

HOW MUCH *IS*

Too Much?



For physicians in small group practices, the biggest challenges can lie in managing staff workloads.

Are staff burdens realistic?

How to spot the danger signs of overload and burnout.

BY BARBARA ALDEN WILSON

The physician partners in the Atlanta-area specialty practice, like most others in today's health-care market, had decided to increase responsibilities among their administrative staff rather than hire any new employees. Several months later, office morale seemed low, staff members were complaining that they were overworked, and the threat of more than one employee quitting was real.

Getting to the bottom of the problem wasn't easy. Talking the problem out with staff got the partners nowhere—everyone involved seemed to take even the most constructive criticism personally. Enter the consulting group, Medical Management Associates, Inc., to assess the situation.

"We spoke to one employee whose job was to schedule surgery and determine patients' insurance precertification," recalls Russ Steele, the vice president of Medical Management Associates. "She said her job required too much of her, and that precertification took up most of her time. But when we tracked her over a period of weeks, we discovered that both responsibilities actually should have taken up only five and a half hours a day. She hadn't been able to get the work done in an eight-hour shift, but she couldn't come up with a reason for this. We

pointed out that it was probably because she socializes too much. You can't talk about your weekend activities 20 times on a Monday and call yourself efficient."

Managed care confusion

Looking at an "overworked" employee's level of efficiency is one of the most logical starting points in a practice that is not working up to par. But workload concerns among support staff are not always unfounded. "Multi-tasking" is a given for employees and physicians alike in most practices, and experts agree that managed care is the culprit.

Elizabeth Woodcock, an Atlanta-based consultant with the Medical Group Management Association's



Elizabeth Woodcock

(MGMA) Health Care Consulting Group, cites one practice that studied how long its staff members were put on hold to get insurance information over the telephone. The average wait per call: 17 minutes.

"The paperwork relating to all the documentation required for managed care has increased for everyone in the physician's office," Woodcock says. "I've never talked to a staff member who feels he or she is underworked. And even with a great office administrator, staffers with complaints will go to the physician."

Another MGMA consultant, Dallas-based Bob Bohlmann, says, "Life as a physician in a small practice or group has become so complicated that many physicians are leaving to join hospitals or larger groups with managers to handle overseeing administrative issues and staff."

Physicians who choose to remain more au-

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onomous must often deal with resentment among staff members. For physicians whose passion lies in practicing medicine and not in administrative hand-holding, the demands of practice management can seem irritating, if not downright ridiculous.

"It used to be that you could put Suzy Q at the front desk to smile and say hello to patients as they came in and to schedule appointments," he says. "But now, doctors have to hire someone with an understanding of managed care—insurance stipulations, primary-care provider requirements and the insurer's referral process—and of how important these things are in maintaining patient flow. And finding competent people isn't easy. With the economy as good as it is, there are fewer good workers available."

What's more, even the best workers may not have the same outlook on work or life in general as the physicians who employ them.

"Some of the people working for you may not have a college educa-

tion. They may be 10 or more years younger than you are, and they probably have far different goals in life than you do," says Debi Croes, a principal with the Croes



Debi Croes

Oliva Group, a practice management consultant group in Burlington, Massachusetts. "And what you consider to be common sense may be something you need to spell out for someone who works for you. I never cease to be amazed at what people do with my instructions. Often, I get exactly what I asked for, but the literal interpretation of the assignment wasn't what I expected."

Add to these challenges the fact that young physicians find little, if any, formal education in practice management during their training, and it's no wonder small group practices can quickly become mired in turmoil.

It's not easy being green

Three years out of school, after a stint in public health, one family physician

in the Northeast was invited to join a small group practice that seemed to be everything he wanted—a moderately prosperous practice in a medium-sized town where most of the population was professional and well-educated. Staffers seemed competent and enthusiastic during his interview. But once he joined the practice, the climate seemed to change.

"There were some very deep-seated problems there that the staff had with the other two physicians," he says. "And the doctors didn't want to deal with them. I was elected to be the diplomat among three camps—the partners, the nurses, and the support staff—and I had no idea how much of a losing situation I was in. The administrative staff would complain to me about their workload. The physician partners would complain to me about the staff's 'cluelessness.' The nurses would complain about having to pick up administrative slack. And pretty soon they all hated me, because I couldn't do anything about the fact that none of them was willing to change."

