Practice Efficiency and Practice Quality: Flip Sides of the Same Coin

Medical practice efficiency is most often measured in terms of overhead ratios, effectiveness ratio, and various staff productivity ratios. However, the quality of care delivered to patients is also directly affected by efficiency.

David Fryefield, MD

Oncologist David Fryefield, MD, medical director at Willamette Valley Cancer Center, Eugene, OR, puts it this way: “Efficiency and quality are flip sides of the same coin. If you can create processes that are very efficient, the quality will go up and errors will go down.”

If you are just starting your career, or considering a practice move, ask if the practice has data on some of the efficiency measures

described in this article. Most important, find out if the practice is paying attention to efficiency: What areas are being monitored? Is there a team approach to improvement? How are reports distributed and used?

Fryefield comments, “It’s difficult to practice oncology today, and it’s going to get harder. If I’m a new doctor looking at a practice, and I know that the practice is willing to examine and measure the way it delivers care and find[s] ways to make it more efficient and make the patient experience better, that would be a practice I’m interested in.”

The pressures in health care—from managed care and workforce shortages to public scrutiny and reimbursement reductions—make monitoring practice efficiency critical. Oncology practice consultant Elaine L. Towle, CMPE, says simply, “Efficiency is essential to the survival of an oncology practice, given the current environment of decreasing revenues and escalating costs.” Towle has more than 25 years experience as a practice administrator and is now director of consulting services for Oncology Metrics, a Fort Worth, TX-based firm that provides data services to the oncology community. She developed the course *Generating Practice Efficiencies* that is part of the ASCO Practice Management Curriculum and is a member of the *Journal of Oncology Practice* (JOP) Editorial board.

How Can You Measure Efficiency?

Collecting and analyzing data are essential first steps in improving efficiency. You can then compare your findings to data from similar practices. This process, called

benchmarking, can help you evaluate specific areas of practice and determine how your performance measures up.

Benchmarking

Benchmarking can be done informally by gathering information about practice specifics through conversations or email groups with colleagues. A more reliable and refined way to measure your practice performance is by using a published standard or data compiled from a formal survey of a number of practices.

Last year, JOP published oncology-specific benchmarks derived from a survey conducted by Onmark (San Francisco, CA) of practices throughout the United States.^{1,2} Some of the key practice indicators reported in the survey are the number of different types of staff per full-time equivalent (FTE) physician, number of treatment chairs per FTE chemotherapy nurse and per FTE physician, number of days for bills to be collected, the cost of drugs per FTE physician, and the percentage of revenue derived from different sources, such as drugs, laboratory, and evaluation and management services. Data were reported for the 25th, 50th, and 75th percentile, in addition to the mean for all practices.

As an example, the Onmark survey showed that the median number of new patients per oncologist in 2006 was 343. You can calculate the number of new patients per FTE physician in your practice and compare it with this benchmark as a starting point for analyzing efficiencies, monitoring performance, and setting goals.

In using numbers from benchmarking sources, be sure you’re comparing apples to apples. For instance, some data on medical practices may vary by geographic region. Your staff costs might be higher than others, not because you’re overstaffed, but because you practice in a tight labor market. And remember that a variance from a benchmark does not in itself mean poor performance: There is no “ideal number.” Keep in mind the nature of your patient population, the physicians’ practice styles, and the goals and priorities of the practice. If possible, use more than one source for benchmark data (see box for some sources of benchmark data, in addition to the articles cited in JOP).

Measuring your own practice performance over time is one of the best sources of comparative data. For example, specific expenses, from transcription costs to latex gloves, and revenue by payer are data that can give you meaningful trends. Compare findings over appropriate intervals, such as every

Sources for Benchmarking Data

- *Performance and Practices of Successful Medical Groups*, published by the Medical Group Management Association: www.mgma.com/surveys or call 877-275-6462.
- *Practice Management Check up*, published by the American College of Physicians: www.acponline.org/pmc/new_checkup.htm.
- *Physician Socioeconomic Statistics*, published by the American Medical Association: www.ama-assn.org/physinfo/products.htm or call 800-621-8335.

quarter or every year. Such data are also useful in comparing performance measures at different practice sites.

