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“Why Benchmark?”

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What is Benchmarking?

- “A standard by which something can be measured or judged.” (Webster’s)
- Started in 1979 by Xerox Corp
- A means of comparing processes (Coding, Overhead, Staffing Ratios, Accounts Receivable) with the performance of others in the same or a similar specialty
- High performer comparison of “best practices” raises the bar



Why is Benchmarking Important?

- Provides a structured approach to data gathering and analysis
- Assists management to develop optimal strategic and operational decisions
- Quantifies measures of performance
- Quantifies the gap between your organization and best practices
- Encourages innovation & creative thinking



Limitations of Benchmarking

- One size does not necessarily fit all—unique practice characteristics and acuity counts
- Not enough published data
- Sample size too small
- Multiple venues of media to assemble all the data needed



Steps in the Benchmark Process

1. Identify the problem—why do you want to make a change? (lower overhead, increase collections, increase productivity)
2. Determine areas to improve with benchmarking (staffing ratios, coding and documentation, 120-day A/R)
3. Get buy-in from top decision makers
4. Know your current processes
5. Compare to Peer Groups
6. Gather accurate data
7. Communicate an action plan driving improvement
8. Develop Dashboard Indicators



Internal Benchmarking

- Why is this important?
- Start with realistic goals—
 - reduce waiting time from 30 to 15 minutes
 - reduce patient complaints by 50%-75%
 - reduce inventory; Just-in-Time ordering
 - increase productivity from Median to 75th P or 75th P to 90th
 - reduce overhead—staffing, supplies, administrative costs commensurate with productivity



How often should you benchmark?

- Center the benchmarking on factors that relate to cost, quality and timeliness (internal)
- Progress must be monitored and rising performance levels reported to all employees—create a dashboard
- Re-evaluate and recalibrate benchmarks at set intervals—part of CQI
- Benchmarking should not be a one-time event, but a continuum



Benchmarking to CMS Coding Patterns – Example of Percentage Comparison

Family Practice MD Ambulatory Visit Coding	New Patient					Established Patient					Consults					Other	Grand Total
	99201 New Level 1	99202 New Level 2	99203 New Level 3	99204 New Level 4	99205 New Level 5	99211 Estab. Level 1	99212 Estab. Level 2	99213 Estab. Level 3	99214 Estab. Level 4	99215 Estab. Level 5	99241 Consult Level 1	99242 Consult Level 2	99243 Consult Level 3	99244 Consult Level 4	99245 Consult Level 5		
Encounters	1	8	18	37	34	95	24	557	1,679	240	1	2	5	22	5	370	3,098
% of Total	0%	0%	1%	1%	1%	3%	1%	18%	54%	8%	0%	0%	0%	1%	0%	12%	100%
CMS Benchmark Code Distribution	2.7%	20.5%	42.9%	27.1%	6.9%	4.0%	8.4%	59.6%	25.6%	2.5%	3.4%	19.4%	41.6%	28.0%	7.5%		
MD # 1 E&M Code Distribution	1.0%	8.2%	18.4%	37.8%	34.7%	3.7%	0.9%	21.5%	64.7%	9.2%	2.9%	5.7%	14.3%	62.9%	14.3%		

Benchmarking to CMS (Center for Medicare and Medicaid Services) Coding Patterns

The logo consists of a teal square with the letters 'DN' in white, positioned to the left of the main title. Below it are two smaller teal squares, one to the left and one below the 'DN' square.

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What can be learned from a simple percentage comparison?

