Canadian Association of Psychosocial Oncology
Association Canadienne d'Oncologie Psychosociale

# CAPO STAFFING FORMULA GUIDELINE FOR PSYCHOSOCIAL ONCOLOGY DISCIPLINES- V.2.0

The purpose of the following guideline is to support administrators making decisions to hire health care professionals working in Psychosocial Oncology (PSO) in Canada. CAPO has undertaken this work to establish the minimum benchmarks in hiring practices for PSO programming. The framework has 10 factors to be considered in hiring practices to support the staffing formula. What makes this work unique is that the work environment and the scope of practice of the discipline needs to be well defined prior to determining other elements like work hours, direct vs indirect patient care activities, labor practices etc. A well-resourced infrastructure with efficient processes for PSO programming paired with highly committed and qualified clinicians will ensure that cancer patients and families receive services that address their needs with positive and measured outcomes.

CAPO chose the discipline of social work, more specifically, Master's prepared Social Workers working in a tertiary cancer centre to develop the framework and formula. The discipline of social work was chosen as traditionally it is the single largest discipline represented in the CAPO membership. The intent is for CAPO to continue to adapt the framework and staffing formula to other disciplines of the PSO interdisciplinary team and also other settings; E.g. psychology, speech language pathology, physiotherapy, nursing specialized in PSO and other clinical programs like community oncology clinics, in-patient oncology units and others. The work was undertaken by a group of administrative leaders and/or clinicians in Canada who work in PSO programming. Given the limited evidence to support this type of work in Canada, the guideline was developed and approved through consensus and later approved by the CAPO Board. An online calculator is available on the CAPO Website to assist cancer agencies in estimating the FTE's for the PSO program.

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**Disclaimer**
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**Background:**

In 2010 the Canadian Association of Psychosocial Oncology (CAPO) released its revised Standards of Psychosocial Health Services for People Affected by Cancer (2010). The national standards define psychosocial oncology (PSO) as a specialty concerned with the social, psychological, emotional, spiritual, quality-of-life and functional [practical] aspects of cancer, from prevention through bereavement. PSO is a whole-person care approach that recognizes distress as the 6th Vital Sign of cancer care; distress should be proactively identified in people affected by cancer followed by an assessment and treatment plan for the management of complex psychosocial issues (Bultz & Johansen, 2011).

The CAPO Standards (2010) were developed to assist cancer facilities, administrators, program leaders and professionals in the delivery of psychosocial health services in Canada by providing a framework for building PSO programs. CAPO has become a "go to" organization in Canada where people make inquiries about the standards and ask clarifying questions for developing PSO programming. A common question posed is about staffing ratios for the disciplines involved in the delivery of PSO care. CAPO has committed to undertake the work of defining staffing ratios for the various PSO disciplines working collaboratively with PSO leads/experts across the country through the work of the CAPO Clinical Advisory Committee.
These are individuals with past/present clinical practices and/or have held leadership positions in psychosocial oncology programming at regional and/or provincial levels.

Below you will find the first staffing formula developed for the discipline of social work, more specifically, Master's prepared Social Workers working in a tertiary cancer centre. The framework (Figure 1) to develop the formula is intended to be adapted for other disciplines of the PSO interdisciplinary team and also other settings; e.g. psychology, speech language pathology, physiotherapy and other settings like community oncology clinics, in-patient oncology units and others. There may also be sub-disciplines within a discipline; for example, the formula does not apply to a social worker working on an in-patient unit who holds a Bachelor of Social Work (BSW). The framework needs to be defined specifically for the scope of practice for BSWs working on an in-patient unit to arrive at a staffing formula. However the ten elements of the framework presented in Figure 1 are required when undertaking this scope of work. The purpose of having different formulas for various disciplines provides an opportunity for administrators to plan the development of PSO programs based on the needs of patients and families affected by cancer. It also provides an opportunity to fiscally plan for the delivery of PSO programming in Canada.

