Empowering Pediatric Practices: Key Performance Indicators & Benchmarking and the Path to Financial & Operational Excellence

Alisa Vaughn, SVP Revenue Operations Office Practicum
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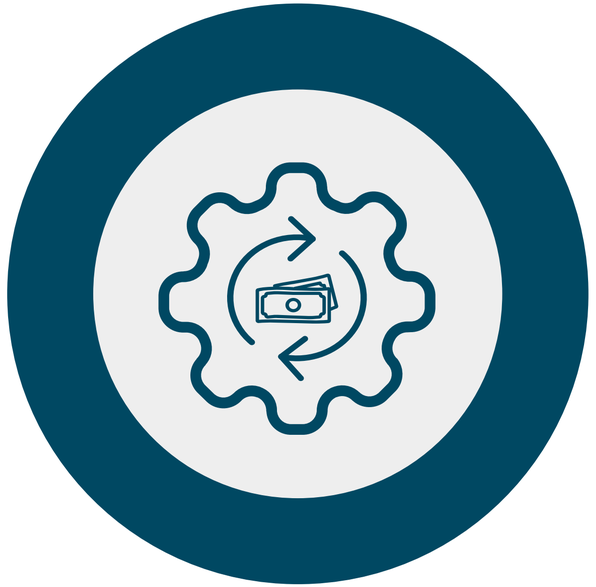
KidsHealthFirst
PEDIATRIC ALLIANCE



Disclosure

I am the Senior Vice President of Operations and shareholder for Office Practicum and shareholder, a provider of electronic health record (EHR) software and services tailored for pediatric practices.

This presentation is intended for informational purposes. The applicability of any content to your particular business or practice depends on the particular circumstances of each situation. Please consult with an appropriate professional for specific advice tailored to your particular practice and/or circumstances.

At the end of this presentation attendees will be able to:

1. Describe essential KPIs for monitoring a practice's financial health.

1. Explore financial metrics can be leveraged to uncover operational insights and drive improvements.

1. Select the inherent operational indicators within each financial KPI and identify areas for potential refinement.

1. Devise actionable strategies, derived from KPI insights, to foster financial and operational excellence.

1. Explain the value of benchmarking to set realistic goals and measure against industry standards.

Alisa Vaughn, CMPE

A little about me...

Hi! I'm Alisa! I have dedicated my entire working history to serving others. I am a servant leader that develops meaningful relationships with my team members so I can encourage and inspire them to reach their full potential.

My success comes from my team's success, no matter the organization. I truly believe that if you focus on the growth and well-being of those that surround and support you, every stakeholder will achieve success. I put my team members needs first to create cultures in which team members feel personally and professionally fulfilled. I love life, am a mom of one, wife, and friend to many.

KPI Introduction

Key Performance Indicators (KPIs):

- *Quantifiable:* Can be expressed in numbers.
- *Measurable:* Can be tracked and analyzed over time.
- *Objective-focused:* Align with specific goals or targets.
- *Actionable:* Guide decision-making and strategy.
- *Relevant:* Pertinent to the practice's goals and mission.
- *Timely:* Updated regularly to reflect current conditions.
- *Versatile:* Applicable across many domains of the practice.

Without tracking KPIs:

- Navigating Blindly
- Guesswork over Strategy
- Missed Informed Decisions

Master the Metrics

Evolving Healthcare Landscape

Not just for Profit

KPIs: Our Financial Vital Signs

- Revenue Insights
- Billing Efficiency
- Focus Areas

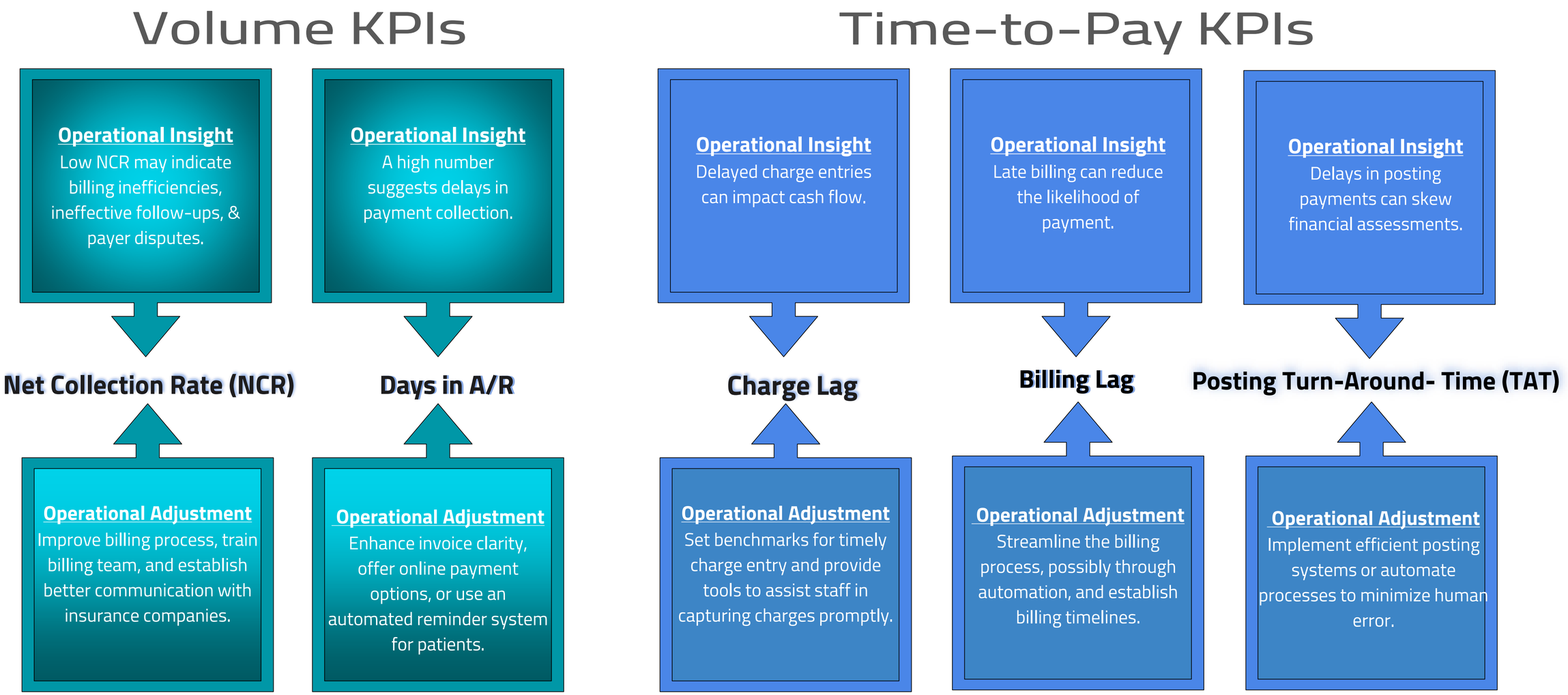
Financial Fundamentals

KPI	What is it?	Formula	What you should know....
Net Collection Ratio (NCR)	Comparison of payments to charges minus adjustments	Total current months payments/total charges from the previous month - current contractual adjustments)	Standard is >98%
Days in AR	Avg time from DOS to paid in full. How quickly are charges turned to cash.	AR Balance/Average Charge/Day	Standard is 30 days or less. Best to look at 3 months of charges and 3 months of payments with a 1 month offset
Denial Rate	Claims are accepted by the payer but not allowed	Total Claims Submitted/Total Claims Denied	Standard is 5-10% ; below 5% most desirable
Rejection rate (Clean Claim Rate)	Claims are not accepted by the payer . Affects POTF	Number of Claims Submitted/Number of Clean Claims	Standard is 98% or above

