

Towards Benchmarking in Health Care Chaplaincy and Pastoral Care in Australia

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Abstract

In the increasingly strong drive towards cost containment, health care chaplaincy in Australia is under pressure to justify its value to health care. Historically chaplain–patient ratios have been used to measure the distribution of pastoral care resources. Recent studies conclude, however, that a chaplain–patient ratio is out of step with the current range of contexts in which health care chaplains now operate. Furthermore chaplain–patient ratios fail to identify and quantify direct and indirect components of pastoral care work. A review of the health care literature found that a time-per-task measurement provides a more empirical measure of the utilisation of current pastoral care resources, particularly when linked with a minimum data set. Numerous workload measurements developed by medical social work, nursing and pastoral care are explained. A number of quantitative measures using the HCCVI minimum data set are proposed.

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Keywords: benchmarking, minimum data set, allied health, chaplaincy, workload measurement.

Australia is facing enormous pressures on health care services. Demographic changes, escalating costs due to technological changes, political reluctance to increase the taxation base, medical advances and increased consumer demands for expensive services have precipitated attempts to apply business management strategies to health care (National Allied Health Case Mix Committee, 1998). These and other changes, have led to a greater focus on classification and measurement of health services.

The contribution of allied health professionals to both health care costs and health outcomes are significant (National Allied Health Case Mix Committee (NAHCC), 2000). In 1994 the Commonwealth government funded NAHCC (a peak body representing twenty distinct professional groups with patient care or clinical support responsibilities that do not fit into the categories of medical practitioners, nurses or dentists) to undertake the National Reference Standards Project. The purpose of this project was to develop a nationally agreed framework of data items and definitions to be collected by allied health professions working in acute health settings. The allied health Activity Classification Hierarchy provides a nationally consistent set of data items that describes allied health services to patients (NAHCC, 2000).¹

¹ Helen Cleak (2002) describes the social work contribution to the development of the NAHCC framework which includes a minimum data set, a classification hierarchy, the set of activity (input) codes and 'indicator for intervention' codes. The advantages and limitations of the system are also discussed.

Historically, health care chaplaincy has been reluctant to work with explicit models of assessment and interventions, although this is changing. A more robust evidence-based approach to professional pastoral care is supported by the World Health Organisation Pastoral Intervention (WHO-ICD-10-AM) code set, which offers four codes for pastoral assessment and highlights the need for initial and subsequent appraisal (WHO, 2002)².

A paper by Carey, Cobb and Equeall (2005) focuses on 'statistical results of pastoral encounters' in two hospitals in Sheffield in the UK. The data they collect on patient and non-patient contact is shown to be compatible with the WHO-ICD-10-AM coding, therefore providing a useful model of measurement for pastoral care (WHO, 2002).

Common standards and core competencies of chaplains have been established for some time (for example, see Spiritual Care Collaborative Network 2007, Catholic Health Initiatives 2002). Health care chaplaincy has also recognised the need for greater consensus and uniformity in collecting information on pastoral practice. A Victorian audit of health care facilities reports a wide range of ways in which pastoral care services are recorded and reported (Holmes & Carey, 2005). This has caused some difficulty in terms of determining resources, costing and identifying trends.

Catholic Health Initiatives in Denver, USA, set forth to develop a template of standardised activities and measures for use in health care organisations (Catholic Health Initiatives, 2002). The feasibility of the Denver project, however, was hampered by two factors: the lack of a pastoral measurement system that could mesh with the performance and productivity measures used by other health disciplines, and the diversity of health care organisations that did not allow for one-size-fits-all solutions.³

The purpose and scope of the present study is therefore to investigate the potential of minimum data sets (MDS) for maximising uniformity and consistency of reporting; report on measurements for quantifying workload using minimum data sets; and to identify the most suitable model(s) for benchmarking health care chaplain resource needs. The present study draws on health care literature on benchmarking found in the following indexes (1980 to 2008): Cumulative Index to Nursing and Allied Health (CINAHL), Medline, SpringerLink and OVID. Internet searches were also undertaken to locate grey literature. The stem search terms used were: benchmarking and minimum data set. Subheadings used in conjunction

² The terms 'pastoral care', 'chaplaincy', 'spiritual care' can refer to different issues and different interventions; however for ease of reference throughout this report the terms will be used interchangeable, so that the reference to one or more of these terms should be considered a reference to each of them. It is however acknowledged that in adopting consensus approach sensitivity to the dissimilarities among the various approaches is reduced.

