Organizational Staffing

Determining hospital risk management staffing through analytics

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This article presents the development of an independent research project to gather time data from hospital risk managers in order to establish an objective, justifiable means of determining staffing levels recommended to support risk management activities and department functions.

WHY ANALYTICS?

Risk management is a profession and, just as other professionals do, risk managers need to track their time and productivity in order to show (or evidence) value. They need to measure how their time and output contribute to the overall goals and achievements of their organizations. In so doing, they will be better prepared to demonstrate the need for additional resources to manage the workload demanded by hospital activities.

The International Standards ISO/DIS 31000 Risk Management—Principles and Guidelines on implementation in Section 5.2, Mandate and Commitment, states:

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<th>The introduction of risk management and ensuring its ongoing effectiveness require strong and sustained commitment by management of the organization, as well as strategic and rigorous planning to achieve commitment at all levels. Management should: . . . ensure that the necessary resources are allocated to risk management.</th>
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Norman Marks, vice president of governance, risk management, and compliance for SAP, evaluates risk management programs by assessing whether an organization has an effective risk culture. One of the attributes he looks for is “sufficient resources for the risk function, including numbers of experienced and trained personnel, budget and other resources necessary to the task.”

However, allocation of resources for risk management has always been difficult in the healthcare environment, where risk management is typically considered a non-revenue-producing department and is always subject to continuous scrutiny for the evaluation and allocation of resources, especially under the ever-present pressure to control expenses related to continued challenges and potential impact of future revenue reduction related to healthcare reform legislation.

Showing the value of risk management

Showing the value of risk management is critical in establishing the case for requesting investment in additional resources. In fact, demonstrating risk management value was one of the top 5 concerns identified in a member
By aligning their goals with the organization’s strategic mission and goals, risk managers will confirm their value to the organization. Risk managers must focus their efforts to promote risk management accessibility, educate staff on risk management’s role, communicate risk management’s achievements, quantify risk management activities, and embrace an enterprise-wide approach to risk management.3

Quantifying risk management efforts and activities was the motivation for a research project to develop a method for establishing an objective, quantifiable means of determining required staffing levels to support risk management activities and department functions. The concept came from past experience in staffing nursing units based on patient acuity levels determined by time studies of nursing activities.

The premise behind the theoretical framework for the research was to gather time data from hospital risk managers to track 24 specific risk management activities in order to determine department staffing (see Figure 1).

THE CURRENT STATE OF RISK MANAGEMENT

The ability to determine required staffing levels for hospital risk management departments is limited due to the current inadequate literature and a lack of quantifiable staffing models. This research was necessary to establish a standardized means and quantifiable formula for objectively determining and justifying hospital risk management staffing levels.
The design of the research study consisted of (1) defining the population, (2) collection of time data on an Excel spreadsheet listing the 24 specific activities, 3 specific risk management roles, and facility demographic data, and (3) data analysis that yielded individual and aggregate results of the time data to determine consistency or discrepancies in specific activity data. The final output revealed the number of full-time equivalents (FTEs) recommended for supporting the workload of the department.

THE BETA SITE
Sheila Hagg-Rickert, senior system director of risk management for CHRISTUS Health, graciously accepted the opportunity for the CHRISTUS facilities to be the initial beta site and the defined population for the staffing research. Ms. Hagg-Rickert also provided valuable input in the development of the data collection tool.

CHRISTUS is a Catholic-related health system providing faith-based care in Arkansas, Louisiana, Oklahoma, Texas, and Mexico, through more than 40 hospitals, including 8 hospitals in Mexico. This diverse healthcare system consists of 32 acute care facilities, long-term care facilities and critical access hospitals. (The initial decision had been to limit the research to the US facilities only.)

Initial data collection
Data was collected on an Excel document that captured time data, risk management roles, and facility demographic information (see data collection sample in Figure 1).

Hospital risk managers were requested to provide estimated amounts of time spent on a weekly or yearly basis for each of the 24 identified risk management activities and then document their responses on the data collection form. They were also asked to document their specific roles and facility demographic information.

The 3 roles used in the study were (1) department head, (2) midlevel risk management practitioner, and (3) clerical support. The ASHRM explanation for these roles was the base definition for each.

Initial research results
A staffing level per facility was calculated based on the data submitted by individuals in the CHRISTUS facilities. Hours reported as overtime were adjusted to half, and the total hours for each individual were limited to 4160, double the standard 40 hours per week. This adjustment was based on industry research and published rate determinations. The FTE per facility was 2.117.

In addition, a rate for facility risk management staffing per 100 licensed beds was calculated. This rate was 0.541, or approximately 1 full-time staff member for every 200 licensed beds. This provided an excellent benchmark unique to CHRISTUS for potential future expansion and for normalizing its current staffing levels.

With the large amount of detailed data available, we were also able to construct a distribution of time spent on each of the 24 risk management activities per facility and by each staff role. On average, each facility spent the most time on claim management, risk identification and analysis, and general risk management activities. Each of these activity types accounted for more than 10% of hours reported per facility. Table 1 lists the activity types that, on average by position type, were identified to each have more than 10% of the reported hours.