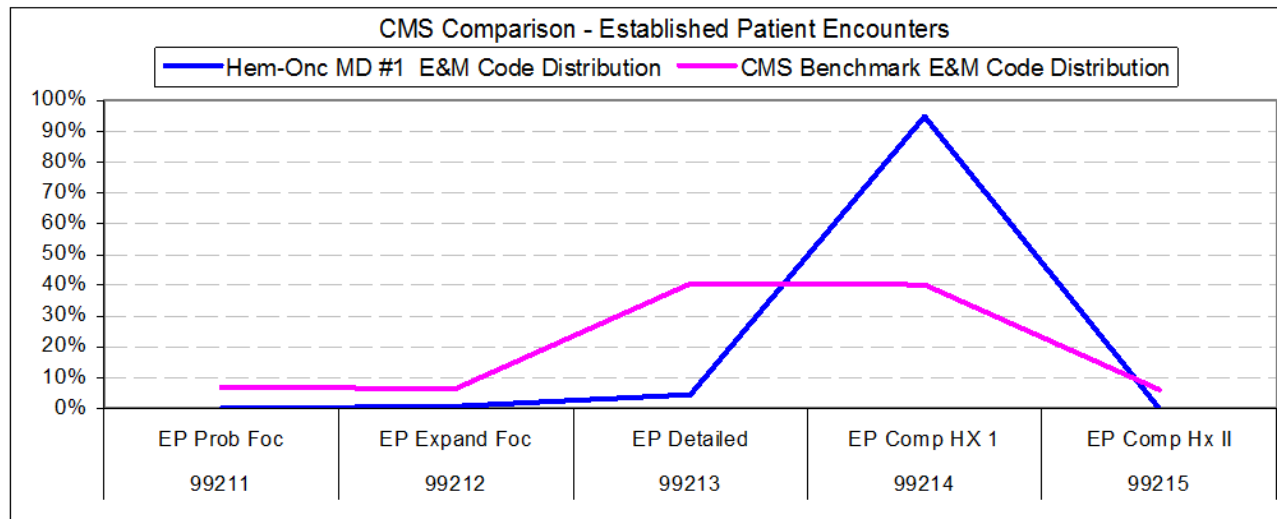
- **New patient** encounters are **only 3%** of all encounters - **too low**. Best estimates are that approximately **10% new patient volume** is required to keep a primary care practice viable;
- Established patient visits are coded at higher levels than peer group. Note that 64.7% of established patient visits are coded at level 4 (99214), compared to only 25.6% for the CMS peer group;
- Consult codes are low in volume but are also shifted to higher coding levels compared to the CMS peer group;
- NOTE: Coding may be absolutely appropriate for the patient mix and visit acuity but this pattern indicates that a coding review should be done to confirm that documentation matches coding levels.



Benchmarking to CMS (Center for Medicare and Medicaid Services) Coding Patterns

- Example: possible default coding, e.g. use of a single code for most visits regardless of actual elements *present* in the exam. Below, note 95% of established patient visits are coded at 99214, compared to a CMS peer value of 40.1%

CMS Coding Comparison Hematology-Oncology Practice	Established Patient Codes				
	99211	99212	99213	99214	99215
CMS Benchmark E&M Code Distribution	6.8%	6.5%	40.6%	40.1%	6.0%
Hem-Onc MD #1 E&M Code Distribution	0%	1%	5%	95%	0%