³ A literature analysis undertaken by School et al. (2008) reported similar observations in Victoria's allied health services. Three broad themes account for the lack of progress with developing workload capacity approaches capable of informing workforce management and developing policy: (i) claims that activity performance could not be adequately captured within a single profession, much less across the gamut of allied health; (ii) concerns that approaches which focus on rigorously defining professional products and services will undermine professional authority about service levels; and (iii) the use of differential approaches to the unit of analysis related to the service intervention or procedure classification across service settings, for example, acute care settings or community rehabilitation settings or private practice settings.

with the stem terms were: allied health, chaplaincy and workload measurement. The literature scan was executed between August and October 2008. Experts in benchmarking projects were asked for supplementary reference material and questioned about analysis of data and key project deliverables, such as applications and measurement methodologies utilised.

Though a broad range of material was reviewed, there are limitations to the depth and scope of the study. The focus of this study is specifically aimed at health care chaplaincy. No attempt was made to evaluate chaplaincy models of practice in other institutions such as university and higher education, the prison service, industry, or the defence forces. The feasibility of benchmarking for improvement was also beyond the scope of this study; however, a number of health care processes have been identified in the review of literature (Ellis & Adams, 2002; Nelson et al., 1996).

A Survey of Chaplaincy Minimum Data Sets

In 1999 a MDS was developed by the Department of Chaplain Services at the Mayo Clinic, Rochester, USA, called the Chaplain Activity Record Electronic (CARE) (Department of Chaplain Services, 2005). The development of a MDS reflects a chaplain's specific skills and competencies. A MDS can be defined as a 'minimum set of items of information with uniform definitions and categories, concerning a specific aspect or dimension of the health care system which meets the essential needs of multiple data users' (Health Information Policy Council, 1983, p. 3, cited in Werley, Zorn & Ryan, 1995). The use of the term minimum is not intended to limit the amount of supplementary information that could also be collected or processed by the data systems. Verran (1986) recommends, however, that MDSs should be as concise as possible to limit the amount of staffing time spent in data entry rather than direct patient care.

The purpose of the CARE program is to provide fiscal accountability for the institutional support of chaplain services. Most health care administrators and managers are not fully aware of the scope of chaplain services. Of particular relevance to this study is its ability to track what has been accomplished with present chaplaincy staff, and to determine how many additional chaplains it would take to address what remains to be done (Department of Chaplain Services, 2005). As a result of implementing the CARE program, the department of chaplaincy services was, for example, able to justify the employment of nine additional EFT chaplains between 1999 and 2005 (Department of Chaplaincy Services, 2005).

The CARE system lists a catalogue of 28 direct service types that demonstrate the scope and extent of the spiritual care ministry provided by chaplains. A further fourteen indirect service types track internal departmental activities. The catalogue is reviewed periodically, service types are added as needed and definitions are refined. Those working with the CARE system hope that this catalogue will eventually contribute to a common dictionary of chaplain-provided spiritual services.

In 2003 the National Health Service (NHS), South Yorkshire, UK, developed a MDS entitled 'Caring for the Spirit' (CFTS). It is important to keep in mind, however, that the CFTS is not strictly an assessment tool. It is a set of classifications which provides a method for capturing

broadly what chaplains do in a consistent form. The CFTS project board provides a useful summary of the potential benefits of adopting a MDS for health care chaplaincy, such as assessing what chaplaincy resources are used in the provision of pastoral care (NHS, 2005, p. 4).

The Healthcare Chaplaincy Council of Victoria Inc. (HCCVI) is similarly developing a minimum data set for pastoral care (MDS-PC). It is important to note that the WHO ICD-10-AM code set has been used to structure the MDS-PC (WHO, 2002). The present content validity of the MDS-PC is being developed with an appreciation of earlier developments. The content of the MDS-PC is supported by comparisons with other relevant MDSs, consideration of chaplaincy activities reflected by the MDS-PC critical interventions and the judgement of potential users. Pastoral care literature, such as that of the Catholic Health Care Initiatives (2002), also contributed significantly to the content validity of the MDS-PC.

