

# How One System Defines Quality

## Collecting Data from Chaplains' Practices in Sisters of Mercy Health System Builds Foundation for Continued Quality Improvement

**T**he chief information officer at Sisters of Mercy Health System recently observed, "Data gives you better questions than you had before." This has certainly been true of data gathered from pastoral services. Since 2006 the chaplains throughout our system have been tracking and trending how they spend their time. The results produced questions and facilitated decisions about priorities and patient care, which led to more questions about patterns of practice and measurement of quality. Each set of data led us to new questions and empowered our chaplains and directors in the work of defining quality of pastoral services.

Here are five primary questions we have explored in recent years.

### 1. WHAT IS THE MEASURE OF QUALITY FOR PASTORAL SERVICES DEPARTMENTS?

Although chaplains in health care have not traditionally focused on measurement, the environment in which they work has increasingly demanded accountability. During the past decade the Centers for Medicare and Medicaid Services and other organizations, such as the business group Leapfrog, have required and spurred health care providers to document quality indicators. Evidenced-based medicine has become commonplace throughout health care. Administrators facing decreased reimbursements and increased costs have turned to Six Sigma and LEAN projects to uncover waste and improve processes. To be relevant in such an environment,

pastoral care departments need to be able to articulate and measure what chaplains are doing for and with patients.

In the late 1990s, Brian O'Toole, Ph.D., vice president of mission and ethics for Sisters of Mercy Health System, invited the pastoral services directors to define quality for their departments. Resulting efforts included surveys of patient expectations, inclusion of customized questions on patient satisfaction surveys and sharing of successful practices with colleagues. Each initiative provided information. Yet, taken together, they also exposed a shortcoming. We knew that chaplains delivered services that were valued by patients and the organization, but we were inconsistent in our understanding of the language about these services. We recognized that we could not measure what we could not name.

### 2. WHAT SERVICES DO CHAPLAINS PROVIDE?

The Mayo Clinic in Rochester, Minn., offered some guidance for our efforts. Challenged by administrators for greater accountability, Rev. Dean Marek and the chaplains at Mayo Clinic had defined chaplains' services, conducted a time study to determine how long these services took to deliver, and used this information to determine costs for the department. In his seminal work published in 2005, he explained, "We began to think in terms of services provided instead of patients visited. We had a comprehensive list of spiritual care services to share with administrators whose understanding of our ministry sometimes seemed limited to praying with or saving souls."<sup>1</sup>

Intrigued by Marek's work, Ken Potzman, director of pastoral services at St. John's Mercy Medical Center in St. Louis, introduced the model to our system and launched a pilot time study in his department. In the following year,



**BY JULIE M. JONES**  
*Ms. Jones is director, mission and spirituality, Sisters of Mercy Health System, St. Louis.*



## How One System Defines Quality

this initiative was expanded system-wide. The first step was to determine the services provided by chaplains. For example, chaplains address the needs of patients and families after deaths and during crises and traumas. They also provide bereavement support, respond to referrals, facilitate support groups, lead public worship, complete spiritual assessments, participate on committees and represent the hospital in the community. In some facilities, chaplains also assist patients in completing advance directives.

### 3. HOW LONG DOES IT TAKE TO DELIVER THESE SERVICES?

After defining the service categories (see pg. 42 for some examples), we embarked on a time study to provide accurate data about the time spent in delivering each service. Chaplains tracked their time for every service encounter and entered this data into a database for six months. This process had its challenges. First, it was tedious. For example, one chaplain who conducted pre-surgical visits documented more than 40 visits a day averaging three minutes each. Others were uncomfortable with such a focus on time and they feared that the time study would lead to quotas mandating how many visits they should complete or how long a visit should be. In response, we continually affirmed that we were collecting data to inform future discussions and facilitate learning. Still skeptical, chaplains tracked their time.

The benefits of this phase were threefold:

- Chaplains and directors had a common lexicon for the services they provided.
- Chaplains became aware of how they were using their time.
- A foundation was established for more system-wide collaboration.

### 4. WHAT DO THE DIFFERENCES AMONG DEPARTMENTS TELL US?

The data analyzed from the time study provided various points of comparison, including the average time to deliver each service in each department and the relative resource units between each of the services. The units show the ratios of time among services. For example, if the unit of service — the least amount of time to deliver a service — is 5 minutes and services provided at a death takes 80 minutes, then a death takes 16 times as long to staff than the basic service (or a ratio of 1 to 16). The unit values gave empirical data to show what most chaplains know intuitively: A death or trauma takes significantly more resources than a routine initial visit. Across the system, the average

time for an initial visit varied from 6 to 14 minutes; the average time for services provided at a death ranged from 25 to 136 minutes. Some differences were explained by variations in size, census and staffing level, but most were related to how each chaplain works with patients.

While exploring the differences among departments, we continued to track chaplains' activities. Working with an expert in performance management, we developed a second database to track activities, using the averages and the relative resource units developed by the time study to calculate percent of total time for the department for specific services. This data informed staffing decisions when new service lines were opened in the system. For example, when a new neonatal intensive care unit was opened, the pastoral care director determined appropriate staffing levels based on data from other pastoral services departments already staffing this type of unit. Additionally, we generated quarterly reports comparing facilities across the system.

