PROGRAM-BASED BUDGET PLANNING

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About the time we can make the ends meet, somebody moves the ends. Herbert Hoover, 31st President

Before we start, please understand, I don't see budgeting as an accountant's exercise. We publish a VCI *Signature Series* monograph, *Fundamentals of Money Management*, which differentiates between tax accounting and managerial accounting (it includes a Chart of Accounts diskette compatible with QuickBooks, by Intuit). I see program-based budgeting as activity and program planning for the coming year; it is a series of healthcare delivery commitments by the practice doctors and staff. The cash budget is only a series of clinical programs to which we have historical data on the income or expense impact on any practice. A good leader promotes income development activities and allows his/her team to increase net by controlling expenses and extending the healthcare delivery programs beyond the professional diagnostician. Therefore, the annual budget cycle includes, in my mind, the annual marketing plan and the communication/training plan for the team, as well as commitment to higher levels of quality healthcare delivery.

PROGRAMS = NET INCOME

More veterinary practice owners are learning that a focus on the front door is good business; they know when their procedures are down. A good program-based budget provides the needed measurements for growth; how many procedures are we doing, and what are the relationships to each other (e.g., dentistries to outpatients, fluids to surgeries, etc.). These measurements are essential to make success happen; it is also called have standards of excellence in the practice's healthcare delivery habits. In the 1998 ISUP text, *Building The Successful Veterinary Practice: Programs & Procedures (Volume 2)*, Chapter Four, and Appendices D, E and F, examples are provided that most any practice can follow to build a monthly cash budget, establish effective Income Statements, and build upon an established Chart of Accounts (the Chart of Accounts in Volume 2 expanded the AAHA system to include more income centers). Mechanically, the income statements of the practice should reflect the major income categories produced by the practice's veterinary software at EOM, and those major categories are then used for the top left-hand column of the budget instead of "sales", and the income history of the last three years can be used to determine the average earning power of each month (percent of annual income). But the chart is not the planning process, and the planning and projections are what is needed to make it happen.

CONTROLLING CASH FLOW

The traditional approach to restrict expenses and inch the prices upward is adequate to maintain average growth to defend against inflation, but it does not promote expansion. The cost of professional services continually rises as do the fixed and variable costs. It is one thing to project an increased income for next year; it is far more difficult to cause it! The secret to obtain those extra degrees of expansion (practice growth) is based on the increasing horizontal (adding services) and vertical (expanding existing services) levels of income available to the practice. Income production (new or expanded services and products) is the major variable in controlling liquidity, also called "cash flow" by some.

To control (or monitor) income levels, fees must be projected and cash must be received (and bad debt must be minimized). We will assume the practice has a clear set of values and core competencies, a future-based vision, and a CONSISTENT practice philosophy in place (an accepted core platform of services and products). This is started with a cash budget, with paired income and expense centers where possible, projected by month, for the coming fiscal year (see the 1998 ISUP text, *Building The Successful Veterinary Practice: Programs & Procedures (Volume 2)*, Chapter 4, Program-based Budgeting):

1. The historical income (percentage of the annual income earned per month) must be established, either by historical records or experience factors. This will help decide the percentage of cost allocation per specific month for variable and semi-fixed expenses.
2. Ancillary income sources must be assessed as opportunities to the practice team available (space and equipment, client acceptance, and human resources). Using historical expenses will be helpful and must be assessed, expanded, and allocated to specific months based on the horizontal and vertical diversification planned for the upcoming year.
3. A flexible model must be established built on zero-based budgeting. Start with the assumed profit level required to make the practice grow at the desired rate in the upcoming year, then look at the income potentials current and possible.
4. The practice plan (vision of the practitioner) outlines the one-year, three-year, and five-year hospital director's health care delivery plan, marketing plan, business plan, staff utilization plan (names vary by practice).

Controlling the cash flow means knowing what is expected then measuring the accomplishment of that performance level. The program-based budget must be compared to actual performance on a monthly basis and adjustments need to be made in the remaining monthly targets if the year end goals are to be met; this is often done in dollars, but when variances occur, you must look at procedure counts or you are just fooling yourself. As I was surfing the net (AOL and NOAH), I watched veterinarians discuss their 1998 increase in gross, the percentage of gross which was due to vaccines or dentistry, and other such “first liar loses” type discussions. When are we going to learn?

