Successful Healthcare Hiring & Employee Retention in 2024

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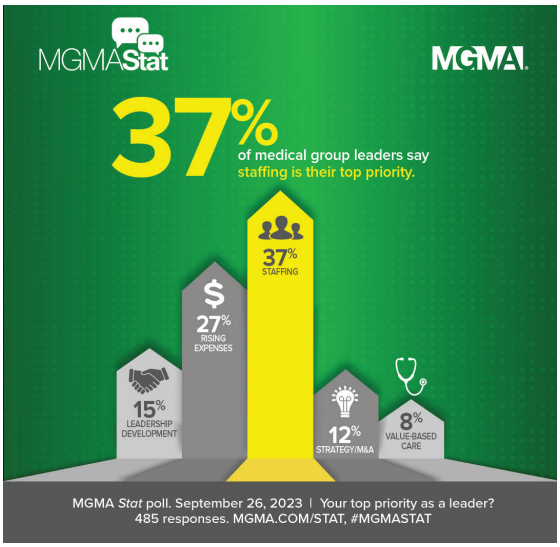
ABOUT MGMA

Founded in 1926, the Medical Group Management Association (MGMA) is the nation's largest association focused on the business of medical practice management. MGMA consists of 15,000 group medical practices ranging from small private medical practices to large national health systems representing more than 350,000 physicians. MGMA helps nearly 60,000 medical practice leaders and the healthcare community solve the business challenges of running practices so that they can focus on providing outstanding patient care. Specifically, MGMA helps its members innovate and improve profitability and financial sustainability, and it provides the gold standard on industry benchmarks such as physician compensation. The association also advocates extensively on its members' behalf on national regulatory and policy issues.

INTRODUCTION

While the new year started with headlines about a strong jobs report amid a year of healthy hiring throughout many sectors in 2023, the medical group and ambulatory care space might feel like it's trapped in time, still looking for qualified candidates and strategies to limit turnover in a competitive labor market.



For three years, staffing has ranked as the top challenge or priority for medical group leaders in MGMA *Stat* polling.

To rise to this challenge, healthcare administrators have shared with MGMA how they have updated and added new employee benefits, revised strategies to recruit and retain medical assistants (MAs) and nurse roles, but the intense competition for healthcare workers remains atop the list of items keeping practice leaders up at night:

- Practice leaders have standardized their approaches to recruiting and prioritizing essential positions over others. This also includes using Lean processes to standardize workflows and paying closer attention to staffing metrics.
- HR leaders have started to create over-hiring plans to avoid unfilled positions and staying fully staffed for more stability amid expected turnover.
- Many have continued or increased use of third-party recruitment services or locum tenens for physicians and advanced practice providers (APPs), particularly for physician assistants (PAs).
- More organizations have embraced offshoring for certain roles, particularly in call centers, prior authorization work and revenue cycle management (RCM) functions.

The prolonged issue of not finding enough of the right people to hire has encouraged some practices to finally embrace artificial intelligence (AI) for certain tasks. "Long-term short staffing is pushing us to implement more AI quickly," one practice leader told MGMA, "and driving the need to motivate and inspire staff in new ways."

Other increasingly creative methods to address staffing shortages include:

- Creating new talent pipelines with a wider array of schools and training organizations, as well as increased development of in-house workforce training programs
- Hiring roles that don't require credentials to complete appropriate tasks
- Expanding methods of advertising open positions, as well as job fairs visited to meet with potential candidates.

Beyond these efforts, the organizations that can afford to have continued to increase pay ranges, benefits and bonuses to minimize turnover and reduce the need to recruit and hire in the current labor market. This report reflects on what's worked and new strategies to improve recruitment, hiring, onboarding, engagement and retention of physicians, APPs, other clinical support staff and nonclinical team members.

QUANTIFYING THE STAFFING CONUNDRUM

The Jan. 3, 2024, Job Openings and Labor Turnover Survey (JOLTS) released by the U.S. Bureau of Labor Statistics (BLS) had a mixed bag of findings for anyone in the market for clinicians or practice staff:

- Overall job openings across healthcare and social assistance were down in November 2023 versus the year before, though still far above levels measured before the pandemic and through spring 2021.
- The quits rate (measuring employees who leave their positions voluntarily) managed to stay relatively stable for the latter half of 2023, offering calm in a sector that saw the rate surge by 70% from its nadir in May 2020 to fall 2021 when the Omicron wave of COVID-19 began and competition for labor intensified in other sectors.

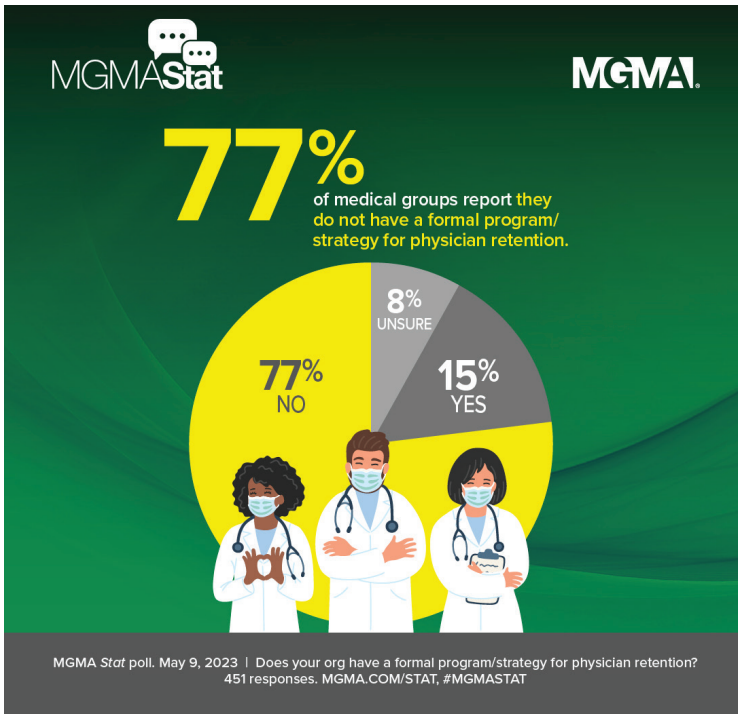
The Employment Situation report offered in early January for December 2023 showed:

- Ambulatory care services posting three consecutive months of job gains to close out the year, with 39,600 jobs added in November and another 19,200 jobs added in December.
- Of those job gains, 16,000 jobs added in November were in physician offices, and another 5,400 physician office jobs were added in December.
- The December 2023 seasonally adjusted participation rate was 62.5%, down slightly from November's 62.8% rate but up from last December's 62.3% rate, which indicates more people are looking for jobs across the economy this winter than last year.

Looking more broadly, job growth across the healthcare sector averaged about 55,000 each month in 2023, up from 46,000 monthly average growth in 2022. While this is welcome news after years of difficulty in a competitive market for labor, the question remains as to how quickly the industry can train and onboard new providers and staff to stem the tide of retirements and other exits from healthcare.

An innovation imperative for physician retention

Not a week goes by without major headlines heralding the concerning forecast of physician shortages across the United States in most specialties, yet there remains a disconnect between what healthcare leaders hope to do to avoid this calamity and what gets done: Almost eight in 10 (77%) medical groups report they do not have a formal program or strategy for physician retention, per a May 9, 2023, MGMA *Stat* poll.



Even for healthcare organizations with a plan, the financial pressures of inflation-bloated expense growth put pressure on them to continue offering high-quality patient care without breaking the bank.

To better understand how to confidently make progress on these issues, LocumTenens.com partnered with MGMA for a new study in the summer of 2023. The findings address:

- Current priorities for healthcare provider organizations around physician retention
- Emerging trends that drive physician satisfaction in their organizations
- Opportunities to address negative factors that lead to burnout, turnover and vacancies.