Such comparisons led to the next question.

### 5. WHAT WERE CURRENT PRIORITIES? WHAT SHOULD BE PRIORITIES?

In the comparative reports we found great variance in the percent of time spent in direct patient care. Directors and chaplains again expressed concern about whether the corporate office would force departments to meet a single standard. In system-wide meetings of directors of pastoral care, we reinforced our intention that chaplains, as the systems' pastoral care professionals, would shape priorities and practices. A shift of thinking began to emerge: Directors began to engage in open conversations about differences among facilities. They took the questions from system-wide meetings back to their departments. As transparency increased, discussions uncovered assumptions and variations in patterns of practice.

For example, when the chaplains in one pastoral services department talked about how they delivered family care, they discovered a discrepancy in tracking. One chaplain counted the number of people in the family as the number of service encounters (see pg. 41 for more information on service encounters). For him, five family members in the room counted as five service encounters. All the other chaplains saw the family as a single unit, and counted it as one service encounter. The director clarified that the accepted system-wide definition matched what the majority were doing, i.e., a single service encounter with a "family" includes all members of the family present at that time. The chaplain



changed the way he tracked encounters to be consistent with others.

After nine months of comparative data, we began to explore what *should* be the priorities and what changes would need to be made to meet those priorities. Across the system, chaplains wanted more time in direct patient care. Departments analyzed their data more fully and engaged in a formal process to determine what was needed to change to increase time for direct care.

### FROM PRIORITIES TO DIRECT PATIENT CARE GOALS

Goals emerged from discussions of priorities. In consultation with a vice president of mission about local hospital or system needs, each depart-

ment set its own goal for percent of time to be spent in direct patient care. Variation across the system reflected differences among facilities and chaplains' responsibilities. In the smallest hospitals with a single chaplain (daily census of less than 60 patients), the single chaplain spends more time in activities like staff education and representing the facility in the community. As a result of the chaplain's time purposely split between direct patient care and other duties, the direct patient care goal is 50 to 55 percent. In our larger hospitals with more than 700 staffed beds and around-the-clock chaplain coverage, chaplains focus almost exclusively on pastoral care and the goals for direct patient care are more than 80 percent. Other time is directed toward staff min-

## DEPARTMENTAL PROCESS TO DEFINE QUALITY FOR SERVICE ENCOUNTERS

*The following is the outline of the process that directors are facilitating in their departments.*

### SET CONTEXT

Remind the group why we are doing this: As a system we are trying to define quality and measurement for this important aspect of patient care. We believe chaplains, our professionals who deliver pastoral services daily, are the best ones to define quality for pastoral services. We are engaging in this process as a system and will be working collaboratively, sharing our results with other departments.

### FOR THE SERVICE CATEGORY CHOSEN ...

#### 1. Identify patterns of practice

*This step will allow chaplains to learn from one another about what each one does.*

- Before your meeting, ask the chaplains to write what they do. If they had to explain to someone how to do this well, what would they write?
- During the meeting, invite the chaplains to share what they do in this service and what they believe is a best practice. Flip chart or gather responses in some way.
- Having heard/seen the variety of responses, what do we as a group conclude are elements of the "best practice" for this service? Use

"dots" to help rank: that is, give the chaplains a number of dots and ask them to rank the most important elements identified. Finalize priorities.

#### 2. Quality: What Does It Look Like?

*This step will likely be challenging and will uncover a variety of assumptions, which will be helpful in articulating an outcome. Ask why and how to help get some of these on the table. The following questions may help start the conversation:*

- What is the desired outcome for this service?
- What would be "quality" for this service encounter?
- How do you know that you made a difference? What is that difference for the patient/family?

#### 3. Measuring Quality and Outcomes

*This step may require some additional work/research.*

- Having identified what quality is, how do you measure this?
  - Does a measurement tool already exist? If not, what could be developed?
  - Are you aware of any other departments that have tried to measure something similar?

- Is there something that could be done as a pilot project?
- What resources can you bring to the discussion? For example:
    - Consult local experts for ideas on performance management/quality improvement
    - Are there clinical care guidelines that could be associated with this service? If so, are there any patient health outcomes that could be measured?
    - Are there models from other health systems that might define outcomes?
    - Is there relevant research around spirituality and health?
  - After looking at these ideas, how will quality be measured?

#### 4. Competency for Success

*This step helps us define what chaplains need to be successful. We will use this in the future as we hire new chaplains and identify needs for professional development.*

- What competency is needed by a chaplain to be successful in this service encounter?
- Look at the certification requirements for the National Association of Catholic Chaplains or the Association of Professional Chaplains. Are there specific standards that apply?



How One System Defines Quality

istry and supporting other hospital initiatives.

Setting and working to achieve the goals has focused pastoral services departments on quality improvement, accountability and professionalism. For the first six months of this fiscal year, at least half of departments are meeting or exceeding their goals.