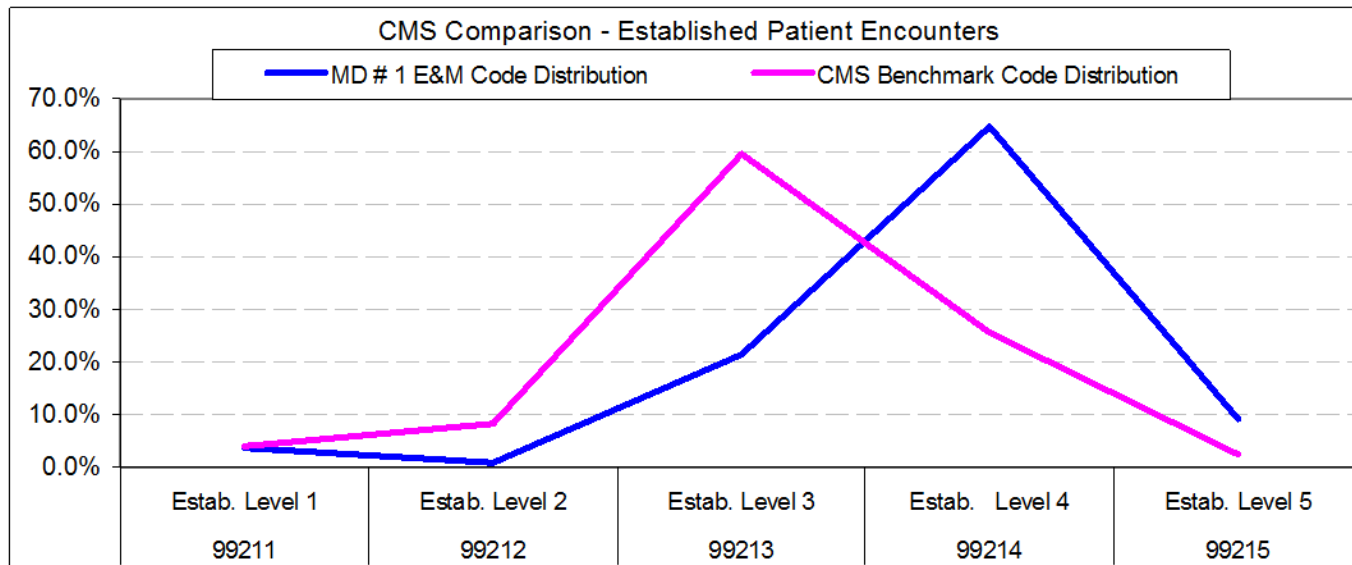




Benchmarking to CMS (Center for Medicare and Medicaid Services) Coding Patterns

- Example: possible over-coding, e.g. coding at higher levels than exam notes support. Note below: shift to 99214 and 99215 codes. Coding may be appropriate to patient acuity but chart review is recommended to insure needed elements are present.

CMS Coding Comparison Family Practice MD	Established Patient Codes				
	99211	99212	99213	99214	99215
CMS Benchmark Code Distribution	4.0%	8.4%	59.6%	25.6%	2.5%
MD # 1 E&M Code Distribution	3.7%	0.9%	21.5%	64.7%	9.2%

