Databender

FREE GUIDE

PE Portfolio Operations

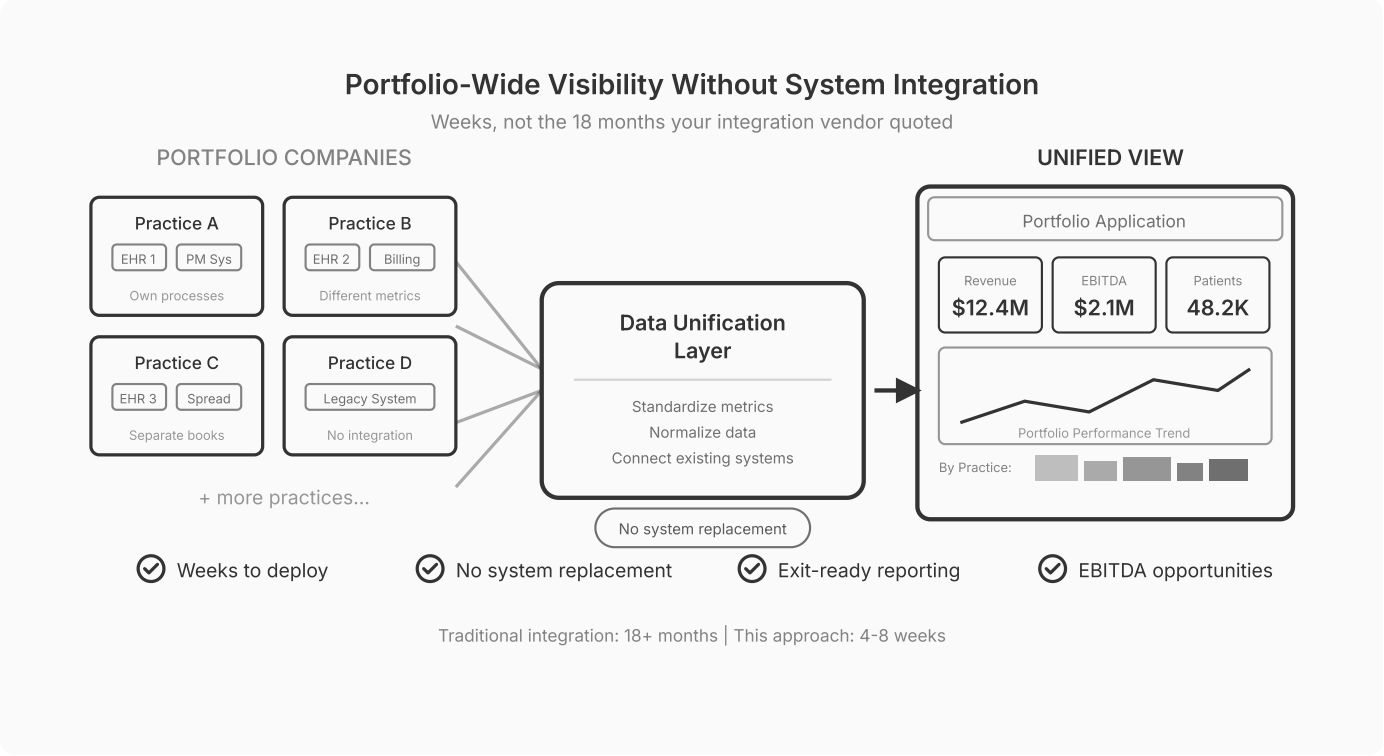
Portfolio-Wide Visibility Without the 18-Month Integration

databender.co | Data & AI Consulting for Growing Businesses

Weeks

Not 18 Months

Get unified portfolio visibility in weeks, not the typical 18-month integration timeline.



You closed on five practices in 18 months. Now you have five sets of books, five PM systems, five versions of "we do it this way," and no consolidated view of anything.

The integration vendor quoted 18 months and $2 million to standardize systems. Meanwhile, your LPs want portfolio-level reporting. Your operating partners want to know which locations are underperforming. Your CFO wants to close the books without a two-week reconciliation nightmare.

Everyone's waiting. Nothing's moving.

