introduction

The fundamental goal of any medical practice is naturally to treat illnesses and to help people. Beyond this though a practice must be able to keep its lights on and its staff paid. Without this, the fundamental goals become unattainable. If you’re reading this eBook chances are you’re interested in finding a way to increase the profitability of your medical practice in an effort to ensure that bigger goals can be met.

This eBook therefore will serve to help you in that quest. In just a few short pages we will introduce some tools available to help you with that mission and familiarize you with their functionality and benefit to your practice. This won’t be the be-all-end-all guide to earning more through your medical practice, but will serve as an excellent starting point to improving the profitability of it. With even the points covered here your practice’s earnings maybe positively effected, which will go a long way in maintaining the overall goals of your practice.
IMPORTANCE OF PRACTICE METRICS / KEY PRACTICE INDICATORS (KPI)

Whatever you call it, practice metrics or KPIs, the important point is that you can’t manage what you don’t measure. Providers are challenged with providing quality patient care and managing their practice as a successful business. While providers go to medical school to learn patient care, medical school isn’t business school. There are a number of useful business concepts that providers and practice administrators need to know, monitor, and manage in order to maximize practice efficiency and profitability.

The MGMA provides a wealth of guidance in the form of guides, reports, practice benchmarks, and dashboards to help practices identify what physician practices are facing, critical measures, comparing results to other practices. Starting with their “Benchmarking Basics” document, practices can learn about the importance of measuring performance across a host of front desk, billing, and clinical operations. You can start your metrics journey by understanding the typical measures other practices are meeting, establishing a baseline of where you are today, setting goals for where you want to be, creating a project plan of operational best practices for each area, engaging staff to execute on those best practices, monitoring how well you’re doing in relation to the baseline, and tweaking best practices as needed to start moving the metrics needle in a positive direction. The first place to start is to identify the benchmarks.
In essence, benchmarking is a strategy whose purpose is to evaluate the effectiveness of different management practices and generate the necessary motivation to set goals for a practice. The idea here is to give a physician an idea where they rank in comparison to a given standard of business operations. For example, this method can show a physician where they stand in relation to other practices for things like patient wait times, turnaround for reimbursement and overall patient satisfaction. The goal is not to generate an all-out-contest to see which practice can do something the best or fastest; rather, the intent is to give physicians who know their practice is not operating at peak efficiency a kind of base-line to compare themselves to for certain key functions. **There are two primary benchmarking categories: operational and revenue.** We’ll spend some time with operational benchmarking first.

**Operational Benchmarking**

Operational benchmarking as the name suggests deals with the benchmarking of all aspects of a practice as it relates to its operation and functioning. A good example of using operational benchmarking effectively is determining what days and times seem to carry the heaviest appointment loads. Once this is uncovered a physician will be able to either spread those appointments more evenly throughout a given week or staff those days and times more heavily and lessen staffing on the days that aren’t so frequently booked for appointments. Doing this helps to both ensure as smooth an operation as possible on those days, but also helps to prevent paying employees to be in the office when there is not anything for them to do.

**Revenue Benchmarking**

The other category of benchmarking is revenue benchmarking. With revenue benchmarking the goals are slightly shifted. This method seeks to examine the financial stability of a practice as well as how to improve or control that stability. Some of this can be highly specific to each practice such as ensuring that the contract a physician has with a specific payer is updated occasionally to reflect the changing costs of providing certain services. If a service provided by a physician becomes less expensive to provide, the payer, often an insurance company, will be more inclined to pay the updated cost of the service rather than the price quoted in the contract. This method can also be more universal such as keeping track of the types of payers a given practice most often deals with. If the most common type of payer becomes governmental, rather than private, for example, then the physician must be able to adjust for this change in reimbursement time in a way that sees a less sharp decrease in revenue.
SPECIFIC METRICS TO TRACK

The important thing to keep in mind in reference to the financial security of your practice is that income is not the be-all-end-all measurement of success. Ultimately, there are several other metrics which should be given just as much attention as revenue to ensure the peak fiscal health of a practice. This section will cover a selection of those metrics as well as any pertinent information regarding their use to you, the physician and to your practice. It doesn’t take an accounting degree to understand these metrics (though that certainly wouldn’t hurt!), but rather a simple grasp of mathematics and a mind for basic business principles.

**A/R Days:** The first of these metrics is the amount of days spent in accounts receivable (A/R). This time period in layman’s terms is the amount of days spent before a practice gets paid for its services. In essence, the lower the number of days spent in A/R, the quicker a practice receives payment for its services. Ideally, the time spent here should be no longer than between 30 and 40 days, though anything below 50 days is considered acceptable. As with all things financial however, there are certain challenges to keep in mind. Among the biggest issues faced by practices with respect to days in A/R is the issue of insurance carriers who are notorious for taking longer than average to pay out on services rendered by the practice. There is no one way to deal with this problem, but it is still one that should be addressed by the practice if it is hindering profitability (say, for example, a carrier that takes 80 days on average to pay, when the practice averages 35 days spent in A/R).