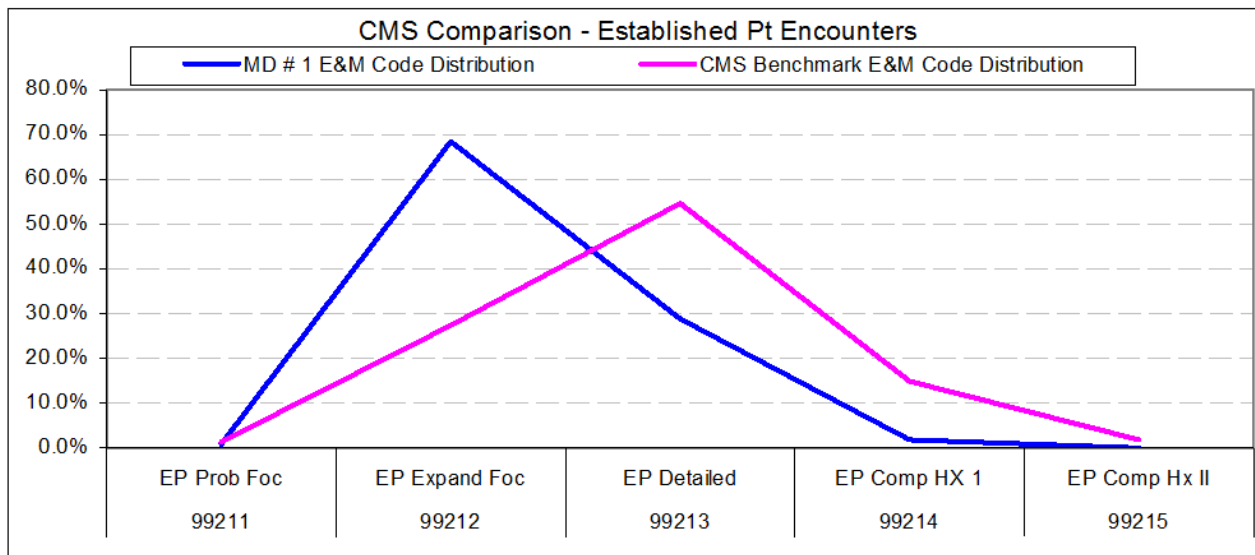




Benchmarking to CMS (Center for Medicare and Medicaid Services) Coding Patterns

- Example: possible under-coding, e.g. coding at lower levels than exam notes support. Note below: 68.5% of visits are coded very low, at 99212. Coding may be appropriate to patient acuity but chart review is recommended. Coding training is indicated if review shows that chart notes support higher level codes.

CMS Coding Comparison Orthopedic Surgery Practice	Established Patient Codes				
	99211	99212	99213	99214	99215
CMS Benchmark Code Distribution	1.3%	27.4%	54.6%	14.9%	2.5%
MD # 1 E&M Code Distribution	0.9%	68.5%	28.8%	1.8%	9.2%





Benchmarking to MGMA (Medical Group Management Association) Data

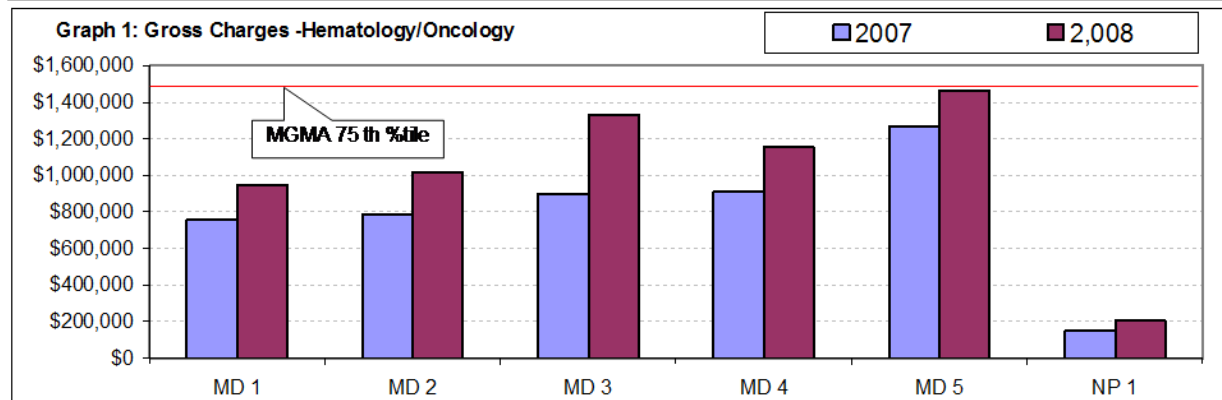
- With MGMA data, bear in mind sample size may be small or practices may be dissimilar to the one in review and therefore **MGMA values provide only a reference point**. MGMA benchmarks provide an indicator of where improvement efforts may be best focused. The biggest disparities indicate the largest opportunities for **work redesign**.
 - Helpful **productivity elements**:
 - Gross Charges
 - Ambulatory Encounters
 - Hospital Encounters
 - Helpful **cost elements**:
 - Total operating costs (as % of revenue, per MD FTE, per encounter)
 - Staff FTE per MD FTE
 - Staff Costs per MD FTE
 - Variations for all of these elements by location if service is delivered at more than one location

Benchmarking to MGMA Productivity Data – Gross Charges

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- Are you comparing apples to apples? What is included in the MGMA number?
- Determine comparison group. Largest variability usually between hospital owned and non-hospital owned practices.
- Note internal benchmarking provided. Notice the large difference between MD1 and MD5, despite supposedly similar practices.