A literature review was conducted in 2019 (see Appendix I) with limited evidence to support a social work staffing formula for PSO, let alone specific to the Canadian landscape for oncology care. The formula presented was reached by consensus with members of the CAPO Clinical Advisory Committee similar to work undertaken by others (Cartmill et. al., 2012; Zebrack et. al., 2012). We anticipate the work for this framework and formula will evolve as provinces/regions implement the formula and share data to continue building the evidence to achieve a standard of hiring practice for PSO programs in Canada.

As you review the document you will note references made to patients. For the purpose of this exercise, patient[1] refers to an individual diagnosed with cancer and family member refers to the patient's closest support network defined by the patient, who may access PSO services for emotional, psychological, social, instrumental and/or spiritual support. We also make reference to client(s) that refers to a patient or family member. Calculations have been rounded off to the nearest decimal with the exception of Full Time Equivalents (FTEs) so that resources may be planned accordingly. An online calculator is available on the CAPO Website to assist cancer agencies in estimating the FTE's for the PSO program.

MSW Staffing Formula for Tertiary Cancer Centres

The discipline of social work was chosen to develop the first staffing formula as traditionally, it is the single largest discipline represented in the CAPO membership. As the work is new, with limited evidence to reflect best practices for staffing PSO programming, it is important that the framework reflects all components shaping staffing decisions. The framework developed can be adapted for other PSO disciplines and CAPO intends to continue developing this work.

As you review the framework, it is important to keep in mind the necessary foundations that support the work environment to maximize the expertise of the discipline. For example, are there efficiencies that will help maximize the clinical work and discipline specific responsibilities; what change management strategies can be put in place to find these efficiencies? PSO professionals are licensed to practice under a regulatory licensing body for the province they work in and there may be variations in practice across provinces in Canada. Labour practices may also vary by discipline, regions and/or provinces. All these elements are important factors to consider when developing a staffing formula and the formula presented here may require being adapted to reflect the work environment where the social worker is being hired.

1 Ideally we would refer to individuals with cancer however given the nature of this technical document, the targeted audience and reference made to technical terms such as in-patient and out-patient, we opted to refer to individuals with cancer as patients.

The framework is comprised of ten factors to consider to arrive at the projected number of FTE social work positions in a tertiary cancer centre. They are:

1. *Principles of the work environment for the discipline*
2. *Scope of practice for the discipline*
3. *Estimation for prevalence of distress*
4. *Defining work hours*
5. *Direct vs. indirect patient care*
6. *Carryover caseload from one fiscal year to the next*
7. *Instrumental concerns vs. counselling and/or psychotherapy*
8. *Group work*
9. *Full social work caseload estimation*
10. *Number of New Cancer Cases referred – Tertiary Cancer Centre*

### *1. Principles PSO MSW Social Worker - Tertiary Cancer Centre*

The principles serve to:

- Describe the discipline and qualifications (e.g. social worker MSW prepared) for which the staffing formula is being developed
- Describe the population being served (e.g. Out-patient vs in-patient cancer patients)
- Contextualize the work environment (e.g. maximizing efficiencies, supports in place for the discipline, well defined processes and others). The work environment is important and usually receives little attention when looking at hiring practices; if the infrastructure of the PSO program is not well developed then it may impact the output of work.

The principles described below are not exclusive but examples to support the work of the discipline with the ultimate aim to best meet the needs of cancer patients and families. We encourage administrators to review the evidence-based guideline *Psychosocial Health Care for Cancer Patients and their Families* (2010) for standards specific to PSO programming.

*Qualifications:*

- The framework displayed in Figure 1 describes the work of a Master's prepared social worker with a license to practice in good standing.

- There may be variations in social work practices across licensing bodies in Canada that are not addressed in this framework. Social workers are expected to practice according to their professional college standards, laws and ethics in their province. For example in Ontario, psychotherapy is considered one of fourteen controlled acts under the Regulated Health Professions Act, 1991 restricted to members of certain professions. Social worker in Ontario registered with the Ontario College of Social Workers and Social Service Workers may perform the controlled act of psychotherapy in compliance with the Social Work and Social Service Work Act of 1998, its regulations and bylaws. There is also a distinction made between psychotherapy services and counselling (OCSWSSW, 2017).
- There are also titles for social workers (e.g. clinical social worker) that are designated in certain provinces and forbidden to be used in other provinces based on legislation and these designations may vary across licensing bodies in the country.
- Administrators are encouraged to work with professional practice leads in their organization to understand the variation in designated titles and practices and/or contact the regulated licensing body in the province.

