How Many Chaplains *Per* 100 Inpatients? Benchmarks of Health Care Chaplaincy Departments*

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Reports the results of a questionnaire survey of a sample of chaplaincy departments directors (N=370) designed to answer the following questions: How many chaplains do various types of hospitals employ per 100 inpatients? What is the relationship between the number of employed chaplains and departmental Clinical Pastoral Education (CPE) programs? How much effort do departments give to outpatient ministry? What percentage of ministry do volunteer chaplains provide? Provides tentative answers to inform the strategic planning processes of chaplains and administrators.

These are difficult times for health care chaplaincy departments. Every chaplain who looks ahead knows that many changes will occur over the next decade. In the face of these long-term changes, nationwide valid and reliable departmental benchmarks become critically important because they can function as guidelines, even standards that can inform strategic planning efforts.

The health care chaplaincy profession lacks information to address important questions about their activities and to serve as benchmarks against which to measure future change. For example, how many chaplains do various types of hospitals employ *per* 100 inpatients? Or again, what is the relationship between the number of employed chaplains and departmental clinical pastoral education (CPE) programs? How much effort do departments give to outpatient ministry? What percentage of ministry do

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volunteer chaplains provide? In this article we provide responses to these and other questions. The results come from a study that examined the impact of health care reform on chaplaincy departments (published elsewhere)[1] and that gathered benchmarking data. We examined the complete indexes (until Fall, 1997) of three chaplaincy journals (*The Journal of Pastoral Care, The Caregiver Journal,* and *Pastoral Psychology*) and found no previously published literature that addressed these benchmarking concerns.

Methods

Sample Selection

We compiled a list of chaplaincy department directors that represented the diversity of the profession by using the membership lists of three national health care chaplaincy organizations. The National Association of Catholic Chaplains (NACC) provided their mailing list of department directors (543 names). The Association of Professional Chaplains (APC), at that time the College of Chaplains and the Association of Mental Health Clergy, maintained no separate listing of directors. Consequently, we reviewed the alphabetic listing of members in their *Directory,* identifying those who were listed as the head of a department. In a second step, we added the names of their most recent "One Person Pastoral Care Department" specialty group because such chaplains would not likely be listed as a director in the *Directory.* This produced 456 names. We built a list of names from the third organization, the Association for Clinical Pastoral Education (ACPE), by contacting Regional Directors to determine whether a supervisor was a department director. This produced 351 names. Since some directors were members of more than one of these organizations, the names were then compared state-by-state and duplicates eliminated, leaving a master list of 1330 names. We then decided that a sample of 500 department directors was adequate (approximately 37 percent of directors listed) and drew a systematic random sample. The questionnaires were completed during December, 1997 and January, 1998 by department directors.

The Questionnaire

While a major part of the questionnaire gathered information concerning the impact of health care reform on departments, extensive attention was also given to departmental and institutional characteristics that would supply results for this report. Usable information was received from 370 (74%) directors after an initial mailing of the questionnaire, a reminder postcard 10 days later, and a second questionnaire two weeks after the postcard to non-responders.

The diversity among the respondents appeared to correspond in a general way to the characteristics of the profession. In geographic terms, the directors resided in the Eastern (25%), Southern (25%), Midwestern (36%), and Western (14%) regions of the U.S. The primary organizational affiliation claimed by department directors included APC (35%), NACC (30%), and ACPE (30%) with five percent leaving the item blank. Departments in institutions of various sizes were also represented. For example, 18 percent reported the institution size as 100 inpatients or less; 26 percent were employed by hospitals with a census of 101 to 200 inpatients. Institu-

[1]Larry VandeCreek (Ed.). "Professional Chaplaincy: What Is Happening to It During Health Care Reform?" *Journal of Health Chaplaincy,* 2001, Vol. 10, No. 1.

tions with a daily census of 201 to 300 inpatients employed 19 percent of the department heads and 15 percent of the respondents described institutions of 301-400 inpatients. Twenty-two percent reported that they worked in hospitals with 401 or more inpatients. Although we made no attempt to compare non-responders to those who provided information, these characteristics regarding geography, professional identity, and institution size support the assumption that the results represent the general range of diversity within the field of professional health care chaplaincy.

Results

A questionnaire item asked whether professional chaplaincy was given departmental status within the institution. In response, an overwhelming majority (93%) responded affirmatively. Only six percent indicated that they did not have departmental status; one percent did not respond to the item.