KEY FINDINGS: MEASURING ENGAGEMENT, SATISFACTION

The best place to start in building strategies to mitigate physician shortages is understanding clinicians' attitudes about their work. The definitions of physician work — beyond their extensive training and use of clinical best practices — have evolved immensely in recent years, including working via telehealth and finding new ways to connect with patients.

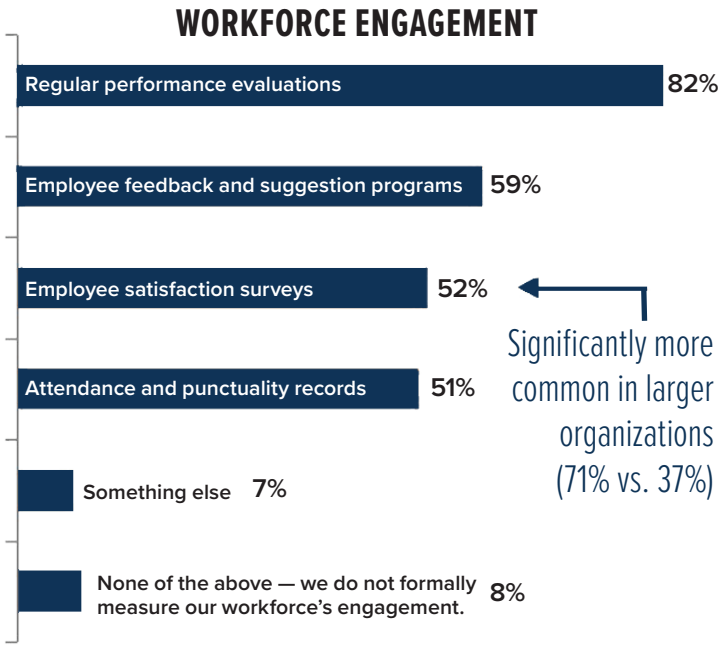
As detailed in the January 2023 LocumTenens.com report, *The Future of Work: Redefining the Role of Physicians in the Gig Economy*, this rapid evolution of physicians' definition of work is the culmination of several significant changes:

- Increasing strain and burnout
- A growing desire for flexibility
- Availability of new opportunities.

But despite the widespread awareness of these issues, there are several opportunities for leaders in healthcare provider organizations to listen better and gather information to address them.

Performance evaluations are the most common metric of workforce engagement

Regular performance evaluations are the top-reported measure of workforce engagement, with just more than eight in 10 organizations using this approach. The usefulness of this approach may vary, as many organizations typically perform evaluations annually or biannually. These evaluations often can end up being more of a review of productivity and quality goals rather than a dialogue with physicians that leads to a better understanding of their satisfaction or the factors influencing any dissatisfaction with the workplace.



Satisfaction surveys are not widely employed to measure engagement

Almost one-half of respondents do not use employee satisfaction surveys as a measure of engagement, and smaller organizations (100 or fewer employees) are far less likely (37%) to use them than larger organizations of more than 100 employees (71%). Beyond that missed opportunity, there were 8% of respondents who reported no formal measures of workforce engagement.

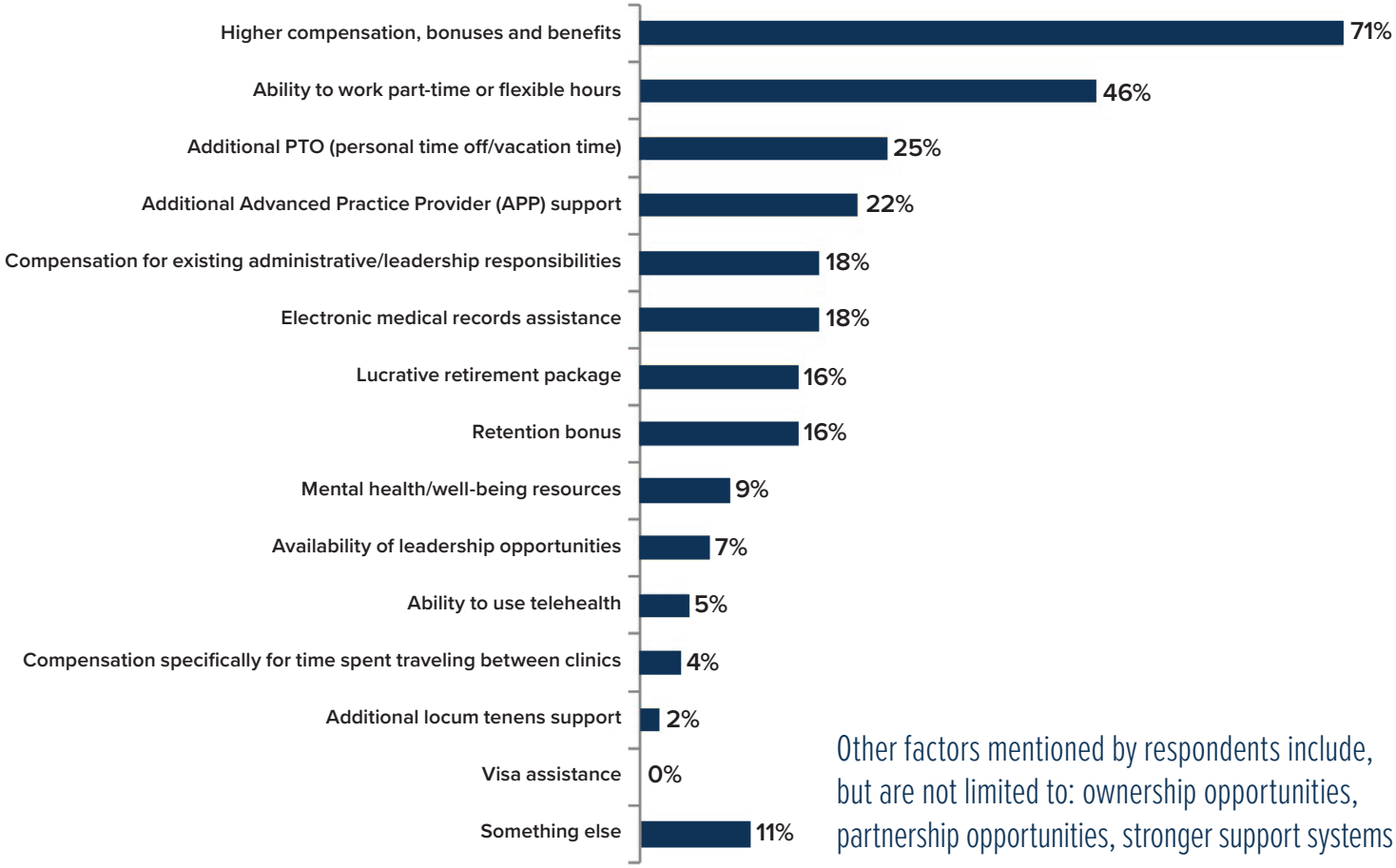
While several surveys of clinicians typically rank compensation, schedules or staffing as top areas that influence dissatisfaction with an employer, the sense of being undervalued or otherwise unhappy with leadership or direction of the organization were highly ranked factors in the earlier *Future of Work* survey report. **The absence of even a satisfaction survey — much less follow-up communication from the organization about the results and how they are being used — can lead many clinicians to conclude that their satisfaction or engagement is not valued.**

Time to focus on individual growth and development: who are your coaches and mentors?

Even for organizations proactively seeking physician sentiment on job satisfaction and engagement, the incentive to keep a physician for the long run might require more than regular goal-setting and budgeting money and time for them to pursue continuing medical education (CME), especially as the competition for physicians in tight markets leads more organizations to boost their CME offerings.

The latest survey found that less than one-third of respondents use either individual development plans (32%) or promotion/advancement rates (30%) with their physicians to measure progress toward career goals. Creating a clear pathway for these clinicians to grow with the organization is a missed opportunity for developing a longer-lasting relationship and improving retention rates.

