Physician Burnout - MGMA Staffing Averages are a Primary Cause

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Full blog post is At This Link

Let's face it ... the job of taking care of patients is much more complex and difficult than at any time in human history.
Advances in diagnosis and treatment proceed at an ever increasing rate. Add in EMR and what seems like a competition between payors to add in increasing amounts of documentation requirements. Recent studies show doctors must perform two minutes of digital paperwork for each minute of patient face time. YIKES.

It wouldn't be so destructive if we had enough help for this drastically expanded workload.

Enter the MGMA Staffing Averages and the Stinkin' Thinkin' they spawn

Follow this thought process for a second.

- You are a Chief Operating Officer, putting together a healthcare delivery organization
- Over time you end up hiring a group of 100 outpatient doctors and Advanced Practice Providers (NP's and PA's)
- Now you also control these provider's staff. You hire, manage and fire them
- And you have a budget

How would you make a decision on staffing ratios?

For instance, how would you decide the ratio of Medical Assistants to doctors in each practice?

If you are like most COO's, you would consult the bible of staffing ratios - The Medical Group Management Association (MGMA) database of averages.

Head's up, the MGMA says that ratio for an outpatient family doctor is 1:1. One MA for each doctor in the office. This means a four provider office would get four MA's in the back office - and that's it.

Here's the conflict this sets up automatically:

> ***PART ONE:***
> ***You and I - as doctors - know that MGMA Average Staffing Ratio is grossly inadequate for the modern practice of medicine*.**
>
> **It is a LOSE:LOSE:LOSE:LOSE situation**
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> **The patient loses.** They are only privvy to the scraps of your attention you can muster between interruptions.
> **Your staff loses** ... they are overwhelmed too. You and your team are simply coping with the fires as they break out.
> **You lose** ... the whirlwind actively destroys the meaning in your practice and the balance in your

life.
And the organization loses too. You can't be as productive as you could be if there were simply more hands on deck to handle the workload that does not demand your level of expertise. Right? The overload blocks you from seeing more patients and billing more dollars.

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PART TWO:
On the other side, the COO can't see what all the fuss is about.

You are staffed to MGMA average which must mean other people can do the job under these circumstances. So what's your problem?

This is CLASSIC BLAMING THE VICTIM

And your practice looks pretty good on paper. With this staffing level, we don't lose as much money as we would if we gave you an additional MA.

There is a powerful financial dis-incentive to staff appropriately
They are balancing the books on the backs of superhuman effort on the part of the MA's and Doctors and APP's each day.

And it is all based on the belief that AVERAGE IS ADEQUATE - when in fact this practice is clearly *penny wise and pound foolish*. And now we have proof I will share below

This AVERAGE is Not OPTIMAL - it is just the least expensive option on the Organization's Profit & Loss Statement. *You would have to STUDY PRODUCTIVITY to see what the OPTIMAL STAFFING RATIO IS.*

You would have to be a leader that cares about the legitimate concerns and exhaustion of your people to test your hypothesis. You would not rely on MGMA and average ratios since they are one of the causes of your provider's legitimate complaints.

To identify the sweet spot of the best care and profit margin to the organization -- you must build a PILOT PROJECT to test...

MGMA Staffing Ratios
VS.
A Higher Staffing Ratio

A breakthrough study now shows the WIN:WIN:WIN:WIN of ignoring MGMA Averages and actually testing for optimal staffing levels in your organization

This up-staffing intervention shows the pervasively positive Return on Investment (ROI) of increasing staffing ratios and minor changes in job descriptions in an outpatient setting. It blows away the MGMA Staffing Ratios with proof that the sweet spot for quality and productivity is well above 1:1.

Here is the Reference:
http://www.nejm.org/doi/full/10.1056/NEJMp1716845

This is a New England Journal of Medicine Perspective piece called:
Beyond Burnout — Redesigning Care to Restore Meaning and Sanity for Physicians

The right-staffing intervention is called ambulatory process excellence, or APEX. The practice site was the A.F. Williams Family Medicine Center at the University of Colorado. This team-based care initiative was headed by Corey Lyon, associate professor at the University of Colorado School of Medicine and Medical Director at A.F. Williams.

Here is what they did.
It is a version of the Super M.A. concept and the breakthrough in this study is the comprehensive measurement of ROI - including financial ROI - showing just how powerful having adequate hands on deck is for everyone involved.

Quoting the article:
"*Under this system, medical assistants gather data, reconcile medications, set the agenda for patient visits, and identify opportunities to increase preventive care. After they complete this structured process, they share this information with a physician or nurse practitioner and remain in the room to document the visit.*

When the clinician leaves, the medical assistant provides patient education and health coaching. This arrangement allows physicians and midlevel clinicians to focus on synthesizing data, performing the physical exam, and making medical decisions without distractions.

Although the program increased the ratio of medical assistants to clinicians from 1:1 to 2.5:1, it required more than simply adding people. APEX required rigorous training for medical assistants, the development of structured protocols to allow them to function semi-independently, and new communication systems. Most of all, Lyons believes, the implementation succeeded because of flexibility and teamwork:

"Providers have to be willing to give up a little control to get the support they need so that they can build better connections with patients without technology interfering."

The Results?

"Within 6 months after the APEX launch

- **Burnout rates among clinicians dropped from 53% to 13%**

- There was also an improvement in the practice's pneumococcal vaccination rates and patient referrals for mammography and colonoscopy screening tests

- With increased efficiency, **the practice was able to add nearly three extra patients per doctor per day**

- Reduce waiting times for new patients who wanted to join the practice

- AND with increased provider productivity, **APEX remained cost-neutral**

... and the University of Colorado health system plans to expand the program to six additional family medicine, internal medicine, and primary care clinics. "

WOW ... all that in just six months in just their first stab at right-sizing their support staff ratio. A magnificent intervention and we still don't know if this is the center of the sweet spot yet!

Even the CFO is happy with this study and they will never stoop to the rote acceptance of MGMA averages again. They know better because they took the time to test *what works in their system*. That is quality leadership: getting everyone on board and pulling in the same direction.

Kudos to Dr. Lyon and the rest of the team and the leaders who bravely said yes to the project. Let's go one step further on the Return on Investment here

They have yet to calculate changes in

- Patient satisfaction
- Error rates
- Physician and staff turnover
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And we both know which way those are headed. These factors will add additional validation of a corporate ROI for this practice model.

The Lessons?

A. You don't know your ideal staffing ratios until you test them. So design and run the pilots to step up to the plate as a true Quadruple Aim Leader
B. There is only one way to determine how to staff your teams ... test, tweak, adjust, repeat
C. The best thing to test is always exactly what the doctors and APP's are asking you for

MGMA Staffing Ratios be damned ... let's get to work.
- Install the Quadruple Aim in your organization NOW

- World-Class Burnout Prevention Training is Here
- The Quadruple Physician Leadership Retreat is Here

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