Adapt and Optimize Your Staffing Model for Value-based Success

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The presenter has nothing to disclose.

Learning Objectives

1. Describe the important relationships between staffing, profitability, and performance
2. Interpret internal and external benchmark data to identify whether a practice has the right number and right skill mix of staff

Learning Objective 1

Describe the important relationships between staffing, profitability, and performance

Importance of Correct Staffing

Staff are the infrastructure and support for provider productivity

In order for your organization to optimize practice efficiency and profitability it needs the right staff with the right training, doing the right things

Optimizing Practice Staffing

What Can Happen with Too Few Staff

- Poor morale
- Staff turnover
- Increased risk of medical errors
- Poor patient experience
- Lower provider productivity
- Etc.

What Can Happen with Too Many Staff

- Poor morale
- Staff turnover
- Increased risk of medical errors
- Problematic service
- Higher staff costs
- Etc.

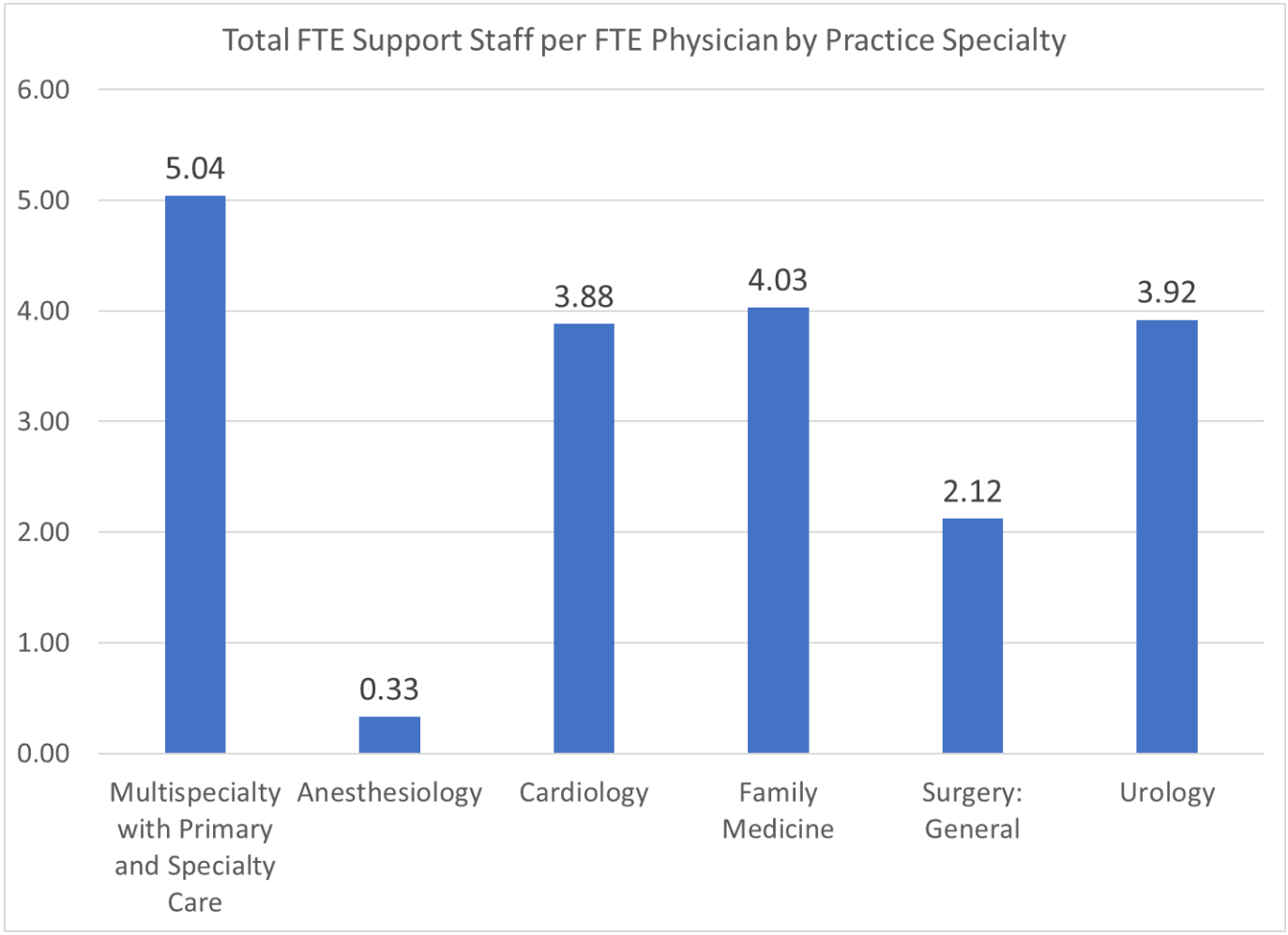
When Staff Support Is Suboptimal

- Limited provider support and lost productivity
- Physicians perform more non-clinical tasks
- Physician Work RVUs decline
- Slower room turnover
- Rushed cleaning and potential increase in infection
- Practice “closed” to new patients
- Patient satisfaction declines
- Poor patient experience
- Etc.