A second item concerned the administrative level of the person to whom chaplaincy directors reported. Responses to this item (Table 1) indicated how the department was integrated into the institution. While ten percent said that they reported to another department director (or an equivalent), a second level administrator supervised most chaplaincy departments (56%). Twenty-one percent reported to the president or the CEO.

Table 1
What is the Administrative Level of the Person to Whom the Department Director Reports?

Administrative Level	Percentage of Directors
Top Level (i.e. President/CEO)	21
Second Level (i.e. VP/Assoc CEO)	56
Third Level (i.e. assistant CEO)	7
Fourth Level (i.e. another department director)	10
Other Arrangements	6

Note: N = 370

Chaplains sometimes comment during discussions that the personal spiritual/religious stance of senior administrators is important because it may influence decisions concerning the department. While it is unlikely that more religious administrators would automatically look favorably on chaplaincy departments, it is true that personal values and experiences can influence administrative decisions. Thus a questionnaire item asked whether directors believed that the religious faith and practice of administrators to whom they reported made a difference with respect to the threat of downsizing the department? The responses were very evenly split; 48 percent replied in the negative and 52 percent believed that this was an important consideration.

Chaplaincy directors also comment that there are frequent personnel changes in the administrative positions to which they report and that it is difficult to explain the role and function of chaplaincy to these new administrators. What was the longevity of the administrators to whom directors reported? The results (Table 2) suggested that although slightly more than half (54%) reported to a new administrator only every five years or more, one-third (33%) experienced more frequent turnover in supervision.

Table 2
How Often Is a Different Individual Placed in the Administrative Position to Which the Department Director Reports?

Frequency of Change	Percentage of Directors
About every year	4
About every two years	7
About every three years	14
About every four years	8
About every five years or more	54
Did not know/left item blank	13

Note: N = 370

The questionnaire asked respondents if they worked in "religiously affiliated institutions," defined as those with "some continued official influence from a faith group." In response to this query, 59 percent of department directors reported that their institution was religiously affiliated. This approximate 60-40 division in the sample was used in further analyses described below.

A questionnaire item asked directors to report the number of full-time equivalent (FTE) chaplains employed by the institution. These results (Table 3) described the frequency with which various size departments occur within the field and they suggest that approximately one-third of departments contain between one and two employed chaplains and another third employ between two and five chaplains.

Table 3
How Many Chaplains Does the Institution Employ (FTEs)?

Number of Chaplains (FTEs)	Percentage of Departments
0.1—0.9	1
1.0—1.9	32
2.0—2.9	14
3.0—3.9	10
4.0—4.9	9
5.0—5.9	7
6.0—6.9	5
7.0—7.9	5
8.0—8.9	3
9.0—9.9	3
10.0 or more	9
No response	2

Note: N = 370

Further analyses refined the results of Table 3 by describing the number of chaplains according to institutional types (Table 4). The table contains medians, means, and modes because the arithmetic mean by itself is not very meaningful when the range is so large. University hospitals appear to employ the largest absolute number of chaplains; the reason for this is unclear.

Table 4
The Number of Employed Chaplains Per Department by Institution Types

Institution Types	Range	Median	Mean	Mode
Nonreligiously Affil. Community General Hospitals (n=124)	0 to 23	1.50		
Religiously Affil. Community General Hospitals (n = 112)	0 to 29	4.00		
University Hospitals (n = 36)	0 to 20	5.75		
Psychiatric Hospitals (n=15)	0 to 10	2.00		
Other Institutions (n = 69)	0 to 17	2.00		
Total Sample (n = 356)	0 to 29	3.00		

Note: Range = the lowest and highest number of employed chaplains reported on the questionnaire. Median = half of the departments employ fewer chaplains than this number and half employ more chaplains. Mean = the average number of employed institutional chaplains reported by directors. Mode = the most frequently occurring number of employed chaplains. *Multiple modes exist; the highest value is reported.

Many chaplains believe that religiously affiliated institutions employ more chaplains. Is this true? The results in Table 5 compared the number of chaplains in non-religious and religiously affiliated hospitals controlling for size of institution as classified by the American Hospital Association.[2] Further, as described in the table note, the relationship between the number of chaplains in these two types of institutions is characterized by a ratio. In all but the smallest institutions, religiously affiliated hospitals tend to employ about twice as many chaplains (*i.e.* the ratio ranging from 1.99 to 2.67).