The Integration Trap

Traditional healthcare IT playbooks say standardize first, then optimize. Pick one PM system. Migrate everyone. Build unified reporting on the standard platform.

The logic makes sense on paper. In practice, it breaks down.

Migration projects take 12-24 months per platform. Staff resist change, especially clinical staff who've used the same system for years. Training time pulls people away from patient care. Data migration errors create billing problems that take months to resolve.

One PE-backed dental group spent $3.4 million and 30 months migrating five acquisitions to a single PM system. By the time they finished, they'd acquired three more practices running different systems. The goal post moved faster than they could reach it.

Meanwhile, the holding period clock ticks. Three years in, and you still can't produce a consolidated P&L that your board trusts.

A Different Approach

What if you didn't need system standardization to get portfolio visibility?

Data extraction is cheap. Every PM system exports data. eClinicalWorks, Athena, ModMed, DrChrono, AdvancedMD. Different formats, different field names, different data models. But the underlying information exists.

The insight is simple: unify the data, not the systems.

Build a data layer that pulls from each practice's existing systems. Map fields to common definitions. Calculate standardized metrics. Generate consolidated reporting. Leave the operational systems alone.

Practices keep running what they know. Your central team gets the visibility they need. Nobody spends 18 months on a migration that might not finish before the exit.

What Unified Visibility Actually Means

Portfolio visibility sounds abstract until you see what it enables.

Revenue per provider comparison. Which physicians generate $800K annually and which generate $400K? What's driving the difference? Case mix? Coding patterns? Collection rates? You can't answer these questions when data lives in five disconnected systems.

Payer mix analysis across the portfolio. One practice might be 60% Medicare with 18% denial rates. Another might be 40% commercial with 8% denials. Seeing both in one view reveals optimization opportunities that practice-by-practice analysis misses.

Operational benchmarking. What's the average days in AR for each location? Which practices have collection rates above 95% and what are they doing differently? Benchmarking requires comparable data, which requires a unified data layer.

Expense normalization. Comparing costs across practices is nearly impossible when each reports differently. One practice capitalizes equipment; another expenses it. One codes supplies one way; another uses different categories. Normalization reveals actual performance.

EBITDA Opportunities Hiding in Your Data

PE healthcare investments live and die on EBITDA improvement. Most platforms leave money on the table because they can't see where it's hiding.

Revenue cycle leakage. Denial patterns, write-off trends, collection rate variance. One 15-location dermatology group found $1.8 million in annual revenue leakage by standardizing their view of denials. Three practices had denial rates twice the portfolio average, all tied to the same coding

errors.

Staffing inefficiencies. Support staff ratios vary wildly across practices. Some run lean and efficient. Others carry headcount that accumulated over years of passive growth. Without standardized productivity metrics, you can't see the gap.

Procurement fragmentation. Five practices buying from five suppliers at five different prices. Consolidation opportunities exist, but only if you can see what everyone's spending.

Underpriced services. Fee schedules drift. One practice negotiated payer contracts in 2019 and never updated them. Another reprices annually. The spread between best and worst rates on the same procedure can run 30-40%.

None of this is visible without unified data.

What Buyers Actually Want

Exit-ready reporting isn't the same as management reporting. Buyers have specific expectations.

Normalized EBITDA with clear add-backs. Your internal reports might include owner compensation or one-time costs. Buyers want to see the normalized number with documentation for every adjustment. That requires consistent categorization across the portfolio.

Same-store growth metrics. Which growth came from acquisitions and which came from organic improvement? Buyers pay different multiples for each. Demonstrating organic growth requires baseline data you probably didn't capture carefully when you bought the practice.

Cohort analysis by acquisition date. How did practices perform pre-acquisition versus post? What operational improvements drove margin expansion? This story matters to buyers, but it requires historical data organized consistently.

Quality metrics that stand up to scrutiny. Healthcare buyers increasingly care about outcomes. Patient satisfaction, complication rates, clinical quality measures. If you can't report these at the portfolio level, you're at a disadvantage.

Building exit-ready reporting in the six months before a sale is painful. Starting two years out is smart. Starting at acquisition is ideal.

The Technical Reality

Unified data layers aren't magic. They require real work. Understanding what's involved helps set expectations.