RETENTION FACTORS FOR PHYSICIANS



Other factors mentioned by respondents include, but are not limited to: ownership opportunities, partnership opportunities, stronger support systems

While individual development plans might be viewed as a tool largely for early-career physicians, organizations should not overlook coaching and mentoring for physicians as an engagement and retention tactic, not to mention a way to establish and sustain a strong organizational culture. "One of the most important things for people staying in their jobs is that they feel the organization is investing in them, and that they understand their vision," said Adrienne Lloyd, MHA, FACHE, CEO and founder of Optimize Healthcare, who emphasized that physician leadership development through coaching and mentoring can lead to "better communicators in terms of establishing and communicating" vision, especially in physician-administrator dyad structures.

Perspectives on motivating physicians to stay

Higher compensation, bonuses and benefits for physicians are viewed as the top factor to retain physicians, as noted by 71% of all respondents. The next highest factor was the ability to work part-time or flexible hours (46%). Additional paid time off (PTO), such as vacation or personal time off, was cited as a top factor by one out of four (25%) respondents.

However, the tight labor market that emerged following the COVID-19 pandemic has made staffing the top challenge among healthcare leaders for the past two years, with the added pressure from inflation and higher expenses tightening provider organizations' budgets and making it difficult to invest in more support staff. More than one in five (22%) respondents said having additional APP support would be a motivating factor for their physicians to stay with the organization.

Putting it all together: Formalizing physician retention strategies

As Kurt Scott, founder and CEO of The Physician Leadership Career Network, wrote for *MGMA Connection* magazine, **building an effective physician retention strategy will require a lot of listening and commitment from the organization's senior leadership to address issues that come up.**

"It's important not to gloss over any issue; doing so will be the fastest way to lose your credibility," Scott wrote. "This does not mean you have to agree with all the recommendations of a retention committee. It means you need to address each, even by simply acknowledging disagreement or explaining why an issue cannot be addressed at this time."

Creating a physician retention committee

Looking at current turnover rates and other bits of data, it's evident that having a committee to review and analyze the numbers for common themes is an important step to "brainstorm and make recommendations for remedies and improvements," Scott wrote.

"In my experience, this piece of the process will improve physician turnover instantly by 5% to 10%. By demonstrating that the issue of physician turnover is being addressed in a structured, formal way, physicians and staff will understand that it is important to the organization, which brings hope for improvements," he added.

Scott recommends that for larger medical groups of 100 doctors or more, the committee should be six to 10 physicians, including your head of physician recruitment/retention. For a group of only a few dozen physicians, the committee should be four to six doctors and whomever leads overall recruitment efforts.

Scott also urges caution about bringing in many nonclinical voices. "Avoid including nonphysician administrators or vice presidents, which can make the committee less credible among the doctors," Scott wrote. "However, include a couple of your most vocal and influential physician naysayers or critics. If you can engage this group, it will help turn them into advocates who will help promote the positive results."

Gathering unique data: Scott suggests groups categorize data into five to 10 categories to address. Individual data points include the following.

Turnover rate and assessing departures: How many physicians are leaving your organization of their own free will or involuntarily? Scott recommended excluding any temporary, interim and locum tenens physicians (any physician you hire or contract with a defined end date) to make your baseline more meaningful.

- **Voluntary departures**: You should understand the issues behind physicians leaving voluntarily. There are two main ways to get this information: ***(1) The autopsy approach***: The exit interview is the best way to hear firsthand about the reasons your physicians leave. Each should be well documented and blinded (name removed) to lower the risk of bias and provided to the committee for analysis. ***(2) Send a simple survey to those who left in the past year***: This can be done electronically via email for better response rates, or it can be mailed.

- **Involuntary departures**: It's important to review everyone's involuntary termination to look for issues that may have been overlooked during the hiring process. Information obtained is sensitive and should be handled appropriately. Results should be blinded before shared with the committee.

Current staff: Create a simple electronic survey to be sent to all your physicians regarding their current feelings about practicing with your organization. You can include multiple reminders to help get more staff engaged.

The survey should ask physicians:

- What one or two issues create the highest level of dissatisfaction in practicing with us?
- What one or two things are responsible for your highest level of satisfaction?
- What one or two issues would cause you to leave for another opportunity?

Results should be tabulated and grouped by category through your retention committee.

Retention committee recommendations

Once the data is collected, the committee should review and categorize. Each category should be addressed individually with recommendations for improvements.

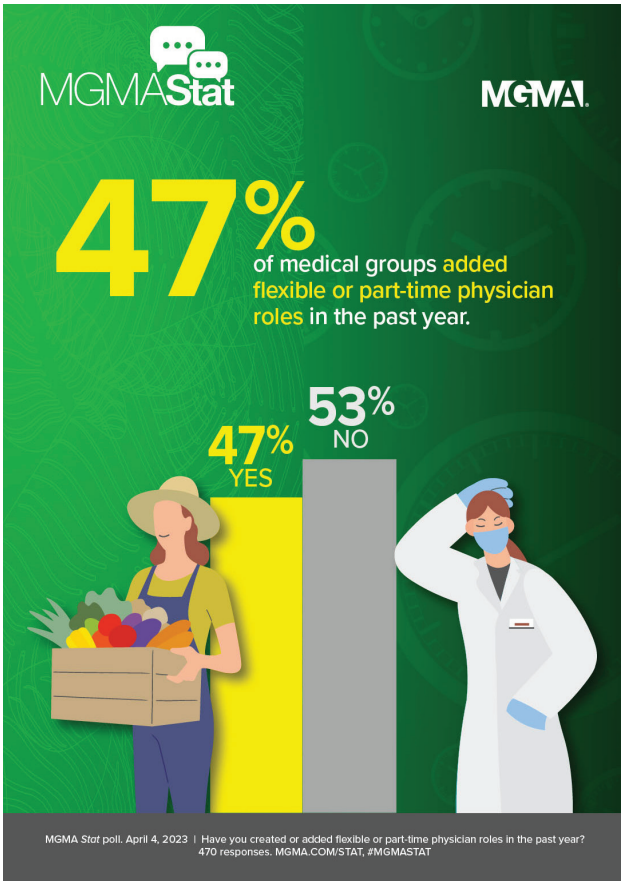
A findings report should be developed for presentation to senior leadership for consideration. That presentation should be attended by your CEO, COO, CMO, CFO and CHRO, head of physician recruitment/retention and the designated retention committee representative or spokesperson.

Discuss all issues, evaluate recommendations, and determine what can be agreed to in this initial meeting. Leave the final report with recommendations for attendees to review on their own, and schedule a second meeting for the following week with expectations that each category will be discussed and addressed.

The results and agreed-upon recommendations should be compiled into a report and presented to the medical staff. This is a subject that hits home with them, so be prepared for a large turnout. The designated committee representative along with senior leadership should be involved in making the presentation to ensure credibility.

Expect this process to take about three to four months to complete. It needs to be a priority, so senior leadership should be driving it forward at every possible opportunity. But followed successfully, it allows organizations to reduce turnover, improve physician satisfaction and engagement, and boost revenue through fewer departures.

Adding flexibility to physician staffing models



A historic physician shortage that's poised to only get worse is forcing many medical group leaders to draw up new recruiting and staffing strategies to ensure a healthy supply of doctors to serve their patient populations.

An April 4, 2023, MGMA *Stat* poll found that almost half (47%) of medical group leaders have added or created part-time or flexible-schedule physician roles in the past year, while 53% did not. The poll had 470 applicable responses.

Medical group leaders responding to the poll told us some of the reasons for the updates to their hiring strategies:

- "Our older docs requested a more flexible part-time policy to help them keep working. Our old policy only allowed half- and three-quarter time."
- "To relieve some of the stress from emergency call."
- "It provides the work-life balance that meets their needs or extends their retirement date further out."