Examine Internal Processes

Qualitative data and logistics are important, too. In analyzing overall patient flow, Towle says that she walks through the clinic as if she were a patient. Studying your practice from the patient's point of view is key to keeping the patient at the center of your efforts to improve efficiency.

Patient waiting times are a critical measurement. Reporting on a pilot study he worked on with US Oncology, Inc (Houston, TX), Fryfield says that "at times patients were waiting for more than half of the time they were in the clinic." Fryfield chairs the Practice Quality and Efficiency program initiated in 2006 by US Oncology. He comments that he was initially somewhat taken aback and even embarrassed by this finding about patient waits, but he has learned it is not unusual. When he has given talks to groups, physicians and administrators have said to him, "Oh, yeah, we've got that problem, too." Keep in mind that improvement can't begin without objectively measuring what's going on and being willing to take action.

Patient Satisfaction

Patient satisfaction is another measure of practice quality and efficiency. Fryfield defines efficiency as "first and foremost having the patient experience be as smooth a process as possible, where the right things happen in a timely fashion."

To measure this efficiency indicator, Fryfield underscores the importance of gathering feedback from patients *regularly* and *systematically*. US Oncology now surveys randomly selected patients each month and reports the results quarterly so that trends can be seen. With a rueful laugh Fryfield contrasts this to a survey his practice conducted 4 years ago with the vague idea of "doing it again sometime."

Even without a regular survey, take time to critically examine the "customer service" aspects of your practice. Is your reception area inviting and meticulously clean? Are current reading material and relevant patient education material

provided? How hard is it for patients to reach a live person on the phone, including during lunch hours, evenings, and weekends?

Key Areas of Efficiency and Quality

Towle finds that the priority areas to examine for oncology practice are pharmaceutical management, appropriate staff numbers and responsibilities, laboratory processing, physician efficiency, and medical records.

Fryfield stresses that each practice must find its own efficiency problems to tackle. "Some focus on the lab; some focus on chemotherapy scheduling. Every practice has found something to look at and has found its own solutions."

Pharmaceutical Management

Pharmaceutical management is especially critical to monitor in oncology practices because it is the single largest expense area. In the Onmark 2006 survey, drug costs represented approximately 65% of total practice costs. Inventory management, purchasing contracts, use of drugs, and mixing chemotherapy are all important components of efficiency in pharmaceutical management.

"Before MMA (the 2003 Medicare Prescription Drug, Modernization, and Improvement Act), many of us kept 10 days' to 2 weeks' of inventory on hand," Towle says. "We convinced ourselves we had to do that. But you can't afford to keep inventory on the shelves and not use it. Most practices have cut back to 3 to 5 days of inventory. It's quite unusual to treat a chemotherapy patient emergently, and most practices can get any drug they need in 24 hours."

Unexplained loss of inventory—which may be the result of physical loss, undocumented waste, or charge capture loss—must be carefully examined. To minimize this inventory "shrinkage," Towle advises daily charge capture audits and regularly monitoring inventory levels.

Drug purchasing contracts should be aggressively negotiated to get the best available prices, making sure that you are not paying more than the amount reimbursed under MMA's average sales price. Moreover, because reimbursement amounts under average sales price can change every quarter, contracts for drugs should be reviewed quarterly and may need to be negotiated more than once a year.

Adding new drugs to the practice formulary should not be an ad hoc process. "In the old days, if a new drug was announced at the ASCO Annual Meeting, someone would come home from the meeting and start using it," recalls Towle. "But those days are gone," she says. When adding new drugs to the practice inventory or formulary, a practice should have a methodical process in place that includes consideration of the cost, the payers' coverage policies, and reimbursement.

When joining a new practice, you may find different drugs in the formulary from what you are accustomed to using. Perhaps your academic center pioneered the development of a certain treatment that you would like to introduce. This may represent an opportunity to suggest a change that improves care. When suggesting an addition to the practice formulary, be aware that the discussion will include financial, as well as clinical, considerations.