**A/R Exceeding 120 Days:** Another metric to keep in mind is when time spent in A/R exceeds 120 days. Here the ideal percentage of cases with this amount of time in A/R is less than 12%, though anywhere between 12 and 25% is considered acceptable. This metric is less to do with measuring how many payers are slow to make payments as it is a measure of your practice’s efficiency at collecting overdue payments. For example, if more than 25% of A/R have gone over 120 days then your practice may need to adopt a more effective method of payment collection or renegotiate contracts with certain insurance providers such that they become more inclined to pay closer to the ideal A/R window of 30 to 40 days.

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Specific Metrics to Track continued

**Net Adjusted Collection Rate:** The next metric is the net adjusted collection rate. Here we look at what a practice actually collected versus what they could have or should have collected based on contractual agreements with payers. The ideal percentage here as determined by industry average is between 95% and 99%. Obviously 99% or better would be ideal, but the low end of the industry average helps to act as a buffer for things outside the practice’s control, such as bankruptcy of payers, loss of insurance coverage and things which cannot be accounted for in the planning and signing of a payment contract. Here it is important to make note of adjustments that need to be made as a result of patient error (such as not filing a claim with their insurance provider in a timely manner). Again, these are things which are strictly outside of the control of a practice and must be noted as such to obtain the truest possible measure of its efficiency with collecting payment.

**Average Reimbursement per Encounter:** Perhaps one of the most important metrics is the average reimbursement per encounter. This rate is a measure of the total amount collected by the practice per claim and as the idea suggests, the higher this rate the more money the practice makes. Here the industry average is somewhere between 35-40% though the ideal percentage for this would be 100%. The purpose of this metric is to analyze and determine whether your practice could realistically see an increase in revenue and if so which areas need improvement to make that happen. An important consideration here is to make sure that this rate is calculated for each individual payer rather than overall for all payers to your practice. Doing this ensures that each payer is looked at like the unique case that they are such that no two methods of increasing reimbursement apply to any given two payers.

**First Pass Resolution Rate:** To piggy-back off of this idea, the final metric worth noting here is one known as the first-pass resolution rate. As the name suggests this metric deals with the percentage of payments made after only one attempt to receive them such as only one bill being issued to a payer. Here the ideal is somewhere around 90% or more of resolutions achieved on the “first pass.” By receiving payment the first time it is requested, a practice is able to maximize their profitability and by extension, their efficiency. As with many of the above metrics the goal here is to achieve the highest percentage of first-pass resolutions possible.

These metrics serve as an added set of tools for a physician to use to examine their profitability by seeing how they stack up compared to other practices that deal in the same areas they do. Something to note is that it wouldn’t be a good habit to measure your practice against another practice dealing in an entirely different area of the medical field. For example, if your practice is primarily allergy and immunology, then to compare your profitability to a practice whose specialty is orthopedics since the amount of patients using those services can vary outright which would imply different standards of profitability for each practice.
THE ROI OF TECHNOLOGY INVESTMENTS

The healthcare industry continues to recognize the importance of managing the practice as a business, a steady stream of new tools and services continue to launch to help providers focus on getting back to the business of healing. These tools include Practice Management (PM) and Electronic Medical Records (EMR) software and other administrative and clinical tools and services designed to help practices outsource and automate time-consuming, inefficient, and costly practice functions.

Practice Management (PM) software

Practice Management (PM) software, while being available for years, has evolved by leaps and bounds to not only efficiently and effectively manage traditional front desk, billing, collections, and financial reporting operations, but to also automate appointment scheduling, confirmations, and filling vacancies ensure schedules are filled and reduce no shows. PM software also may have integration with insurance eligibility verification, patient payment estimators, electronic statements, point-of-care, online payment processing, and automated collection processes to maximize the ability to collect outstanding balances sooner. While a strong PM system and add on tools and services have a cost associated with them, the key is to conduct a cost-benefit analysis based on the hard cost versus the quantitative (money saved/revenue gained) and qualitative benefits (staff able to focus on other key projects/patient satisfaction/staff satisfaction) expected from implementing and actively using the tools to achieve KPI goals.

