

# How Many Staff Members Do You Need?

Crystal S. Reeves, CPC

*While there's no one staffing formula that fits every practice, industry benchmarks can point you in the right direction.*



Many physician practices struggle long and hard with finding just the right number of staff members to work in just the right jobs at just the right time. Few practices ever master the struggle and reach staffing “utopia.” Those that do attain favorable staffing levels and stability tend to experience it only briefly.

The mistake many practices make is adopting an oversimplified and reactionary approach: If the work falls behind or everyone is pleading for help, they add staff. And if overhead expenses grow too high, they cut personnel costs.

**Over-staffing brings an increase in costs, but not always a corresponding**

This backward-looking approach seldom works, creating a pendulum effect that results in having either too many or too few staff members on board. Over-staffing brings an increase in costs, but not always a corresponding increase in efficiency or quality. Under-staffing can lead to decreased patient

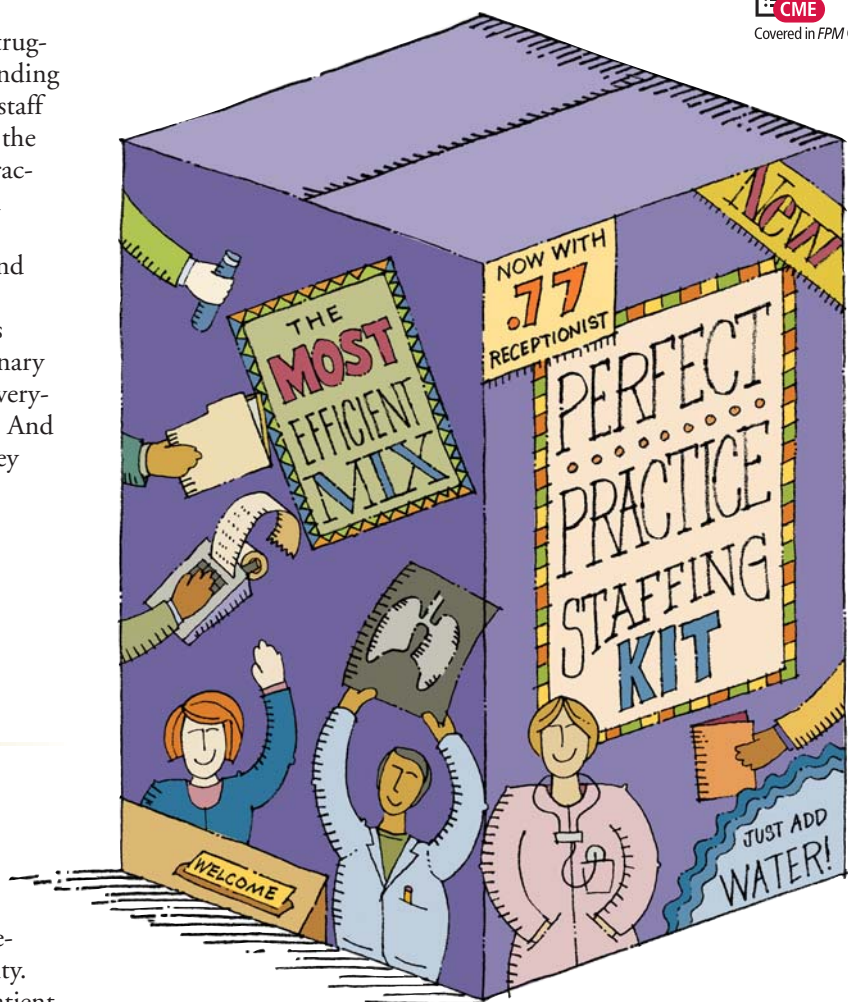


ILLUSTRATION BY MICHAEL SPRONG

*Crystal Reeves is a principal of The Coker Group, a national health care consulting firm in Atlanta. She is also an author and national speaker on medical practice management issues. Conflicts of interest: none reported.*



Many practices take an oversimplified and reactionary approach to staffing: If work is behind, they add staff. If overhead expenses are too high, they cut staff.



The most effective way to determine your staffing needs is to consult industry benchmarks, allowing adjustments for unique circumstances within your practice.



To ensure you are comparing apples to apples, understand how the benchmarks you are consulting were derived and follow the same methodology in calculating your own numbers.



The support-staff-per-FTE-physician ratio indicates the number of full-time staff members it takes to support one full-time physician in a given practice.

satisfaction, reduced collections and poorer financial performance.

So what is the secret to successful staffing? Although the answer depends greatly on hiring people whose work ethic, experience and expertise make them well suited for the job, physicians can attain a general idea of their staffing requirements by comparing their practices to industry benchmarks and making adjustments to the numbers, as needed.