THE FRONT DOOR MUST SWING

The secret is what makes YOUR front door swing, Every practice has a different formula, but there are common components, and they are called programs (as in program-based budgeting). We realize that a pre-anesthetic laboratory screen is REQUIRED in virtually every case (although the intensity and scope varies), and as stated in a recent Nevada State Board letter, 80 percent of the surgery cases should have fluids running. (When was the last time you took a fluid therapy refresher for CE?). We have stressed the grades of dental conditions, and recording of the grades in the medical records, to the point where those doing it have doubled their income. We even have a Colorado practice who has contacted Dr. Marv Samuelson (VARL) for assistance to develop dermatology as an income center program (e.g., even in Colorado, 15 percent of the dogs coming in the front door have atopy).

But let's go forward with fundamentals and see what you are taking for granted, especially in **surgical cases**. We know in our hearts that **pre-anesthetic blood screening** is essential . . . one State Board has publically informed every practitioner in the State that 80 percent of surgery cases should be on **fluids** . . . we read about pain management, and listen to seminars, yet believe clients can make a knowledgeable decision about pain management with no training - **post-surgical pain killers** are not optional - everyone knows PAIN IS INHUMANE! Yet every day, there are practitioners putting animals at risk, and themselves into liability, by practicing wallet medicine instead of quality medicine.

How about **radiology**? Fact: most every practice has forgotten that a **radiographic baseline** of the thorax is good medicine. A boarder who is coughing does not always have kennel cough. Dogs do have other problems. For instance, a negative Difil test tells you about circulating microfilaria, not adult heartworms in the thorax. Current literature shows that some of the coughing cats previously diagnosed as asthmatic are actually heartworm infested, even in non-endemic areas. ONLY an X-ray can do this effectively. Consider this: Dr. Bob Smith (radiologist, University of California - Davis) believes that dogs with a negative OR positive heartworm test still deserve a thoracic X-ray series before starting the preventive care or treatment protocol. Moving on to the abdomen, when was the last time you did an IVP or cystogram? There are more things than just foreign bodies occurring in the abdomen. Have you ever considered the diagnostic advantage of a Baro-spheres when doing a laparotomies, since leakage is not a by-product of these pellets? During a short course recently held, it was stated, *"Use of the Penn Hip technique to aid in the diagnosis of hip dysplasia and the introduction of Baro-spheres for barium studies have proven diagnostic advantages"*, and one of our clients attended and KNEW he could go back to practice and virtually double their income in this area.

Look at the advances in **cardiac evaluation**. The handheld ECG which gives a lead-II rhythm strip can be used with every annual life-cycle consultation (yes, I know you call it an annual exam, but which sounds more accurate?). The handheld ECG is economical enough that if it was used for each "annual", at a fee of $2.00 additional, it would be totally paid for in less than six months; then it is a NET-NET program every time it is used! The use of echocardiology is on the rise; within five years most quality practices will be using it regularly. This modality is technique-driven and relatively easy to read; the

difficulty lies in determining where and how to place the transducer. As Dr. Larry Tilley states so often, “Telemedicine now allows a practice to be in contact with a specialist - even across the country - within minutes”.

Reflect on the **blood pressure diagnostics** of your practice. It cannot be emphasized enough. Every practice should be using a blood pressure device daily (e.g., Doppler). We have some practices which ensure that the feline blood pressure monitoring is part of the annual life cycle consultation. It has been shown that 60-plus percent of the cats in renal failure can have hypertension. It has also been shown that hypertension can be manifested in such unusual signs as anisocoria. Dr. Mike Garvey (AMC, NY) has stated that blood pressure measurement is paramount - for more than hypertension . . . up to 30 animals die every day from hypotension for every animal that dies from hypertension.

ECONOMICS 101 ALA DR. TOM CAT

“Tom Cat, we will damage our relationship if we add these unneeded diagnostics.” You are right, if they are unneeded. But in every case stated above, there was a medical need. The fact that you have taken radiology for granted means the overhead is still larger than the income from the program center. Yes, program center -- not income center, not profit center. The front door swings because we believe in our health care programs and share that conviction with clients as NEEDS for their animal(s). If you don’t medically believe it is needed, NEVER do it!