Beyond the Basics

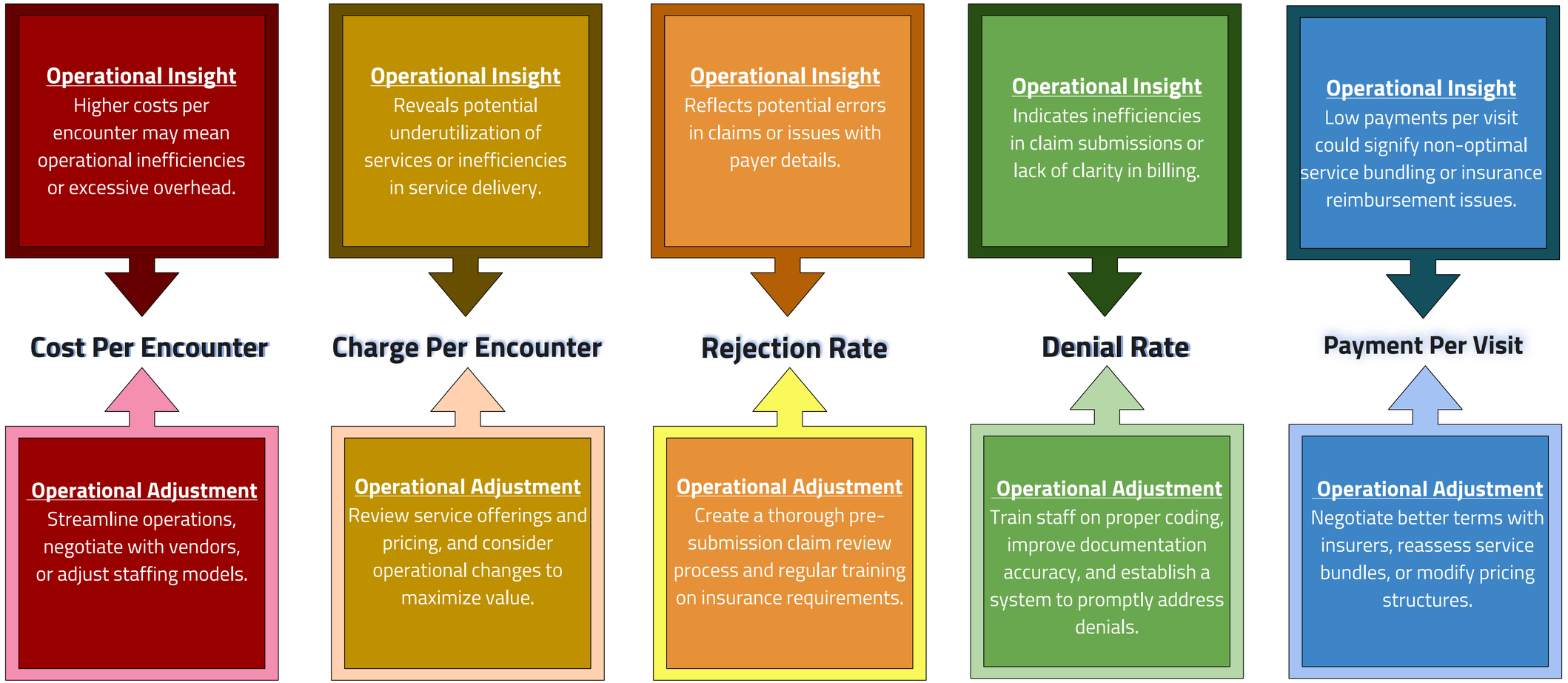
KPI	What is it?	What you should know....
Charge Lag	Number of days from the DOS to when the visit is converted to a billable claim	Immediate to 3 days is ideal
Billing Lag	Number of days from when charge is entered to when the claim is actually sent/submitted to the payer for reimbursement	24 hours or less is ideal
Charge Per Encounter	Total Charges/Total Visits (same time period)	Should align with visit ratio trending
Payment Per Visit	Total Payments/Total Visits (same time period)	Provides visibility into average reimbursement per visit across all visits
Posting Turnaround Time	Average time it takes to post payments or adjustments once EOB/ERA is received after adjudication	24-48 hours is ideal
Cost Per Encounter	Total Operating Expense/Visits	Valuable when negotiating with managed care companies

