Cost Cutting and Productivity in Medical Practice: Five Steps to Making Your Practice Lean

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Introduction

Medical practices are currently under unprecedented financial pressures. In addition to a steady erosion of reimbursements for services provided, the operating costs for medical practices are rising much higher than the consumer price index (Figure 1).

Cutting costs, however, is not enough to survive in today's healthcare economy. There are unique challenges in a medical practice compared to other businesses which hamper attempts at achieve financial efficiency. In our highly regulated industry with its many barriers created by insurers and state law, the severely limited ability to negotiate fees or increase prices, limited opportunities to scale production or achieve economies of scale, and the constant pressures to monitor and improve quality, the process of achieving financial efficiency is exceedingly difficult.

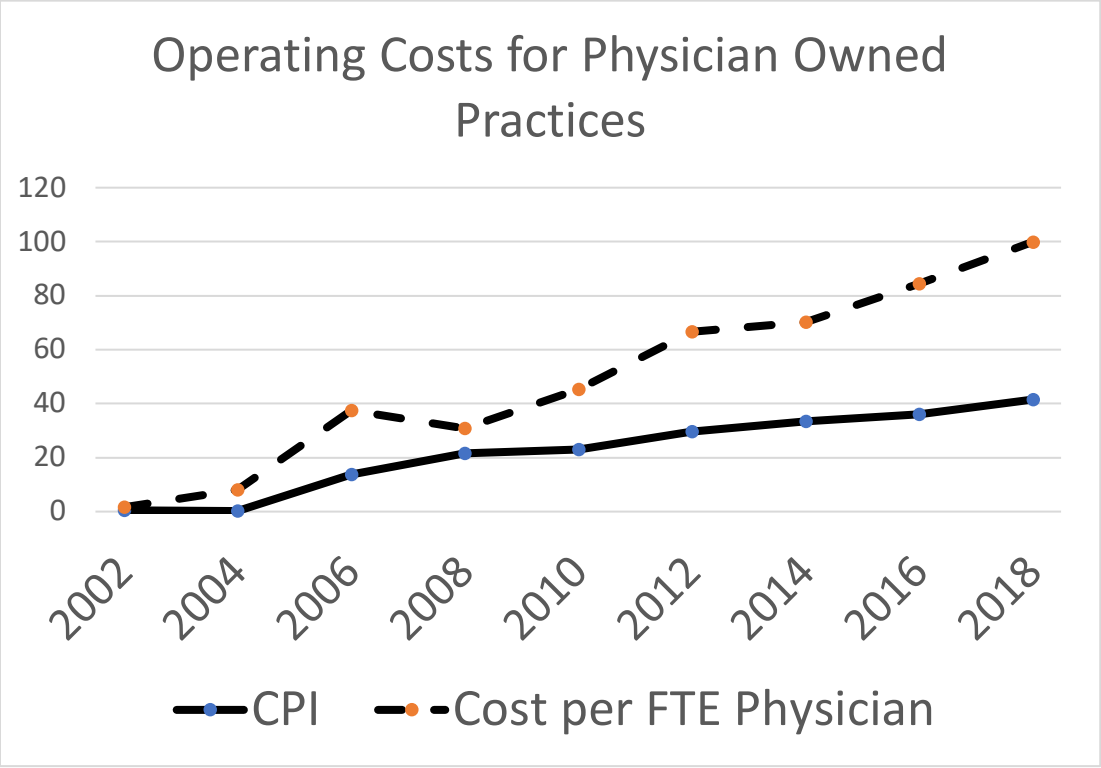

Figure 1. Operating costs per Full Time Equivalent (FTE) Physician compared to Consumer Price Index (CPI) based on 2018 MGMA data

Cutting Overhead Is Not Enough

The typical prescription for improving financial efficiency in any business is to analyze the cost structure and reduce financial waste. This traditional idea of running a "lean" business assumes that minimizing financial expenditures would improve financial outcomes. Unfortunately, this oversimplifies the complex problem of maximizing revenue and profits. Therefore, although keeping costs low is important, a focus on improving financial efficiency and productivity is also required. This toolbox article introduces what it means to be lean in medical practice and lays out a 5-step process to improve financial efficiency.

What does it mean to be "lean"?

The *Lean Method* is a formal process, originally created by executives at the Toyota Corporation, to improve production in factories. It is a process of quality improvement which aims to improve financial and operational efficiency by decreasing costs, improving quality of the output, empowering staff, and improving workflow. This method aims to provide a cultural shift in an organization to one that promotes efficiency in all aspects of production. There are excellent resources that detail more about this method listed below, but a formal discussion of this method is outside the scope of this toolbox article.