Practices can also add efficiency by standardizing approaches to therapy. Standardization improves both pharmacy and nursing efficiency. "It really helps the staff to know how patients will be treated, regardless of which doctor writes the order," Towle notes. To gain efficiencies from standardization, she suggests starting with discussions of hydration and antiemetics, and then addressing treatments for specific cancer diagnoses.

Staff and Physician Responsibilities

The skills and expertise of all staff should be appropriately used for maximum efficiency. Periodically analyze routine tasks, looking at who does what, how it is done, and whether anyone else can do it. For example, it is ineffective for nurses to routinely have responsibility for tasks such as filing, monitoring vital signs, or handling precertifications and authorizations. Medical assistants and administrative staff can be used to ensure that nurses are free to perform more direct patient care functions, including patient education, counseling, and phone triage.

Noting that new patients drive practice growth and are key to the economic prosperity of oncology practice, Towle says, "If you get a call from a consultant to refer a patient, the physician must be available to see the patient right away." Thus, making sure physicians can function efficiently must be a priority. "You don't want physicians to have to search for that CT [computed tomography] scan that should be in the chart. Or to go in an exam room and not be able to find the gloves they need. And someone else should be making the prescription refill calls."

Effective use of midlevel providers (nurse practitioners, physician assistants, or clinical nurse specialists) is one staffing approach that can increase patient volume at a lesser expense than adding a physician. Benchmarking data from the Onmark survey showed that the average number of new patients for oncology practices with midlevel providers in 2006 was 436, compared with 266 for practices without midlevel providers.² In the November 2006 issue of *JOP*, nurse practitioner Tina Maluso-Bolton offers a full discussion of dos and don'ts for successfully integrating advanced practice clinicians into an oncology practice.³

The oncologist's role in the care of hospital inpatients is another area of physician efficiency to examine. Many oncologists find that inpatient duties are the least efficient part of their duties, but they recognize that the hospital is a

continuing source of patient referrals. Use of a hospitalist service, hiring a physician to assume primary rounding duties, rotating rounding duties among oncologists within the practice, and using a midlevel provider to see hospital inpatients are all potential strategies to maximize the oncologist's productive office time.⁴

Practice efficiency is not all about using other staff to make the doctor efficient, however. Noting that the traditional perspective has been doctor-centric, Fryfield makes the point that everyone has an essential role, and physicians themselves must do everything they can to make the practice efficient. As an example, he asks, "How often is the order complete when the nurse is ready to give therapy? We found it wasn't 100%, resulting in the nurse having to go back to the doctor, who might be making rounds. So then the nurse had to find the partner."

Fryfield stresses that a team culture must prevail to deliver better care. "It's a group activity—we're all there together to make things better." He draws an analogy: "Which is more important in driving a car, the brakes or the steering wheel? They're both essential." He adds that a fundamental tenet of a continuous quality improvement process is that it's blameless.

Laboratory Processing

The efficiency of the lab is an important part of patient flow and quality of care. Examine turnaround times, the flow of charts and reports, staffing, and processes used.

In his practice, Fryfield's analysis of the patient waiting time at each step of the clinic visit revealed that the lab received four to six patient charts at once from the receptionist, and then called patients in one at a time while the other patients waited. Understandably, the lab believed that more phlebotomists were needed to keep up with the patient load at peak times. "What was efficient for the receptionist was very inefficient for the lab," Fryfield comments. By making a few simple changes in how the lab was notified, his practice was able to reduce the peaks in patient flow.

This example demonstrates two important points, Fryfield notes. "First, everyone along a process can be making rational and efficient decisions, but the process as a whole does not work. Second, often only a few simple changes are needed to fix the problem." He emphasizes that studying and measuring the processes is essential to identify the inefficiencies.

The finances of laboratory services should also be carefully examined. Many oncology practices run their own laboratories and are happy simply to break even financially, in the interest of convenience to both patients and physicians. Don't be lulled into accepting the status quo, however. Look critically at the operation and make sure the lab is not operating in the red.