And for those of you who take one film to “save the client money”, remember what every text and radiologist has stated, *“If it looks like a duck, sounds like a duck, and walks like a duck, it must be considered a duck . . . and ducks state very clearly, QUACK, QUACK, QUACK!”* If radiology is needed, two views are needed. To provide half the care is a violation of professional ethics and the Practice Act. Think of lameness cases where you have said, “If this does not get better, we may need to take radiographs”. The client brought a suffering animal to you because they wanted “PEACE OF MIND”, and you only offered them “tincture of time”. And you wonder why they never come back? Lameness generally requires radiology to determine the appropriate treatment as well as the prognosis, and in client relations, they came to you because you are the diagnostician!

The ability to believe in good medicine is the cornerstone of a successful practice. The ability to convey this need to clients is the cornerstone of a profitable practice. The overhead of a veterinary practice is pretty fixed (in well managed practices, less than 50 percent of the gross income is spent on monthly P&L expenses, not counting rent, doctor monies, and ROI benefits (quarterly rate stays below 48%). So, it is the delivery of services and products within existing staff and facility capabilities which can make the net income difference.

TODAY IS THE FIRST DAY OF THE REST OF YOUR LIFE

We really don’t care what you have already done; that is past. What we care about is what you are willing to do. Every year, new continuing education courses mean you have

the opportunity to enhance practice programs. The continuing education experience which does not add one new program per day of CE attended was a wasted expense. The new program is designed to provide better care, and there is a value associated with that client benefit. That value, as assessed to clients, should be reflected in your program-based budget for the year. The cash flow reports from that computer in your office ONLY reflect the “belief level” of the providers in the new program(s) being offered. The choice is yours, we are here to help, but the belief starts in your gut and ascends to your heart. When your heart believes in the program, the clients will accept the care as needed and essential. It is your choice -- lower the net each year, or provide better health care delivery programs.
JUST DO IT!
THE PRACTICE BUDGET TEAM

The control of the cash flow from programs that match the core values of the practice is a team responsibility and as such, the plan must be a team effort. The practice budget team should include the practice owners, bookkeeper, office manager, lead technician, lead receptionists, and an outside mentor. The technician and receptionist should be involved in those areas where they have a first-hand interest and impact but need not be involved in all parts of the team planning. The outside mentor can be a CPA, consultant, attorney, or psychologist. To be most effective, they must be detached from the practice's patient healthcare plan.

To be most effective, this entire day of isolated planning sessions is without spouses. The spouse, as with any client, usually has a hidden agenda and will muddy the team effort, even if just to wait on the sidelines for a meal companion. It would be appropriate to form focus groups of respected clients to discuss potential healthcare service opportunities before the off-site planning session. After the budget planning session, this type of client-centered input may be counter-productive to the success of the plan.

The budget planning team needs a playing field (established rules and historical game experience), and that is usually the past financial statements. The planning team needs to meet at an off-site location about three to six months before the fiscal year begins and use the historical data to develop a strategic plan for the practice's cash flow. To be most effective, the practice manager becomes the meeting coordinator and handles all the following:

1. Ensures the "silence of the confessional" between the planners and the staff during the planning process.
2. Coordinates the meeting location, room requirements, meals, and other quality of life support functions.
3. Distributes a meeting syllabus (outline and general ideas) three days before the meeting, seeking other new business that must be returned not less than 24 hours pre-meeting.
4. Re-publishes the revised agenda (increased outline detail, with meeting time allocations) the day before the meeting, with the appropriate resources needed to allow participants to come well prepared.

5. Sets the following times in stone (unusual times help ensure team complies to expectations):

   a) For the key team members (owners, practice manager, and CPA or bookkeeper), possibly with a mentor, start at 7:33 a.m. with a very light breakfast (the mind works better on a lightly filled stomach), coffee, tea, and juice.

   b) At 7:57 a.m., start review of the previous financial statements using an overhead projector so all can see and discuss the key elements (view graphs prepared of previous fiscal year, all twelve months, of the income statements and balance sheets).

   c) Have a practice cash budget outline prepared using percentages per month per element of income or expense, as available, for handout after the historical review and before brunch.

   d) With the arrival of the adjunct team members (associate doctors, lead receptionist, and senior technician), provide a light brunch at 10:37 a.m.

   e) With the expanded planning team, start a review at 10:56 a.m. of the projected program-based budget percentages that were developed from historical data on the previous practice team performance and client utilization habits, and brainstorm which programs can be added or expanded in the next fiscal year (don't kill a single idea during this brainstorm, just write them down and tape them to the wall).

