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Why Benchmark?

How Medical Practices Can Use Benchmarking to "Raise the Bar"

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Thank Xerox for benchmarking. It's an industry standard now, but it wasn't until 1979 when Xerox (whose market share had fallen from 80% to 35%) started comparing its methods and processes to those of its Japanese affiliates, that benchmarking was born. In healthcare, we use benchmarking to compare processes such as CPT coding, overhead, staffing and accounts receivable ratios with the performance of others in the same or similar specialty.

Why is this important? Several reasons: It provides a structured approach to data gathering and analysis, assists management in development of optimal strategic and operational decisions, and encourages innovation and creative thinking. Benchmarking shouldn't be a one-time event, but rather a continuum integrated into the practice's continuous quality improvement plan.

External benchmarking (comparing to Medical Group Management, CMS data or other venues of media) has limitations. Sometimes the sample size is too small or there are unique practice characteristics, like patient acuity, that make comparison difficult. Due to those types of factors, experts recommend internal benchmarking, which is the process of comparing your own data to yourself and measuring over time, take place once you establish a threshold.

Starting with Realistic Goals

Center your benchmarking on factors that relate to cost, quality and timeliness. Realistic goals – such as increasing productivity from the Median to 75th percentile or reducing patient waiting time by 50% - that can be affected through team effort and buy-in from top decision makers are best. Once you've established goals, develop a communication plan that drives the improvement process and disseminate it to all staff. Create settings that allow staff to discuss the indicators and strategize how to keep momentum going. Use dashboards with a set of metrics relevant to the practice and understandable by everyone involved to help accomplish this.

For instance, in one consulting engagement, a Derry, Nolan & Associates client wanted a dashboard that scored their Aging Accounts Receivable (> 120 days), Days in A/R, New Patient Visits, Work RVUs (Relative Value Units), Staff Ratio FTE and Direct Expenses per Total RVUs. The six measurements were compared by current period to the last six months and the prior year to see what trends were occurring. From those scores, we were able to help the practice determine what changes needed to be made and implemented process changes as appropriate.

Using MGMA Data

Remember – when using MGMA data the sample size may be small or the practices dissimilar (hospital vs. non-hospital owned; less than 10 physicians or greater than 10 physicians); MGMA values provide a reference point **only**. MGMA benchmarking's true value is that it provides **indicators** of where to focus improvement ef-

forts. Usually, the biggest disparities indicate the largest opportunities for **work redesign**. Staff costs vary greatly by region, so it may be necessary to use regional tables for this element, but as this will decrease the size of the comparison group, use of "all practice" values may be more practical.

Regional differences should not affect these elements:

- General Operating cost as a percent of revenue, since staff cost is not included
- Staff FTE per MD FTE
- Variations for all elements by location if service is delivered at more than one location (great internal benchmarking tool)

For example, a large site-to-site variation indicates a lack of standard processes and a need for workflow review and redesign. It's even possible that too large a variation requires evaluation to determine if the practice should consider consolidation to eliminate a non-viable service location.

Typically, medical practice clients have chosen Derry, Nolan & Associates to focus on selected measures for benchmarking. Consider Specialty Clinic ABC, whose operating costs were high by all three measures (Percent of Revenue, Per MD FTE, Per Encounter), but particularly in cost per encounter (166% of MGMA Median) due to low number of encounters per MD FTE. Medical Records were at 338% of Median, indicating the organization had thrown a lot of labor at their issues. This led our consulting team to redesign the workflow using rapid process improvement work sessions to get the group in line with MGMA data.

So: Why benchmark? So you can keep raising the bar! Benchmarks provide an effective tool for ongoing sustainable success when you use them to develop improvement plans and communicate those plans to all staff for implementation.

For a copy of Crystal Nolan's presentation "Why Benchmark" as delivered at the WA-OR MGMA Conference in May, visit www.derrynolan.com.