Finding the Right Staffing for Maximum Profitability

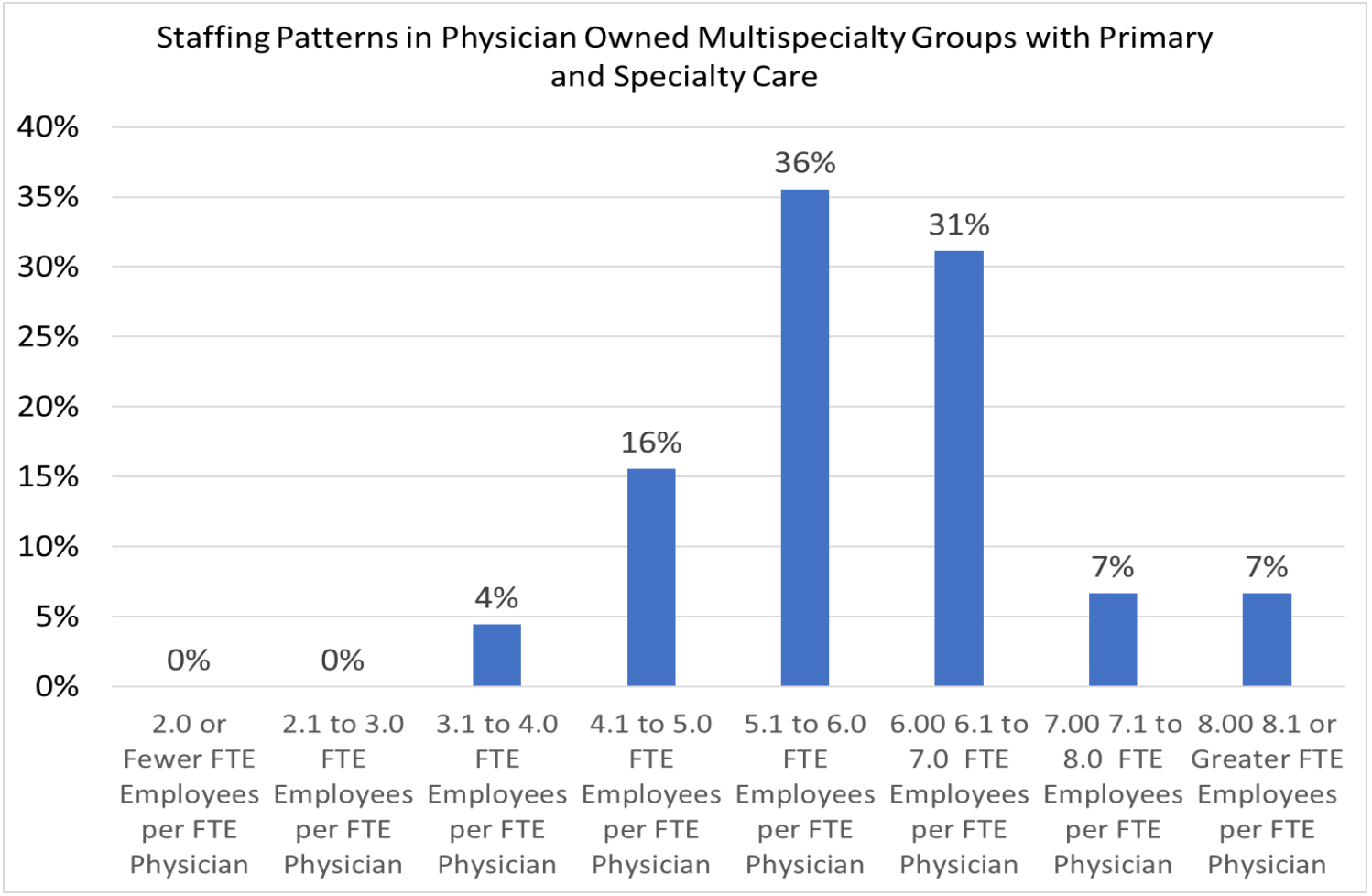
- Medical groups have different staffing levels
- Financial performance at various staffing levels reflects the ability of staff to facilitate production