See Figure 2 for details of the top 10 activities.

Figures 3 through 5 illustrate the top 10 activities by position type.

This part of the output showed CHRISTUS how risk management hours were currently allocated. CHRISTUS is now in a position to further investigate the breakdown of general risk management activities and work toward optimizing the distribution of duties and responsibilities for the organization.

BENEFITS AND VALUE OF STUDY
Since the initial analysis, the database has grown to more than 20 hospitals/evaluated organizations and provides a depth of risk management time data for future benchmarking purposes. We have also been asked to opine an average rate of FTEs based on a comparison of demographic information maintained in the overall database.

The significance and value of this research is groundbreaking. Now a quantifiable model exists to objectively provide

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Figure 2:
Hours Spent per Activity – All Position Types

Figure 3:
Hours Spent per Activity by Department Heads
justifiable staffing levels based on an analysis of time data to support hospital risk management functions and activities. With the continued focus on cost containment in the hospital environment, the output this analysis provides will prove to be invaluable to hospital risk managers.

The value of the study is in the critical analysis of the data and asking the questions of how and who are providing risk management services within the organization. The first step in designing and planning a creative staffing plan is to thoroughly assess the full range of functions currently performed by the risk management department. Consideration should be given to the following steps/questions provided in the ASHRM Risk Management Handbook when using data for the analysis of how risk management services should be provided.

Five major steps are involved in developing a creative staffing plan. These are:

1. Assessing the full range of current functions.
2. Evaluating options for internal and external transfer of functions.
3. Determining new staffing plan after functions are transferred.
4. Establishing processes to manage the external resources effectively.
5. Developing monitors to assess the plan’s effectiveness and make changes as necessary.

The results presented in this article are from the initial research completed on multiple hospitals that participated in the study. The following comments are from the hospitals that utilized the results of the data to make changes and improvements in how they delivered their risk management services.

The director of risk management from a large healthcare system in Rhode Island stated, “I absolutely used the data as one of the elements to make the necessary decisions to restructure my department.” Based on their staff responses and how they compared the roles, they were able to utilize the data analytics to drive staffing decisions. They also took a critical look at the time spent on each activity for each role in an effort to determine more efficient ways to deliver those services.

They determined that the coordinators at each facility had different responsibilities and they made the decision to make these roles more consistent in work responsibilities. Decisions were made to discontinue some “tasks” because they did not provide value to the department or the organization. Responsibilities for other tasks were transferred to departments that were more appropriate to provide or own those activities.

The staffing data in combination with the changing state reporting requirements for adverse events were used to identify and justify the need for an additional staff member. The department was completely restructured, and duties were reassigned based on an analysis of the workload data and the changing reporting requirements. The data were presented, and the additional staff position was approved by hospital leadership.

Another example of how the data were used to provide the necessary support for requesting additional staff members was requested by the director of risk for a large faith-based healthcare system. The director stated that he was developing a systemwide risk management program and needed to determine how many staff members would be required to provide a consistent risk management systemwide service. The positions/FTEs he was requesting to fill currently did not exist and he had no objective means of justifying to his leadership how many positions were necessary to achieve the risk management goals of the organization. He requested us to complete a comparison utilizing the database to determine how his organization/system measured up with other hospitals in our research.

It was determined that it would require 5 FTEs to support and provide the risk management services necessary for his staffing proposal. This proved to be an invaluable benchmark. The director presented the information to his system leadership and received approval for all 5 positions.

CONCLUSIONS

Just as the correct analytics will play a critical role in the success or failure of an accountable care organization, the analytics in this study establish an objective means to justify the allocation of resources in order to appropriately staff a hospital’s risk management program. This research establishes a tested baseline and distribution of time spent on 24 specific risk management activities per facility and by role. Hospitals and healthcare systems also derive overall benefit from the improved understanding and functioning of their risk management departments. The analytic model described here is an invaluable tool for risk managers to support their own functions and the goals of their organizations. If you would like to discuss how this model could work for your organization, have wanted objective data to justify department staffing, and would like to have your data included in the database, contact Chrystina Howard at chrystina.howard@willis.com or Ken Felton at kenneth.felton@willis.com.

REFERENCES


ABOUT THE AUTHORS

Chrystina M. Howard, ARM, CRM, CIC, is a senior vice president in the Willis Global Solutions Consulting Group with 20 years’ experience in risk analysis and consulting. She is a frequent speaker to regional and national risk management organizations on strategic risk management, ERM, and analytics. Chrystie holds bachelor’s degrees in the fields of mathematics and French, and a master of science degree in mathematics. Kenneth W. Felton, RN, MS, CPHRM, DFASHRM, is a senior vice president, senior clinical and enterprise risk management consultant with the Willis National Healthcare Practice. He has been recognized in 2009 and 2010 as a Power Broker in Healthcare by Risk and Insurance. He is a former president of the Connecticut Society for Healthcare Risk Management.