### How to do it

The first step in benchmarking is to find reliable sources of data for physician practices, such as the Medical Group Management Association (MGMA), Practice Support Resources (PSR), the American Medical Association (AMA) and the American Medical Group Association (AMGA), as well as local medical societies (see the list on page 48 for contact information). When comparing your practice with industry performance standards, try to find data for practices similar to yours and consult at least two sources for a broader perspective.

The next step is to determine what to measure. When it comes to staffing, most practices want to know the answers to two questions: Do we have enough individuals to do the work? And are our staffing costs in line with those of other similar practices?

To answer these questions, look for benchmarks that address the following:

1. The number of support staff per full-time-equivalent (FTE) physician,
2. The percentage of gross revenue spent on support staff salaries.

The grid on page 47 shows two sets of staffing benchmarks – one from PSR and one from MGMA.

The third column in the grid provides a place for practices to enter their own data for comparison. For

practices to be able to compare “apples to apples,” it is important that they understand how these benchmarks were derived and follow the same methodology in calculating their own numbers. Different surveys may use different methodologies (you can usually find them described within the survey document), but they will generally resemble the following:

#### Support staff per FTE physician.

### KEY POINTS

- Practices can begin to assess their staffing levels by consulting industry benchmarks, which are widely available.
- When comparing their staffing levels to benchmark data, practices may need to adjust their numbers based on unique circumstances.
- High physician productivity may justify higher staffing levels than the benchmarks suggest.

The support-staff-per-FTE-physician ratio indicates the number of full-time staff members it takes to adequately support one full-time physician. (Midlevel providers are not included in this calculation but will be accounted for later under “Adjusting the numbers.”) The Medical Group Management Association (MGMA), one of the leaders in practice benchmarking, uses the following methodology to determine FTE physicians:

1. Determine how many physicians in your practice work “full time” (defined as the minimum number of hours considered to be a normal workweek in your practice).

2. For each physician who works less than full time, divide his or her average number of hours worked in a week by the full-time standard to determine FTE status. For example, if Dr. A works 30 hours a week in a practice that considers 40 hours to be full time, his FTE status is .75 ( $30/40 = .75$ ).

3. Based on steps 1 and 2, above, calculate your total number of FTE physicians. For example, if you have two full-time physicians and two physicians who each work 30 hours per week in a practice where 40 hours is a full workweek, your number of FTE physicians would be 3.5 ( $1+1+.75+.75=3.5$ ).

Follow the same process for determining your FTE support staff. Then, divide the number of FTE support staff by the number of FTE physicians. This quotient is your staffing ratio. For example, 15 FTE support staff divided by 3.5 FTE physicians = 4.3 FTE support staff per FTE physician.

**Staffing expenses as a percent of revenue.** To determine staffing expenses as a percent of revenue, divide the amount paid in staff salaries by gross revenue for the same

Many practices cannot accept their numbers at face value.

period. For MGMA benchmarks, this figure includes support staff salaries and benefits. Others, such as Practice Support Resources, Inc. (PSR), include salaries only. A practice should be able to obtain its staffing expenses from the year-to-date information available on its profit and loss statement.

### Adjusting the numbers

Many practices cannot accept their numbers at face value. Extenuating circumstances within practices often have an effect on staff size requirements or account for staffing salaries that are higher or lower than benchmarks. For this reason, practices should consider the following points before deriving any conclusions regarding their staffing numbers.

**Midlevel providers.** Practices may need to adjust their target staffing levels based on whether they employ nurse practitioners or physician assistants. For example, the MGMA 2001 *Cost Survey*<sup>1</sup> provides benchmarks of 0.38 MLPs and 4.67 support staff per FTE physician in family practice. If your practice has no midlevel providers, your staffing needs may be lower. If your practice has a high number of MLPs per physician, you will likely need more staff than the benchmarks suggest in order to support the additional providers.

**Physician productivity.** Practices may also need more or less staff than the benchmarks suggest depending on the number of patients each physician sees in a day and the number of procedures and ancillary services the office provides. Therefore, when comparing FTE physicians, it is also advisable to compare gross charges per physician or the number of visits per week or per year.

For example, PSR's 2001 *Practice Management STATS Quick Reference*<sup>2</sup> provides the following physician productivity benchmarks for family physicians:

- Total annual gross charges: \$417,000 to \$550,000,

- Ambulatory visits per week: 95 to 125,
- Inpatient visits per week: 6 to 12.