Different Specialties Staff at Different Levels



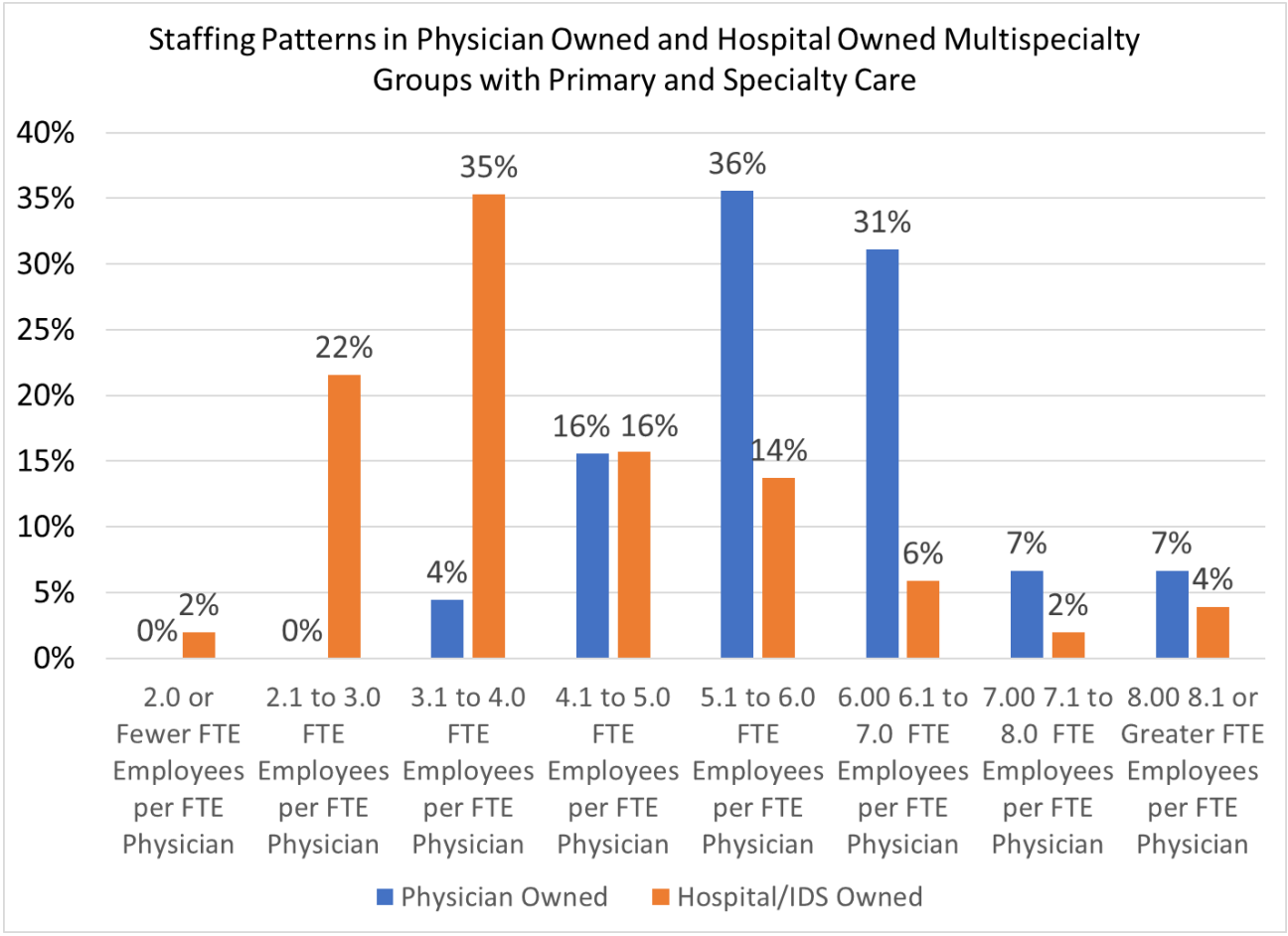
Source: DataDive for Cost and Revenue: 2018 Report Based on 2017 Data

Within a Specialty, Practices Staff at Different Levels



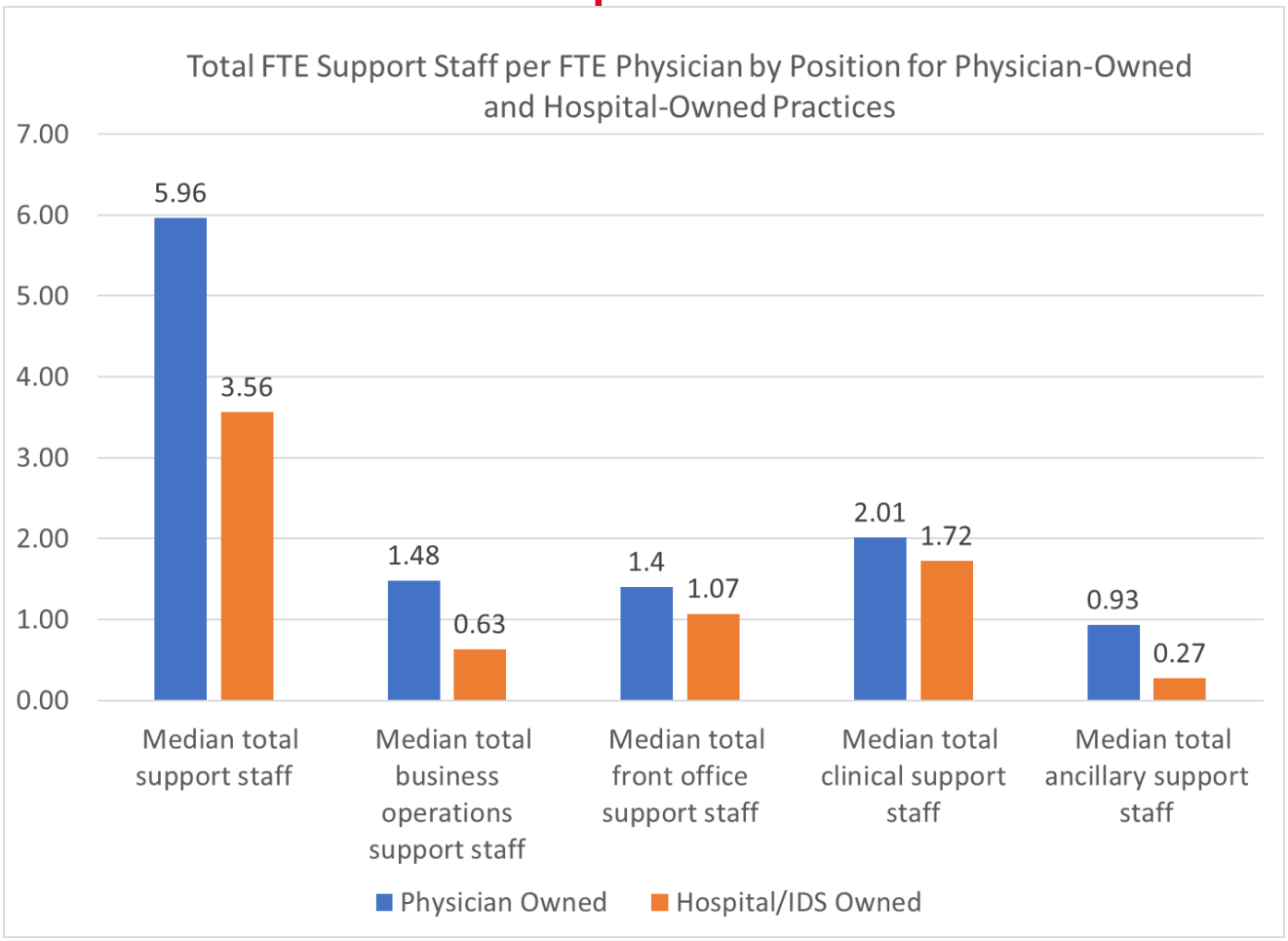
Source: DataDive for Cost and Revenue: 2018 Report Based on 2017 Data