EXPERT INSIGHTS FROM MGMA CONSULTING:

"Each of the categories for MGMA's Better Performer practices are driven by people. All the tech and automations in the world won't eliminate the need for people in your practice. The biggest challenge with staffing isn't turnover or people who 'don't want to work' — it is ignoring the role of culture in staff performance. Employee engagement and staff performance are driven by two things: skilled leaders and systems that optimize people performance. Practices that measure leadership competencies and provide leadership training have higher levels of employee engagement. Optimizing systems starts with analyzing your processes for each step of the lifecycle of the employee. Is your interview process effective? Do employees know how their success is measured? Does your practice prioritize people management through regular discussions with team members, individual goal setting and action-oriented feedback? Practices that prioritize their people strategy are not only surviving, but they are also thriving."

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Among practice leaders who did not add new part-time or flexible-schedule physician roles, the prospect of hiring for nontraditional roles in the future depended largely on:

- Whether looming retirements come from hard-to-recruit specialties
- Physical space limitations within existing facilities
- Being able to do part-time in the given specialty and take equal call
- The economic costs of onboarding and credentialing versus the lower revenue creation of part-time physicians
- Determining whether staffing models could be adjusted to add more clinical support staff for existing physicians, including part-time and flexible-schedule physician assistant (PA) and nurse practitioner (NP) positions.

Still, there are many organizations that are laser-focused on finding physicians who are eager to work a full schedule or have had poor experiences with part-time hires in the past, especially around the physician's expectations to earn closer to full-time compensation. "It never works out to where they see enough patients" to either cover costs or earn the type of living they hope for, one practice leader told MGMA. Others said it's just a matter of mindset for the organization: "We need fully engaged physicians," one practice leader told us.

CONSIDERING THE COSTS OF PHYSICIAN VACANCIES

In a recent MGMA webinar "Thinking Outside the Box: Creative Physician Recruiting for Hard-to-Fill Positions," Tara Osseck, MHA, and Neil Waters, both regional vice presidents of recruiting at Jackson Physician Search, detailed the new approaches that help secure the right candidates amid growing competition for a shrinking supply of physicians, as **about 2 in 5 physicians will reach retirement age in the next 10 years.**

Finding the right solutions should consider the costs of losing a key physician without a replacement lined up. **"The estimated lost revenue for a noninvasive cardiologist opening that sits vacant for six months is about $1.15 million," Osseck said. "A gastroenterology vacancy sitting open for the same amount of time is about $1.4 million. … An ophthalmology vacancy is the equivalent of $1.6 million in lost revenue."**

When it comes to time to fill a vacancy, Osseck noted that the industry average across all specialties is around that six-month mark, but that the most-competitive specialties or most-difficult-to-recruit regions might need an additional six months to fill a physician vacancy.

Beyond the lost revenue of physician vacancies, there are other major implications, such as lost market share, the effect of burnout on other physicians and providers trying to make up for the vacancy, and added costs from using a locum tenens provider, Osseck added, while the search for a permanent replacement is underway.

"Physicians now know their financial worth more than ever … and they're deciding for themselves how their current positions stacks up," Osseck noted, to offers for improved benefits packages or the promise of a better work-life balance in a flexible scheduling scenario.

SHIFTING WORK-LIFE EXPECTATIONS

Waters recalled work to help find a psychiatrist for an East Coast hospital to meet the burgeoning demands for mental health specialists. While psychiatrists saw exceptional growth in telehealth during the COVID-19 pandemic, the hospital could not make it work for this role, as the psychiatrist would be needed to evaluate admitted patients.

To find a workable solution for candidates, a seven-days-on, seven-days-off schedule helped make the position more enticing despite the on-site requirements in a high-demand specialty. This more flexible approach got the vacancy filled in 90 days rather than the specialty average of 8.4 months. Other hard-to-recruit physician roles have even seen longer periods of days off following a seven-days-on work schedule.

Waters said that most healthcare organizations have an idea of how much flexibility they could ultimately offer when casting the net for a new physician but don't incorporate it into the recruiting strategy, which can be costly in the long run.

"If you have the strategy in mind, go ahead and start talking about it early, even before you start your recruitment," Waters suggested. "The quicker you can implement those strategies aggressively, you're going to be putting your best foot forward. ... If it drags out, it's just going to cost more money in the long term."

EXPERT INSIGHTS FROM MGMA CONSULTING:

"Engaging in candid conversations about physician compensation isn't just a best practice; it's vital to retaining physicians and reducing turnover. After all, physicians are no different from anyone else — they want to understand their compensation and know it's fair. Physician compensation methodologies vary widely, and compensation plans are often cumbersome and complex for administrators to administer, let alone explain. Provider compensation data, the predominant source for establishing physician compensation, is expensive, requires training to interpret effectively, and is not easily accessible to physicians. A lack of transparency and open communication with physicians regarding compensation can lead to mistrust and misunderstanding with employers. Don't assume that 'no news is good news' when you're not hearing from your physicians. Make it a priority to check in routinely. Physicians have identified two-way communication as one of their top priorities and expectations from healthcare leaders. Employing these strategies distinguishes highly effective leaders and organizations!"

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Bidding war: Why private practices are struggling to retain nursing staff

BY
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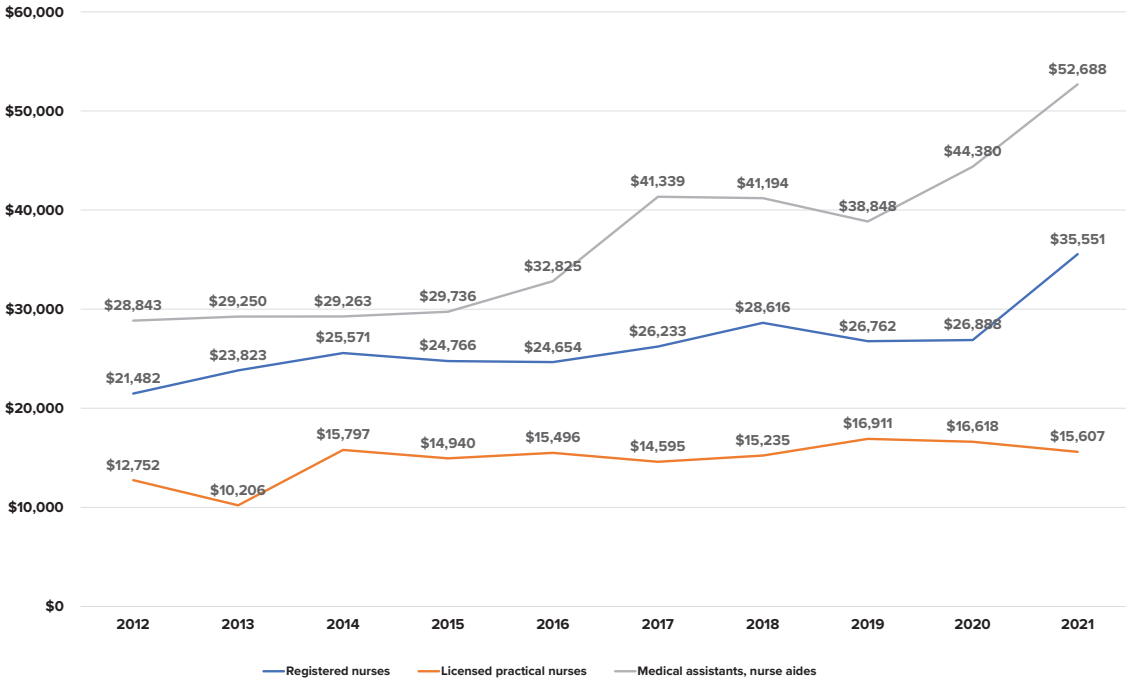
While the United States and global economies have largely recovered from the financial crises spurred by the COVID-19 pandemic, the aftereffects of the pandemic are still being felt. Despite supply chain snarls, the nation went on a post-lockdown buying spree, which depleted inventory levels and increased demand for products and services, which resulted in the highest jump in inflation rates in 40 years.

