How Many Employees Are Optimal?

The COVID-19 pandemic has precipitated a reason to re-examine staffing ratios.

BY JON A. HULTMAN, DPM, MBA

One common question has been raised by our podiatric practices during the COVID-19 pandemic as they furlough employees. This is, "How many staff members does a practice actually need?" One of the largest overhead costs incurred in an office is that of staff salaries. Physicians attempting to control this expense while maintaining quality should focus on achieving *optimum* staffing ratios rather than simply cutting positions. It turns out that achieving this goal is easier said than done. How do we determine the ideal ratio of full-time staff to doctor (FTE staff/Dr.)? Doctors looking to their peers in hopes of finding useful benchmarks will find a wide variation in this ratio—even among those who have practices of comparable patient volume and revenue.

Variation in staffing ratios for medical practices is extreme—ranging from one FTE staff/Dr. to as many as ten. What effect does this differential have on treatment and financial outcomes? Two practices can take in equivalent revenues and have similar patient volumes in which the doctors in one group are able to keep 60% of what they produce, while those in the other keep only 30%. This disparity was traceable almost entirely to a significant difference in the staffing ratios of the two practices—the ratio deemed "necessary" by each of them to (1) treat equal patient volumes and (2) process similar numbers of business transactions. One thing is clear: staffing ratios have an impact on both productivity and costs—with the *optimum ratio* defined as that which (1) achieves the highest level of productivity, without sacrificing quality, at the lowest cost.

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A multitude of factors lead to this variance in staffing ratios. Process bottlenecks are often used as excuses for adding more and more staff. It becomes difficult to pin down the factors which cause one practice to utilize twice the number of staff as another to achieve the same results when the two practices are equivalent in their numbers of doctors, patients, and revenue. Working the same number of hours, the doctors in the practice with fewer staff earn far more than those with more. How are they maintaining their level of productivity with fewer staff?

The Simplest Model

To gain an understanding of how difficult it is to determine optimum staff size, let us start with the simplest model—a practice with one doctor, one nurse, and three treatment rooms. The FTE staff/Dr. ratio for this practice is "one." This is typical in the high tech, "micro-practice" model. In this model, the doctor and one staff person divide duties—the two alone able to

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do whatever tasks need to be done to treat all the patients and complete all the paperwork. What happens when we go from this "simple," one doctor, one staff, three-treatment-room model to a practice with three doctors and nine treatment rooms?If we were to carry this micro model forward to a three doctor practice and maintain the FTE/Dr. ratio at one, the practice would have a staff size of three; however, what often happens when doctors merge in this way results in something very different. As the practice grows to three doctors, staff numbers frequently triple to nine (or more) increasing the FTE staff/Dr. ratio to three (or higher). It often takes nine staff to accomplish what was once achieved by three.

In some practices, this same number of doctors may even employ up to fifteen staff. In general, the FTE staff/Dr. ratio tends to increase as the size of a group increases—often exponentially. Adding staff *can* sometimes increase productivity; however, in most cases it does not. Personnel are typically added to a practice simply to "handle" the increased complexity and magnified inefficiencies brought about by a growing practice, rather than for purposes of increasing productivity. Most often, the cost of the salaries for the additional six staff in our three-doctor example does not achieve its equivalent in benefits. In fact, because of increasing inefficiencies in a growing practice, each staff person added beyond the optimum number generally provides only marginal return for his/her additional cost—often as little as 15% of this cost. Hiring additional staff often leaves a practice with less profit and those in it still feeling understaffed!

A study conducted by Toyota determined that when using traditional, dependent series processes, only this 15% marginal benefit is gained from each additional employee hired. The researchers determined that at any given time, 85% of Toyota's workers were accomplishing nothing. In reality, only 5% of these employees actually were "not working". Of the remaining 80%, 25% were performing unnecessary tasks, 30% were "waiting for something", and 25% were working inefficiently—all of which effectively accomplish nothing—the same as "not working". These "idle times" are created by "invisible" inefficiencies present within every process—inefficiencies created by bottlenecks, variation, waste, and a need to interrupt fellow employees to obtain information.

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When staff size is optimized and FTE/Dr. ratios lowered, a practice gains far more than a 15% benefit from each staff member. The basic difficulty in determining an optimum staff number is that, within any practice, the volume and urgency of tasks fluctuate from minute to minute, hour to hour, and day to day. At one moment, the phone is quiet, and at another, it is "ringing off the hook." In the first scenario, no staff members are required; yet, the second might require three people to handle the phone.The same holds true with every task within a practice—checking patients in or out, calling to verify insurance eligibility, entering demographic and billing data into a computer, providing patients with information, responding to patient questions, opening and distributing mail, escorting patients to treatment rooms, quoting fees, assisting the doctor, or making return appointments.

In spite of the fact that all staff *should* be able to perform any of these duties when work is backed up, they often *cannot*—even when their own assigned tasks are "quiet" at the time. This is usually due to the fact that staff members have not been cross-trained, office policies are outdated, or job descriptions limit what each staff member is allowed to do. When processes are inefficient and backlogs build up, the typical "solution" is to hire more staff rather than redesign and streamline the blameworthy processes and rethink outdated training and job descriptions.

A focus on redesigning processes and workflows so that current staff members are able to utilize their time efficiently and effectively is an alternative to constantly hiring more personnel. It is a fact that even during busy periods, each member of the staff can be idle more than 50% of the time—his/her time spent "waiting for something," looking for information (and often interrupting yet another employee to obtain that information), or performing duties which are not necessary (duties which could be eliminated).This idle time needs to be captured and used effectively. When applied in a targeted, well thought out manner, today's technology can be instrumental in enabling efficient processes which assist in the effective use of wasted time and in avoiding some of it altogether. This is possible because

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technology can be located anywhere in the practice. This saves time because it eliminates geographic barriers, creating the possibility of performing multiple duties, in parallel, at any time, from any location in the office. Any temporarily idled employee, at any location, can answer the phone without the need to transfer the call elsewhere because s/he can complete the necessary "transaction" himself/herself—a transaction such as responding to a patient question or scheduling an appointment. This use of previously wasted time greatly lessens the need for adding more staff.

The goal in this three-doctor example practice is to train a staff of six to be capable of functioning during busy times as though it were a staff of nine. This can be made possible through the implementation of effective processes and technology, paired with cross-training and empowerment of staff. This saves unnecessary staff expenses, and it is likely that, should a practice later feel the need to hire more staff, these new members will be employed for purposes aimed at increasing productivity rather than at reducing backlogs—a *proactive* as opposed to a *reactive* response. The COVID-19 pandemic has precipitated a reason to re-examine staffing ratios. Achieving an optimum ratio is not only good for doctors, it is also good for staff—especially those who desire long-term careers that are both secure and rewarding. **PM**

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Dr. Hultman is Executive Director, California Podiatric Medical Association, President, Medical Business Advisors, specializing in practice evaluations, valuations, and mergers. He is the author of *Reengineering the Medical Practice and Medical Practitioner's Survival Handbook*.