[2]Healthcare InfoSource Inc, *Hospital Statistics* (Chicago, IL), p. 2.

Table 5:
The Ratio of FTE Chaplains in Nonreligiously and Religiously Affiliated General Hospitals By American Hospital Association Census Classifications

Census Class	Nonreligiously Affil. Comm. Hospitals (N = 124)					Religiously Affil. Comm. Hospitals (N = 110)					
	N	Range	Median	Mean	Mode	N	Range	Median	Mean	Mode	Ratio*
1 to 50	1	na	na	2.00	2.00	5	1.0 to 2.8	1.00	1.36	1.00	0.68
51 to 100	16	1.0 to 2.5	1.00	1.17	1.00	24	1.0 to 6.0	2.75	2.81	1.00	2.40
101 to 200	43	0.5 to 6.0	1.00	1.52	1.00	29	0.0 to 12.0	3.80	4.02	4.00	2.67
201 to 300	24	1.0 to 12.0	1.62	3.03	1.00	19	2.5 to 10.4	6.00	6.04	7.00	1.99
301 to 400	24	1.0 to 12.0	2.87	4.18	1.00	15	1.0 to 14.0	8.00	8.34	9.00	2.00
401 to 500	7	1.0 to 7.0	5.00	4.31	7.00**	8	4.0 to 22.0	11.00	11.46	16.00	2.66
Over 500	9	0.0 to 23.0	6.00	7.02	6.00	10	5.0 to 29.0	14.12	14.52	19.00**	2.07

Note: Hospital census categories reflect the average daily census in the institutions as reported by department directors and are based on American Hospital Association guidelines. N = the number of Directors in Pastoral Care Departments who responded to the questionnaire. *Ratio is calculated by using the mean number of employed chaplains in religiously affiliated hospitals divided by those in the nonreligiously affiliated hospitals. Thus, in Row 1, religious affiliated hospitals with a census of 50 patients or less report 0.68 (1.36÷2.00) employed chaplains for every 1.0 in the nonreligiously affiliated hospitals. **More than one mode exists; the highest value was selected.

Table 6
The Number of Employed Chaplains Per 100 Patients by Institution Types

Institution Types	Range	Median	Mean	Mode
Nonreligiously Affil. Community General Hospitals (n=124)	0.00 to 8.00	0.92	1.22	0.67
Religiously Affil. Community General Hospitals (n = 110)	0.00 to 11.20	2.64	2.90	2.67*
University Hospitals (n = 36)	0.00 to 3.33	1.24	1.50	2.00*
Psychiatric Hospitals (n=15)	0.08 to 4.00	1.00	1.20	1.33*
Other Institutions (n = 66)	0.15 to 12.00	0.96	1.66	1.33
Total Sample (n = 356)	0.00 to 12.00	1.33	1.85	1.33

Note: These results are created by dividing the total number of chaplain FTEs in each Department by the median census of each institution and multiplying that result by 100. * Multiple modes exist; the highest value is reported.

The descriptive results in Table 5 were used to determine the number of chaplains employed per 100 inpatients. The results (Table 6) suggested that the mean number of chaplains employed per 100 patients ranged from 1.20 to 1.66 chaplains, the exception being religiously affiliated hospitals that employed an average of almost three (2.90) chaplains per 100 patients. The mean number of chaplains per 100 patients for all settings was 1.85. The median results are somewhat lower and perhaps more accurate because the arithmetic means are influenced by the wide range in the data. The median results suggested that overall half of the hospitals employed less than 1.33 chaplains and the other half employed more.

Questionnaire responses also provided information concerning various internal chaplaincy department characteristics previously unreported in the published literature. We asked directors to report the percentage of the ministry devoted to outpatients. Over one-third (37%) of the directors reported less than 10 percent of their departmental effort was devoted to this patient population; 43 percent reported that between 10 and 29 percent of the department's ministry was given to these patients. Seventeen percent reported that more than 30 percent of their department efforts were devoted to outpatients.

A questionnaire item asked for the "approximate percentage of departmental ministry provided by volunteers" (Table 7). Again, the wide range of data is evident, making the mean somewhat less meaningful. Both the median and the mode suggest that volunteers provide between 10 and 20 percent of department ministry.

The questionnaire also gathered information concerning accredited CPE programs by NACC or ACPE and their relationship to institutional and departmental characteristics. A slight majority of department directors (53%) reported no accredited CPE program; these data suggest the percentage of departments in the total field of health care chaplaincy that contain accredited programs.