The economic forces that affected the country also impacted physicians and hospitals. Medical groups substantially recovered from the loss of revenue and increased costs in 2020; however, many of the problems that practices experienced in 2019 and 2020 are continuing, especially their ability to recruit and retain staff at a wage scale that competes with businesses inside and out of healthcare.

Evidence of this problem 2022 *MGMA DataDive* survey results for physician-owned multispecialty groups with primary and specialty care who experienced a 6.5% one-year increase in total support staff expense from $370,060 to $393,961 per full-time-equivalent (FTE) physician.

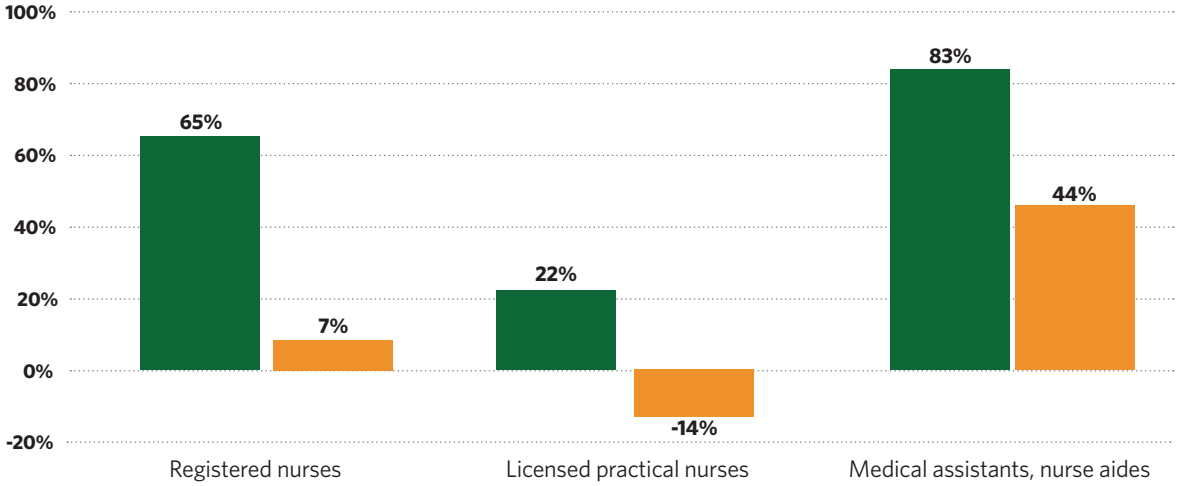
Drilling down, much of the increase in staff costs can be attributed to the increase in the cost of nursing staff. Figure 1 displays how the cost per FTE physician for registered nurses (RNs), licensed practical nurses (LPNs), and medical assistants (MAs) has changed over the past 10 years. The graph shows how physician-owned multispecialty groups with primary and specialty care experienced a substantial increase in RN and MA costs.

FIGURE 1. 10-YEAR CHANGE (2012-2021) IN COST PER FTE PHYSICIAN FOR NURSING STAFF IN PHYSICIAN-OWNED MULTISPECIALTY GROUPS WITH PRIMARY AND SPECIALTY CARE



Sources: *MGMA DataDive Cost and Revenue*, 2013-2022 (based on 2012-2021 data)

FIGURE 2. 10-YEAR PERCENT CHANGE (2012-2021) IN COST AND STAFFING PER FTE PHYSICIAN IN PHYSICIAN-OWNED MULTISPECIALTY GROUPS WITH PRIMARY AND SPECIALTY CARE



Sources: *MGMA DataDive Cost and Revenue*, 2013 and 2022 (based on 2012 and 2021 data)

Since total staff cost is a function of the number of staff members and their average compensation, Figure 2 shows the percent change in total cost along with the change in staffing levels. Examining the graph, the increase in cost of MAs is largely driven by an increase in the staffing level; however, while LPN costs have increased by 22% in the 10 years, their staffing level actually decreased 14%. Most importantly, physician-owned multispecialty groups with primary and specialty care saw their RN staffing cost per FTE physician surge by 65% despite only increasing RN staffing levels by 7%.

While the *MGMA DataDive Cost and Revenue* records practice expenses revenue and staffing information, the *MGMA DataDive Management and Staff Compensation* publishes compensation and fringe benefit information for executives, managers, and staff members. Table 1 shows the median compensation paid by physician-owned and hospital-owned groups for their nursing staff during the first three years of the COVID pandemic.

While physician-owned groups experienced substantial increases in the total costs of nursing staff, in the context of national inflation, their annual compensation increase did not keep up with the cost of living. The table shows that nurses working in hospital-owned groups had much greater annual increases in median compensation than their private practice peers.

TABLE 1. COMPENSATION OF NURSING STAFF IN PHYSICIAN- AND HOSPITAL-OWNED MEDICAL GROUPS, 2019-2021

MEDIAN COMPENSATION FOR NURSING STAFF IN PHYSICIAN-OWNED GROUPS				
	2019	2020	2021	Percent change 2020-2021
Medical assistant	$35,718	$35,279	$36,823	4.4%
Licensed practical nurse	$45,341	$43,936	$45,238	3.0%
Registered nurse	$59,780	$60,237	$61,434	2.0%
MEDIAN COMPENSATION FOR NURSING STAFF IN HOSPITAL-OWNED GROUPS				
	2019	2020	2021	Percent change 2020-2021
Medical assistant	$36,173	$36,816	$39,416	7.1%
Licensed practical nurse	$42,988	$43,666	$47,222	8.1%
Registered nurse	$68,567	$67,113	$72,647	8.2%
COMPENSATION IN HOSPITAL-OWNED GROUPS AS A PERCENT OF COMPENSATION IN PHYSICIAN-OWNED GROUPS				
	2019	2020	2021	
Medical assistant	101%	104%	107%	
Licensed practical nurse	95%	99%	104%	
Registered nurse	115%	111%	118%	

Sources: *MGMA DataDive Management and Staff Compensation*, 2020-2022

More importantly, nurses in hospital-owned practices have substantially greater compensation than similar nurses in private practice.

The differential in nursing compensation by group ownership in 2021 ranged from 4% for LPNs and 7% for MAs to a full 18% for RNs, whose median compensation in hospital-owned practices was $11,213 greater than RNs in physician-owned practice.

The difference in median compensation for nursing staff indicates a potential problem for physician-owned medical groups. It is widely reported that many nurses left the profession during the pandemic due to overwork and burnout, and that there is a national shortage of RNs and only a slightly lesser shortfall in LPNs and MAs. Even though much of nursing turnover occurred in inpatient facilities, the effect is felt industrywide, as it occurred alongside an increase in the demand for nurses due to the aging population and increased complexity of ambulatory care and inpatient services.

PHYSICIAN-OWNED PRACTICES ARE SEVERELY CONSTRAINED IN THEIR ABILITY TO MATCH THE COMPENSATION LEVELS OFFERED BY HEALTH SYSTEMS. AS INCREASED SALARY LEVELS RAISE OPERATING COSTS, A PRIVATE PHYSICIAN PRACTICE EITHER HAS TO INCREASE PRODUCTION OR REDUCE THE COMPENSATION OF ITS OWNING PHYSICIANS. IN PAST YEARS, NEW TECHNOLOGY ENABLED PRODUCTIVITY INCREASES THAT KEPT PACE WITH INCREASED OPERATING COSTS, BUT MEDICAL GROUPS COULD BE IN A SITUATION OF DIMINISHING INCREASES IN PRODUCTIVITY.

Economists understand that the effect of high demand and scarcity of resources often results in a redistribution to the parts of the economy willing to pay the most. In effect, the national nursing shortage and the high demand for professional nurses could easily result in a "bidding war" among healthcare entities. For years, physician-owned practices were able to recruit and retain nurses with promises of a better working environment and regular scheduled hours. Unfortunately, if the pay differential continues to diverge, the "deep pockets" of hospital systems may well overcome the attraction of working in a private practice.