The MDS-PC is being field tested in four health care facilities before further adjustments are made. It is acknowledged that difficulties exist in articulating and describing chaplaincy work in sufficient detail, yet as Clark and Lang note (1992, p. 109) 'if we cannot name it, we cannot control it, finance it, research it, teach it or put it in to practice'. This difficulty has major implications for patient care as it results in the provision of inadequate information about chaplaincy skills and resources for health policy and health economics.

Table 1 describes the characteristics of three minimum data sets used in pastoral care. The feature that all three share is the understanding of chaplaincy workload as comprising all chaplaincy activities carried out by the chaplain, that is, direct and indirect care activities. Direct care activities might include, for example, making a phone call on behalf of the patient, organising a referral. Indirect care chaplaincy activities might include CPE education, attending staff meetings and supervision. Special features of the HCCVI MDS-PC are the pastoral care indicators for assessment (what the chaplain believes is the most relevant issue of the patient that has led the patient to seek or be referred to a professional chaplain), a record of interventions applied, and items related to outcomes. While outcomes alone do not guarantee quality when linked with interventions, applied professional processes and outcomes can be better understood.

The following table offers a comparison between the three MDSs surveyed:

Table 1 Comparison of Pastoral Care Minimum Data Sets

	Australia	USA	UK
Name of data set	HCCVI	CARE	CFTS
Purpose	Describe & quantify pastoral care activities	Determine costs and effectiveness of pastoral care services	Collect chaplain activity data
Scope	State of Victoria	Hospital specific	National
Vocabularies used	<p>Pastoral Assessment Activities</p> <p>Appraisal of spiritual well being</p> <p>Use of a specific spiritual assessment tool</p> <p>Multidisciplinary case meeting</p> <p>Other pastoral assessment</p> <p>Unspecified pastoral assessment</p> <p>Pastoral/Spiritual Care Activities</p> <p>Building rapport</p> <p>Befriending</p> <p>Providing loss and grief support</p> <p>Being present at times of uncertainty and waiting</p> <p>Making meaning</p> <p>Facilitating spiritual wellbeing</p> <p>Pastoral/Spiritual Counselling and Education</p> <p>Pastoral/Spiritual counselling</p> <p>Education</p> <p>Ritual/Worship</p> <p>Blessing</p> <p>Christening or Baptism</p> <p>Naming</p> <p>Prayer</p> <p>Communion</p> <p>Anointing</p> <p>Funeral/Memorial Service</p> <p>Meditation</p> <p>Other Rituals</p> <p>Unspecified Ritual/Worship</p> <p>Other Pastoral/Spiritual care</p> <p>Unspecified Pastoral/Spiritual care</p> <p>Pastoral Care Outcomes</p> <p>Crisis subsided</p> <p>Comfort/healing/peace</p> <p>Accessed inner strength</p> <p>Able to identify key issues/unresolved issues</p> <p>Forgiveness/reconciliation</p> <p>Purpose/meaning found</p> <p>Restored/generated hope/faith</p> <p>Cultural issues resolved</p> <p>Connection/belonging</p> <p>Enhanced communication</p> <p>Emotional release</p> <p>Progress with grieving</p> <p>Reflective review of life story</p> <p>Improving self image</p> <p>Deepening spiritual awareness</p> <p>Value/being valued</p> <p>Participation in decision making</p> <p>Support system in place</p> <p>Referral to internal or external agency</p> <p>Unknown</p> <p>Department Interventions/ Activities</p> <p>Pastoral care administration (includes clinical services)</p> <p>Ethics organisational support</p> <p>Quality assurance activities</p> <p>Preparation of pastoral care education material</p> <p>Delivery of pastoral care (to others)</p> <p>Worship/Ritual Preparation</p> <p>Worship/Ritual delivery</p> <p>Professional development</p> <p>Undertaking research</p> <p>Supervision of students</p> <p>Conference organisation (professional administration activities)</p> <p>Presence on the ward/residence</p> <p>Other</p> <p>Unspecified</p> <p>Department Activity Outcomes</p> <p>Professional knowledge increased</p> <p>Awareness of pastoral care/spirituality in the organisation increased</p> <p>Resources for pastoral care within the organisation enhanced</p> <p>Best practice supported</p> <p>Community connections, networks, relationships strengthened</p> <p>Incorporation of pastoral/spiritual care considerations in organisational decisions or actions</p> <p>Other Outcome</p>	<p>Direct Service Types</p> <p>AM Admit</p> <p>Anointing</p> <p>Anticipated Death</p> <p>Bereavement</p> <p>Care Conference</p> <p>Code 45</p> <p>Crisis Care</p> <p>Death</p> <p>Ethics Consult Coordination</p> <p>Ethics Consult Participation</p> <p>Ethics Contact</p> <p>Family Care</p> <p>Funeral/Wake</p> <p>Group Facilitation</p> <p>Home Visit</p> <p>Hospice Home care</p> <p>Office drop in</p> <p>Pastoral Contact</p> <p>Pre-surgical care</p> <p>Public worship</p> <p>Research Intervention</p> <p>Retreat Care group</p> <p>Ritual/Sacrament</p> <p>Scheduled Spiritual Assessment</p> <p>Spiritual Care</p> <p>Staff Care</p> <p>Staff Care Group</p> <p>Staff Development/Training</p> <p>Indirect Service Types</p> <p>Administration</p> <p>CPE Administration</p> <p>CPE Meeting</p> <p>CPE Preceptorship</p> <p>CPE Supervision</p> <p>CPE Teaching</p> <p>Meeting</p> <p>Mission support</p> <p>Preparation time</p> <p>Professional organization</p> <p>Research</p> <p>Rounds</p> <p>Supervision</p> <p>Volunteer Co-ordination</p>	<p>Chaplaincy Activity</p> <p>Number and duration of initial episodes of spiritual care categorised as being either routine or emergency.</p> <p>Number and duration of continuing episodes of spiritual care categorised as being either routine or emergency.</p> <p>Number and duration of religious services in ward/prayer room/chapel</p> <p>Number and duration of funeral</p> <p>Duration of time spent 'being there' categorised by location within the hospital setting.</p> <p>Duration of time spent in training trust staff not members of the chaplaincy department.</p> <p>Duration of time spent in activities categorised as continuing professional development.</p> <p>Duration of time spent travelling between sites.</p>