Is it Time for a Group Manager?

Small groups of two to four physicians usually don't have staffing or patient volume to support a full-time group manager, according to Bob



Bohlmann, a consultant with MGMA's Health Care Consulting Group. However, if the group grows to five or more physicians or the current partners feel overwhelmed with personnel issues, hiring a group manager may be a smart idea.

The top reasons for hiring an office manager, according to Russ Steele, the vice president of Medical Management Associates, Inc., in Atlanta, are:

- Physicians' lack of time to address employees' day-to-day concerns
 - Scheduling staff members' hours/vacation time
 - Lack of knowledge regarding how to hire support staff
- Most medical group managers

in large group practices have masters' degrees in health-care or business administration (MHAs or MBAs), some with MDs as well. But in a small practice, according to Bohlmann, the senior support staff person is often promoted to be the office manager. In an atmosphere where support staff often become friends over a period of time, the newly promoted office manager may face problems acquiring credibility and authority. "Sometimes, seniority isn't enough, and you need to hire a

group manager from outside the practice," says Bohlmann.

In other cases, hiring a group manager with experience "in the trenches" as a support staff person may serve a small practice better than hiring a person with advanced degrees but little or no practical experience.

"If you can see a pattern of leadership and you can verify good references, the experienced staffer or office manager who has moved up through the ranks may be just the person for the job," says Steele. ■

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Croes says the first thing young physicians must realize is that they are not trained in human resources management, "and the learning curve is HUGE."

"Before you even begin practicing, seek out peers and senior physicians who are working in well run small practices," she says. "Attend seminars at medical conferences. Look into management classes at your local community college, anything to learn more about how to manage employees."

The family physician described above, now with another practice in a neighboring town, says training and course work in practice management would have helped him. The American Medical Association Young Physicians Section agrees. A few residency programs offer training on the business aspects of practice, according to the section. As of this writing, the Young Physicians Section is planning to ask the AMA to survey senior residents and recent graduates at the association's annual meeting in December. The survey will ask respondents about their exposure to practice-management issues during training. Residency program directors also will be surveyed about practice-management curricula. This information will be used to develop recommendations for practice management course work as a prerequisite to completing medical school.

Croes says she is not sure that credit requirements are necessary for bringing prospective physicians up to speed on the demands of practice management. "I am always in favor of helping people understand reality," she says. "But learning to manage a practice successfully is a series of many tiny steps. There is no magic bullet."

Strategies for small group success
What to do about staff and workload issues?
Experts in the field suggest the following:

- **Hire the staff you need.** It's tempting to try to keep your personal income up by keeping the staff small, but too few support staff will cost you in the long run. "Patients dump doctors when they can't get through on the telephone or when they're kept waiting for two hours beyond a scheduled appointment time," says Steele.

Woodcock maintains that all of the better-performing practices she's worked with say that they are overstaffed. "They understand that staffing can be used to leverage a physician's time," she says. "No one but the physician can bill for time. With volume comes profit, so proportionately, even with a larger staff, you can still create more revenue. In general, four hours of pay for extra staff is paid for with one additional patient per day."

Schools of thought differ on how to determine the staffing you need. According to Bohlmann, some physicians prefer to hire according to how many physicians share the practice. A 1998 staffing study by the MGMA, for example, shows that the median number of staff positions per physician in family medicine is 4.53; in general surgery, the median number of staff positions per physician is 2.75. Another choice, Bohlmann says, is to base staffing on the practice's income level. On average, 30 percent of a multi-specialty office's net revenue goes to paying staff; the figure is slightly lower—28 percent—for a family practice. Physicians may choose to hire as many staffers as that figure allows. Other practices hire staff based on patient volume, setting a ratio that can change as the practice changes.

Of course, the staff required also depends on the skill level of the people you

hire. Croes recommends assigning tasks so that each employee is working at the top of his or her skill level in at least one job duty. "That way, you're getting best return on the salary you're paying," she points out. "And they'll feel challenged but not overburdened. I may not feel right about asking one of my staff members to fax all my correspondence, but it wastes my time—at my skill level—to be standing in front of a fax machine 20 times a day. So I may ask that person to do that mundane chore, but also to help revamp our interoffice communication."

You may want to consider hiring an office manager if you or your partners are having difficulty following up with day-to-day administrative matters. (See "Is it Time for a Group Manager?" page 25.)