Physician-owned practices are severely constrained in their ability to match the compensation levels offered by health systems. Essentially, as increased salary levels raise operating costs, a private physician practice either has to increase production or reduce the compensation of its owning physicians. In past years, new technology enabled productivity increases that kept pace with increased operating costs, but medical groups could be in a situation of diminishing increases in productivity.

Physician-owned practices are experiencing many problems, but most executives are not prepared for having to substantially increase staff compensation — but they may have to if they want to survive. In a bidding war, there will be only one winner — the one with the most money to spend.

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Staffing to demand: Illuminating your medical group's staffing needs

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As ambulatory volume increases, it is essential for clinical practices to utilize efficient staffing models that align with patient demand. Optimal, appropriate full-time-equivalent (FTE) staffing is contingent upon the right staff performing the right tasks at the right time.

National staffing benchmarks exist, including those published by MGMA; however, assessing and operationalizing a consistent staffing model across many clinics can prove challenging for a large medical group with multiple practice variations and levels of efficiency.

Use of a staffing-to-demand (S2D) model allows comparison of an individual practice's current staffing levels to what is required to meet the specific patient demand of the practice. S2D combines two key elements — standard work and staffing models — to ensure ambulatory clinics are appropriately staffed to provide high-quality, reliable care to patients, as well as to ensure each staff member is functioning at the top of his/her license. The result of conducting an S2D analysis is a highly specific ambulatory staffing model, which can be further leveraged across a medical group to share best practices and drive operational success.

THE S2D MODEL

Rush University Medical Group (RUMG), which consists of more than 100 clinical practices throughout Chicagoland, lacked a standard and data-driven approach to clinical staffing, leading to considerable variation among practices. While ambulatory clinics inherently have some variation in the tasks performed before, during and after an office visit, these differences can lead to unnecessary delays and have negative implications on operations and finances.

These variations included how long it took staff to perform similar tasks, such as rooming a patient or coordinating care. Additionally, the type of staff utilized for routine tasks varied by practice. For example, rooming and assessing patient vitals, which is standard work for a clinic visit, was performed by a variety of different job titles across the medical group. Further, RUMG noticed that tasks associated with care coordination (including answering patient messages, phone triage and completing prior authorizations) were increasing year over year. This often resulted in practice leaders requesting additional staff based on perception rather than actual data.

In response to this, S2D was implemented across all RUMG practices, illuminating practice-level staffing needs. RUMG utilized MGMA staffing benchmarks as an essential starting point and then conducted S2D analyses to discover variances between current and needed staffing at the practice level. MGMA staffing models provided a guide as to how other national practices utilize staffing per visit and staffing per physician clinical FTE. If the internal S2D analysis did not align within a deviation of the MGMA models, the medical group sought to review the S2D output.

The success of any new project requires a robust change management strategy, and S2D was no different. The medical group communicated to senior leaders, directors, managers and frontline staff regarding the importance and benefits of the S2D work for each practice. Numerous conversations occurred between the project team and leadership as to the application of the model to each leader's unique practice. Additionally, the medical group engaged and explained the work to the physician leaders. Ensuring all practice managers were aware of the project prior to observers entering the clinic to begin the S2D analysis was crucial to the project's success.

CALCULATING CURRENT CYCLE TIME

As a first step in measuring standard work, a team conducted in-clinic observations of clinic coordinators, medical assistants (MAs) and registered nurses (RNs). The observation team documented standard tasks and the time it took to complete each task (see figures at right and next page).

The number of observations per task varied by practice and staff size, with the goal of capturing an average or typical task duration. For example, a smaller practice with fewer MAs may only require one or two observations to determine the average task duration. While this assessment has focused on work performed by clinic coordinators, MAs and RNs, it can easily be applied to any role in the practice.

CLINIC COORDINATOR CYCLE TIME ANALYSIS TEMPLATE

CLINIC COORDINATOR TASK OBSERVATIONS	AVERAGE (MINUTES)
Check-in (new and returning patients)	
Work queue	
Schedule procedure/visits	
Respond to incoming/outgoing calls	
Checkout	
Check next day's schedule for incomplete HARs	
Virtual visit/telemedicine patient check-in	
EHR in-basket messages	
Interpreter services, patient transportation	
Clean patient waiting area (a.m. and p.m.)	
Post payment, close cash drawer, drop off deposit	
Office function: print/mail letters, sort mail/fax, scan	
Maintain/retrieve medical records	
Schedule patients from waitlist	

MEDICAL ASSISTANT CYCLE TIME ANALYSIS TEMPLATE

MA TASK OBSERVATIONS	AVERAGE (MINUTES)
Room patient (include vital time)	
Clean room and machines	
Schedule procedure/visits	
JCO readiness tasks (daily, weekly, monthly)	
· Daily (Ex: Fridge temp)	
· Weekly (Ex: Replenish supplies)	
· Monthly — Prep for EOC rounds	
Point of care testing	
· INR, A1c, etc.	
· Pregnancy test	
· Rapid flu	
Procedure (each listed separately)	
Injections	
· Vaccines	
· Medication	
Specimen collection	
· Urine sample	
· Stool sample	
Other screening/testing (varies based on specialty)	
Labs	
· Urinalysis	
· Blood draw	

CALCULATING NEEDED CAPACITY

Utilizing the cycle time for each task, and considering the practice's current and budgeted visit volume, RUMG took a data-driven approach to compute necessary staffing volumes, illustrating the standard tasks performed by the MAs and incorporates budgeted volume, which is usually patient volume or can be specific to the task (e.g., the number of messages or procedural volumes). Next, the total number of hours dedicated to each task is calculated, and then converted into an FTE by dividing by 2,080. An additional 0.20 FTE was added to account for any non-productive time, such as vacation.

REGISTERED NURSE CYCLE TIME ANALYSIS TEMPLATE

RN TASK OBSERVATIONS	AVERAGE (MINUTES)
Patient education	
· Self-administration medication demonstration	
· Procedure/surgical education	
· Testing education	
Procedure	
· List each procedure type separately	
Schedule procedure/visits	
Injections	
· Vaccines	
· Medication	
RN telemedicine	
· Phone or virtual visits on RN template	
Prior authorization	
Message (Return patient call by phone)	
Message (MyChart messages)	
Letters (FMLA, return to work, etc.)	
Triage messages/calls	
Maintain/retrieve medical records	
Schedule patients	

An important consideration in calculating needed capacity is quantifying care coordination. RUMG struggled with quantifying the time needed to complete some types of work, such as phone messages, prior authorizations or other tasks related to care coordination. In collaboration with information systems, RUMG was able to request reports that accurately captured time stamps for work performed in the EHR, which allowed for more accurate data. ›

MA TASKS AND FTEs NEEDED	MINUTES PER PATIENT (AVERAGE)	ANNUAL VOLUME	TOTAL MINUTES	TOTAL HOURS	NEEDED FTE
Room patient and clean room	12	10,392	124,704	2,078.4	1.00
Administer injections	10	400	4,000	66.7	0.03
Procedure: Hydrogen breath test	45	332	14,940	249.0	0.12
Procedure: H-pylori	30	10	300	5.0	0.00
Procedure: Esophageal motility	90	141	12,690	211.5	0.10
Procedure: Anorectal motility	90	141	12,690	211.5	0.10
Daily Joint Commission readiness	11	240	2,640	44.0	0.02
Monthly Joint Commission readiness	30	12	360	6.0	0.00
Weekly Joint Commission readiness	13.3	48	638.4	10.6	0.01
Procedure: Bravo	30	47	1,410	23.5	0.01
Stock and disinfect rooms at beginning and end of day	45	480	21,600	360.0	0.17
Total in-clinic tasks					**1.57**
Virtual visit prep	15	4,454	66,810	1,114	0.54
Total virtual visits					**0.54**
Follow-up, cancellation and referral work queue scheduling	3	7,000	21,000	350	0.17
Call patients about next day in-clinic appointment	3	10,392	31,176	520	0.25
Schedule procedures and put in orders	2.3	990	2,277	38	0.02
Messages	5	1,680	8,400	140	0.07
Prior authorizations Med APP (paper)	20	1,400	28,000	467	0.22
Prior authorizations Med APP (electronic)	10	1,400	14,000	233	0.11
Prior authorizations Med MDs (paper)	45	1,400	63,000	1,050	0.50
Prior authorizations Med MDs (electronic)	10	1,400	14,000	233	0.11
Total care coordination tasks					**1.46**
All MA tasks + 20% non-productivity					**4.27**

For high-resolution versions of these figures and PDF downloads, access the full article at mgma.com/s2d.