Gross Charges	Hema/Onc MGMA Median = \$1,086,161			Hema/ Onc MGMA 75th% = \$1,488,955			% change 2007 - 2008
	2007	% of MGMA Median	% of MGMA 75th %tile	2,008	% of MGMA Median	% of MGMA 75th %tile	
MD 1	\$757,798	70%	51%	\$945,941	87%	64%	25%
MD 2	\$785,110	72%	53%	\$1,014,663	93%	68%	29%
MD 3	\$901,222	83%	61%	\$1,333,985	123%	90%	48%
MD 4	\$914,327	84%	61%	\$1,151,735	106%	77%	26%
MD 5	\$1,266,350	117%	85%	\$1,460,519	134%	98%	15%
NP 1	\$148,209	14%	10%	\$206,059	19%	14%	39%





Benchmarking to MGMA Productivity Data – Ambulatory Encounters

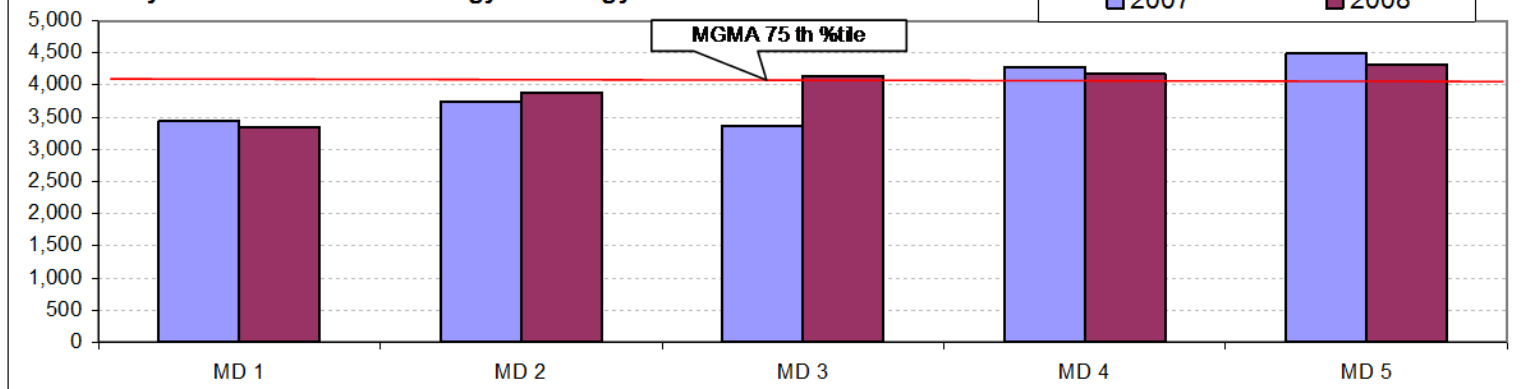
- Determine your comparison group. Largest variability is usually between hospital owned and non-hospital owned practices.
- Note this is the same group as previous slide. Ambulatory visits are at 75th percentile but gross charges average 80% of MGMA 75th percentile. Warrants further investigation into coding and charging procedures.

Hema/Onc MGMA Median = 2,822

Hema/ Onc MGMA 75th% = 4,093

Ambulatory Encounters	2007	% of MGMA Median	% of MGMA 75th %tile	2008	% of MGMA Median	% of MGMA 75th %tile	% change 2007 - 2008
MD 1	3,443	122%	84%	3,353	119%	82%	-3%
MD 2	3,747	133%	92%	3,887	138%	95%	4%
MD 3	3,371	119%	82%	4,146	147%	101%	23%
MD 4	4,284	152%	105%	4,180	148%	102%	-2%
MD 5	4,494	159%	110%	4,314	153%	105%	-4%