KPI Versatility

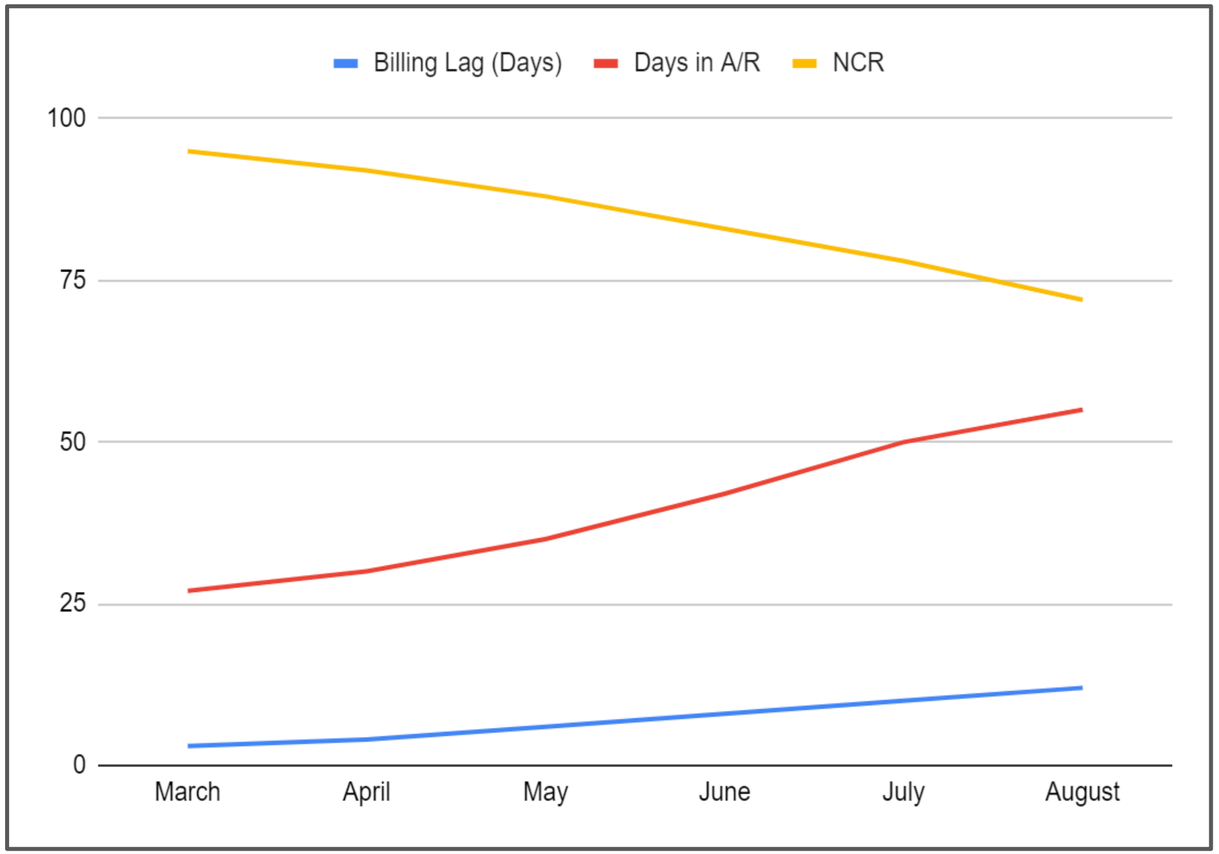


KPI Versatility, cont.

Efficiency KPIs



Spotting Opportunities & Turning Insight Into Action



KPI Analysis:

- Days in A/R increasing, indicating delays in receiving payments.
- Billing Lag increased suggesting potential inefficiencies in the billing department.

Operational Insights:

- Do you have staffing shortages?
- Is your biller new?
- Has visit volume dramatically risen?
- Has your denial rate increased?

Potential Actions:

- Adjust FTEs to accommodate need
- Invest in EHR training
- Evaluate Denial Rate & Trend