Electronic Medical Records (EMR) Software

The other core practice tool is EMR. Implementing an EMR tightly integrated with your PM and carefully implemented for providers to maximize digital alignment to specific workflows can help practices ensure they take full advantage of payment and incentive programs, including the Medicare CMS Quality Payment Program (QPP) and the Medicaid EHR Incentive Program. Providers that have already been actively adhering to PQRS and EHR Incentive Program requirements may find the first year of the QPP less burdensome, making it easier to secure positive payment adjustments for Medicare, and even earn bonus. One critical requirement is to have a certified EHR program as it will contain features, tools and functionality that will allow providers to capture and report the data required for QPP Quality and Advancing Care Information measures, as well as to attest to improvement activities that can be enhanced through your PM or EMR software.
The most important way to ensure some kind of ROI on a technological investment is to choose a product that will fill a direct, immediate and long-term needs of your practice. The scope of the technological landscape is ever-changing and the side-effect for business owners of any kind, especially medical practices, is that the need to update existing technology occurs much more frequently than it used to. This can be stifled somewhat by choosing software that is easily updated and will stand the test of time. If we compare EMR software to a word processing program for a moment there are only a select few that have stood the test of time and still exist sometimes decades after their creation. Those programs are easy to update and you lose no information during that updating process. Finding an EMR program such as this will make the frequent updating of the system to the most functional version a much more painless and less expensive process.

Beyond this, there are four main attributes of a given program or system which will help a physician to decide on the one that most closely meets the needs of their practice.

1. The most user friendly thing an EMR system can do is do what the user needs to do in the least number of steps/mouse-clicks possible. It should be a short and simple process to maneuver through the various menus to get the information you need and this should take as little clicking around as possible.

2. The ability to handle both clinical responsibilities and professional ones. If a system can only handle the patient records, then a practice will need to purchase software to handle the office-related tasks like scheduling appointments separately, adding expense to the upgrading of software. Finding software that can accomplish both of these necessary tasks is vital in ensuring an ROI.

3. Rather unsurprisingly, it will also be beneficial to find software that is capable of the things discussed in point #2 as well as handling the financial aspects of the practice. Successfully integrating these three common office needs into a single integrated suite of software and tools will save money, which is just as big a component of seeing an ROI as getting your money’s worth out of the product.

4. There is serious ROI potential in cloud-based EMR software. Transitioning to cloud-based software practically eliminates maintenance fees and upgrade costs. This also phases out the need for on-site hardware-based storage such as hard drives. These systems are also often more secure than on-site storage methods.
How to Improve Profitability for Your Medical Practice

MAXIMIZE LONG-TERM ADOPTION AND SATISFACTION

Equally as important as finding the right software for your practice is ensuring a smooth, seamless implementation process. The first aspect of this implementation that needs to be addressed is ensuring that the implementation merges into the existing flow of productivity within the practice. There are a number of ways to accomplish this, but one of the most effective ways is to outline the practice’s operations as they exist and then see where the easiest places to implement the new software are. Writing this out by hand or via computer as a spreadsheet or document is a good way to be able to look at office practices all in one place and see the areas where integration would fit best and where it wouldn’t. However, this process cannot exist strictly as an administrative effort; the entire staffing team must be brought on board to voice their ideas and concerns so that the transition truly is a smooth, seamless process.

It can be incredibly effective to assemble an EMR implementation team. It is imperative to be successful in implementing the new EMR software that the members of this team come from different backgrounds and roles within the practice, such that all members of the practice are represented and their voices heard. Once the team is in place the three phases of implementation (planning and preparation, reassuring staff and motivating organizational change) can begin. With the first phase, the goal is to ask any necessary questions to the software vendors as well as get the rest of the staff on board with the transition. From there, phase two can commence. This phase’s focus is on assuring the staff that the EMR software transition is going to benefit them as well as the wider practice in both the immediate future and in the long run and that all of the potential stress and extra hours spent working will be worth it. The final phase centers around motivating organizational change, which includes examining practices that may need to be suspended, altered or altogether removed from the organization to make the transition as smooth as possible. Also included here are practices which the organization should possibly institute as new such that they will benefit not just the transition, but also the continued use of the new software.
CONCLUSION

We hope that as a result of the information presented here, you should now be more familiar with the myriad of ways you can help improve the profitability of your practice. The goal of every physician is the optimal health of patients and doing what they can to ensure that health is attained and sustained. However, to operate without any consciousness for the business end of your practice is a recipe for disaster. With the information presented here that side of your practice should be easier to understand, maintain and with any luck, grow!

About Henry Schein MicroMD

Henry Schein MicroMD, a subsidiary of Henry Schein, Inc., provides simple yet powerful EMR and Practice Management solutions that facilitate the delivery of superior patient care, automate incentive and quality reporting activities, streamline operations for today’s busy providers and assists practice in meeting HIPAA Security requirements. Full-featured, time-tested, and budget-friendly, MicroMD EMR is 2014 Edition Complete Ambulatory certified software that helps small practices, large medical groups, community health centers, and billing services accelerate progress toward a paperless environment and secure health information exchange with minimal disruption and stress. Learn more at micromd.com.

References

Maximizing Pay-for-Performance Opportunities – i2i Population Health
Five Key Metrics to Financial Success in Your Practice - AAFP Assembly
Lessons for Financial Success: Benchmarking Basics - MGMA

Resources

MGMA Practice Resources - http://www.mgma.com/practice-resources/overview