Workload Measurements in Health Care

In reviewing the health care literature relating to workload measurements, only a few studies that used a data base application and that were applicable to pastoral care were found (Wendling et al., 2007; Kossman et al., 2005; O'Brien-Pallas et al., 1988). Workload measurements based on patient acuity were not included. Acuity is a nursing measurement used to determine the amount of staffing necessary for an individual patient based on clinical complexity. This is not an appropriate term to use for chaplain-patient care encounters. The time spent is the standard of care. Two studies were specifically developed for pastoral care (NHS, 2005; Department of Chaplain Services, 2005), but no single method stands alone for determining workload and staffing needs. Given this, the components of each health care workload measurement have been adapted to the metrics of the MDS-PC.

Medical Social Work

Traditionally, social workers have measured their contribution to patient care in administrative terms, using statistical documentation such as the number and type of services provided (Berkman, 1980). In an effort to determine adequate staffing levels, the Mayo Clinic's section of Medical Social Work utilises a computer application Med Soc (Kossman et al, 2005) and a 'productivity formula' to calculate demand (the amount of time in hours spent working with patients) and capacity (the amount of time in hours available to work with patients). After capacity and demand have been identified, productivity can be defined as the percentage difference between demand and capacity.

For staffing purposes 1463 hours per calendar year (38 hours a week) is considered an equivalent full-time (EFT) position in Mayo Clinic's section of Medical Social Services. With the use of the productivity formula each medical social worker or caseload can be measured against this objective standard. Duffield, Roche and Merrick (2006) point out, however, that while this measurement can be used to determine whether staffing levels have reached or exceeded the allocation of staffing hours, it does not provide an indication of changes to workload because of changing patient acuity or staffing levels. Evaluation of social worker productivity should focus on the effectiveness and organisation of the care activities as well as efficiency.

Nursing

The MDS Nursing Workload Measurement (MDS-NWM) was developed by L. Adams Wendling to determine the number of EFT nurses needed to complete a Medicare assessment process using the Resident Assessment Instrument (RAI). Estimated minutes of time were the empirical referent chosen for the MDS-NWI. Each activity was assigned a numerical value based on means obtained from four groups that recorded nursing time required to complete the RAI process (Wendling et al, 2007).