   f) At 12:30 p.m., break for lunch on-site, resume at 2:04 p.m. to develop expected income per program area of interest to support cash budget. This is often where the "reality check" is provided by the nurse technician and client relations receptionist to mediate the "grand ideas" of the key team. Human resources are only so flexible and expandable, and these two persons must stand up for the quality of life of the staff. Pros and cons, alternatives, and methods to reach the "grand ideas" need to be the target of the discussion, but it may require adjusting the personnel budget, equipment budget, or even the facility size.

   g) Soda, juice, coffee, and tea break at 3:31 p.m. Key staff rejoin at 3:47 p.m., but without CPA/bookkeeper, technical assistants, and receptionist (released for remainder of day).

   h) Resume with emphasis on new business areas, marketing potentials, and client acceptance factors. Extra expenses (e.g., training, space, equipment) to support new income areas need to be explored in detail. Compromises will now be required based on the input provided by the lead nurse technician and receptionist coordinator. At least 60 percent of their ideas need to be incorporated to have the budget be perceived by the team as realistic and a useful process.

i) Supper break at 5:45 p.m. for two hours, time to relax and unwind. Attempt to stay away from excessive food or drink indulgences, since there is still work to do.

j) Rejoin at 7:46 p.m. for a "wrap and polish" session of all that has gone before, to expand on core competencies, core values, and practice philosophy applications. Ensure you include a staff impact assessment and communication plan. This may include an additional training budget. Also center on those portions which were provided by the technician and receptionist that could not be used, as well as the changes that will be needed to make the annual program a success.

The need for the communication plan is critical for two elements: the paraprofessional staff and the clients. A draft transition plan, a month-by-month sequence of changes or additions for the next year, would be an appropriate and organized method to communicate the decisions of the budget planning process. This plan should integrate all the different plans, and ensure that no member of the staff would be tasked with more than three new functions/habit changes per month.

MINIMUM BUDGET DISCUSSION ELEMENTS

The syllabus and the refined agenda discussed above need to contain certain elements, including: equipment, debt retirement, quarterly financial comparisons, cash outflow discussions, receivables, bad debt allowance (less than 1.5 percent), charity at the exam table (less than 3 percent of gross), employee discounts (less than 20 percent without IRS complications), tax laws, space potentials, computerization upgrades, people allocation per area (based on gross, with quarterly targets, such as 8.5 percent technicians, 7 percent receptionists, 2 percent kennel, 3 percent administrator), and finish with a fee schedule that supports the budget for people and equipment upgrades.

Key financial and operational relationships need to be discussed, to determine indicators that management can observe to easily monitor trends on a monthly basis. Examples would include, but should not be limited to:

cost of drugs and medical supplies (12 to 15 percent),

paraprofessional salaries (17 to 21 percent),

total W-2 compensation, doctors clinical and staff (less than 43%),

percent of transactions that are new clients (target 10%),

number of new clients by referral (greater than 60 percent),

percent gross from vaccinations/dentals/surgery/anesthesia/etc.,

percent of gross for mailing (greater than 0.6 percent),

number of transactions (or percent appointment fill) per veterinarian,

percent "net" given away (adjustments/discounts by veterinarian),

aging rate of accounts receivable (30-, 60-, or 90-day accounts by dollar amount),

the rate of follow-up scheduling by doctor

diagnostic ratio (pharmacy sales:diagnostic sales)

Some ratios, like the "Pharmacy Sales to Diagnostic Sales" by veterinarian, is a very individual ratio, but centers the doctor's attention on what they can do for the quality of care provided by the practice. Many of these can be graphed for more clarity when evaluating trends. In the ISUP text, *Building The Successful Veterinary Practice: Programs & Procedures (Volume 2)*, there are eleven graphs and two charts in the Appendix for watching “the tips of the practice iceberg” on a monthly basis - we call it a dozen dots a month, although it is a baker’s dozen (13)! These are indicators to watch so you know when to look deeper into the operational trends or fiscal management of the practice.

Beware of the easy factors so often published without "the rest of the story", such as average client dollars per transaction (ACT). The ACT is often counter-productive since it centers attention on the wrong thing. What is the "computer's definition" of a transaction; is the ACT reported by veterinarian or by hospital; what is the over-the-counter sales impact; what is the income per inpatient visit versus outpatient visit; what are the payroll hours per transaction; what is the return rate per year (client or patient)? Some consultants demand that the square footage of the practice be used to compute cost centers, but the allocations of circulating space makes potentially profitable areas appear worthless. Evaluate services within the resources available to the practice and maximize income from each cost center. The bottom line of fee structuring is simply, if you are within about 10 percent of the community high, variances from national norms are not significant for the clients who seek quality veterinary healthcare services!

