal strategic or operational decisions.

The benefits of benchmark performance measures include:

1. Provides the capability to quantify measures of performance.
2. Quantifies the gap between your organization and best practices.
3. Encourages new ideas, innovation and creative thinking.

4. Provides a foundation for strategic planning and operations improvement.
5. Maximizes the fact that physicians are researchers and generally accept an objective data driven process.
6. Provides an objective basis for discussing operations improvement.
7. Identifies specific improvement opportunities.

Best practices can come from any industry, as demonstrated by the famous story of how Henry Ford created the assembly line process for the automobile. Initially, automobiles were too expensive for most people to afford. This was due to the high cost of specialized assembly. Henry visited a meat packing plant and viewed their process. A side of beef was placed on a hook and moved from one end of the building to the other. Throughout the process employees would cut off particular parts of meat. Ford adopted this process in reverse for the automobile industry by beginning with a frame and having employees add specific parts as it moved through the assembly process. As a result, he was able to significantly reduce the cost to produce an automobile and pay his employees better than average wages. This is a classic example of improving quality and reducing cost through process redesign. In short, benchmarking not only shows what is, but also what can be.

A practice usually knows, in broad terms, its comparative financial performance. Performance benchmarks within the healthcare industry provide information on how your organization ranks in specific critical areas compared to your peers. This focuses the management on the specific opportunities to take a significant step forward. The benchmark process can be applied to a variety of areas as an improvement process. An example of applying benchmark reporting to patient care is a well-designed coding, audit and reporting system. Improving coding and documentation in a practice will result in the following benefits:

- Measurable improvement in the peer review process.
- Improvement in patient care quality.
- Reduction in professional liability exposure.
- Reduction in payer audits.
- Reduction of Medicare compliance exposure.
- Potential increased reimbursement resulting from "Right Coding."

- Reimbursement improvement due to a reduction in claim denials.

The benchmark information provides the practice with documentation of clinical performance improvement. This will allow the practice to focus peer review in the most relevant areas.

An operations focused benchmark analysis will provide a high level assessment of "where to look" for improvements. Based on the assessment findings, the key indicators can be selected as "dashboard" indicators in the practice monthly reporting to track improvement progress. Key operational areas include:

- Profitability and Cost Management.
- Productivity Capacity and Staffing.
- Accounts Receivable and Collection.
- Managed Care Operations.

How this can be applied to a physician practice will be examined in the next section. It will include both competitive analysis and external benchmarking outside the healthcare industry. This will include developing the best practices indicators to identify areas for potential improvement. Determining which indicators should be used will need to be based on maximizing the return on investment for the improvement effort.

Steps in the Benchmark Process

It is important for an organization to have a clear understanding of why it wishes to make a change. Reasons for change include a desire to increase profits, improve effectiveness, encourage new ideas, plan more effectively for change, better understand best practices or to guide strategic planning and design. The benchmarking process provides an effective tool to delineate the problem and determine the critical drivers for an organization. This process has two phases:

Problem Identification - This includes creation of specific performance targets. In the benchmarking process, a best practices external benchmark against which to measure internal performance will need to be chosen and used to identify variances. Once these variances from best practices are uncovered, targets for improvement can be set.

Action Plan Development - This includes development of the detailed steps to successfully implement the improvements identified. Behavior does not change automatically after targets are identified. The action plan provides a bridge if it includes the steps to encourage appropriate behavior. It describes the actions that need to be taken, assigns responsibility and establishes a timetable for completion. Designing the plan that will work effectively in your organizational culture will need to be addressed.

These two phases can be implemented in the following seven steps:

1. Determine areas to improve with benchmarking.
2. Build buy-in for the project.
3. Understand your current processes.
4. Develop appropriate benchmarks and peer groups.
5. Gather accurate data.
6. Create and communicate an action plan that drives improved performance.
7. Develop "dashboard" indicator reporting.

These steps provide the process to implement a successful improvement program that incorporates the benchmark process. The specific issues to be addressed in each step are as follows:

Step 1: Determine Areas to Improve with Benchmarking

This is often more complex than it seems. Start by determining which processes or issues are most important and/or in need of improvement. Identification of critical areas of performance is the starting point. An example of an operations focused analysis is shown in **Table 1**. The table provides suggested indicators based on industry best practices as noted. It provides the benchmark indicators that can be used to provide a competitive analysis discussed above. The significant variance areas are indicated in bold print. When the root cause is identified, process redesign can be initiated. In our operations assessment, the driving issue frequently is front-end process errors, which cause many of the issues later in the process.

Redesigning the registration and scheduling process can be optimized by looking at world-class companies outside of healthcare that are focused on customer service.