The average time needed to complete the RAI process reported by the participants was 1.55 hours, and the average number of assessments completed per week was 38.04. Using the results of this pilot study the nurse manager was able to forecast 1.28 registered/licensed nurse EFT to complete the mandated RAI assessment process. This was calculated by

multiplying 1.55 hours x 38.04 x 52 weeks, and dividing this by 2080 (EFT hours per year) to get the projected EFT needed to complete the RAI process. Therefore it was identified that 1.47 EFT nurses were required to complete the RAI process.

Health Care Chaplaincy

To date, the dominant measure used to quantify the distribution of pastoral care resources in hospitals has been chaplain–patient ratios. An audit by Holmes and Carey (2005) of Victorian metropolitan hospitals used chaplain–patient ratios based on the number of chaplains available relative to the number of occupied beds, inpatients, outpatients, staff and combined statistics. In Victoria's hospitals the lowest chaplain–patient ratio was 1:11 at the Peter McCallum Cancer Centre, with the highest of 1:980 at the Kingston Centre. Interestingly, when looking at combined statistics for chaplains working with inpatients, outpatients and staff, the highest ratio rose to 1:338,978 at Maroondah Hospital, with a lowest combined ratio of 1:1133 at Calvary Health Care Bethlehem. The study also notes average ratios across Victorian metropolitan hospitals, with the average chaplain to bed ratio being 1:269 and an average combined patient and staff ratio of 1:84,251. From these statistics the survey recommended 'one chaplain/pastoral carer to 270 beds (1:270) as a guideline for the establishment of staffing levels and that this ratio be increased by the calculation of additional time units based on staff numbers, specialist units and other responsibilities' (Holmes & Carey, 2005, p. 18). Also, it was further recommended that the 'Department of Human Services fund all public health care facilities having 270 beds or more with a full-time Pastoral Care Co-ordinator' (Holmes & Carey, 2005, p. 18).

Benchmark chaplain–patient ratios have been proposed in the USA. A study by VandeCreek et al. (2001) provided data on the employment and deployment of chaplains in health care settings that included pastoral departments. The results indicated that the mean number of chaplains employed per 100 patients ranged from 1:20 to 1.66 chaplains, the exception being religiously affiliated hospitals. The mean number of chaplains per 100 patients for all care settings was 1:85. Tim VanDuivendyk gathered benchmarking data from 76 hospitals and found that the average chaplain–patient ratio without CPE residents was 1:90 (VanDuivendyk, 2003). For hospitals with CPE programs and residents, the ratio was 1:53. A survey by Flannelly, Weaver and Hanzo (2004) of 6650 licensed health care facilities in the USA reported that the average EFTs per 100 patients were closer to the figures presented by VandeCreek et al., 2:90 and 1.22 respectively. Overall, research would indicate that a single chaplaincy–patient ratio cannot be universally applied, due to the diversity of needs in different care settings.

The present study has surveyed a sample of health care organisations in Victoria: Austin Health, Barwon Health, Epworth Freemasons Hospital, Peter McCallum Cancer Centre, and Peninsula Health. Chaplains in these organisations were asked to describe the approach they used to determine their chaplaincy–patient ratio. Of the five organisations, one noted that the ratio was a budgetary decision, one reported it was an historical standard, two reported that the ratio was a clinical standard based on professional judgement, and one noted that there were no protocols for establishing chaplain–patient ratios.

In the USA Flannelly, Weaver and Hanzo (2004) reported that chaplain–patient ratios were largely based on how highly chaplaincy was valued by the institution. Consideration was

also given to the number of volunteers, local clergy involvement, type of organisation (i.e. religiously affiliated or non-affiliated organisations), patient census and population density.

A recent literature review of models of health care chaplaincy service and practice (NHS, 2008) reports that chaplain–patient ratio is out of step with the current range of contexts in which chaplains now operate.⁴ Such contexts include community-based mental health work, day-case work, outpatient clinics and so on.⁵ Furthermore, bed-based ratios do not sufficiently account for the increasingly specialised nature of the work done by chaplains, including risk assessment, crisis intervention, advocacy, responding to cultural and religious diversity, ethics, integration of patient’s story into a larger faith perspective, ritual support, end-of-life issues, bereavement and grief counselling and so on (Le Doux Sakauri, 2003; Woodward, 2002).