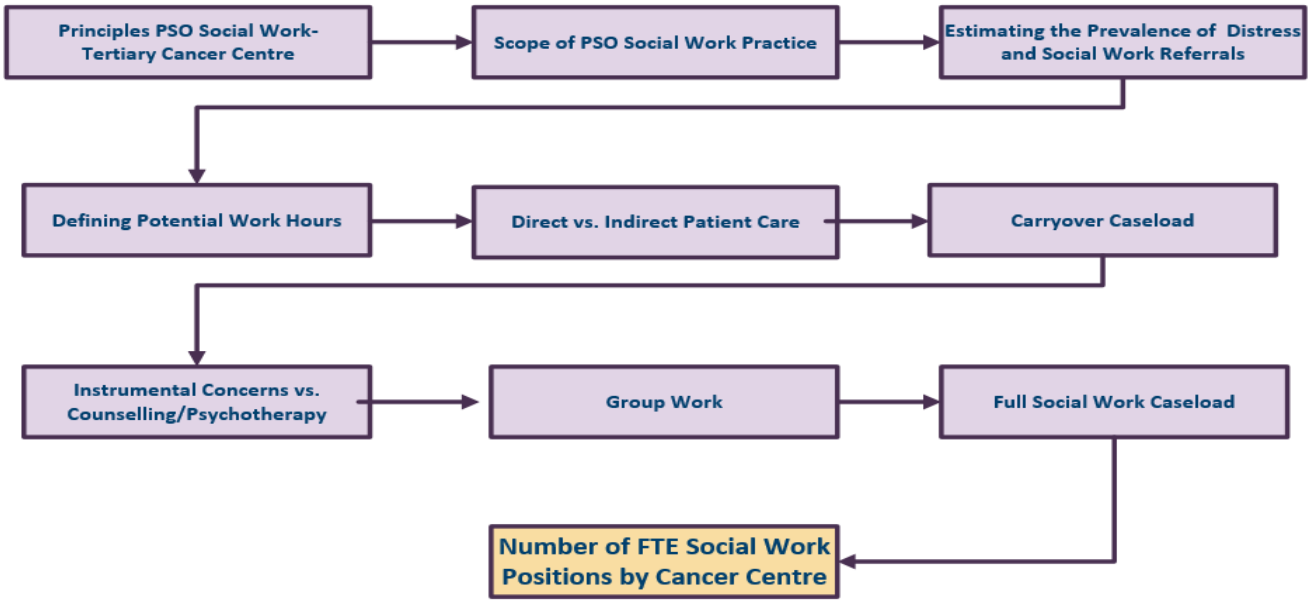


Figure 1. Framework to Develop PSO Staffing Formula

*Work Setting:*

- The framework is based on a social worker employed in a tertiary cancer center providing out-patient services to cancer patient.

*Program setting:*
Other principles and work environment to consider for the social worker:

- Member of a larger PSO program team; e.g. psychiatry, psychology, spiritual care and others and the social work role is well integrated as part of the larger interdisciplinary team with oncologists, nurses, radiation therapists and others.
- Works within a cancer program that supports patients completing patient reported outcome (PRO) measures as part of a distress screening program (e.g. ESAS-r, PhQ-9); scores are acknowledged, reviewed, and tracked over time for progress with interventions planned accordingly with measurable outcomes.
- Focuses the caseload on counselling and/or psychotherapy (psychotherapy may be a controlled act that the social worker performs pending the regulatory licensing body in the province as described under section one) and complex navigation/advocacy issues.
- Holds clinical and other non-clinical responsibilities that maximize the social worker's expertise and time; e.g. administrative supports are available to process referrals, appointments scheduled electronically, processes are streamlined for efficiencies through change management strategies etc.
- Works with various stages of the cancer journey from prevention, pre-diagnosis (highly suspicious), diagnosis, treatment, rehabilitation, survivorship, recurrence, palliative care, end of life care and bereavement.
- Provides individual, couple, family and/or group work interventions.
- Works mostly with adults however pending the clinical focus, a social worker may be interacting with clients across the lifespan.
- Works within a program that has a triage systems developed to process new referrals based on urgency, need and client consent.
- Works within a system with PSO resources organized in a fashion to accommodate urgent referrals; e.g. one social worker takes urgent calls for the day, with flexibility in schedule to accommodate.
    - The interdisciplinary team understands that a client may need to wait to see the social worker for an urgent referral; in time of crisis, a member of the interdisciplinary team may need to stay with the client until the social worker is available. Internal process mapping is useful for these processes to be well defined to avoid unrealistic expectations.
- Holds responsibilities outside direct clinical practice as outlined under #2 Scope of Social Work Practice.
- Has access to some form of supervision to support clinical practice that may vary according to experience.
- Supported with educational opportunities to maintain/enhance/advance clinical practice.
- Works within a safe and supportive work environment with a good balance of work between direct and indirect patient/client care activities to minimize the chances of burnout.

- Works with different service delivery models; face to face, telephone, and/or online visits available.
- Has access to an electronic charting system.
- Has access to an electronic workload measurement system to track direct and indirect workload activities with clear guidelines and policies in place to capture all work-related responsibilities; for example, family members seen in session alone are captured as a unique client in the workload measurement system.
- Is part of a PSO program that measures outcomes e.g. patient satisfaction, patient wait times and others.
- Has access to appropriate office space to ensure total privacy for client interactions and documentation.
- Works within Occupational Health and Safety measures under the umbrella of other policies and procedures of the organization.

***2. Scope of Social Work Practice:***

The following description of social work practice in psychosocial oncology is adapted from two documents: the Association of Oncology Social Work Scope of Practice (2001) and the Cancer Care Ontario Recommendations for the Delivery of Psychosocial Oncology Services in Ontario (2018). Oncology social workers provide:

- Services to people diagnosed with cancer, families, and caregivers through clinical practice providing comprehensive psychosocial services and programs across all phases of the cancer care continuum. More specifically they:

    - Provide psychosocial assessments and interventions for cancer related distress.
    - Work with PROs within a step care model to address symptoms such as anxiety, depression and suicidal ideation. Provide psychoeducation, counselling, and evidence based psychosocial therapeutic interventions to patients with concerns related to cancer treatments, such as cognitive changes, fatigue, sexual health, insomnia, caregiver distress and other presenting psychosocial problems.
    - Provide family and couple assessments with ability to provide supportive interventions to help children adjust to a family member's diagnosis of cancer.

    - Facilitate care for patients with mental health concerns who often have unique challenges in accessing and receiving cancer treatments.
    - Coordinate and lead case conferences with patient/family and the interdisciplinary team as needed.
    - Provide counselling and/or psycho-education to clients transitioning to rehabilitation and survivorship.
    - Engage patients and family members in conversations for advanced care planning and provide them with psychosocial support and interventions for end of life care.
    - Provide information and emotional support to patients requesting Medical Assistance in Dying (MAiD) and families; provide navigation of services, advocacy and referrals as required within the broader interdisciplinary team.
    - Provide counselling and/or therapeutic interventions for anticipatory grief and legacy work; offer grief and bereavement counselling to families.
    - Provide advocacy and link patients to resources and supports in their home and/or community.
    - Design and develop many group modalities such as therapeutic groups, educational groups, and assist and support community stakeholders interested in developing and sustaining peer led support groups.
    - Assist patients and families with navigating the healthcare system, and offer practical support with housing, transportation and assistance with completion of forms to access financial assistance
- Services/education to institutions and agencies to increase knowledge of the psychosocial, social, cultural and spiritual factors that impact coping with cancer and its effects, and to promote the provision of quality psychosocial programs and care.
- Services to support and debrief staff and/or teams who are impacted working in oncology.
- Services to the community through education, consultation, research and volunteering to utilize, promote or strengthen the community services, programs, and resources available to meet the needs of cancer survivors.
- Services to the profession to support the appropriate orientation, supervision and evaluation of social workers working in oncology; participate in and promote student training and professional education including supervision of student practicums in oncology social work.
    - Participate in research to advance the evidence-based practice of psychosocial oncology; present at scientific/academic meetings, and participate in expert panels to advance the standards of PSO as part of professional and academic responsibilities.