(According to PSR, these ranges cover about half of the practices surveyed, with about 25 percent above and 25 percent below the ranges.) Using these figures, a practice may want to adjust the number of FTE physicians it uses in estimating appropriate staffing. Physicians whose productivity figures fall near or beyond the extremes of these ranges may cause a practice's actual

number of FTE physicians to be misleading. For example, consider a practice with three FTE physicians has total annual gross charges of \$1,800,000. If you divide total charges by the range maximum,

\$550,000, the adjusted FTE physician number comes to 3.27. The higher physician productivity could warrant higher staffing levels.

**Satellite locations.** Satellite locations are a great way to increase a practice's patient base, but sometimes they call for heavier staffing. If the satellite location functions as a full-time independent practice with its own support staff, then its staffing levels should be comparable to those of traditional practices. However, if a practice's satellite location is

**The well-organized physician will probably require fewer support staff than one who is less organized.**

### SPEEDBAR®



Special circumstances within a practice may account for staffing levels that are higher or lower than the benchmarks.



Practices that employ midlevel providers may require more staff to support them.



Physicians who are extremely productive, or those who see fewer than, say, 90 patients per week, may cause a practice's actual number of FTE physicians to be misleading.



Physicians' practice styles and degree of organization can also affect the number of staff they need to support them.

### A QUICK COMPARISON

The grid shown here provides two sets of staffing benchmarks for family practice (one from Practice Support Resources' 2001 *Practice Management STATS Quick Reference* and one from Medical Group Management Association's 2001 *Cost Survey*). Practices can list their own staffing numbers in the third column and compare and adjust their numbers as needed. PSR provides a range for surveyed practices, while MGMA provides the median. Other sources of benchmarking data are listed on page 48.

	PSR	MGMA	Your practice
Support staff per FTE physician	3.0-5.0	4.67	
Support staff cost as a percentage of gross revenue*	25-27%	31.57%	

\*PSR includes only support staff salaries in this calculation; MGMA includes support staff salaries and benefits.



A practice with highly experienced staff members may operate smoothly with staffing levels below the benchmarks.



If a practice outsources functions such as billing and bookkeeping, it could justify staffing levels that are less than the benchmarks.



High staffing costs (figured as a percentage of revenue) could indicate a revenue problem, not a staffing problem.



Staffing costs may need to increase in the short-term to strengthen revenue in the long-term.

used only part of the time, with physicians and office staff floating between the two facilities, the practice's total staffing needs for the two locations may be slightly greater.

**Practice styles.** Physicians should also consider how their practice styles affect their staffing needs. The well-organized physician who sees patients on schedule and completes paperwork in a timely manner will probably

require fewer support staff than one who is less organized. Likewise, staff members who must deal with patients disgruntled from extensive waiting, or who must search through piles of charts to find the record they need, will not be able to accomplish as much work in a given time period. An office's layout, its practice management system and patient demographics can also

**Reducing staff to save money can be like stopping your watch to save time.**

impact staff members' efficiency. If your staffing levels are higher than the benchmarks, consider whether your practice style, facilities and equipment justify the additional staff, or whether your practice needs improvement in one or more of these areas.

**Staff expertise and experience.** Practices also should bear in mind that the experience and expertise of their support staff will often have an effect on the number of

support staff needed. If the practice's employee-turnover rate is high, that usually means the practice is functioning in "training" mode a large portion of the time. New employees generally require more time to perform routine tasks and responsibilities than do veteran workers. Those staff members who have been with the practice for two or more years are likely to perform their jobs more efficiently, to look ahead at what needs to be done, to make decisions on their own and to relieve the doctor of some low-level tasks. If your staffing ratio is high compared to the identified benchmarks, figure the percentage of staff members who have been with your organization for less than one year. If this number is over 30 percent, it may explain why your staffing levels are high. To cut down on the number of staff members you'll need in the future, begin exploring ways to attract and retain more experienced staff members.

**Work performed by others outside the practice.** A practice's staffing needs are also affected by the duties it delegates to others outside the practice. For example, physicians may receive services from a hospital network or a management services organization (MSO) — services such as managed care contract negotiation and credentialing, transcription, billing, human resource management and general bookkeeping functions. Adjusting for those functions will alter the number of staff members your practice requires.

To gauge how large an adjustment to make for work performed outside the practice, you can consult MGMA's *Cost Survey*, which breaks down the median number of staff members per FTE physician by job responsibility as shown in the table on page 49.

If your practice does not perform clinical

## BENCHMARKING RESOURCES

Physicians can access reliable benchmarking information from a number of resources, including the following:

### American Medical Association

*Physician Characteristics and Distribution in the US* (AMA members: \$150; Nonmembers: \$170) and *Medical Groups in the US* (AMA members: \$74.95; Nonmembers: \$99.95). Call 800-621-8335 or visit [www.ama-assn.org/ama/pub/category/2672.html](http://www.ama-assn.org/ama/pub/category/2672.html).