For a medical practice, "becoming lean" refers to more than cutting expenses. Medical practices seeking to be "lean" must direct their valuable human and financial resources to efforts that return value to the practice financially and otherwise. This process will require the calculation and tracking of several financial and operational metrics but especially the interpretation of those values in the context of your priorities and goals.

Five Steps to Getting Lean
1. **Know the benchmarks and put them into context.**
2. **Staff efficiently and manage productivity.**
3. **Take a task-based approach to achieving efficiency.**
4. **Account for the "human capital" of your practice, especially time.**
5. **Continuously manage costs without cutting corners.**

STEP 1: KNOW THE BENCHMARKS AND PUT THEM INTO CONTEXT.

What are the typical benchmarks used for financial efficiency?

Overhead or Cost/Revenue Ratio

Overhead is defined as the total of the operational costs excluding costs that can be directly attributed to a specific billable service. For example, the cost of a stent required for a procedure is a direct cost whereas the rent of the endoscopy suite is an indirect cost. The indirect costs combine to form the total overhead. This value is most optimally utilized when it is subdivided into as many different segments as possible, i.e., "overhead for the endoscopy suite" versus "overhead for the practice."

MGMA data reports that the average private practice group has overhead which accounts for about 60% of revenue. Gastroenterology practices should aim to keep their own overhead ratio lower than that. Furthermore, viewing overhead out of context can lead to poor business decisions. Overall profit, for instance, may go down if overhead is too low! Often, reducing some expenses will also reduce profits substantially. The overhead ratio of your practice must be considered in the context of your goals. True financial efficiency cannot be achieved by reducing costs alone.

2018 MGMA Benchmarks: Physician-Owned Gastroenterology (Percentage of Total Revenue)

BENCHMARK	MEDIAN	75th Percentile	90th Percentile
Total Operating Cost	54.2%	58.2%	73.1%
Total Support Staff	17.7%	21.3%	24.7%
- Business Operations	3.8%	4.6%	8.23%
- Front Office Staff	3.3%	4.8%	7.6%
- Clinical Support	4.8%	5.8%	9.1%
- Physician Salary	36.7%	49.5%	51.1%

Efficiency of Revenue Cycle Management:

Several of the metrics used to measure the financial efficiency of your business operations are more aptly measures of RCM or revenue cycle management. These include days in accounts receivable and the percentage of claims that go through on the first pass. These measures are especially valuable in assessing the efficiency of billing and collections. Having a low number of days in accounts receivable (closer to 30 days and certainly less than 60 days) can significantly improve cash flow for the business. For a detailed description of revenue cycle terms and measurements, we recommend the ACG Practice Management Toolbox "Optimizing Revenue Cycle Output" posted in March 2018.

STEP 2: STAFF EFFICIENTLY AND MANAGE PRODUCTIVITY:

Staffing and Staff/Provider Ratio.

Staff salaries and benefits typically represent the largest expense for a medical practice, usually accounting for 25% of total revenue or about one-half of the overhead. Therefore, measuring and comparing your staffing ratios is an important part of your

assessment of efficiency. The “staff to provider ratio” is also a useful metric that can also be compared to national benchmarks. The appropriate goal for this value will vary considerably based on various practice characteristic such as setting, provider type, and even clinical focus. National MGMA benchmarks will range from about 3-5 Full Time Equivalents (FTEs) of staff per provider. Some variables that may affect this ratio include the size of the practice, the number of advanced practice providers, and whether the practice is affiliated with a hospital system. Larger groups and hospital owned groups often have staff employed in their institutions for services like accounting, marketing, and other professional services. Their ratios are skewed compared to smaller private practice groups. Outsourcing functions will also skew the results.

Applying Staffing Benchmarks to your Practice

OPERATIONAL FACTORS TO CONSIDER
1. **Physicians versus Advanced Practice Providers**
2. **Amount of Hospital-Based Care (reduced staffing requirements)**
3. **Satellite Offices (Increase Staffing Required)**
4. **Centralized Billing versus outsourced billing (3-8% of revenue)**
5. **Outsourced Professional Services**
6. **Staffing for Ancillary Services**
7. **Staffing Crossover to Ambulatory Surgery Center**

Staffing Versus Productivity

Measuring your staff ratios is not enough to become truly lean. Although measuring productivity is uncommon in medical practice but can be extremely helpful. In the setting of an Ambulatory Surgery Center, we consider it an essential management tool. Parkinson’s Law (Attributed to British Naval Historian C. Northcote Parkinson) is that the time to complete work will expand to fill the time allotted to it. Simply defined, productivity is the total staff hours paid by your organization per billable patient encounter. The management tool commonly used to improve it is the “at management request” (AMR) process. We recommend the development of a variable “target hours paid” and then comparing it to the “actual hours paid”. This results in a productivity ratio that can be followed and used for staffing decisions.