The present study concludes that pastoral care would benefit from a more empirical method that shows how chaplains use their time, how they structure their visits, and what impact their activities have on patient outcomes. This in turn would inform decisions concerning the appropriateness of current chaplain–patient ratios.

Two chaplaincy departments, one in the UK and one in the USA, report using a time-per-task measure for chaplaincy workload and demand for chaplaincy services. The NHS CFTS project board conducted a survey in which data was gathered from fifteen different pastoral care departments in acute care and mental health settings. This survey reported on what a typical week was comprised of and what kind of chaplaincy activities were undertaken (CFTS, 2007). From this data averages were calculated and a profile created. No attempt has been made in this survey to categorise activity by location or in a time frame and the survey did not cover what was not done – that is, the time between tasks and administrative time generally.

The Department of Chaplain Services, Mayo Clinic, USA has also used a computer-linked time-per-task workload measurement. This application has gone through several iterations since it was first developed in 1999. Using the CARE program, spiritual care services were tracked over a six-month period. Actual work measurement studies conducted by the department reported that, despite the variable patient/family dynamics and chaplain pastoral styles, there was a verifiable average time for a range of chaplaincy service types (Department of Chaplaincy Services, 2005). The time-per-task measurement of the CARE program describes exactly what is provided by chaplain services. As such it offers a good starting point for assessing chaplaincy resource needs of pastoral care departments. A major limitation of the CARE program is that there is no measurement of quality (Marek, 2008).

⁴ The National Health Service Scotland *Caring for the Spirit* project board (2002) reports that the traditional parochial model operated by the Christian denominations continues to influence and shape the provision of spiritual and religious care in the UK National Health Service. However, this approach to service provision is challenged on a number of fronts including secularism, pluralism, a shortage of priests and ministers, lay ministry, and crucially the increasingly specialised nature of health care chaplaincy in a secular institution funded from public finance.

⁵ A report of public sector nurses’ working conditions in Victoria found that once mandated ratios were in place, employers have an economic incentive to employ fewer nurses, and/or fewer hours of nursing labour FTE positions (Wise, 2007). On mandated nursing ratios in Victoria refer to appendix 1.

MDS-PC CALCULATIONS

Costing Chaplain Services

The proposed HCCVI MDS-PC, when linked to a time-per-task measure, captures an estimate of how much chaplaincy time and how many additional chaplains will be required to provide spiritual care to patients, staff and families in a health care setting. Using the CARE model the mean times for chaplaincy types and averages are standardised from a wide continuum of experienced and inexperienced chaplains.

The following hypothetical scenario demonstrates the process that might be used to calculate the cost of chaplaincy services from the MDS-PC data:

Service Type: Pastoral Ritual/ Worship

Baptism/naming	40 minutes
Prayer	10 minutes
Communion	20 minutes
Funeral/memorial service	50 minutes

To assign a relative resource unit (RRU) to each service type, the service that requires the least amount of time and degree of competence, namely the prayer category, needs to be identified. This is based on the average time spent in prayer with patients, that is, 10 minutes. This is the baseline unit of service and is assigned an RRU of 1.00.

A RRU is assigned to each service type, based on the smallest unit of chaplaincy service. From this baseline measurement every other service type is defined. So, for the above scenario:

Service Type: Pastoral Ritual/Worship

Baptism/naming	$40 \text{ minutes} \div 10 = 4.0 \text{ RRU}$
Prayer	$10 \text{ minutes} \div 10 = 1.0 \text{ RRU}$
Communion	$20 \text{ minutes} \div 10 = 2.0 \text{ RRU}$
Funeral/memorial service	$50 \text{ minutes} \div 10 = 5.0 \text{ RRU}$

From the total RRUs, and the ritual/worship work load for a month, the cost of a unit of service (UOS) can be calculated, using in this case a one-month hypothetical chaplaincy department budget for ritual/worship of \$3700.

Service Type: Pastoral Ritual/Worship

5 Baptism/naming	$\times 4.0 = 20 \text{ UOS}$
60 Prayer	$\times 1.0 = 60 \text{ UOS}$
40 Communion	$\times 2.0 = 80 \text{ UOS}$
8 Funeral/memorial service	$\times 5.0 = 40 \text{ UOS}$

TOTAL = 200 UOS

$$\$3700 \div 200 = \$18.50$$

From this figure, the actual cost of each service type may be determined.