MANAGEMENT IMPLICATIONS

Once current and needed capacity were calculated, RUMG created a dashboard for each clinic, which compared actual versus needed FTEs (see table below). The variance for each clinic, positive or negative, was made available to practice and medical group leadership, and provided key management insights. These dashboards have been utilized for budgeting and hiring of staff, as well as for insight as to which clinics can share staff across multiple practices. As a practice's visit volume increases or decreases over time, this data informs requests for additional positions.

COMPARISON OF ACTUAL VERSUS NEEDED FTEs

CLINIC: ALLERGY AND IMMUNOLOGY	ACTUAL FTEs	NEEDED FTEs	VARIANCE
Medical assistant	2.0	1.8	+0.20
Registered nurse	2.8	2.9	-0.10
Clinic coordinator	3.0	1.7	+1.30

Historically, the medical group had a position control committee that reviewed requests for incremental and new positions for staff. Most of the feedback regarding the committee were that asks were made instinctually rather than through a quantifiable presentation. The committee evolved to require a quantifiable number based on the S2D framework. All positions — either replacement, incremental or new — are brought to the position control committee and reviewed based on the S2D dashboard.

STANDARD WORK

The previously private practices in the medical group had numerous variations in operations before joining the unified physician group. A huge benefit of S2D was the creation of standard work across all clinics. The standard work was developed through best practices identified by the observers. For example, if Clinic A is rooming patients within nine minutes, and Clinic B is rooming patients within six minutes, then the variance leads the team to explore what Clinic B is doing to be more efficient. Leadership has since standardized the best practice of Clinic B and applied it across the medical group. There were also inefficiencies identified throughout the practices that were eliminated. Ultimately, the more efficient a clinic becomes, the less time it would take to complete a particular task; e.g., a decrease in cycle time across the practice.

TOP OF LICENSE WORK

Ambulatory practices are most effective when staff operate at the top of their license, doing the tasks they were hired to do. If not, we need to shift the right work to the right people. The observations throughout all clinics that led to the S2D model illuminated the medical group's focus on top of license work. For example, the observers found in many practices that nurses and even physicians were rooming patients. As a result, the medical group applied a consistent model of MAs rooming patients.

FUTURE CONSIDERATIONS

The S2D model is dynamic and should be evaluated by practice leadership periodically. The medical group has asked that each practice refresh the S2D model at least quarterly. A next step in gauging the overall success of the S2D model will be to analyze the impact on patient, provider and staff engagement. If clinics have the right staff performing the right tasks, we would expect to see an increase in quality care for patients and highly engaged employees. Of course, no quantifiable model can take the place of empowering the leadership team and staff to improve operational efficiency.

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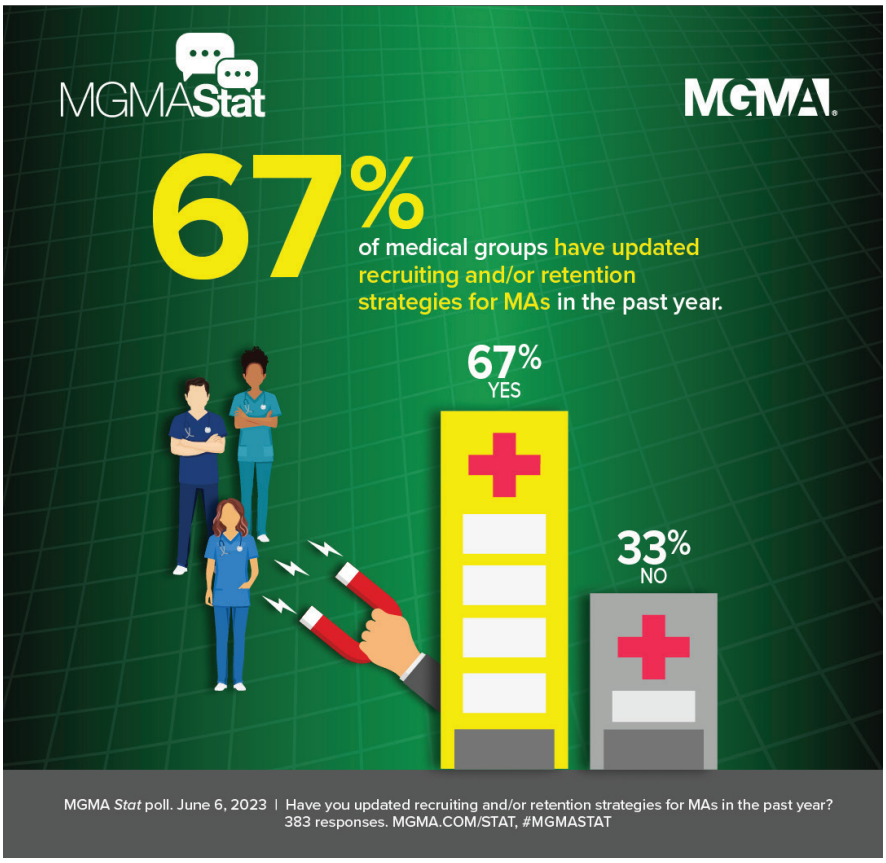
Shifting strategies to improve medical assistant recruitment and retention

It's no secret that hiring medical assistants (MAs) following The Great Resignation has been a challenge, affecting almost all practices, and that MAs have been among the toughest non-physician roles to hire in recent years, according to past MGMA *Stat* polls.

So, what's the secret to improving recruitment and hiring strategies for medical groups to get talented candidates on board and stay there for the long term? That's what a June 6, 2023, MGMA *Stat* poll sought to find out.



About two-thirds of medical group leaders (67%) report they updated recruiting and retention strategies for MAs in the past year, versus 33% that did not.

Among the one-third of practice leaders who responded "no," MGMA asked if they were having difficulty hiring or retaining MAs. Many of these respondents pointed to an extreme scarcity of applicants for the open jobs they've posted. As for those not reporting such difficulty, they were asked which factors drove their success:

- In many cases, the respondents' organizations mostly use nurses and have little need to recruit or retain MAs. Other respondents in college towns that can hire a lot of pre-med students in their gap year report good hiring but a decent amount of turnover every May and June.
- Others pointed to strong organizational culture and team atmospheres that make employees want to stay.

WHAT'S WORKING IN RECRUITMENT AND RETENTION

As one practice leader told MGMA: **"First we completed a new market analysis to see our position in the market with pay. We have brought our pay scale more in line with the study results. We have made our referral program more robust. We are requiring our management to be more proactive with performance feedback to our new hires, as well as ensuring all 90-day reviews are completed. We feel good communication, true interest in the employee well-being and competitive pay are the core for retaining employees in this competitive market."**

Some of the most common responses from other respondents to the poll included:

- Increased compensation (including equity pay adjustments) and bonus incentives
- Increased use of sign-on bonuses tied to a one- or two-year commitment
- Efforts to match outside offer letters and not requiring certification for some candidates with experience
- Engaging outside agencies for a larger pool of candidates and expanding advertising of open jobs
- Broadening a practice's presence at local job fairs and making offers on the spot
- Increased collaboration with nearby MA school programs, as well as apprenticeship programs and outreach to high school students to encourage them to consider work as MAs
- Implementation of in-house training and certification programs, often with cross-training efforts
- Creating career ladders with tuition support
- More part-time positions
- Transitioning mostly administrative duties off MAs' plates

BUILDING MA TRAINING CAPACITY

One of the biggest obstacles to hiring MAs during the post-pandemic labor market has been the scarcity of training capacity for new MAs to join the workforce. As detailed in the July 2022 *MGMA Connection* magazine, Cone Health in North Carolina invested in its own training program to pick up where the nearby community colleges and technical schools were unable to keep pace with the demand for certified MAs (CMAs).