## 3. Estimating the Number of Patients Requiring Social Work Interventions

Fitch's model (Figure 2) that defines the type of psychosocial services cancer patients require and the proportion of patients who will require professional interventions underscores the importance of tailoring services in a way to maximize access to the most appropriate health care provider. A step care model mitigates the burden placed on psychosocial specialists to address all distress scores identified on a distress screening scale and/or patient reported outcome measure; e.g. the ESAS-r or PhQ-9 (Howell et al., 2015).

For social workers, it is expected that most patient referrals fall within the second box from the bottom of the triangle (Figure 1) with 35% to 40% of patients requiring some type of professional intervention. In an ideal world, all cancer patients requiring this type of service would be referred to a PSO/psychosocial specialist. Despite many cancer centres in Canada having implemented distress screening programs, there is limited public data available to understand the effectiveness of the cancer system to link patients and families to the services they require. We also recognize that this work was undertaken prior to the pandemic of COVID-19 and practices may have shifted (The Quebec Cancer Coalition, 2020).

For the purpose of this exercise, we estimated the number of new cancer patients requiring the services of a social worker to be 35% vs the higher estimate of 40%. As more data becomes available, the staffing formula can be adjusted. If the rate of referral falls below 35%, PSO programs are encouraged to review referral patterns and work with the interdisciplinary team, patients and families to promote access to PSO services. At minimum, 35% of new cancer patients should be referred to a PSO professional for counselling and/or psychotherapy.

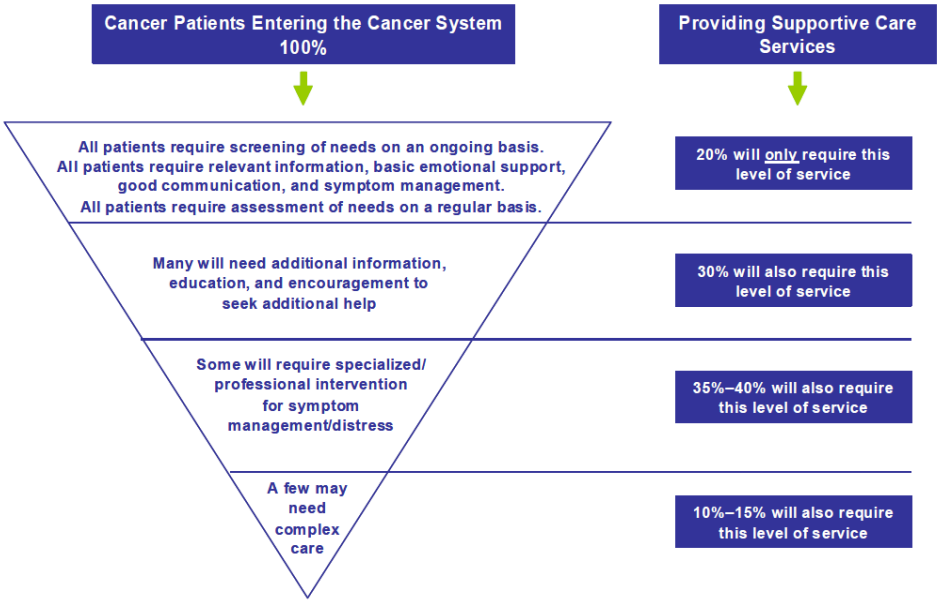


Figure 2. Service Provision Based on Proportion of Patients Requiring Assistance (Fitch, 2008)

