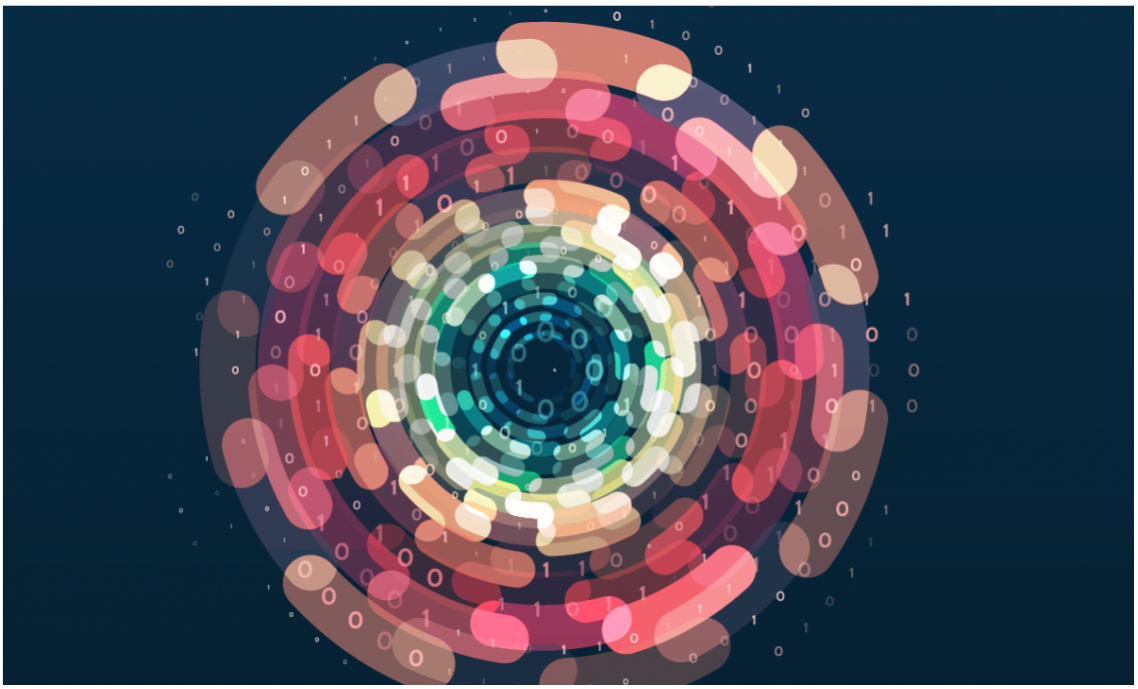
Data Before Drama



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How many times have you heard sentiments from colleagues, administrators, employees – and perhaps yourself – describing your practice? When it comes to the business of a medical practice, we often rely on anecdotal evidence to manage:

> *If appointment lead times are rising or patients are being turned away, our response is: "Well, we're just too busy…"*
>
> *If patient or employee experience is suffering, our response is: "She [referring to a patient or employee] is just crazy…"*
>
> *If collections are dropping, our response is: "It's just Medicaid; they are the worst…"*
>
> *If the fill rate of our schedule is declining, our response is: "If only patients would show up…"*

In a world where you use evidence to make decisions about caring for patients, it's surprising to consider the lack of rigor related to managing the business of medicine.

Anecdotes often serve as the basis for decision-making. The deficiency of evidence may result in determinations that hinder the practice.

In management, data are evidence – and they can prevent the drama that adversely affects many medical practices.

While this list is not exhaustive, it provides a foundation to build your practice's management metrics to avoid problems that ensue from a failure to understand an opportunity.

Demand:

- Measure patient requests – fulfilled and unfilled, including inbound phones, faxes, and electronic referrals.
- Keep tabs on the oldest outstanding request and the volume.
- Track the new patient requests separately; this is particularly important for specialists.
- Recognize that the longer the lead time for appointments, the lower the attendance rate. That results in reduced volume, unless well-managed.

Supply:

- Monitor the minutes or slots available for patient care, ideally establishing a fair (equal) expectation for available capacity if there is more than one provider.
- Measure, also, the weeks worked, as time is the practice's most precious asset. Use data related to availability of provider appointments to determine how much demand (new and established patients) can be accommodated. This may inform your practice's protocols about limiting or closing patient panels, as applicable. (See below section regarding patient panels for primary care.)

Receivables:

- Our business model centers on collecting based on accounts receivable, not sales.
- Identify days in receivables outstanding and the aging of receivables.
- Also watch for the *inputs*: payer mix (and shifts), production (relative value units and volume), denials (volume and type), and services (CPT codes).
- Further, be sure to account for the revenue cycle nuances that have a substantial impact on data. For example, credit balances offset accounts receivable and should be accounted for on billing reports.
- Further, receivables sent to a collection agency should be written off the books and tracked using a write-off adjustment code. Changing protocols related to collections, therefore, can significantly impact the data.

Experience: It's challenging to gather data about the experience of stakeholders, but that doesn't mean that we shouldn't try.

- Capture patient experience through simple, one-question post-call and/or post-visit

survey (for example, “Using a scale of 0 to 10 where 10 is Very Likely: how likely are you to recommend the practice to a friend or family member?” See sidebar on “Net Promoter Score.”).
- Administer the survey yourself – or look for a vendor that can support the capture and delivery of *timely*
- Consider a suggestion box (physical or email); although it can be painful, scan your online reviews to understand patients’ views of your practice. If you spot a bad review aimed at another business (which happens often), follow steps to report it. (Instructions outlined here.)
- Have postcards ready with directions to post an online review – proactively give one to any patient who offers a compliment; ask them to share their praise with their community. Although not every patient will, this small step builds a positive online reputation and costs very little.
- Your team is another guidepost for experience – listen during staff assemblies, hold 1:1 meetings with your employees (and ask for feedback about the practice), and always perform exit interviews.
- For specialty practices, identify your top-ten referral sources – meet (at least once per annum) and listen to their feedback.

Given the complexity of a medical practice, analytics may vary based on how data are run. Therefore, establish a dashboard, agree on definitions (inclusion and exclusion criteria, as well as timing), and allow self-service viewing for your team. Sit down with every employee in a management role, share the dashboard, and provide examples of how data can be useful. During meetings, ask your team to share evidence – and use it yourself for management decision-making.

Data can – and should - prevent drama!

What is a Patient Panel?

A patient panel is the cohort of patients under a primary care physician's care, including direct in-person or virtual encounters and the associated indirect, non-visit work. The latter includes everything from preventive and chronic care management to messages and refills. The calculation of a patient panel focuses on attribution. Sum the number of unique patients seen within the past three years.[1] Next, adjust for acuity and complexity. For this step, consider guidance from industry experts like researchers from the University of Wisconsin's Department of Family Medicine or Dr. Mark Murray, who co-authored several articles about the topic, including "The Right-Sized Patient Panel: A Practical Way to Make Adjustments for Acuity and Complexity."[2] Increasingly, patient panels are managed via a care team approach – a physician joined by a nurse practitioner, for example. In this case, the calculations are made for the pair. The notion of a "perfect" panel size is elusive, although many believe that number is between 1,500 and 2,500 patients per provider. Most importantly, the panel should be a size in which the physician, provider, and/or care team can effectively and efficiently deliver quality primary care.

[1] The calculation may be 12, 18, or 24 months; there is no industry standard.

[2] Weber, R. MS, & Murray, M. MD, MPA (2019, November/December). The Right-Sized Patient Panel: A Practical Way to Make Adjustments for Acuity and Complexity. *Family Practice Management, 26*(6), 23-29.