Hospital and Physician Owned Groups Staff Differently



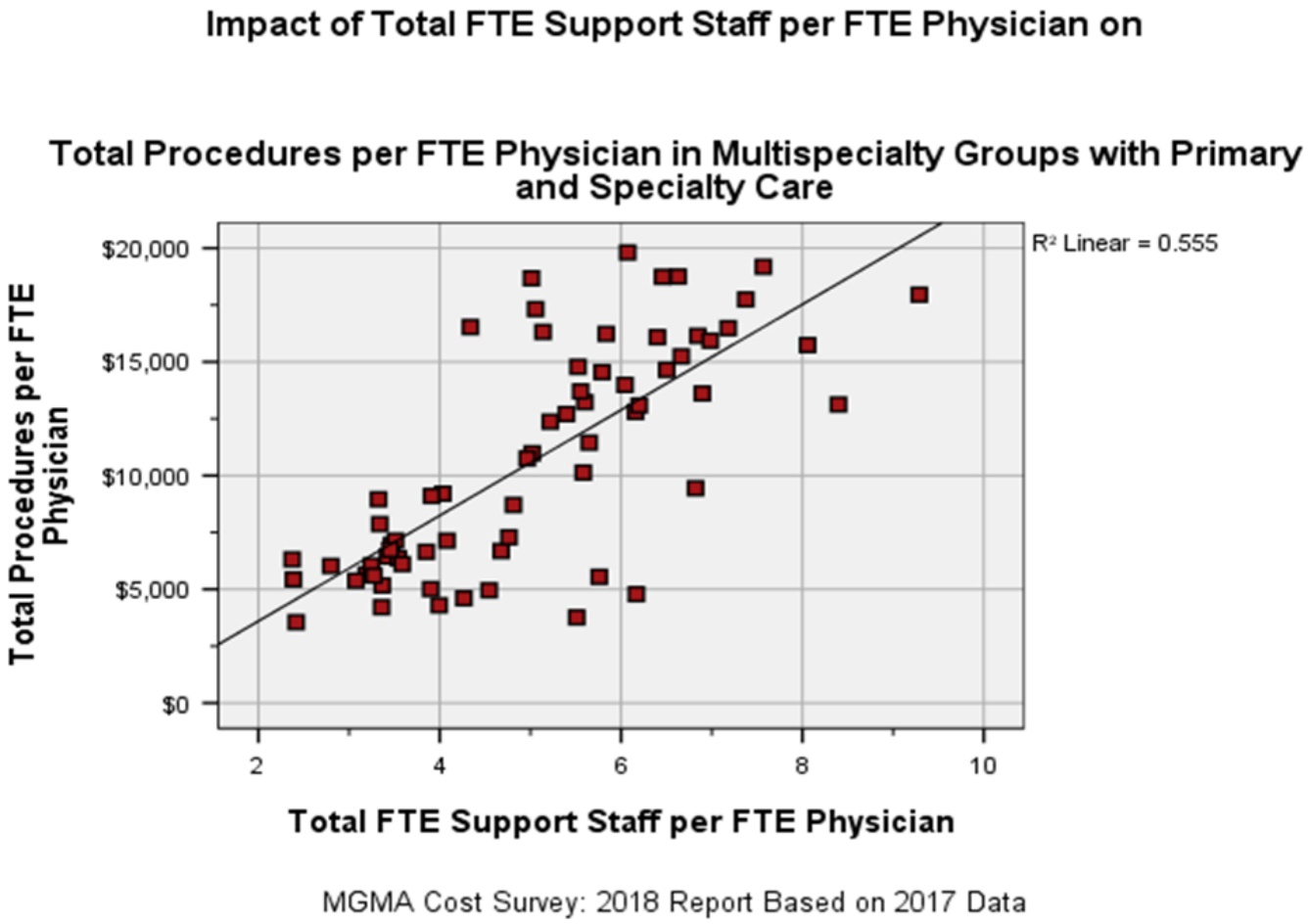
Source: DataDive for Cost and Revenue: 2018 Report Based on 2017 Data