Consider the following suggestions for improving the cost effectiveness of the lab⁵:

- Reassess staffing requirements
- Obtain volume discounts for test materials
- Use automated technology
- Code appropriately to ensure blood-handling reimbursement

Medical Records

“One of the most inefficient areas in many practices is medical records,” Towle reports. Illustrating how record systems can affect efficiency, she describes the physician who opens Mrs Smith’s chart only to find that the most recent computed tomography scan is not there. So, the doctor steps out and asks the staff to track it down, then returns to the patient. A few minutes later, and even more frustrated, the physician again leaves the examining room to ask about the scan.

Both Towle and Fryefield think that switching to electronic medical records (EMRs) is an important, positive step for practices to take. “As payers become increasingly interested in looking at quality and having physicians report on quality measures, an EMR will allow practices to pull the needed data,” Towle comments. “Ultimately, payers will move to true pay for performance, and EMRs will be essential to practice success.”

Towle notes that an electronic records system eliminates the “unfiled CT scan” problem. Electronic records also eliminate the time spent simply trying to find a chart that has been pulled for some reason. She adds with a laugh that in the world of paper charts, HIPAA compliance has helped with this problem, “because at least charts don’t leave the facility—you don’t find them in the physician’s car anymore.”

Illegibility of handwritten notes and orders is another problem that can be eliminated with electronic record systems. As an example of problems caused by this, Towle points to one of the most serious, “when Dr Jones goes away, and a nurse practitioner or physician partner needs to care for someone but can’t decipher his notes.”

The use of a common template for orders and notes enhances practice efficiency. Again, this is an advantage of electronic systems. If your practice is not yet ready to switch to electronic records and order entry, use printed templates and forms for as much of the paper records system as possible. Fryefield observes that an EMR is “not an answer, it’s a tool. If you have bad processes in place, it’s not going to change

that.” He also points out that when you measure and analyze a process and begin to develop a solution, most of the time there is “both an electronic component and a people component.”

Look for Professional Help

Some practices will need professional consultation to analyze their efficiency and determine how to improve. As always in seeking outside advice, asking other oncologists for recommendations is a good way to find a consultant. Another resource is your hospital’s quality improvement department. “The hospital has people with expertise, and it’s reasonable that they might provide guidance about consultants and resources to use,” Fryefield offers. The Medical Group Management Association (www.mgma.com) is another source for referral to practice management consultants.

Towle offers these suggestions⁷ for what to look for in a practice efficiency consultant:

- Familiarity with oncology practice
- Experience working with practices of similar size and organization (eg, community *v* hospital-based)
- Experience with the areas that your practice has identified as your top three issues

You will get the best results if you are systematic in analyzing your practice efficiency. Most important, you must be disciplined in implementing and monitoring changes. Fryefield advises that a practice should expect to dedicate some resources to ongoing improvement. In his practice, which has three locations, eight medical oncologists, and four radiation oncologists, a nurse is devoted half time to this activity.

Asked to identify the biggest efficiency challenges he has seen since starting practice in 1984, Fryefield takes a broad view, while putting the importance of the challenge in perspective: “The practice of oncology has become so much more complex—more treatments, more drugs, more specialties involved, more staff, more patients. But the processes we use for providing care are often the same ones we’ve used for many years. Processes that might have been fine 15 to 20 years ago are completely inadequate today. The complexity of oncology practice is skyrocketing and pushing the specialty forward. We need to start looking at the way we deliver care.”

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References

1. Akscin J, Barr TR, Towle EL: Benchmarking practice operations: Results from a survey of office-based oncology practices. *J Oncol Pract* 3:9-12, 2007
2. Akscin J, Barr TR, Towle EL: Key practice indicators in office-based oncology practices: 2007 Report on 2006 data. *J Oncol Pract* 3:200-203, 2007
3. Maluso-Bolton T: Advanced practice clinicians. *J Oncol Pract* 2:289-293, 2006
4. Maximizing physician efficiency: Reaching a balance between inpatient hospital rounds and an office-based practice. *J Oncol Pract* 2:287-288, 2006
5. Pros and cons of outsourcing laboratory services. *J Oncol Pract* 2:162-163, 2006