### *4. Defining Potential Work Hours*

Each region/province defines work hours based on human resources practices of the organization, occupational health and safety standards and collective bargaining units. The benefits of including this type of information in a staffing formula are to reflect the actual work hours available for service provision. If the work hours differ than what is described in the calculations, adjustments can be made accordingly. Below is how we arrived at defining work hours (hrs):

- 1 full time equivalent (FTE) social worker = 1950 hrs per year based on 37.5 hrs of work per week; that is 7.5 paid hrs per day
    - To note that people are usually at work 8 hours per day however the two paid breaks of 15 minutes are usually unpaid; so we started with 7.5 paid hours.
- Assumes 4 weeks (wks) of vacation (37.5 hrs x 4 wks = 150 hrs) on average for someone new in the position
- Assumes 12 statutory holidays (12 days x 7.5 hrs = 90 hrs) on average
- 1950 hrs in a year – 150 hrs for vacation – 90 hrs for statutory holidays = 1710 hrs of work for 1 year
- 1710 of work hrs available ÷ 7.5 hours = 228 days of work available
- 228 days x .5 hrs for paid lunch break = 114 hrs
- 1710 work hrs – 114 paid lunch break hrs = 1596 of potential work hours
- Does not consider sick time, unpaid leave, family leave etc.
- 1596 work hours in 1 year for 1 FTE social worker

### *5. Direct vs Indirect Patient Care:*

Direct patient care focuses on the work of the social worker with the client and/or in preparation to meet with the client. It is everything related to that one referral, contacts in person or via technology, preparation work for the visit, follow-up work for advocacy and or navigation, consulting team members etc. Indirect patient care is everything outside of working with a client like attending meetings, participating in rounds, completing workload measurement, giving a talk in community/to health care professionals, supervision of students, doing research etc. Most provincial agencies and/or regions will define direct and indirect patient care activities for workload measurement. The most common split is 80% for direct patient care and 20% for indirect patient care. For the purpose of this framework:

- 1596 hrs of work are available for 1 FTE social worker
    - 80% direct patient care = 1277 hrs for direct client contact
    - 20% for indirect patient care = 319 hours for all other activities outside clinical practice

If direct patient care exceeds 80% consistently, this is usually a sign of high volume workload that cannot be sustained and additional resources are required to meet patient needs and to prevent staff burnout. Also, if the PSO program is part of a teaching hospital where academic responsibilities are assigned to the social worker such as teaching, student supervision, research etc. the split may be adjusted to 75% for direct patient care activities and 25% indirect patient care activities. We have calculated the formula based on these scenarios found in Table 3. Pending circumstances or trends, it can be adjusted to 70%/30% split respectively.

***6. Carryover Caseload from Previous Year:***

Fiscal years are usually calculated from April 1 to March 31 or January 1 to December 31; regardless of the timeline applied for a fiscal year, this has implications to calculate a staffing formula. Working in an out-patient tertiary cancer centre, patients are not necessarily discharged based on a fiscal year timeline; for example, if a patient is newly referred to a PSO program in March 2021 and requires services for the following two months, they will not be discharged April 1, 2021, they remain on the caseload. This is important to recognize in developing a staffing formula because the calculation takes into consideration the number of clients referred in a fiscal year plus the client caseload that will carry-over into the next fiscal year.

There is very little data publicly available to understand the carryover caseload in PSO programs across Canada. Some of the clinical leaders were able to look at their data and reported up to a 20% carryover caseload. It is important to make the distinction between numbers of clients carryover caseload vs allocation of time; e.g. the carryover caseload n = 400 clients but not all 400 clients may be seen in the new fiscal year. It is important to capture how many clients will actually be seen in the new fiscal year to determine the hours for the carryover caseload.