Practice Ownership Changes Staffing Requirements



Source: DataDive for Cost and Revenue: 2018 Report Based on 2017 Data

How Staffing Relates to Productivity



MGMA Cost Survey: 2018 Report Based on 2017 Data

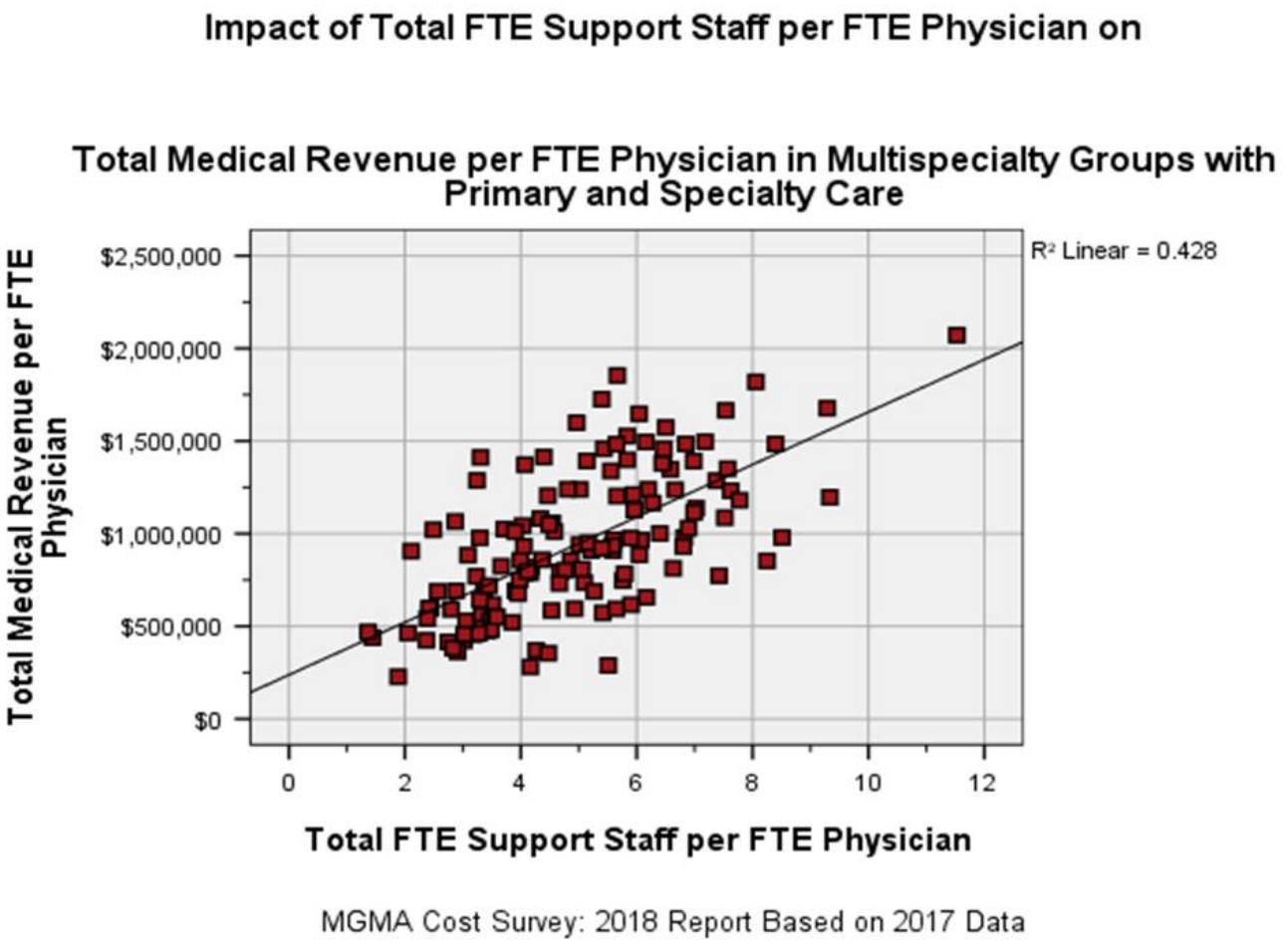
Effect of Staffing on Productivity

The data suggest:

As the number of support staff per FTE physician increases, there is an increase in the total number of procedures

The variance in the number of procedures at the same staffing level suggests there are substantial differences in the staffing model, staff functions, and medical group processes