Ambulatory Encounters - Hematology Oncology

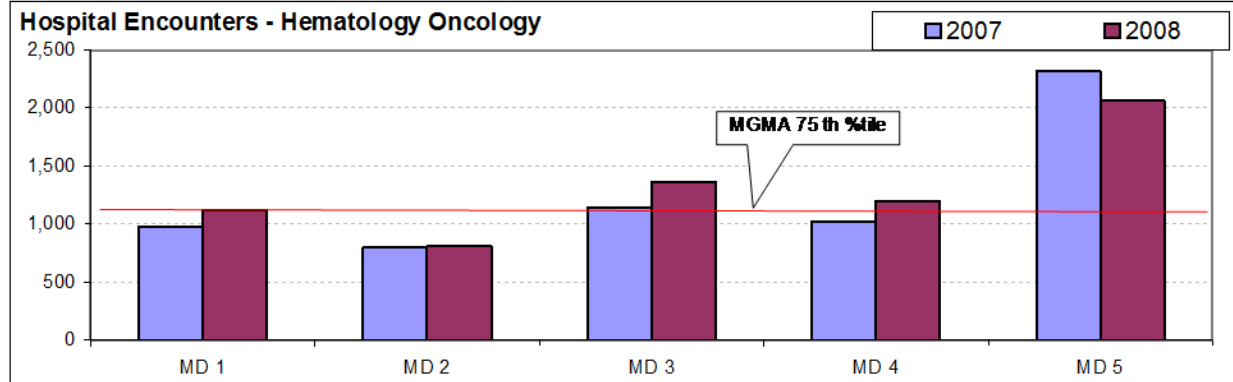




Benchmarking to MGMA Productivity Data – Hospital Encounters

- Compare apples to apples. MGMA Data is for 1.0 FTE. MD A in the three productivity slides is 0.8 FTE so the numbers have been adjusted to 1.0 FTE equivalent.
- Notice internal benchmarking:
 - Large differences in the sizes of the hospital practices (MD 2 vs. MD 5)
 - Increase in hospital volume from 2007 to 2008 for all except MD 5.

Hospital Encounters	Hema/Onc MGMA Median = 592			Hema/ Onc MGMA 75th% = 1,040			% change 2007 - 2008
	2007	% of MGMA Median	% of MGMA 75th %tile	2008	% of MGMA Median	% of MGMA 75th %tile	
MD 1	978	207%	118%	1,117	236%	134%	14%
MD 2	796	134%	77%	806	136%	78%	1%
MD 3	1,139	192%	110%	1,361	230%	131%	19%
MD 4	1,024	173%	98%	1,200	203%	115%	17%
MD 5	2,315	391%	223%	2,062	348%	198%	-11%



Benchmarking to MGMA Cost Data – General Comments

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- Staff costs vary greatly by region; may be necessary to use the regional tables for this element. This decreases comparison group size, so use of 'all practice' values may be more practical.
- Large cost variation between hospital owned and non-hospital owned practices. Hospital owned usually have lower productivity.
- Elements that should **not** be affected by regional differences
 - General Operating cost as % 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)

Benchmarking to MGMA Cost Data – Selected Measures



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- Operating costs high by all 3 measures but particularly cost per encounter due to low number of encounters per MD FTE
- Medical Records FTE per MD FTE and Cost per MD FTE very high. Work redesign and staff reduction would be recommended
- Clinical staff FTE would be at peer levels if productivity measures at MGMA 75% percentile; staffing is too high if production is at the MGMA Median