How are training positions in these CPE programs funded? Of the 210 directors who reported a CPE program, a large majority (81%) reported funding only by the institution. Nine percent reported funding from outside sources for up to two positions. The remaining ten percent reported three or more training positions funded from other sources.

Finally, the association of three variables with the number of FTE employed chaplains per 100 inpatients was explored. These variables included the presence of a CPE program, the percent of time devoted to outpatient ministry, and the number of volunteer chaplains used by the program (Table 8). In that table, the positive correlations indicate that the number of employed chaplains rises with the presence of a CPE program, the percentage of time devoted to outpatient ministry, and the percentage of department ministry carried out by volunteers (negative correlations indicate an inverse relationship). Here it is important to give attention primarily to those results marked as statistically significant. The results suggest that the departments in nonreligiously affiliated community general hospitals and university hospitals with more employed chaplains tend to also have CPE programs ($r = .27$ and $.36$ respectively). A modest positive association between department size and the presence of a CPE program existed when all chaplaincy departments were taken together ($r = .12$).

The association between the number of employed chaplains per 100

patients and the percentage of department ministry to outpatients is statistically significant only when all the departments are taken together (r = .18). The percentage of departmental ministry carried out by volunteer chaplains is inversely related to department size for nonreligiously affiliated community general hospitals and university hospitals (r = -.23 and -.47 respectively). When the departments in all settings are considered together, the results suggest that volunteer chaplains are significantly associated with a smaller number of employed chaplains per 100 inpatients (r = -.22).

Discussion

This appears to be the first publication that describes health care chaplaincy departments in the U.S. across three national health care chaplaincy organizations. This lack of information may reflect a tendency on the part of professional chaplains to be concerned only with their own departments and situations rather than the profession as a whole. This limited scope of interest, however, impoverishes the profession because it contributes to diverse expectations concerning staffing patterns among administrators and department directors. The details reported here can serve as benchmarks and guide future studies that seek to determine long-term changes in the field. They can also be helpful in creating departmental strategic plans because these details can function as guidelines.

The results suggest that department directors tend to report to second level administrators and that 25 percent report to someone new about every three years or less (Table 2). These frequent changes can be anxiety producing because other research has found that, for directors, the "personal relationship between the administrator and the director (is) very important."[3] The anxiety is likely accentuated by the possibility that new administrators may find it increasingly difficult to fund chaplaincy efforts given institutional financial constraints. This suggests that it would be helpful for the national organizations to create materials for directors to use as they explain the roles, functions, and benefits of chaplaincy.

The information provided on the number of chaplains employed by various types of institutions was previously unavailable. The results in Table 5 suggest that religiously affiliated hospitals tend to employ about twice as many chaplains as unaffiliated hospitals regardless of their patient census. The important questions here concern what outcomes flow from this finding. Does it suggest, for example, that the benefits of chaplaincy might be identified by comparing selected outcomes in these two settings? There is considerable evidence, however, that religious affiliated hospitals currently face severe difficulties and that the influence of their religious tradition is diminishing.[4] Chaplaincy directors in religiously affiliated hospitals should be alert to changes in the level of traditional religious influences in their institutions and encourage these influences whenever possible.

The number of chaplains *per* 100 inpatients provides new information concerning the staffing ratio throughout the country (Table 6). Here it is

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[3]M. Patrice McCarthy, "Health Care Reform: Analysis of Narrative Responses from Directors of Pastoral Care Departments." In: VandeCreek, (Ed.). "Professional Chaplaincy: What Is Happening to It During Health Care Reform?" *Journal of Health Care Chaplaincy*, 10(1), in press.

[4]Gerald A. Arbuckle, *Healthcare Ministry: Refounding the Mission in Tumultuous Times* (Collegeville, MN: The Liturgical Press, 2000).

Table 7
Percentage of Departmental Ministry Provided by Volunteer Chaplains by Institution Types

Institution Types	Range	Median	Mean	Mode
Nonreligiously Affil. Community General Hospitals (n=117)	0 to 100	20	28	10
Religiously Affil. Community General Hospitals (n = 106)	0 to 60	10	12	10
University Hospitals (n = 34)	0 to 100	20	20	20
Psychiatric Hospitals (n=25)	0 to 50	10	13	10
Other Institutions (n = 57)	0 to 80	10	14	10
Total Sample (n = 339)	0 to 100	10	19	10

Note: Table data are percentages.