How Staffing Relates to Total Medical Revenue



MGMA Cost Survey: 2018 Report Based on 2017 Data

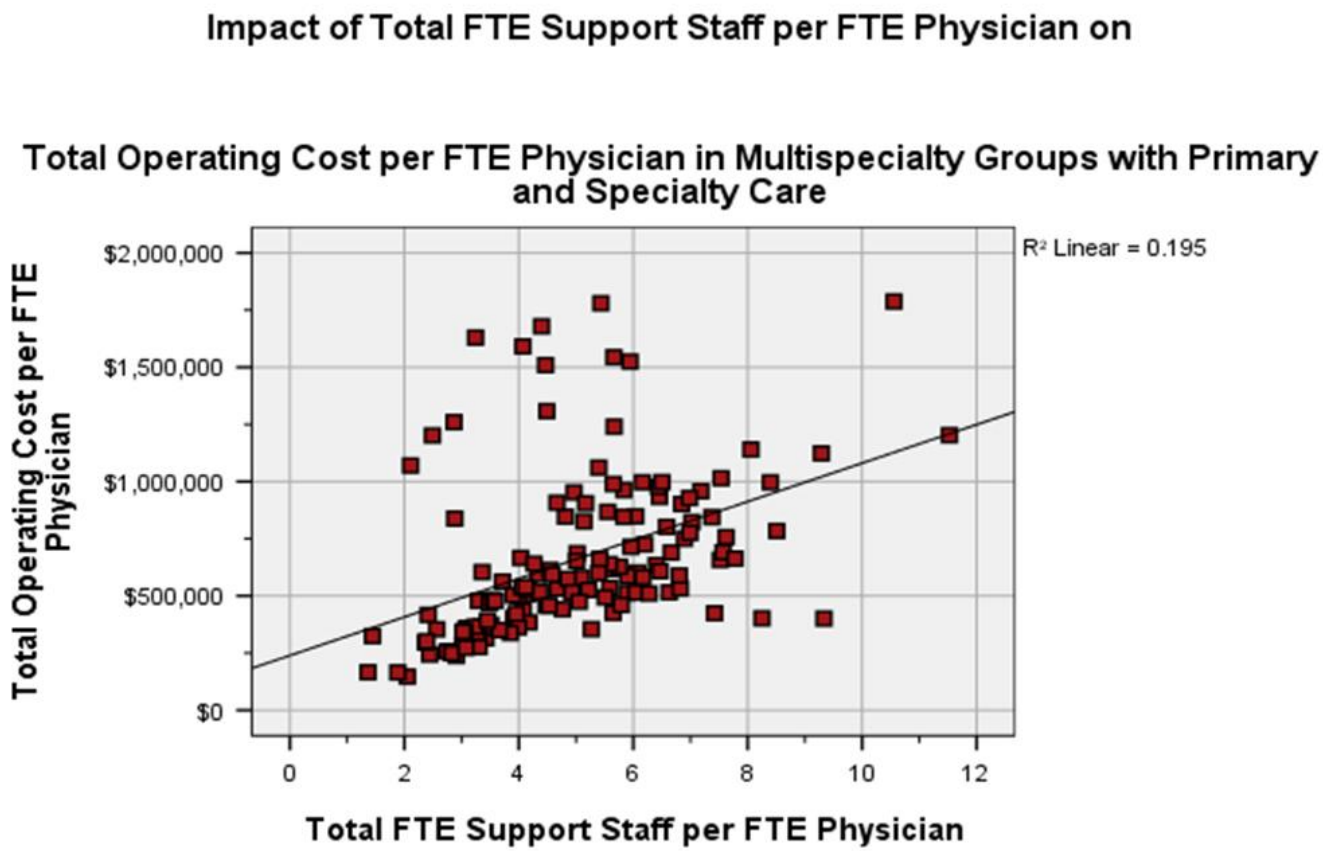
Effect of Staffing on Total Medical Revenue

The data suggest:

As the number of support staff per FTE physician increases, there is an increase in productivity and a resulting increase in total medical revenue

The variance in the amount of total medical revenue at the same staffing level suggests there are substantial differences in the staffing model, staff functions, and medical group processes