It's a good idea to talk with colleagues in successful practices similar to your own to get an idea of how they handle staffing. While your direct competitors may be mum on the subject, others outside your area may be more forthcoming. Local and regional medical association or medical management association meetings are a good place to strike up such a conversation.

- **Pay your staff well.** "You can't put a \$7- or \$8-an-hour person on the front desk anymore," says Steele. "Practices that pay more get better people." By the same token, make sure employees and potential employees understand the role that benefits play in a positive work experience. "Younger workers will change jobs for even 25¢ more an hour," Steele points out. "You need to get them to look beyond their wage."

For each position on your staff, find out what other local physicians pay. Good sources of this information include local recruiters, hospital physician-relations personnel or human resources staff, and local medical associa-

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tions. Even the classified ads in your local newspaper may be a good source of information.

- **Remember, they're employees, not family.** "I see this all the time—physicians and office staff relating as if they're family," says Woodcock. "Often, one person is not pulling his or her weight, and it's obvious who it is. But the physician will say, 'But she's been here forever! I can't fire her!' The decisions are based on personal feelings instead of business sense."

"You can't be friends with subordinates," asserts Croes. "It's very important that you go over with the staff what their duties are and how you expect them to spend their time. Then, follow through if they consistently fail to meet your expectations. Check with an attorney if you're unsure about what you need for grounds for dismissal."

Often, Woodcock notes, conflict develops between the "front" (receptionists, managed-care coordinators, records clerks) and "back" (clinical support) staffs. "A lot of the time, the physician has no relationship with the front people, and doesn't even know their names," she says. "This can set up a great deal of animosity. Just knowing everyone's name and having a meeting for the WHOLE staff at least once a month can go a long way toward keeping things running smoothly."

Croes also recommends distributing written protocols to each staff member and keeping a set easily accessible to everyone. "Not necessarily an employee handbook, but even 10 key sheets of paper with written rules about each position's basic functions."

- **Know the danger signs of overwork.** Telephones that go unanswered. A "complaining atmosphere" among employees. (You can probably sense ten-

sion when you walk into the front office; employees may suddenly stop talking when you walk into the room.) High turnover among staff members. (People staying in their jobs for less than a year.) Patients complaining of employees' surly attitudes.

If any or all of these crop up in your practice, it's time to reevaluate how the office is being run. "Before calling a meeting with the staff, sit down and look at whether you're giving employees conflicting tasks," says Croes. "You can't, for example, expect one person to put patients in exam rooms and answer the phone at the same time. You can, however, have that person put patients in exam rooms for more than one doctor in the practice."

Calling in a hired gun

If you're at a loss for how the practice began to unravel, it may be time to call in a consultant for a one-time or short-term assessment and reconfiguration. This is often the fastest way to resolve staff problems, because a good practice management consultant can quickly diagnose the problem.

"I can walk into a practice and practically smell disaster," says Bohlmann.

What once seemed like a good idea to improve efficiency can, in the eyes of an experienced consultant, be the first thing to eliminate in a floundering practice.

"I was just in a major practice where they had this system of producing stick-on labels for each patient for each part of an appointment," Croes recalls. "But it was actually slowing the patient care process down. The labels were piled on top of each other on many of the charts, and no one seemed to know which labels had become obsolete in terms of the patient's care. It made no sense!"

But in a practice where an office manager has come up with such ideas, the

opinion of an outside consultant may be met with resentment. Physicians should present the idea of bringing in a consultant as way to help with communication, emphasizing that staff and office manager input will be important to the consultant's assessment of the practice.

"We always look to the office manager, if there is one, and staff to help us figure out what's really going on in the practice," says Steele. "And often, when we report our findings and suggestions, the information sits better with the employees than it would coming from the physicians or coworkers."

The best way to find a consultant is often through word of mouth. Generally, according to the consultants interviewed for this article, local consultants can do the job well—you don't necessarily need a national name to turn a practice around. And calling in a consultant is not a sign of personal weakness.

"Physicians tend to be perfectionists," says Bohlmann. "They are used to solving complicated medical problems. But personnel problems are a whole different thing. Chances are most physicians in small groups will need a little help at some point, whether it's by attending a seminar or having a consultant do some major work. There's no shame in that."

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Barbara Alden Wilson is a regular contributor to UO.