The veterinary computer systems of today are designed to give abundant "data". This most often is minimal "information" for management decision making. A savvy practice manager must be able to take the information available and process it into knowledge that can be used for the good of the practice. In any practice, less than 30 factors are needed to reveal the monthly trends. In the area of laboratory services, expenses should be tracked by in-house versus commercial and income should be tracked by preventative, pre-surgical, and medical support functions. The

examination/office call (better called "doctor's consultation") should be tracked by rechecks, normal, and extended consultations. In a healthy, mature practice, monthly operational expenses, *without the major variables of rent, DVM salaries or return on investment (ROI)*, would be expected to be between 45 percent to 48 percent of the gross. The AAHA Chart of Accounts, expanded in the ISUP text, *Building The Successful Veterinary Practice: Programs & Procedures (Volume 2)*, provides an easy access and comparison to the regionalized database of the profession. *Quicken* or *QuickBooks* (from Intuit) are excellent software systems for expense summaries and accounts payable needed to support the Chart of Accounts.

Comparisons could include: outpatient drugs and medical supplies versus inpatient drugs and medical supplies, vaccination income as a percentage of gross, hospitalization income, X-ray income compared to expenses, over-the-counter sales, nutritional sales of prescription versus other products, boarding fill rate, baths per transaction, or the eleven fiscal charts provided by Catanzaro & Associates, Inc. Other expected ratios include rent at one percent per month of the fair market value (triple net lease), DVM wages (owner(s), et al) at 18-23 percent, CPA and legal fees at 0.8-2 percent, office supplies at 1.4-2.2 percent, or maintenance costs of 0.5-1.5 percent. In more progressive practices, healthcare parameters such as ECGs per thoracic X-ray or kidney dysfunction laboratory profiles per six-years-old or older canines examined are monitored since they relate to income potentials.

MANAGERIAL EFFORTS

Using the practice team to keep the budget plan on track will be enhanced when the accurate data is shared in a timely manner, using a format that is user friendly. Remember, the staff knows how much a practice takes in each day (they close out the computer), they just don't know what the costs are in most cases. The team which is used to keep the budget on track will provide feedback which will show the benefit of the time taken to make the information readable. The practice management methodologies required to make the budget plan happen is as simple as driving "A TRUCK", or in easier terms:

A = accuracy of data

T = timeliness of data availability

R = reformatted as information

U = user friendly

C = control cost of capturing data

K = keep on track monthly

The use of a posted "Dinner Bell Chart" (*Building The Successful Veterinary Practice: Programs & Procedures (Volume II)*, Appendix), helps the staff see the monthly income participation. It is simply a graph with appointment days on the horizontal axis and income on the vertical axis. The target line (done in highlighter) starts each month at zero and ends at the cash budget projection for that specific month. The daily gross receipts are posted on the chart at the end of each day, in a cumulative fashion ($1860 on day one, then $1435 on day two, would put the day two dot at $3295). The gross income dots are connected in dark ink each day. At the end of the month, if the dark

line is above the highlighter line, the owners take the staff to dinner. While at dinner, the dinner site of the next Dinner Bell Chart celebration is chosen by the staff. If the cost of the site selected seems excessive, the owner simply adds that to the target before announcing the cash projection figure for the next month. As an added benefit and team builder, each third Dinner Bell success celebration should include the families or significant others of the staff members. They make the practice success sacrifices, too.

When the staff centers on offering the services each animal needs (or the practice needs for professional healthcare decisions), the income should take care of itself. This statement is based on four assumptions:

1) that caring practices only "sell" ***peace of mind*** -- they give the client two "yes" alternatives which they are "allowed to buy" to meet the needs stated;
2) that the veterinary practice environment for horizontal and vertical diversification has been developed;
3) that it is well understood by the staff and healthcare providers; and
4) the team has been appropriately trained in both competencies required and client communication techniques.

These four assumptions are easier said than done, but that is the art of management rather than the science of accounting. The program-based budget is a system based on quality care, client-centered service, and patient advocacy . . . the accountant's propensity for stating the obvious with an expense-based budget must be left in the past as lessons learned . . . the future is in making the front door swing, more times for your existing clients,