MGMA Cost Comparisons	Hemat-Onc Practice 2008	MGMA Median	% of MGMA Median	MGMA 75th % tile	% of MGMA 75th
Total Operating cost as % of Revenue	87%	83.00%	105%	85.37%	102%
Total Operating Cost per MD FTE	\$3,860,293	\$3,541,056	109%	\$4,197,336	92%
Total Operating Cost per Encounter	\$1,034	\$622	166%	\$866	119%
Medical Receptionist cost per MD FTE	\$39,440	\$29,737	133%	\$44,042	90%
Medical Records cost per MD FTE	\$45,010	\$11,379	396%	\$16,279	276%
RN Cost per MD FTE	\$140,539	\$112,193	125%	\$141,532	99%
Total Clinical Staff Cost per MD FTE	\$212,797	\$134,332	158%	\$190,608	112%
Medical Receptionist FTE per MD FTE	0.97	1.06	91%	1.53	63%
Medical Records FTE per MD FTE	1.26	0.37	338%	0.56	225%
RN FTE per MD FTE	1.69	1.88	90%	2.55	66%
Total Clinical Staff FTE per MD FTE	3.63	2.50	145%	4.03	90%
RN Staff FTE per 10,000 encounters	3.19	3.52	90%	5.08	63%
Total Clinical Staff per 10,000 encounters	9.72	5.19	187%	6.86	142%
Total Front Office Support per 10,000 Enc.	3.50	4.42	79%	6.85	51%
Total Support Staff Cost per encounter	\$113.08	\$101	112%	\$138	82%



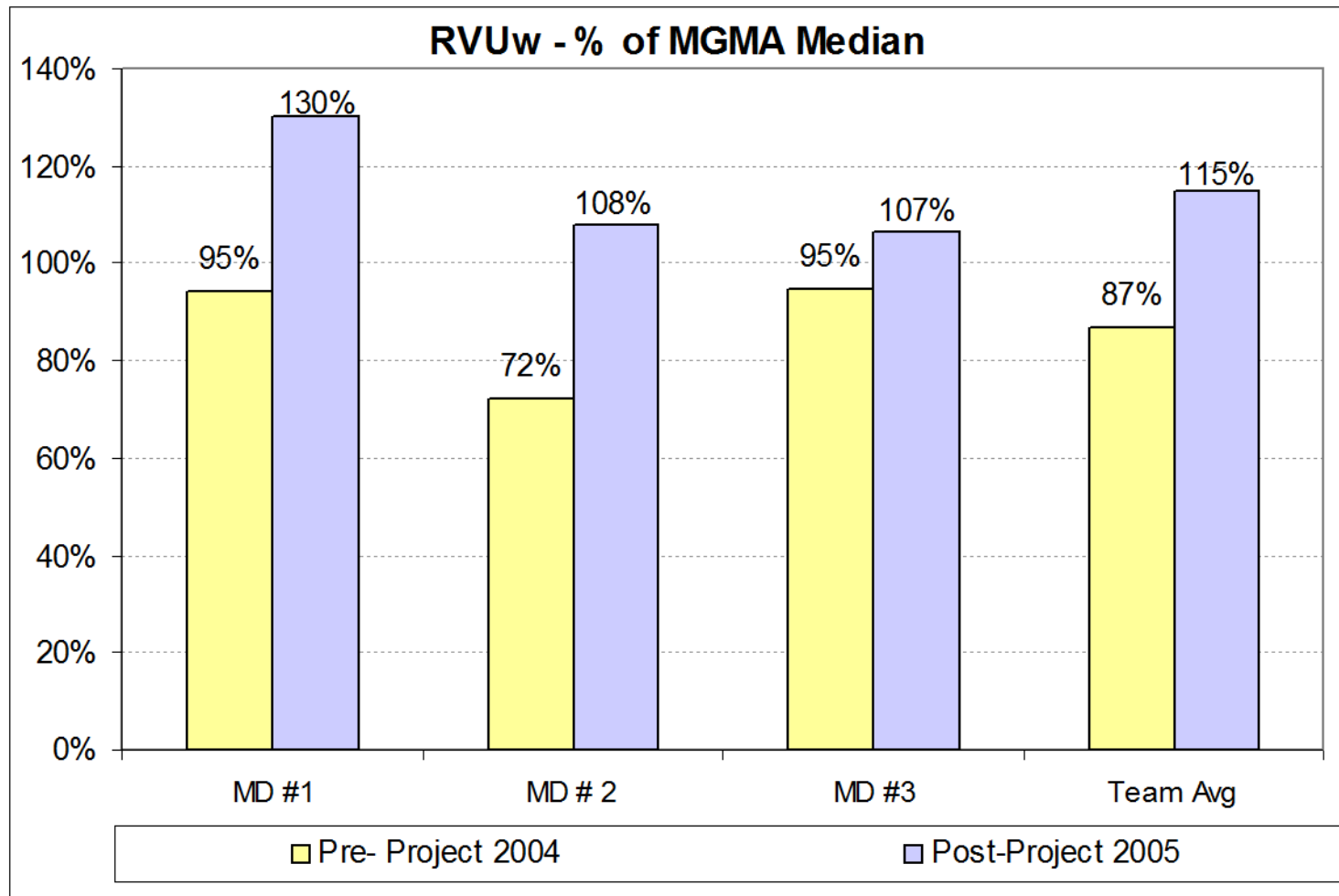
Benchmarking to MGMA Cost Data – Internal Variation Between Service Sites