Similar programs have shown positive results in recent months. According to *Community College Daily*, the Alamo Colleges District — a network of community colleges in San Antonio, Texas — partnered with the College of Health Care Professions to build an "earn-and-learn" MA program catering to working adults who sought flexible and evening class schedules to become CMAs. The program is funded for the next four years via a 1/8-cent sales tax that helps pay for workforce development in the area, according to Diverse Education.

TRAINING MAs FOR NEW TECHNOLOGIES

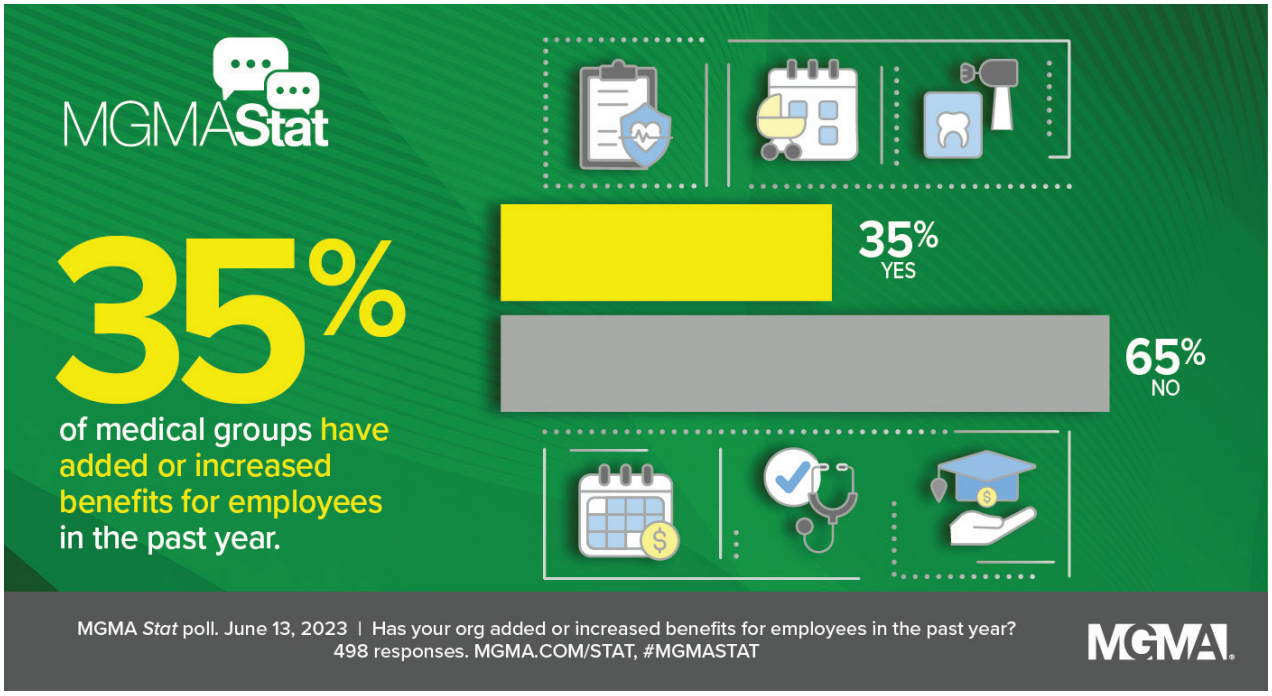
Even though the long-term future of telehealth is uncertain, as the industry shifts beyond the COVID-19 public health emergency, the vast expansion of virtual care delivery is still an important topic for healthcare leaders looking ahead to future workforce training and development strategies.

A recent report by the University of Washington (UW) Center for Health and Workforce Studies suggests that MAs using telehealth during the pandemic were capable of the transition but could have benefited from more education and training on virtual care services, as reported by *mHealth Intelligence*.

The study also noted telehealth training alongside the other elements of evolving MA roles as the industry shifts, especially in the primary care space: "The most common roles that surveyed physicians reported MAs could take on with proper training included those related to population health: management of patients with chronic health conditions such as diabetes, identifying patients in need of preventive screening and EHR data extraction for managing patient panels," the UW report read.

Pace of employee benefit additions and improvements cooled in 2023

While competition for certain roles in medical group practices remains intense, fewer healthcare leaders said they expanded or added to their employee benefits as a tool to recruit and retain those workers last year.



A June 13, 2023, MGMA *Stat* poll found that 35% of medical groups added or increased benefits for employees in the past year, while 65% reported "no." The poll had 498 applicable responses.

The poll results mark a 10-percentage-point shift from a similar MGMA *Stat* poll from May 31, 2022, which found nearly half (45%) of medical groups had made improvements or additions to the slate of benefits offered to employees. However, the latest poll shows the share of group practices working to boost their benefit offerings is still above levels noted in a June 8, 2021, poll that found only about one in four (26%) of groups were adding or expanding employee benefits.

Healthcare leaders are still on guard for potential turnover and losing out on talented candidates, as better wages and benefits were the top reason given for employee exits in a February 2022 poll, well ahead of factors such as burnout, retirement or leaving the workforce. While sectors such as technology saw sizable layoffs in the past year, demand for labor in ambulatory care remains high alongside the demands for care as practice leaders address lingering issues from the COVID-19 pandemic and The Great Resignation.

THE TOP CHANGES IN EMPLOYEE BENEFITS IN 2023

A larger majority of group practices reported not making updates or additions this year compared to 2022, and many of those leaders told MGMA that their efforts in this area have been put on hold after either greatly expanding benefits in the past two years or being in a financial situation in which hiring is frozen or headcounts are falling, and expanded offerings are not sustainable.

However, leaders at group practices that did not expand or add offerings told MGMA that they are considering making changes to:

- Employer contributions to 401(k) match
- Paid sick leave, wellness and mental health days
- Employee assistance programs (EAP)
- The tenure-based bands/tiers at which employees earn more paid time off
- Shifts of siloed time off buckets into a single bank usable for any purpose
- More health savings account (HAS) offerings
- Short- and long-term disability insurance plans
- New pet insurance and legal aid offerings.

As group practices continue to face challenges in recruitment and hiring for high-demand candidates, several respondents to this poll noted that their benefit offerings expanded into areas around professional development for their workers, such as access to certifications, training or improved tuition reimbursement. This focus reflects MGMA's polling on MA recruitment and retention strategies, which noted many healthcare leaders finding success by creating career ladder programs and other routes for clinical staff to grow with the organization.

FAMILY LEAVE AND REPRODUCTIVE HEALTH

One of the most common responses from healthcare leaders who added or expanded benefits this year were focused on maternity and paternity leave, especially as more states mandate or plan to implement paid family leave in 2024. Employers in states that enact paid family leave should pay close attention, as maternity and paternity leave often are implemented to offer fathers the same benefit as mothers.

According to the brokerage Newfront, reproductive care and family planning benefits — including coverage for abortion-related medical expenses and infertility care — have been on the rise as health reimbursement arrangements (HRAs) respond to the 2022 Supreme Court decision to overturn *Roe v. Wade*.

EVERYBODY LIKES TO SAVE

While the pace of inflationary growth has cooled significantly since the summer of 2022, most consumers are still paying much higher prices for everyday goods than they did in 2020, and many employers have responded by creating or using an employee discount program that offers perks on grocery items, recreational passes and more.

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