Baptism/naming	$18.50 \times 4.0 = \$74.00$
Prayer	$18.50 \times 1.0 = \$18.50$
Communion	$18.50 \times 2.0 = \$37.00$
Funeral/memorial service	$18.50 \times 5.0 = \$92.50$

This process would need to be repeated for every service type on the MDS-PC, based on real-time averages collected over a six-month trial period to reflect current pastoral care practice.

Calculating Staffing Levels

Average data collected from the MDS-PC enables projected EFT staffing levels to be calculated for specific ministry areas. The EFT proportion is calculated by dividing the total number of UOS required for a particular service type by 6 to turn this amount into time. The result is then multiplied by 12 to generate an annual figure, and divided by 1976 (EFT hours per year; 38 hours per week) to get the projected EFT for each service type the chaplaincy offers.

This may be summarised in the following formula:

$$\text{Staffing level for service type (EFT)} = ((\text{monthly UOS} \div 6) \times 12) \div 1,976$$

So, for example, using the hypothetical example of the MDS-PC service types cited earlier:

Service Type: Pastoral Ritual/Worship

5 Baptism/naming	$\times 4.0 = 20 \text{ UOS}$
60 Prayer	$\times 1.0 = 60 \text{ UOS}$
40 Communion	$\times 2.0 = 80 \text{ UOS}$
8 Funeral/memorial service	$\times 5.0 = 40 \text{ UOS}$

TOTAL = 200 UOS per month

$$\begin{aligned} \text{Staffing level for Pastoral Ritual/Worship staffing} &= ((\text{monthly UOS} \div 6) \times 12) \div 1,976 \\ &= ((200 \div 6) \times 12) \div 1,976 \\ &= 0.2 \text{ EFT} \end{aligned}$$

Calculating Chaplaincy Workload

The MDS-PC may be used to track actual workloads over a year to determine whether current staffing levels are sufficient or require adjustment. Using the Kossman (2005) model the data may highlight a need for increased staffing levels, for ministry development or

decreased staffing levels, or it may indicate that there is a close match between demand and capacity. It is assumed here that a single EFT represents 1976 hours per year (38 hours per week).

So, for example, the MDS-PC might record that 4940 hours of ministry has been exercised in the hospital over the year (see example no. 1 in the table below). This is 11.1% over the capacity of 2.25 EFT, representing the work of one full-time and two part-time chaplains, and an equivalent to a further 0.25 EFT. From this data a case could be made for increasing the hours of the two part-time chaplains from 1.25 EFT to 1.50 EFT. Similarly, if the total annual activity tracked by the MDS-PC was 4312, or 3% under capacity, this might spur management into looking for new ministry opportunities in the hospital or reducing staffing levels (example no. 3). If the MDS-PC hours matched the current staff capacity, this would be an affirmation that current staffing levels and workloads are matched (example no. 2).

Example no	Demand hr	Capacity hrs	Difference %	Description of situation
1	4940	4,446	+ 11.1%	Demand exceeds capacity
2	4446	4,446	0%	Demand matches capacity
3	4312	4,446	- 3.0%	Capacity exceeds demand

Conclusion

The metrics of the MDS-PC can serve as the basis for reporting in a consistent form, within and across pastoral care departments, current utilisation of pastoral care resources. A time-per-task measurement when applied to the MDS-PC is a valuable tool that can calculate such things as the cost of chaplaincy services, projected staffing levels to maintain these services, and workload capacity. Studies show that these measurements and analysis capability will also provide a vehicle for communicating among chaplains and with other professions working in health care.