Table 8

The Relationship of the Number of Employed Chaplains Per 100 Patients By Institution Types to the Presence of a CPE Program, the Percentage of Outpatient Pastoral Care, and Percent of Volunteer Chaplains

	CPE Program	% Outpatient Ministry	%Volunteer Chaplains
Nonreligiously Affil. Community General Hospitals	.27**	.09	-.23*
Religiously Affil. Community General Hospitals	.04	.06	-.09
University Hospitals	.36*	.20	-.47**
Psychiatric Hospitals	-.29	-.25	.10
Other Institutions	.28	.13	-.05
Total Sample	.12*	.18**	-.22**

NOTE: The Ns for the various hospital categories are approximately those reported in Table 1. The table data are correlations. The CPE column evaluates the presence of a program on the number of employed chaplains per department. The percent of outpatient pastoral care row describes its relationship to the number of employed chaplains. The percent of volunteer chaplaincy examines its association to the number of employed chaplains. *Correlation is significant at $p \leq .05$; **Correlation is significant at $p \leq .01$.

important to note that these results in no way imply whether this ratio constitutes "best practices." These results simply reflect a clinical standard that has developed over the years and how chaplaincy is valued/not valued in institutions. The profession would benefit from explorations as to how chaplains use their time, how they structure their visits, and what impact their activities have on patient outcomes. This, in turn, could inform decisions as to whether the current ratio is appropriate.

The current health care market emphasizes outpatient settings and the study results suggest that chaplaincy has developed a very limited presence there. Does this reflect missed opportunity? A number of dynamics could explain why outpatient ministry is limited. They include the continued critical need of acutely ill hospital patients and their families who require attention and the anxiety chaplains may experience as they try to enter the outpatient context. It is also likely that funding this ministry creates additional problems because outpatient medicine is often funded differently than inpatient care. There is much room for further research and exploration here.

Findings reported in Table 8 suggest significant associations with the number of employed chaplains. They suggest that departments with more chaplains *per* 100 inpatients tend to contain CPE programs ($r = .12$), provide more outpatient ministry ($r = .18$), and use fewer volunteer chaplains ($r = -.22$). The professional and financial factors that account for these results merit addition research attention. For example, some of the strongest associations are found in the relationship between the number of employed chaplains *per* 100 inpatients and use of volunteers. Would further research results reveal that volunteer chaplains take the place of employed chaplains? If so, at least two further important questions emerge. First, is the quality of ministry and the circumstances within which it is delivered, equivalent for employed chaplains and volunteers? Second, assuming some differences between employed and volunteer chaplains can be established, in what circumstances are these differences appropriate and acceptable? If a difference between the quality and content of pastoral care provided by employed staff and volunteers remains unclear, then it must seem logical to at least some health care administrators to conclude that there is no need to spend money by employing chaplains to carry out pastoral care functions.

At least four possible limitations must be taken into account when interpreting these results. First, it is possible that, despite efforts to avoid bias, the sample is not representative. Health care chaplaincy is very diverse across the three organizations and certain types of departments may have been excluded from the sample. We note, for example, that the project did not include directors from the *Directory of the National Association of Jewish Chaplains.*

Second, when the data are broken down into subcategories, the number of departments can become rather small. For example, only 15 departments in psychiatric hospitals are represented. In Table 5, the sample representing the smaller and larger hospitals is limited. The trustworthiness of these data, therefore, is less certain.

Third, these results were gathered in late 1997 and early 1998 after health care reform had already begun. They cannot be regarded, therefore, as reflecting health care chaplaincy before reform efforts began. That information is unfortunately forever lost. The current results are helpful

because they at least provide some information concerning the profession in the closing decade of the twentieth century.

Fourth, these results do not answer all of the benchmarking questions that are important to departments. For example, these results do not answers questions about chaplaincy in expressly Catholic or the various Protestant health care institutions. The results are likely not very helpful to various non-hospital health care chaplaincy departments such as long-term care and hospices. These are simply classified as "Other" in the various tables in this report. Additionally, the profession possesses very limited information about the extent of training among its members, its impact on their ministry, their productivity, and the costs of chaplaincy.

In summary, these results provide information about health care chaplaincy departments that can inform current strategic planning processes. They also invite similar studies in the future as the profession seeks to understand itself and plan its future.

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