An excellent resource on assessing manpower in your practice, and a 360-degree approach of needs assessment and hiring the best staff, is the ACG Practice Management Toolbox “Human Resource Management and Staff Development in Your Practice: Hiring and Keeping the Best Staff” posted in May 2018.

STEP 3: TAKE A TASK-BASED APPROACH TO ACHIEVING EFFICIENCY

Rather than relying on national benchmarks, which are misleading for the reasons mentioned above, we recommend a task-based method to management. This means to identify and evaluate specific necessary tasks performed by your practice and then managing to achieve the optimally efficient method to provide it. This method changes

the focus of practice decisions from reducing overhead and improving profit and loss statements to optimizing concrete functions in a task-by-task manner. This shifts the management focus onto a discussion of true overall quality and value.

Examples of Specific Tasks for Task-Based Management
1. New Patient Scheduling
2. Telephone Services
3. Patient Check-in
4. Pre-Encounter Data Entry
5. Post-Encounter Care Coordination
6. Procedural Scheduling
7. Patient Education
8. Measuring patient Experience
9. Revenue Cycle Management

STEP 4: ACCOUNTING FOR "HUMAN CAPITAL" IN YOUR PRACTICE – ESPECIALLY TIME

What is Human Capital and how can it apply to practice efficiency?

Human capital is a concept which can be traced back to the 18th century but was popularized by contemporary economists. The Oxford English Dictionary defines it as "the skills, knowledge, and experience possessed by an individual or population, viewed in terms of their value or cost to an organization." In medical practice, there are various assets of considerable value which cannot be directly measured in monetary terms.

Examples of "assets" in terms of human capital might include higher patient satisfaction, employee satisfaction, physician/owner satisfaction, increased referrals, reduced provider turnover and improved quality measures such as the Adenoma Detection Rate (ADR). Conversely, things that might be considered "costs" in human capital include physician time, staff time, patient time, increased staff turnover, and loss of information. Assigning values to these assets and prioritizing them is critical to your practice. Expenditures to improve them may be very well spent. Therefore, we recommend including them along with your assessment of financial efficiency and considering them before making cost cutting decisions.

Time – The Most Valuable Human Resource

Assessing "human capital" requires the consideration of time. Without a consideration of time spent delivering services provided or processes delivering care, other measures of efficiency lose meaning. *We recommend a review of services provided to your patients in the context of the time it takes to provide them*. Be sure to consider the number and type of staff required, the location of service and the extent of required physician involvement. Specific services, such as endoscopy, hemorrhoid banding, wireless pill camera testing, or esophageal motility testing should be assessed in terms of direct costs, average revenue and time required. This assessment may inform your practice

about the most financially efficient way to serve your patients. This assessment may also inform decisions, such as the most efficient place or time to provide these services.

Efficiency Through Scale: Would increasing the size of your business improve financial efficiency?

Practice growth and consolidation is a major business trend in gastroenterology today. These trends have been accelerated by private equity investment firms' acquisition of private practices of all sizes into large single-specialty platform companies. Hospital systems and Integrated health systems have hired or acquired the practices of thousands of physicians. These entities have expressed several reasons to promote this trend:

a. Increase in specialization – in-house call centers for the GI practices, a billing/accounting team, an employed marketing team, etc.
b. Increased negotiating leverage for reimbursement contracts.
c. Reduced negotiated costs for purchased services and expenses (materials for endoscopy, lease/rent agreements, etc.)
d. Improved ability to offer ancillary services such as pathology or clinical research.
e. Decrease in the need to outsource professional services such as revenue cycle management or accounting.
f. Decrease individual risk when developing new technology adoption into practice.
g. Improved acquisition and cost sharing of data and data management may improve ability to negotiate improved revenue/payments in a value-based healthcare paradigm.

There are also a variety of potential disadvantages to large scale which should be considered when considering growth as a solution for financial efficiency.

a. Increased complexity and change in culture: Large organizations rely on extensive organizational structures which separate administration from providers and staff at the point of care. These structures can harbor and hide considerable inefficiency that is difficult to identify and correct. The bureaucracy separates decision makers from the consequences of those decisions which leads to a variety of organizational risks.
b. Communication breakdowns: In smaller practices, staff and providers work closely with administration in an environment where highly effective communication is based in face-to-face interaction and frequent contact. As group size increases, less efficient means of communication may lead to the delay or even loss of important information and result in inefficiency and revenue loss.
c. Loss of coordination and imperfect mechanization. Large systems often attempt to standardize or "mechanize" care delivery across various locations and providers. The systems of mechanization such as information technology tools can be very costly and often do not return the value promised. Work-flow management may suffer significantly before these issues are corrected.

d. Reduced motivation. Staff and providers in successful small practices usually feel very connected to the financial well-being of the practice. There is a strong sense of responsibility which leads to alignment of goals, increases in productivity and more creative solutions to the needs of the practice.