Additionally, the process to set goals has proved empowering to chaplains. Darren Tourville, supervisor of pastoral services, St. John's Regional Health Center, Springfield, Mo., describes the benefits this way:

"The activity log has raised both our professionalism and our satisfaction as chaplains here in Springfield. We've had quite a bit of interest among chaplains in meeting our goal of direct patient care. It has really improved our focus. What started out as merely a statistical mandate

from the corporate office has filtered into a unifying activity."

**FULL CIRCLE: HOW DO WE ASSESS THE QUALITY OF PASTORAL SERVICES?**

After more than a year of reviewing comparative data and increasing focus on direct patient care, questions of quality re-emerged. The data about how chaplains were spending time had focused on accountability, but we did not have data about the quality of those services. Currently we are working to define quality. Each department is exploring two service categories with a formal process to:

- Identify the patterns of practices among chaplains.
- Name the elements of the best practice.

**EXAMPLES OF SERVICE CATEGORY DEFINITIONS**

**General Guidelines**

Log multiple services per patient encounter, if appropriate. For example, a chaplain walks into the room for an initial visit and the patient needs assistance with advance directives and chaplain provides this. Log as two services: initial visit and advance directives.

Night call — chaplain or director should be logging services provided by paid staff that take night calls (not volunteers).

Service Category	Direct/Indirect	Definition
Bereavement	Direct	Bereavement program or activities. <ul style="list-style-type: none"> <li>■ This category would include time spent sending sympathy cards, planning or holding a memorial service and any work with bereavement groups.</li> <li>■ Any time spent with family immediately following death should be counted under death, not bereavement.</li> <li>■ Questions arose about cards to families. Does each one count separately? <i>Decision: continue to record as was done in data collection period.</i></li> </ul>
Crisis	Direct	Response to an unusual emergency event such as patient receiving news about new or poor prognosis, family argument, etc. Also includes grief ministry provided to patient when death of a loved one occurs.
Meetings	Indirect	Hospital meeting attended (or committee work completed) in your role as chaplain. <ul style="list-style-type: none"> <li>■ Would include management meetings, staff meetings, chaplain-to-chaplain consults, hospital-wide meetings on policies or practices and any other non-patient related meetings.</li> <li>■ Meetings related to patient care or family issues should not be tracked here.</li> </ul>
Network Community	Indirect	Networking with ministers, priests, religious organizations and community service organizations.
Spiritual Assessment	Direct	Formal process of completing an in-depth spiritual assessment that was requested or required can be oral or written in the chart. In the initial visit, spiritual assessment should be included under routine/initial visit.



- Define quality and outcomes for the service.
- Determine measurements for quality.
- Name competencies necessary for quality.

By the end of this year, we will have completed this process for nine service categories and begun pilots for measurements of quality. We are sharing learning across the system and expect this work to lead us to the next round of questions.

### OVERALL LEARNING

Although our activity log is not perfect, having the data about how chaplains and departments are focusing their time and resources has provided an important foundation for continued quality improvement within our system. What began as a system-office-driven initiative has resulted in greater chaplain satisfaction and engagement and increased focus on quality.

Along the way we have learned some important lessons:

- Clarify service definitions up front, before the time study. We actually had to do two time studies because our initial definitions left room for interpretation.

- In defining services, focus on *services* provided not *activities* of the department. In retrospect, we would not include initial visits in our log. We would include only services that might be provided in an initial visit, such as assistance with advanced directive, grief, etc.

- Consider using definitions that another system has already developed so you have comparative data external to your system.

- Align goals throughout the system — directors' goals, departmental goals, system-wide collaboration — to reinforce accountability and transparency.

- Address the fears that naturally arise. Use data to open learning and questions. We consider it a success to find more questions when looking at a comparative report.

- Facilitate pastoral care directors to develop their management skills by providing data, tools, processes, support and accountability.

Overall, the activity log has been an important part of quality improvement within our system. Ken Potzman sums it up well:

“The activity log project has helped us as a pastoral services team to identify what are the major activities of a chaplain, on average how much time is involved in each of those activities, and to look at where we spend our time. When new chaplain services are requested due to expansion or movement into new areas, we have a basis for knowing how much chaplain time is required to meet the needs. It has enabled us to set goals for our pastoral team, both collectively and with individual chaplains. It allows us to track our efforts in meeting those goals. Identifying the major service events has also helped move us into setting specific standards of care for those service events and quality measurements assuring that those standards are being met. The activity log project is like the base of a triangle. It has enabled us to move from identifying what we do (service events) to tracking how long it takes to do them (time units) to identifying ‘best practice’ for each service event, and then measuring quality to assure we are providing what we have identified as ‘best practice.’ This project has helped make us a more effective and efficient pastoral services team.”

Data truly has led to better questions than we had before. ■



Comment on this article  
at [www.chausa.org/hp](http://www.chausa.org/hp).

### NOTE

1. Dean Marek, “How Much Does It Cost for Chaplain Services?: Fiscal Approach Actually Raises Department’s Standing,” *Vision*, National Association of Catholic Chaplains, July 2005. Available online at [www.nacc.org](http://www.nacc.org).