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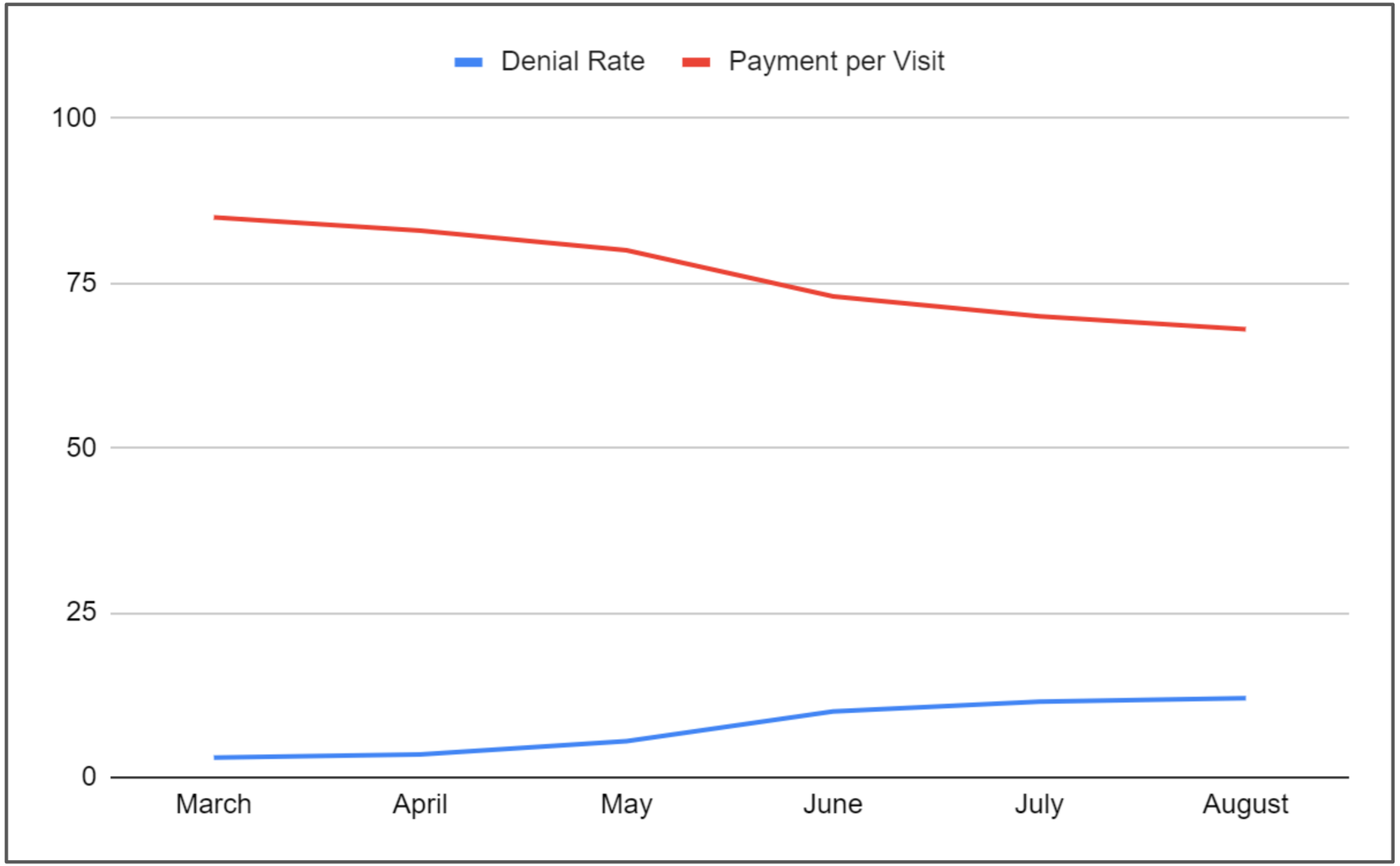
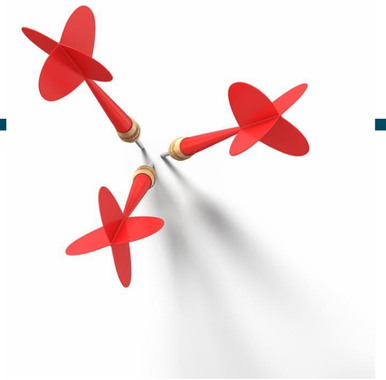


Harnessing Benchmarks

Benchmarking in healthcare simply means measuring and comparing performance metrics of an organization to itself or other practices.



Internal Benchmarking

Setting targets based on best practice, experience, and other internal goals (like financial goals)

- **Best for** setting unique standards for your unique circumstances.
- **Can be biased** due to lack of perspective outside the organization.

External Benchmarking

Comparing your business's performance against other, *similar* practices

- **Best** for getting a measure of performance versus the industry. "Outside Perspective"
- **Requires** a carefully considered "apples to apples" comparison to be effective.

Unlocking the Power of Benchmarking

Why stop at participation?

Why not dig deeper?