### American Medical Group Association

*Medical Group Compensation & Productivity Survey* (AMGA members: \$175; Nonmembers: \$250) and *Medical Group Financial Operations Survey* (AMGA members: \$175; Nonmembers: \$250). Call 703-838-0033 or visit [commerce.amga.org/store/category.cfm?category\\_id=2](http://commerce.amga.org/store/category.cfm?category_id=2).

### Medical Group Management Association

*Cost Survey* (MGMA members: \$240; Nonmembers: \$450) and *Performance and Practices of Successful Medical Groups* (MGMA members: \$265; Nonmembers: \$475). E-mail [surveys@mgma.com](mailto:surveys@mgma.com), call 877-275-6462, ext. 895, or visit [www.mgma.com/surveys/](http://www.mgma.com/surveys/).

### Practice Support Resources Inc.

*Practice Management STATS Quick Reference, Individual Specialty* (\$45) and *14 Specialties* (\$199). Call 800-967-7790 or visit [www.practicesupport.com](http://www.practicesupport.com).

## MGMA STAFFING BENCHMARKS BY JOB CATEGORY

MGMA's 2001 *Cost Survey*, breaks down the median number of staff members per FTE physician for family practices as shown below. (Warning: Do not expect the sum of these numbers to equal the overall median staff-per-FTE-physician ratio; that is determined separately.)

General administrative	0.24
Business office	0.80
Managed care administrative	0.16
Housekeeping, maintenance, security	0.14
Medical receptionists	1.0
Medical secretaries, transcribers	0.34
Medical records	0.43
Other administrative support	0.13
RNs	0.44
LPNs	0.40
MAs, nurse aides	0.76
Clinical laboratory	0.34
Radiology and imaging	0.21
Contracted support staff	0.23

lab and radiology services and sends transcription to an outside source, for example, the total number of full-time staff you require is probably going to be less than MGMA's benchmark of 4.67 per physician.

**Staff salaries.** The final adjustment involves comparing staff salaries to gross revenue. When using this comparison, it is important to be aware that revenue (the money brought into the practice) depends largely on the staff's ability to get the work done. Understaffing in the billing office or inexperienced staff at the front desk will usually result in lower revenue for the practice. Thus, reducing staff to save money can be like stopping your watch to save time – a futile exercise. In fact, staffing costs may need to increase in the short-term to strengthen revenue in the long-term.

If your staffing costs as a percentage of revenue are much greater than comparison figures, first examine whether you have a revenue problem, not a staffing problem. For example, your fee schedule may be too low, you may have poor managed care contracts or you may need to improve your collections. Revenue problems can paint a darker staffing picture than actually exists.

**Better-performing practices tend to have slightly more support staff per physician.**

If a practice's staffing levels are slightly higher than the benchmarks yet its performance is strong in other key areas, its physicians should be cautious about reducing staff. Studies performed by MGMA, as well as other private organizations, illustrate that better-performing practices (those with high patient satisfaction levels and high revenue) tend to have slightly more support staff per physician. This finding highlights the problem of taking benchmarks at face value, a factor that needs to be paramount in the minds of physicians and managers as they pursue the most favorable staffing levels for their practices. Only by combining industry data with your own unique knowledge about your practice will you be able to move forward with an enlightened staffing plan. **FM**

Send comments to [fpm@aaafp.org](mailto:fpm@aaafp.org).

1. *Cost Survey: 2001 Report Based on 2000 Data*. Englewood, Colo: Medical Group Management Association; 2001.
2. *Practice Management STATS Quick Reference (Family Practice)*. Independence, Mo: Practice Support Resources; 2001.

## Moving forward

Once the practice has completed the benchmarking process, the physicians and practice leaders need to ask themselves the following questions before making any staffing changes:

- Am I happy with the way the practice is currently functioning?
- Am I willing to improve my own efficiency so I require less staff time?
- Am I willing to pay more for staff in order to attract and retain more experienced workers?
- Are my staff and patients satisfied with the way the practice functions?

## SPEEDBAR®



Before making staffing changes based on the benchmarking process, physicians should examine how well their practice is functioning overall.



If a practice's staffing levels are slightly higher than the benchmarks yet its performance is strong in other key areas, its physicians should be cautious about reducing staff.



Better-performing practices tend to have higher staffing levels.



Combining industry data with your own unique knowledge about your practice will produce an enlightened staffing plan.