How Staffing Relates to Total Operating Cost



MGMA Cost Survey: 2018 Report Based on 2017 Data

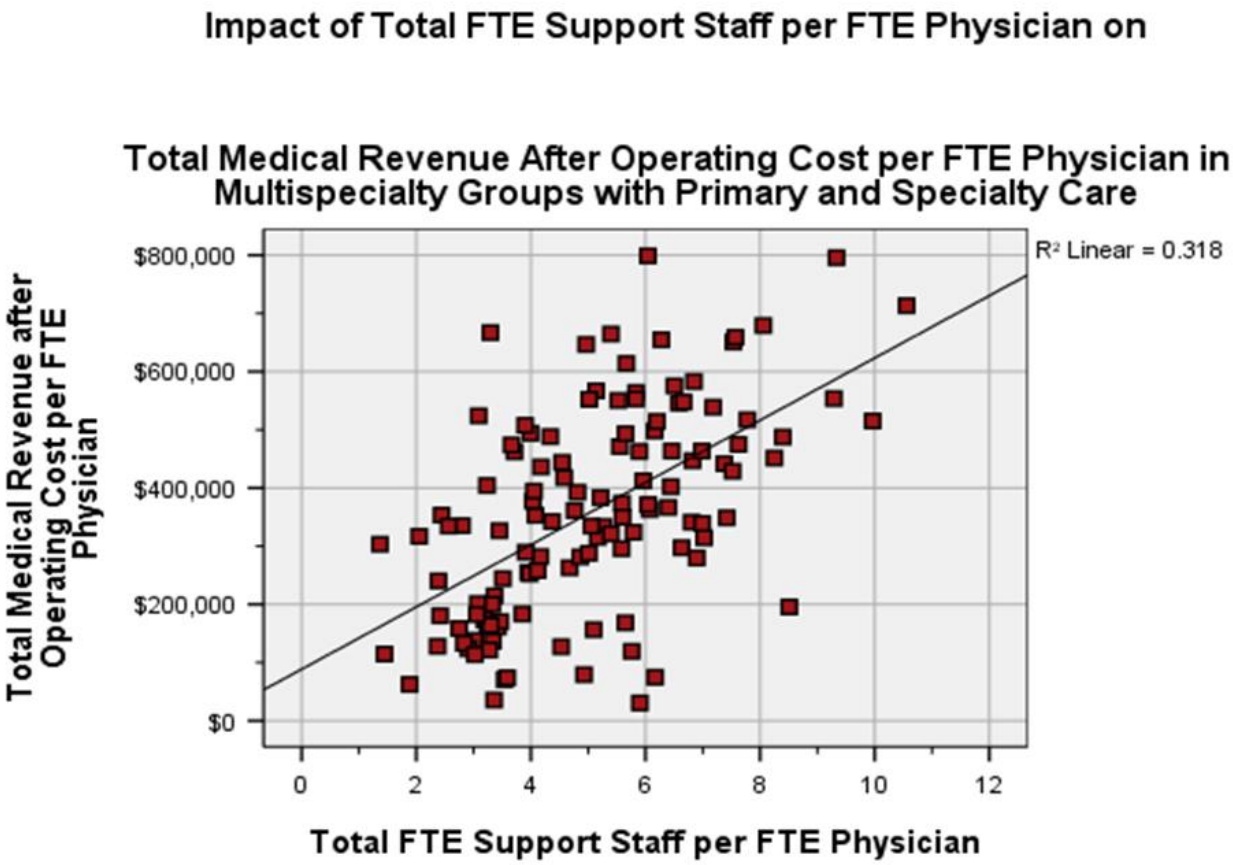
Effect of Staffing on Total Operating Cost

The data suggest

As the number of support staff per FTE physician increases, staff salaries and benefits increase

The variance in the amount of total operating cost at the same staffing level suggests there are substantial differences in the staffing model and salary levels

How Staffing Relates to Profit



MGMA Cost Survey: 2018 Report Based on 2017 Data

Effect of Staffing on Profitability

The data suggest

As the number of support staff per FTE physician increases profit often, but not always increases

The weak relationship of staffing and the amount of total medical revenue after operating cost suggests that the impact on profit is not necessarily the result of having more staff, but having the right staff doing the right things

Practices with Greater Production have Higher Staffing

Staffing Levels per FTE Physician by Work RVU Productivity for Physician Owned Multispecialty with Primary and Specialty Care				
	1st Quartile (<6,326 WRVUs)	**2nd Quartile (6,326 - 7,514 WRVUs)**	**3rd Quartile (7,515 - 9,500 WRVUs)**	**4th Quartile (>9,500 WRVUs)**
Median total business operations support staff	*	1.29	1.48	1.61
Median total clinical support staff	*	1.84	2.28	2.41
Median total front office support staff	*	1.19	1.46	1.37
Median total ancillary support staff	*	0.97	0.84	1.13

Source: DataDive for Cost and Revenue: 2018 Report Based on 2017 Data

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Increased Productivity Is Related to Increased Revenue, Costs, and Profitability

Revenue, Expense, and Profit per FTE Physician by Work RVU Productivity for Physician Owned Multispecialty with Primary and Specialty Care				
	1st Quartile (<6,326 WRVUs)	**2nd Quartile (6,326 - 7,514 WRVUs)**	**3rd Quartile (7,515 - 9,500 WRVUs)**	**4th Quartile (>9,500 WRVUs)**
Median total medical revenue per FTE Physician	$934,684	$1,137,281	$1,391,277	$1,573,100
Median total operating cost per FTE Physician	*	$686,484	$825,488	$996,853
Median total medical revenue after operating cost per FTE Physician	$487,550	$443,963	$463,394	$575,460
Median total physician compensation per FTE Physician	$345,377	$388,757	$395,181	$418,475

Source: DataDive for Cost and Revenue: 2018 Report Based on 2017 Data

Optimizing Staffing to Maximize Profitability

- There is a relationship between staffing levels and profitability
- Productivity, revenue, expenses and profits increase with the number of staff per FTE physician.
- Medical groups focusing on minimizing costs may constrain production to the point that profitability is reduced

Learning Objective 2

Interpret internal and external benchmark data to identify whether a practice has the right number and right skill mix of staff

A Systematic Approach to Evaluating Staffing

Defining your current practice environment

- What staffing model is used by the practice?
- Does the facility design limit efficient practice?
- Does the practice take advantage of economies of scale?
- What staff duties are shared?
- Who are the key parties who make decisions in designing the practice model?

First, Assess Quality and Patient Satisfaction

Is quality and patient satisfaction OK?

- If yes, proceed to the next step
- If not, you may not have the right mix and the right number of staff with the right training and incentives needed to provide quality services with high patient satisfaction and you need to address this problem as well as other issues you identify in the assessment

Second, Assess Revenue and Productivity

Is revenue and productivity OK?

- If yes, proceed to the next step
- If not, you may not have the right mix and the right number of staff with the right training and incentives needed to enable your physicians and nonphysician providers to maximize their patient service time and you need to address this problem as well as other issues you identify in the assessment

Third, Assess Employee Cost in the Context of Inputs, Revenue and Outputs

Is employee cost in the context of inputs, revenue and outputs OK?