Understanding Your Report

Staffing											
Blind #	2	3	4	5	6	7	AVERAGE	MEDIAN	MIN	MAX	# Respondants
Revenue and Charges											
Revenue per Visit	$ 182.31		$ 196.20	$ 180.77	$ 198.79	$ 207.34	$ 194.77	$ 201.09	$ 139.64	$ 242.09	20
Practices with 25% Medicaid or less only	$182.31				$198.79		$ 200.65	$ 203.68	$ 139.64	$ 242.09	14
Practices over 25% Medicaid only			$196.20	$180.77		$207.34	$ 181.05	$ 188.49	$ 141.82	$ 214.13	6
Charge per Visit	$ 213.27		$ 316.23	$ 269.38	$ 265.06	$ 239.13	$ 291.81	$ 287.22	$ 213.27	$ 388.23	20
Average Charges per Provider	$1,235,622		$1,148,069	$1,102,939	$897,976	$1,006,048	$1,253,758	$1,158,252	$790,710	$2,424,096	18
Average Charges per MD	$1,235,569		$1,084,510	$1,103,758	$608,679	$1,004,395	$1,244,190	$1,099,438	$547,168	$2,832,785	18
Average Charges per NP	$585,123			$1,102,202	$602,239		$813,728	$757,898	$521,727	$1,324,742	13
Average Charges per PA	$788,365						$619,242	$619,242	$450,119	$788,365	2
Average Visits per Provider	5794		3630	4094	3388	4207	4569	3733	2594	10436	17
Average Visits per MD	4688		3230	4021	3209	4159	4476	4021	2174	10887	17
Average Visits per NP	2811			4160	3269		3284	3217	1548	5058	12
Average Visits per PA	3374			#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	2
Total Office Visits	33,899		17,148	8,729	31,032	4,996	32,148	26,674	4,423	98,677	20
Total Well Visits	14,384		6,615	2,940	11,664	1,655	12,892	10,078	1,655	37,855	20
Total Sick Visits	19,515		10,533	5,789	19,368	3,341	19,256	16,596	2,049	60,822	20
Total New Visits	1,257		670	359	1,489	867	1,276	855	307	3,847	20
Total Est visits	32,642		16,478	8,370	29,543	4,129	30,873	25,541	3,880	95,124	20
Total Consultations	0		0	0	0	0	-	-	-	-	20
% well visits	41%		39%	34%	38%	33%	40%	40%	32%	54%	20
% sick visits	59%		61%	66%	62%	67%	60%	60%	46%	68%	20
% new visits	5%		4%	4%	5%	17%	5%	4%	2%	17%	20
% estab visits	95%		96%	96%	95%	83%	95%	96%	83%	98%	20
% Consultations	0%		0%	0%	0%	0%	0%	0%	0%	0%	20
Total % well and Sick	100%	0%	100%	100%	100%	100%					
Total Missed Visits % of total visits	1.3%		8.3%	3.3%	2.4%	9.1%	6%	3%	1%	34%	19
Private Missed Visits % of total visits	0.0%		1.4%	1.3%	0.0%	1.3%	2%	1%	0%	13%	19
Medicaid Missed Visits % of total visits	0.0%		6.8%	2.1%	0.0%	7.8%	2%	0%	0%	16%	19
Overhead %	68.33%		65.21%	68.21%	67.48%	59.35%	68%	66%	56%	86%	18

Decoding Key Metrics: Average, Median, Min, Max

- **Average (Mean):** The average is calculated by adding up all the numbers in a set of values, and then dividing by the count of the values. It represents the central value of the data set.

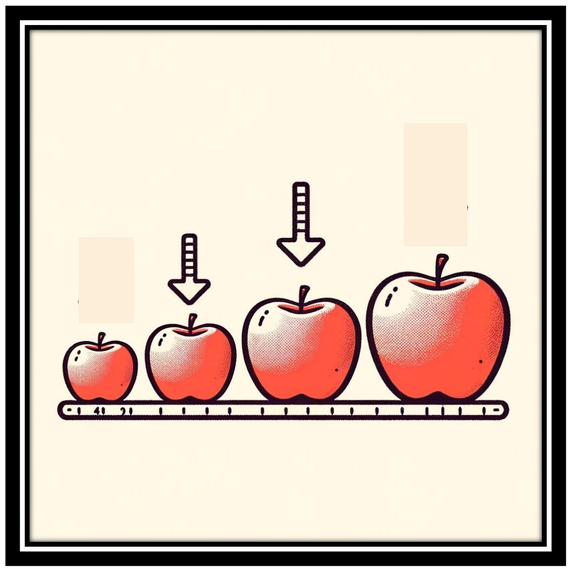
- **Median:** The median is the middle value in a list of numbers sorted in ascending or descending order. If there is an even number of observations, it is the average of the two middle numbers. The median is a useful measure of the center that is not skewed by outliers.

- **Min (Minimum):** The minimum is the smallest number in a set of valu
  It represents the lowest point or the least value in the dataset.