Step 2: Build Buy-in for the Project

The starting point is to look at the top decision makers. In a group practice, the physicians are key leaders. This is important in two respects. First, they are the owners and set the pace for the rest of the organization. Second, they are researchers by training and are very comfortable with the data driven objective process. A simple questionnaire tool **Table 2** can be developed to get consistent responses back in the data gathering process. Areas indicated with an answer of "no" indicate areas of potential improvement. Other key stakeholders will need to be identified and included in the process.

Communication is key to success for the process. This starts with the information that exists currently in the organization. If information isn't being shared, it isn't being employed. Therefore, a mechanism for sharing information will need to be in place or developed. There will also need to be incentives so that information sharing becomes a strength upon which the organization can build. Regular communication points need to be built into the process and participants rewarded. This can be as simple as movie tickets, etc. to recognize positive performance. This starts up front and continues throughout a successful implementation. This is needed to accomplish an organizational culture change that will remain in place permanently.

Step 3: Understand your Current Processes

The purpose of this step is to gain a thorough understanding of the process "as is." If the existing process is misunderstood, it is nearly impossible to compare it to the results of a benchmarking or best practices review.

This step involves determining the appropriate tools to study the process. This can be addressed in several ways, including use of the questionnaire described in Step 2, or could include teams to work on individual processes. This is an excellent opportunity to update policies and procedures, and set-up for documenting changes to improve the process going forward.

Step 4: Develop Appropriate Benchmarks and Peer Groups

True benchmarking looks outside of the organization and the industry to truly optimize the process. The example we have used is an operational assessment. This includes comparisons with data from other physician practices. The benchmark information is from MGMA. Some of the physician professional colleges for the different medical specialties are an additional source of benchmark information.

An example of how to take this beyond a competitive analysis is to look at the process with a comparison to best practices outside healthcare. A case in point would be the registration process we discussed as being benchmarked to world-class customer service companies. Examples would include hotels, car rental agencies and related companies.

The first step in looking for "outside" benchmarks is to start looking at information from payers and accrediting bodies as sources that measure quality and efficiency. Specific examples include: National Committee for Quality Assurance (NCQA) - The Health Plan Employer Data and Information Set (HEDIS®). www.ncqa.org/Programs/HEDIS/

The Leapfrog Group founded by [The Business Roundtable](#) (BRT), a National Association of Fortune 500 CEOs. www.leapfroggroup.org

The challenge is to initiate creative thinking outside the scope to improve the results. The team will need to be challenged to focus on the appropriate benchmarks to foster this process. The key is to focus on the major processes that are identified for improvement.

In **Table 2** of our example, the interview process identified clinical support as a barrier to improving physician productivity. A typical primary care practice will have between 2,300 and 2,800 patients per physician, and each physician would see 30 patients per day. Consider doing an analysis of phone calls per day. Calls per doctor should be between 150 and 200 per doctor. Benchmarks are available for the different types of calls including prescription refills, appointments and other calls. The next step would be to analyze prescription refills. Studies show 25 percent of patients leave a physician office not having all of their prescriptions refilled. Subsequently, the physicians office will call in the prescription that could have been

handled during the visit. These staff efficiencies translate to more time for the clinical staff to support the physician while seeing patients.

The other consideration in completing this step is selecting benchmarks that accomplish two goals. The first goal is to ensure that data collection within the practice is not burdensome, or better yet, that data collection is a by-product of another process. In our example of telephone call analysis the information may be a by-product of the telephone reporting system. The second goal is to set-up the selected benchmark as part of the regular monthly or quarterly reporting system. This is important to provide monitoring of the improvement progress. In addition, a summary of key practice benchmarks included in the reporting system can be helpful to physicians who are less comfortable or interested in traditional financial reports.

Step 5: Gather Accurate Data

The definition of data will need to be well-defined to ensure consistency between internal and external data. Internal data collection capabilities need to be considered in setting these criteria.

The healthcare industry has not embraced benchmark development as extensively as other industries. External data may be limited or not available. Obtaining benchmark information in this situation can involve developing a collection tool and soliciting information from identified peers. Data collection tools should minimize complexity and maximize consistency. In order to assure improved success, it is important to share your findings with your benchmark partners as an incentive for them to participate in the process. Prepare adequately for site visits with benchmarking partners to optimize data collection.

In addition, it is necessary to obtain information from the best performers regarding how these results were achieved. The true benefit to benchmarking is both identifying best performers and understanding the process changes needed to achieve improved performance. Once this is understood the next step is "thinking creatively" to take performance beyond best practices levels.

