Optimizing staffing levels: A science and art

It’s the same news. We are — and have been for some time — in times of decreasing and stagnant reimbursement. The ongoing challenge for medical practice executives is to improve the bottom line, and we have a range of approaches — including adding programs to increase revenue, examining services/relationships for profitability and analyzing costs to achieve savings. Revenue-enhancing services such as adding lasers, in-house labs, surgical centers, MRIs, bone densitometry and retail sales of related products have yielded positive results.

The ways to achieve cost savings are numerous. Benchmarking is an important one; it can arm you with the data you need to make certain business decisions in a well-informed manner.

As an industry, medical practice professionals examine services lines, including long-standing staples, and make hard decisions to cut programs to save money — including those that yield weak financial results. To ensure positive cost/benefit ratios, some practices have severed relationships with carriers, even companies that insure the elderly and indigent, when costs outweigh financial benefits.

Savings in medical and office supplies have been achieved by putting a practice’s book of business out to bid and choosing less expensive items and brands. Business insurance policies have been analyzed and less costly carriers have been selected to underwrite everything from malpractice to employment-practice liability insurance. And employee benefit expenses have been examined yearly, with alternate health insurance carriers and coverage considered.

Despite all of these ways to cut costs, staffing represents the greatest percentage of practice operating costs, according to MGMA Cost Survey data. Most professionals examine these costs for savings. Some have cut staffing levels — to the detriment of productivity and patient care. Others have frozen compensation, which leads to disgruntled employees and can cause retention issues.

An alternate approach to assessing this large operating cost line item is available. Benchmarking staffing levels with MGMA Cost Survey resources allows you to compare practice staffing with your peers to ensure best practices. The survey contains numerous ways to compare and analyze your figures with a range of data, thus allowing you to make more informed decisions.

The most basic staffing analysis requires calculating the practice staff and provider full-time-equivalent (FTE) counts, dividing those numbers to create a staff-per-provider ratio, calculating the staff-per-provider ratio using Cost Survey data, and comparing the practice and survey ratios. Data are available as a median and various percentiles ranging from 10 to 90 for a broad statistical comparison.

You can also get a more specific version of this analysis by combining employee FTE counts into department groupings and position titles from the survey. In other words, staffing ratio comparisons can be made by grouping practice employees into business operations, front office support, clinical support and ancillary support staff and performing the same calculations. Alternatively, you can compare staffing ratios by job title, such as licensed practical nurses, medical receptionists and patient accounting. Statistics per work RVUs, number of patients, encounters, total procedures and square footage enhance your analysis.
The MGMA Cost Survey contains operating cost data by defined department groupings and position titles, which enables you to do a comparison of practice staffing costs with benchmark staffing costs. Again, data are available as a median, and various percentiles ranging from 10 to 90 allow you to do a broad statistical comparison. This is a high-level analysis. If practice costs are not in line with the benchmark, it might be necessary to do a review of compensation at the position level. Although Association surveys do not address state compensation rates for typical staff level positions — such as medical assistant, billing associate and medical secretary — you can tap other resources, such as state affiliates and association-specific websites, for this data.

When using MGMA DataDive, the web-based, interactive version of the Cost Survey report, set the applicable filters and review possible categories to drill down into the benchmark data and get an enhanced comparison of practice data to benchmarks.

Benchmarking is both a science and an art. It enables the medical practice executive to assess how the practice is doing compared with other practices, but it does not provide a complete picture. Equally key pieces of information include practice-specific factors, such as patient complexity, patient population and service mix. They complete the picture.


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