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References

- Berkman B 1980, 'Psychosocial problems and outcome: an external validity study', *Health and Social Work*, pp. 5-21.
- Carey LB, Cobb M & Equeall D 2005, 'From pastoral contacts to pastoral interventions', *Scottish Journal of Health Care Chaplaincy*, vol. 8, no. 2, pp. 14-20.
- Catholic Health Initiatives 2002, *Measures of chaplain performance and productivity*, Catholic Health Initiative, Denver, USA.
- Clark J & Lang N 1992, 'Nursing's next advance: an internal (international) classification for nursing practice', *International Nursing Review*, vol. 39, no. 109.
- Cleak H 2002, 'A Model of Social Work Classification in Health Care', *Australian Social Work*, vol. 55, no. 1, pp. 38-49.
- Department of Chaplain Services 2005, *CARE (chaplain activity record-electronic)*, Department of Chaplain Services, Mayo Clinic, Rochester, United States.
- Duffield C, Roche M, & Merrick E 2006, 'Methods of measuring nursing workload in Australia', *Collegian*, vol. 13, no. 1, pp. 16-22.
- Ellis J & Adams C 2002, 'The essence of care: implications for practice', *Community Practitioner*, vol. 75, no. 1, pp. 22-3.
- Flannelly KJ, Weaver AJ & Hanzo GF 2004, 'Factors effecting healthcare chaplaincy and the provision of pastoral care in the United States', *The Journal of Pastoral Care & Counseling*, vol. 58, no. 1-2.
- Holmes C & Carey L 2005, *Pastoral care and chaplaincy provision within metropolitan health and aged care services in the state of Victoria*, Health Care Council of Victoria Incorporated, Melbourne, Victoria.
- Kossman HD, Lamb JM, O'Brien MW, Predmore S, Prescher LSW 2005, 'Measuring productivity in medical social work', *Social Work in Health*, vol. 42, no. 1, pp. 1-16.
- Le Doux Sakauri M 2003, 'The challenge and heart of chaplaincy', *Health Progress*, vol. 84, no. 1, pp. 26-9.
- Marek D 2008, Correspondence from D. Marek, Director of Chaplain Services, Mayo Clinic United States, 5 December.
- National Allied Health Casemix Committee 1998, *IFI /outcomes development project draft Three*, NAHCC, Melbourne, Australia.
- National Allied Health Casemix Committee 2000, *National Allied Health Service weights scoping project*, Workshop Notes, NAHCC, Melbourne.
- National Health Service Scotland 2005, *Caring for the spirit: implementation plan guidance notes*, National Health Service Scotland, retrieved 2 October 2008, <http://www.mfghc.com/cfts/cfts_mds_05.doc>.
- 2002, *Spiritual care in NHS Scotland*, National Health Service Scotland.
- Nelson EC, Mohr JJ, Batalden PB & Plume SK 1996, 'Improving health care. 1. The clinical value compass', *Journal of Quality Improvement*, vol. 22, pp. 243-58.
- O'Brien-Pallas 1988, 'An analysis of multiple approaches to measuring nursing workload', *Canadian Journal of Nursing Administration*, vol. 1, no. 2, pp. 8-11.
- School AM, Boyce RA, Ridoutt L & Santos T 2008, 'Workload capacity measures for estimating allied health staffing requirements', *Australian Health Review*, vol. 32, no.3 pp. 548-58.
- Spiritual Care Collaborative 2004, *Common standards for professional chaplaincy*, Spiritual Care Collaborative, retrieved 2 October 2008,

- <<http://www.spiritualcarecollaborative.org/docs/common-standards-professional-chaplaincy.pdf>>.
- VandeCreek L, Siegel K, Gorey E, Brown S, Toperzer R 2001, 'How many chaplains per 100 inpatients? Benchmarks of healthcare chaplaincy departments', *The Journal of Pastoral Care*, vol. 55. no. 3, pp. 289-301.
- Verran J 1986, 'Patient classification in ambulatory care', *Nursing Economics*, vol. 4, no. 5, pp. 247-51.
- Wendling LA, DeDonder J, Tidwell S, Pimple C, Schmiot L & Okeson D 2007, 'Budgeting nursing workload for required minimum data set assessments', *Journal of Nursing Management*, vol. 15, pp. 442-8.
- Werley HH, Devine EC, Zorn CR, Ryan P, Westra BL 1991, 'The nursing minimum data set: abstraction tool for standardised, comparable, essential data', in Lang NM (ed.) *Nursing Data System: The Emerging Framework*. American Nurses' Association: Washington, DC, pp. 19-30.
- Woodward J 2002, 'Health care chaplaincy: a reflection on models', *Modern Believing*, vol. 41, no. 2, pp. 20-30.
- World Health Organisation 2002, 'Pastoral Intervention Codings', *International Classification of Diseases (ICD)*, No. 10, Australian Modification (AM), World Health Organisation[ICD-10-AM].