- Assess employee cost per FTE physician, employee cost as a percent of total medical revenue, and employee cost per Total RVU
- If not, you should benchmark your staffing levels against similar organizations to determine if you have the right mix and the right number of staff for your type of practice and you need to address this problem as well as other issues you identify in the assessment

A Practical Exercise in Staffing

You are the administrator of a 20 doctor multispecialty group with primary and specialty care who received a call from the group's managing partner to visit his office. He describes that while he was at the state medical society conference he discussed practice operations with other physicians. He is concerned that the practice's overhead is too high because the group is overstaffed.

The practice has a board meeting in a week. You are asked to provide a comparison report on practice overhead with recommendations for how to reduce staff to correct the problem.

Step One: Identify Appropriate Metrics

Metrics to measure overhead and staffing

- Total medical revenue per FTE physician
- Total support staff salary and benefits per FTE physician
- Total operating cost per FTE physician
- Total medical revenue after operating cost per FTE physician
- Total operating cost as a percentage of total medical revenue
- Total support staff per FTE physician
- Work RVUs per FTE physician

Step 2: Determine Data Resources

Sources of internal data

- Personnel chart
- Statement of Profit and Loss

Source of benchmarking comparison

- MGMA DataDive for Cost and Revenue

Practice Staffing and Financial Information

Practice Data					
	Practice Data	Standardized Metric (per FTE Physician)	MGMA Median*	Variance	% Variance
Number FTE Physicians	20				
Total Operating Cost	$17,990,640	$899,532			
Total Medical Revenue	$28,718,200	$1,435,910			
Total Medical Revenue after Operating cost	$10,727,560	$536,378			
Total Support Staff	132	6.60			
Total business operations support staff	30	1.50			
Total front office support staff	34	1.70			
Total clinical support staff	52	2.60			
Total ancillary staff	16	0.80			
Total Support Staff Cost	$8,342,910	$417,146			
Total Operating Cost as a % of Total Medical Revenue		62.6%			
Total Work RVUs	182,180	9,109			
Total Support Staff per 10,000 WRVUs		7.25			

Comparing the Practice to External Benchmarks

Benchmark Comparison					
	Practice Data	Standardized Metric (per FTE Physician)	MGMA Median*	Variance	% Variance
Number FTE Physicians	20				
Total Operating Cost	$17,990,640	$899,532	$801,938	$97,594	12.2%
Total Medical Revenue	$28,718,200	$1,435,910	$1,238,879	$197,031	15.9%
Total Medical Revenue after Operating Cost	$10,727,560	$536,378	$506,153	$30,225	6.0%
Total Support Staff	132	6.60	5.96	0.64	10.8%
Total business operations support staff	30	1.50	1.48	0.02	1.4%
Total front office support staff	34	1.70	1.40	0.30	21.4%
Total clinical support staff	52	2.60	2.01	0.59	29.4%
Total ancillary staff	16	0.80	0.93	(0.13)	-14.0%
Total Support Staff Cost	$8,342,910	$417,146	$270,023	$147,123	54.5%
Total Operating Cost as a % of Total Medical Revenue		62.6%	61.5%	1.2%	1.9%
Total Work RVUs	182,180	9,109	7,514	1,595	21.2%
Total Support Staff per 10,000 WRVUs		7.25	7.18	0.06	0.9%

* Physician Owned Multispecialty Groups with Primary and Specialty Care Tables

Source: MGMA 2018 Data Dive for Revenue and Cost

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Staffing Case Study Assessment

1. What is shown in the data?
2. Is the practice's overhead too high?
3. Is the practice overstaffed?
4. What appears to be the problem?
5. What should the practice administrator do?

In life's classroom everything not covered in lectures or in the readings will be covered on the final exam

Are there any questions?

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About MGMA

- The Medical Group Management Association (MGMA) equips practice administrators and executives with the knowledge and tools to lead high-performance physician group practices in a complex and evolving healthcare environment. As the leading association for practice administrators for nearly 90 years, MGMA provides the education, advocacy, data and resources that healthcare organizations need to deliver the highest-quality patient care. MGMA also produces the most credible medical practice economic data in the industry and provides industry-leading board certification and Fellowship programs through the American College of Medical Practice Executives (ACMPE).

- MGMA and its 50 state affiliates comprise more than 33,000 administrators and executives in 18,000 healthcare organizations in which 385,000 physicians practice. MGMA represents physician groups of all sizes, types, structures and specialties, and has members in every major healthcare system in the nation. MGMA is headquartered in Englewood, Colo., with a Government Affairs office in Washington, D.C.

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Mr. Gans is a national authority on medical practice operations, patient safety, quality, payment methodologies, and health systems organization. He advises the Medical Group Management Association staff and members on all areas of medical group practice, sharing expertise through personal communications, workgroups, presentations, webinars, member community postings, and journal articles.

Mr. Gans received his Bachelor of Arts degree in Government from the University of Notre Dame, a Masters of Science degree in Education from the University of Southern California, and a Master of Science in Health Administration degree from the University of Colorado. Mr. Gans retired from the United States Army Medical Service Corps in the grade of Colonel, U.S. Army Reserve, is a Certified Medical Practice Executive and a Fellow in the American College of Medical Practice Executives.

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