A system will need to be in place to summarize the differences between your organization and best performers into an organized set of facts that identifies root causes. This facilitates development of the

action plan.

In order to develop this culture, the organization will need to encourage and support these activities. The organization can build in an award system through the staff incentive program. If your organization does not have a staff incentive program, strong consideration should be given to using this process as a basis for initiating an incentive program.

Step 6: Create and Communicate an Action Plan that Drives Improvement

Developing an action plan will provide a framework to focus efforts and organize information for a successful implementation process. The considerations for developing the action plan include the following:

1. Break implementation into manageable phases.
2. Provide sufficient completion time.
3. Provide the resources to support the implementation.
4. Stress simple solutions.
5. Establish a schedule of regular status meetings.

This process establishes the project team, defines roles, responsibilities, provides the expected return on investment and sets a timetable for implementation. A sample plan is included in **Table 3**. The improvements noted are based on the findings from **Tables 1** and **2**. The return on investment for each step provides an aid in prioritizing steps and judging implementation success.

The interview results should be used to identify members who indicated an interest in a particular area. They should be strongly considered for improvement team leaders to recognize the importance of their input during the interview process. Additionally, members who criticize a process are also potentially improvement team leaders with an opportunity to "fix the problem." Constructively channeled, this can be an opportunity to achieve improvement and change organizational culture. A key part of positive culture building is turning the "complainer" into a positive force.

The key constituencies (physicians, management, and staff) need to provide input and receive feedback throughout the process to ensure that all issues are addressed. To ensure buy-in, all parties that were involved in data gathering should provide input in developing the action plan.

Step 7: Develop "Dashboard" Indicators so Improvement is an Ongoing Process

A regular schedule to report on the status of the implementation is a key component of successful implementation. The best way to achieve this is to build it into a regular status meeting or the monthly review process, selecting benchmarks used as key indicators that measure the desired improvement. Use the opportunity to establish key indicators with historical graphing as part of the routine reporting system. The Information Systems person should be involved to minimize the need for manual entry of information. This can provide a snapshot of the overall practice operations for the physician owners who are not financially oriented.

Limitations of the Benchmark Process

One benchmark will not tell the whole story. A well-designed set of benchmark comparisons serves as a road map to practice problem areas. Unique practice characteristics, such as geography, age of practice and patients, service mix, and practice style can affect validity of national benchmarks for the practice. It is important to modify national benchmarks to reflect any differences. At the same time, differences should not be used to rationalize variances inappropriately. Comparison data will never be perfect and will need to be stated and accepted as part of the process.

Because this is a change process, it is critical that an objective assessment be made of the organizational culture, staff, and management. Elimination of barriers to performance improvement, as well as the organization's willingness to create and manage change, will need to be in place. Many of the sources of healthcare benchmark information may be either old information or difficult to obtain. The MGMA information cited varies between one to two years old and is developed through a manual survey process.

The payers have a significant amount of billing related information.

To be readily usable, Medicare information will need to be obtained from a third-party proprietary vendor. Commercial payers are frequently either not willing to share information or present it in a negative fashion. The industry will need to address this issue as employers and patient rights groups develop more information for their respective uses. Current technology such as the Internet and electronic medical records will need to be utilized to close this gap.

Conclusion

The benchmark approach combined with identification of best practices provides a very effective process to be successful. Implementation of the seven-step process will create the context in which to identify issues, set targets, take action and measure your success. Applying this to the four operational areas identified (profitability, productivity, receivables and managed care) will provide an objective straightforward approach to achieving improvement focused in the areas that will have the most impact.

Going outside the healthcare industry to identify best practices is the key to identifying breakthrough improvements. The challenge is to recognize the limitations of benchmarking even within the healthcare industry and the data limitations for practices. It takes an organization that is will to admit they can do better and is determined to make internal improvements.

In the long term, a commitment to develop better information, more effective operational methods and the application of appropriate technologies are the keys to success. The combined benchmark and best practices provides the basis to achieve long-term sustainable success.

Many times managers believe that they already know their industry and how their organization compares. But ask yourself: when was the last time your organization developed a formal process to study and measure best practices? If the answer is, "It's been awhile," then it is the right time to add significant value to your organization by taking that benchmarking and best practices instrument from your toolbox and put it in place.

ENDNOTES

1. The CPA Journal Jan 2001 Improving financial performance through benchmarking and best practices
Susan Leandri
2. MGMA Performance and Practices of Successful Medical Groups, 2001 and 1999.
3. Elizabeth Woodcock MGMA Presentation, May 21, 2001, How to Run an Efficient Practice, Nashville, TN.