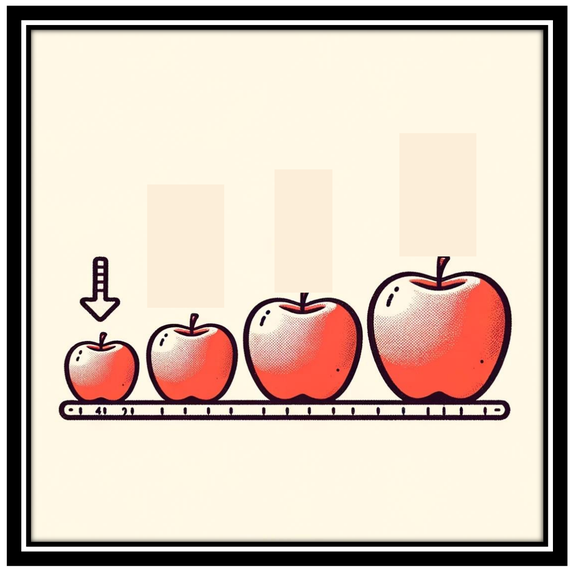
- **Max (Maximum):** The maximum is the largest number in a set of valu
  It respresents the highest point or the greatest values in the dataset.

Metrics by Apples

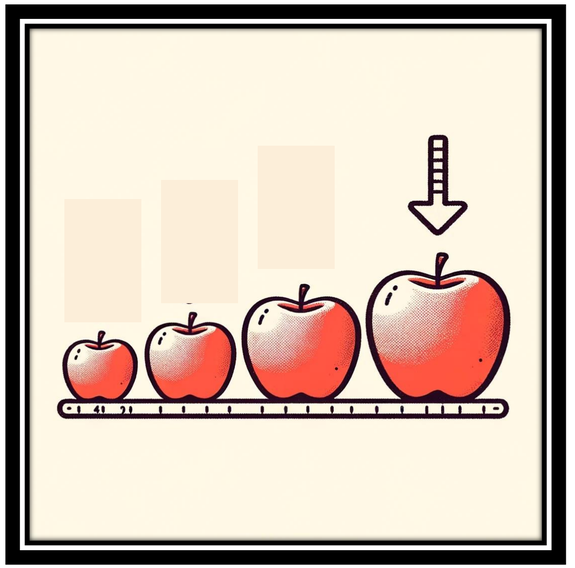
Average



Median



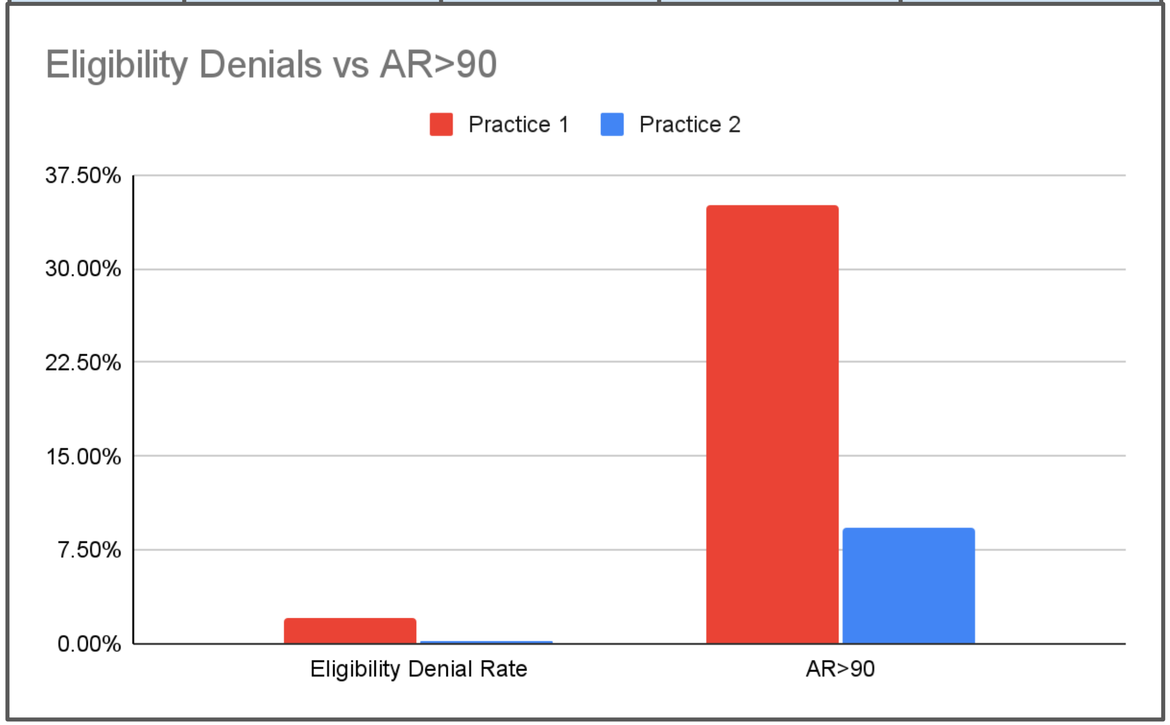
Min



Max

Benchmarking: Similar Comparison

	Eligibility Denials (Mthly)	Eligibility Denial Rate	AR>90	Days in AR
Practice 1	$6,020	2%	35.07%	17.53
Practice 2	$516	0.15%	9.30%	11.89



- **Geographical and Regionally similar**
  ➔Georgia
- **Practice Size**
  ➔3-5 providers
- **Similar Payer Mix**
  ➔40% MCD
- **Same Date Range**
  ➔January 2023 to July 2023

KHF Report: Comparing Blind # 2 & Blind & # 8

Staffing						
Blind #	1	2	3	7	8	
# FTE Providers	17.09	7.88	1.28	1.13	5.13	
Staff per Provider Ratio	2.98	4.09	4.33	3.56	5.46	
Accounts Receivable						
TOTAL DAYS IN A/R						
0-30 days	72%	85%		50%	64%	
31-60 days	15%	6%		22%	19%	
61-90 days	6%	4%		14%	8%	
91-120 days	4%	2%		4%	10%	
120+ days	2%	3%		10%	0%	
Total	100%	100%		100%	100%	
Days in AR	9.91	22.26		34.17	13.30	
Practices with 25% Medicaid or less only	9.91	22.26	-		13.30	
Revenue and Charges						
Revenue per Visit	$ 220.80	$ 182.31		$ 207.34	$ 172.92	$
Practices with 25% Medicaid or less only	$220.80	$182.31			$172.92	
Practices over 25% Medicaid only				$207.34		
Charge per Visit	$ 282.99	$ 213.27		$ 239.13	$ 258.70	$
Average Charges per Provider	$1,249,051	$1,235,622		$1,006,048	$2,359,327	
Overhead %	55.97%	68.33%		59.35%	58.90%	
Payor Mix						
Total % Medicaid (Medicaid + CMOs)	7.4%	2.0%	47.7%	53.0%	0.0%	
Practice % Aetna/Coventry	14.76%	18.08%	7.1%	4.04%	23.1%	
Practice % Cigna	12.22%	13.03%	6.4%	6.28%	15.9%	
Practice % UHC	12.41%	14.01%	7.4%	11.94%	19.5%	
Practice % BCBS	40.32%	26.82%	25.5%	20.94%	34.3%	