Data extraction. Each PM system needs a connection. APIs exist for most modern systems. Legacy systems might require database extracts or file transfers. Some vendors resist external data access. Plan for vendor negotiations.

Schema mapping. "Revenue" in one system might include adjustments. In another, it's gross charges. Mapping requires understanding what each field actually contains, not just what it's labeled.

Refresh frequency. Daily updates suffice for most operational reporting. Near-real-time matters for some use cases. Batch nightly processing is simpler and cheaper. Match frequency to actual needs.

Data quality. Practices enter data inconsistently. Procedure codes get miscategorized. Dates get fat-fingered. A data layer doesn't fix garbage in; it just centralizes the garbage. Quality improvement has to happen at the source.

Ongoing maintenance. PM systems update. New practices get acquired. Definitions change. Someone needs to own the data layer long-term.

What to Prioritize First

You can't unify everything at once. Start where the value concentrates.

Financial reporting comes first. Revenue, expenses, AR, collections. This is what boards and LPs care about. Get this right before expanding scope.

Provider productivity comes second. Visits, procedures, revenue per provider. This drives most operational improvement initiatives.

Revenue cycle metrics come third. Denial rates, days in AR, collection rates. Once you have financial data flowing, these metrics become calculable.

Clinical metrics come last. Quality measures, patient outcomes, satisfaction scores. Important but less urgent than financial visibility.

Resist the temptation to boil the ocean. A working financial data layer in 60 days beats a complete solution in 18 months.

Build vs. Buy

You can build this yourself. You can also buy it. Trade-offs exist either way.

Building in-house gives you control and customization. It also requires technical talent, ongoing maintenance commitment, and time. Most PE platforms don't have dedicated data engineering teams. Building one to solve this problem is expensive.

Healthcare-specific platforms exist for this exact use case. They've already solved the extraction and mapping problems for common PM systems. Implementation is faster. But you're dependent on their roadmap and their data model might not match your needs exactly.

General BI tools with healthcare connectors offer flexibility at the cost of configuration effort. They're not turnkey, but they're also not locked into healthcare-specific limitations.

The right answer depends on your team's capabilities, your timeline, and how much customization you need. For most PE platforms, speed matters more than perfection. Buy something that works and customize later.

Change Management Isn't Optional

Technology is the easy part. Getting people to use it is hard.

Practice administrators have their own reports, their own metrics, their own ways of measuring performance. A central data layer threatens local autonomy. People resist.

Start with problems they care about. An administrator struggling with AR aging gets interested in a tool that shows collection patterns by payer. Frame unified reporting as helping them do their jobs, not surveilling them.

Involve practice leaders in metric definition. When someone helps create a benchmark, they're more likely to trust it. When it's imposed from above, they'll find reasons why their practice is different.

Celebrate wins visibly. When unified data reveals an improvement opportunity and a practice captures it, tell that story. Success breeds adoption.

Timeline Expectations

Realistic timelines for a 10-practice portfolio:

Weeks 1-4: Data source inventory, connection setup, initial extraction testing. Expect surprises. Some systems will be harder to access than expected.

Weeks 5-8: Schema mapping, data quality assessment, metric definition. This is where the real work happens. Rushing this phase creates problems downstream.

Weeks 9-12: Dashboard build, validation with finance team, refinement based on feedback. The first version will be wrong. Plan for iterations.

Months 4-6: Rollout to practice administrators, training, adoption support. Technology is live but not yet trusted. This phase determines whether it sticks.

Three months to first useful dashboard. Six months to broad adoption. Compare that to 18 months for system migration.

The Long Game

Unified data isn't just about the current hold period. It's about building a platform.

Each acquisition gets easier when you have a proven integration playbook. New practice joins the portfolio, data connection gets established, they appear in consolidated reporting within weeks. That operational maturity matters to buyers.

The data layer becomes infrastructure. Operational initiatives, growth strategies, and M&A due diligence all run faster when you can see clearly. The investment pays dividends across everything you do.

And when it's time to exit, you're not scrambling to build the reports buyers want. You're showing them data you've been using to run the business for years. That credibility gap closes sales.

> *Running a PE-backed healthcare platform? Let's talk about portfolio visibility or explore our healthcare solutions.*