BIBLIOGRAPHY

Benchmarking-a Misconceived Business Asset, The British Journal of Administrative Management, Paul Bishop, Jan/Feb 2001.

Benchmarking 101, Purchasing Journal, Ken Stock, May 17, 2001.

MGM Update September 15, 2000, Better-Performing Practices Focus on Managing Revenue Cycle, Kelli Davis.

Improving Group Practice Performance with Benchmarking, Journal of the Healthcare Financial Management, Mary Witt, February 2001.

The National Outcomes Management Project: A Benchmarking Collaboration, The Journal of Behavioral Health Services and Research, Naakesh Dewan, November 2000.

100 Top Hospitals, Modern Healthcare, February 26,2001

Table 1. Operational Benchmark Analysis

	Your Practice	Best Practices*	Variance
Profitability and Cost Management			
Net income or loss per FTE physician	\$150	\$755	19.87%
Operating cost per FTE physician	\$310,388	\$314,402	98.72%
Operating cost as a % of total medical revenue	53.57%	55.58%	96.38%
Total physician cost per FTE physician	\$248,614	\$245,211	101.39%
Total support staff per FTE physician	\$166,113	\$169,226	98.16%
Ancillary revenue to gross charges ratio	12.61%	20.81%	60.60%
Productivity Capacity and Staffing			
Total worked RVU production per FTE physician	5,399	5,698	94.75%
Total charges per FTE physician	\$879,060	\$966,503	90.95%
Total patients per FTE physician	2,253	2,288	98.47%
Total procedures per FTE physician	12,428	13,458	92.35%
Square footage per FTE physician	1,850	1,863	99.30%
Accounts Receivable and Collection			
Adjusted FFS collection percentage	97.17%	98.57%	98.58%
Days gross FFS charges in A/R	58.47	51.87	112.72%
Percentage of AR over 120 days	18.36%	13.76%	133.43%
Bad debts due to FFS activity per physician	\$6,485	\$6,310	102.77%
Co-payment collection at the time of service	63.80%	96.30%	66.25%
Managed Care Operations			
Net capitation revenue per physician	\$115,887	\$128,783	89.99%
* Source: MGMA 2001/1999 Best Practices - All Multispecialty Groups			

Table 2. Internal Questionnaire Sample

	Yes	No	Comment
General and Key stakeholder Interview:			
The physicians are satisfied with profitability of the practice			
The practice manager/physicians has targeted specific areas to be improved			
Benchmarks have been established and monitoring of key operating indicators is in place			
The payer mix is reasonable based on demographics			
Fees are set at the appropriate level			
The level of physician workload is appropriate			
The practice is adding appropriate new patients			
Competition is adversely affecting the practice			
The Internet is used in the practice			
The relationship between the physicians is good			
The physicians are satisfied with the office efficient and that patients are treated with respect			
Front Office:			
Paperwork is mailed to patients prior to their first visit or they are requested to arrive 15 minutes early			
Patient is asked to verify demographic and/or insurance changes for each occurrence of service			
The driver's license, insurance and pharmacy cards are copied during registration			
Precerts and eligibility checked electronically instead of by phone			
The staff is trained and is using the Medicare ABN form			
Co-payments are collected at the time of service			
The receptionist knows the outstanding balance of patient accounts and co-payments at time of treatment and tactfully ask for payment			
A sign is clearly visible in the office stating, "all fees are expected to be paid at the time of treatment"			
There is a training program in place for front-end personnel			

There is a binder or other reference source, which contains participating MCO list. Each plan includes: plan descriptions, contact phone numbers, referral requirements, non-covered services, co-payments, referral lab and pre-certification requirements.			
CONSISTENT payment and payer plan codes are used			
Patients are informed as to their responsibility to obtain care approvals			
The patient information form is complete			
New patients are provided a copy of the policy covering payment of accounts			
Credit cards are accepted for private payments			

Quantifiable Improvements	Improvement Amount	Steps to Complete	Responsible Party	Completion Date
Incremental net revenue from Nurse Practitioner to complete a workup on new OB patients	\$48,422	Each practitioner will need to process an office charge super bill.	Nancy - NP	10/1/2002
Incremental revenue from ultrasound expansion	\$80,467	Track care provider's referrals to support ultrasound expansion.	Physicians	10/2/2002
Add full-time ultrasound technical staff	(\$50,000)	Hire tech and develop additional duties for schedule down times.	Margaret Manager	10/3/2002
Improve collection of co-payments at the point of service	\$25,000	Redirect the current staff or hire.	Margaret Manager	9/15/2002
Improve patient opinion of the registration process		Simplify the patient information process based on hotel approach to check-in.	Margaret Manager	11/15/2002
Total	\$103,890			