Practice % Humana	3.96%	2.06%	0.7%	1.99%	3.6%	
Practice % Other Payors	8.97%	23.96%	5.4%	1.37%	0.9%	

Comparison & Analysis

- Blind #8 has a higher percentage of AR in the 0-30 days range than Blind #2, which indicates that Blind #8 may be more efficient in collecting payments quickly.
- Blind #2 has a smaller percentage of AR over 120 days compared to Blind #8, suggesting better long-term collection processes or potentially less challenging accounts.
- The total AR days are significantly lower for Blind #8 (13.30) compared to Blind #2 (22.26), which shows that Blind #8 processes their receivables faster.

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Comparison & Analysis

- Revenue per visit is higher for Blind #2 than for Blind #8, which could be due to a variety of factors including the types of services provided, patient demographics, or insurance reimbursement rates.
- The charge per visit is also higher for Blind #2, which may correlate with the higher revenue per visit.
- Blind #8 has significantly higher average charges per provider, which could indicate a larger volume of services provided or higher charging rates for services.

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- Blind #8 has significantly higher average charges per provider, which could indicate a larger volume of services provided or higher charging rates for services.
- Blind #2 has a higher overhead percentage than Blind #8, which could mean that Blind #2 has higher operating costs relative to its revenue.

Q & A

Thank You! Let's Connect!

Alisa Vaughn, CMPE

Senior VP Operations @ Office Practicum | CMPE

Office Practicum™

The OP Way

Providing inter-connected care that empowers practitioners and patients by providing **transformational, innovative, stable, market driven solutions.**

Our Mission:

It's Time to Innovate Health