- Large site-to-site variation indicates lack of standard processes. Work flow review, redesign and standardization would be indicated.
- Differences may indicate a non-viable delivery service location
- Note high Staff FTE per MD FTE and Cost for Total Clinical Staff at Location A. Note high Reception and Medical Records values at Location B. Both require further evaluation.

Staff FTE and Expense by Location					
Location	Staff	FTE	Cost	FTE per MD FTE	Cost per MD FTE
Location A	MD	1.23	-	-	-
	RN	1.80	\$149,115	1.46	\$121,232
	Total Clinical	6.80	\$400,133	5.53	\$325,312
	Reception	1.00	\$37,648	0.81	\$30,608
	Med Records	1.10	\$35,750	0.89	\$29,065
Location B	MD	1.23	-	-	-
	RN	1.80	\$151,830	1.46	\$123,439
	Total Clinical	4.00	\$233,402	3.25	\$189,758
	Reception	2.00	\$82,576	1.63	\$67,135
	Med Records	2.30	\$81,073	1.87	\$65,913
Location C	MD	4.33	-	-	-
	RN	4.50	\$373,641	1.93	\$160,361
	Total Clinical	13.90	\$813,483	3.21	\$187,871
	Reception	3.60	\$147,966	0.83	\$34,172
	Med Records	5.20	\$189,244	1.20	\$43,705



Coding to support provided level of service





Dashboards—Keep Score

- Define metrics set that's relevant to the practice
- Select a few key metrics leadership understands
- Use dashboards facilitatively, not just for reporting results
- Use expense-related dashboards for cutting costs and meeting budgets
- Check Practical Data Solutions for info on customized scorecards for individual practices
 - http://www.pds-online.com/?custom_reports



Dashboard Example

	Current Month	6 mos YTD '09	2008	MGMA 75 th %	YTD Variance 75 th %
A/R > 120 d	\$225,000	\$225,000	\$198,000	\$260,000	(\$35,000)
Days in A/R	32	32	30	28	4
New Patient Visits	60	400	820	No data	n/a
Work RVUs Prov.	833	5,400	11,760	13,000	7,600
Staff ratio FTE Prov.	3.5	3.8	3.2	4.2	0.4 FTE
Dir Exp per Total RVUs	\$23	\$24.60	\$21.50	\$36	\$11.40



Summary

Using benchmarks, combined with the identification of best practice standards, can provide a very effective tool for ongoing sustainable success.

Development of an improvement plan and communication of plan to all staff is key to successful implementation of findings.

Keep raising the bar by doing **internal benchmarking**, as opposed to external.



Sources:

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- Lean Thinking, James P. Womack & Daniel T. Jones, 1996, Pg. 264