Being Lean Changes in Times of Crisis - When Other Considerations Supersede the Need for Efficiency:

The quest for financial efficiency has many limitations, which becomes especially obvious in times of unexpected upheaval or emergency. The COVID-19 pandemic is an obvious example. When faced with dramatic shifts in care delivery, the realization that gastroenterology procedural care is largely an elective specialty, and challenges to the survival of our operations, many expenses needed to be prioritized. Suddenly, acquiring adequate personal protective equipment (PPE) despite shortages, for instance, became an expensive but necessary priority. The “new normal” of intermittent staff absences for various reasons required that practices maintain higher overall staffing levels, as well as leveraging the advantages of cross training and flexible schedules. The ACG Endoscopy Resumption Task Force made excellent recommendations about these and other financial considerations during the pandemic. The broader lesson is that financial efficiency is maintained in an ever-changing business environment that cannot be viewed out of context.

STEP 5: MANAGING COSTS (CONTINUOUSLY) WITHOUT CUTTING CORNERS

Reducing expenses is a challenge that must be attended to diligently and continuously. There are many ways to reduce expenses in your medical practice without negatively affecting the quality of service. Expense reduction is a true test of expert management and requires consistent attention as well as negotiations on behalf of your financial goals.

Remember A-V-A-T

AVAT is an acronym for “Any Vender Any Time”. It is a reminder to re-evaluate all vender pricing and contract details at every new contract cycle. Supply contracting is the practice of directing market share to a single vender in exchange for better pricing on a variety of purchase items. This can result in rather long-term relationships with a particular vender or manufacturer, even after the price advantages are lost. At the end of each contract cycle, the pricing should be again negotiated and purchasing opened to receive the best possible prices from competitors. In other words, do not stay with a vender just because of your history with them. Get the best deal every time.

Group Purchasing Organizations (GPO)

GPOs are an essential part of doing business in medical practice. GPOs allow practices to leverage the advantages of large-scale purchasing entities. These are especially

useful for endoscopy equipment and supplies and for pathology lab equipment and supplies. Check with the purchasing officers at your local hospital for GPOs that you might be able to join. The MGMA, state medical societies, and national professional societies are other places to look.

Avoiding Unnecessary Equipment Expenses.

Medical and non-medical equipment are purchase items that offer excellent opportunity for savings without harming your operations or reducing service. We recommend purchasing used equipment whenever appropriate, especially when equipment is necessary but rarely needed. Crash cart equipment and defibrillators are excellent examples. Maintenance of equipment, such as endoscopes, is a large expense. We have found that third-party maintenance contracts (rather than directly from the manufacturers) can result in significant savings without a reduction in service quality. Finally, when equipment is still usable but becoming aged, we often keep it in reserve for future needs, rather than sell it or dispose of it when making new purchases. These and other savings are part of a culture of cost management that will make your organization financially efficient.

Cost-Cutting Recommendations
1. **AVAT- Be prepared to switch venders at every contact cycle.**
2. **Use supply contracting and GPOs for supplies and equipment.**
3. **Purchase used equipment whenever appropriate.**
4. **Consider third-party service agreements for maintenance of your equipment.**
5. **Keep old equipment in reserve.**
6. **Extend the life of assets.**
7. **Marketing should be reconsidered for maximal value.**

Negotiate Continuously

All expenses should be listed, revisited, and examined for the opportunity to renegotiate. Rent, lease, or mortgage payments should be negotiated annually while maximizing the reduction of debt and increase in equity. Rethinking and optimizing

available space is important as well. Managers should also feel empowered to negotiate rates, look for? savings, and minimalize use of real-estate.

CONCLUSION: A FIVE PART PLAN TO BECOMING LEAN

Being “lean” means to be financially efficient. National benchmarks are a good starting point, but the task requires the consideration of practice-specific tasks and finding optimal solutions to meet your goals. Increasing practice scale may improve some efficiencies but also has significant potential limits or disadvantages. This toolbox article outlines a 5-part process that will help practices of all sizes assess their current financial health and to achieve financial efficiency and success.

Suggested Reading

(In addition to other ACG Practice Management Toolbox Articles Mentioned)

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10. MGMA Data Dive 2017 and 2018 (Available for MGMA Members)