For the purpose of this exercise, we came to consensus that 20% of time should be allocated at a minimum for carryover caseload at any point in time during the year. The formula in Table 2 permits cancer centers to adjust the number as needed for the carryover caseload. We also recognize that the pandemic may have shifted trends and practices (The Quebec Cancer Coalition, 2020). The following was agreed upon as a minimum to calculate the formula:

- It is estimated that up to 20% of the possible direct client work hours (n = 1277) is required for the carryover caseload going into the next fiscal year. This accounts for clients referred toward the end of the fiscal year and clients who may return for services due to a new psychosocial concern e.g. coping with cancer recurrence. These are unique clients:

- 1277 hrs x 20% = 255 hrs
    - Estimate approximately 4 hours per client @ 1hr per session
- 255 hrs ÷ 4 hrs per client = 64 clients
- **64 client carryover caseload**
- **255 direct client contacts for carryover caseload**
- Total hours of work remaining **1022** for new fiscal year

### *7. Counselling/Psychotherapy vs Instrumental Concerns*

The staffing formula is based on MSW prepared social workers with a focus on providing counselling and/or psychotherapy to cancer patients and/or family members. Going back to Fitch's model of PSO care (Figure 2), services are organized in a fashion to maximize efficiency through a step care model. This means that patients have access to educational materials to understand their treatments, how to cope with cancer, services available in the community like peer led support groups, services available through the Canadian Cancer Society, medications not covered by private insurance plans but covered through other programs etc. This leaves a portion of patients who may still require the services of the social worker to navigate the system or advocate for further resources in complex cases, defined as instrumental concerns. The formula is based on the following breakdown:

- Counselling and/or Psychotherapy:
    - New consult: 1.5 hours
    - Follow-up 1 hour x 5 visits = 5 hrs
    - 1 client for counselling and/or psychotherapy = total of 6.5 hrs on average
    - 6 direct client contacts (on average)
    - It is estimated that counselling and/or psychotherapy represents 70% of the individual/couple/family sessions
- Instrumental Concerns:
    - New consult: 1.0 hr
    - Follow-up 1 hr x 2 visits = 2 hrs
    - 1 client for instrumental concerns = total 3 hrs on average
    - 3 direct client contacts
    - It is estimated that instrumental concerns represent 30% of the individual/couple/family sessions

The formula was developed with the understanding that some people will require more visits than others; for example a complex case for instrumental concerns may require more than 3 visits and people seeking counselling and/or psychotherapy may require less than 6 visits. This is why a workload measurement system is required to track caseload and distribution of new referrals over time.

### *8. Group work*

Various types of groups may be offered by social workers; some groups may be more psycho- educational in nature and may take less group sessions while other groups may be more therapeutic in nature or psycho-education is provided over several weeks. Again, a workload measurement tool is essential to track in real time the group work and gauge what a reasonable workload is, recognizing that the work environment is not static but fluid. For example, if a social worker is not providing group work in the first fiscal quarter, more individual referrals can be directed to this worker; however if by the next quarter the social worker is offering more than one group, there may be less room in the schedule to accommodate individual referrals. If no groups are offered throughout the year, the time allocated for group work can be calculated to accommodate more individual referrals. For the purposes of building this formula, the following numbers were achieved based on the observations of some PSO leads in Canada and data available to them:

- Based on 8 clients on average joining a group
    - 1/2 hour per client to screen = 4 hours (8 direct client contacts)
        - 3 hours per group x 6 weeks = 18 hours defined as:
            - Prepare content 0.5 hours
            - Set up room 0.5 hours
            - Facilitate 1.5 hours
            - Notes for the group 0.5 hours
        - 8 clients x 6 weeks = 48 direct patient contacts'
- If offering 1 group:
    - Total unique clients for 1 group: n= 8
    - Total ***worked hours*** for 1 group: 4 + 18 = 22 hrs
    - Total direct ***client contacts*** for 1 group: 8 for screening + 48 for intervention = 56

The above formula is based on one group that can be adapted for multiple groups. For example:

- If offering 3 groups:
    - Total unique clients: 3 groups = 24
    - Total ***worked hours*** for 3 groups: 22 x 3 = 66 hrs
    - Total direct ***client contacts*** for 3 groups: 56 x 3 = 168

***9. Full Caseload of Social Worker:***

The estimated full caseload for the social worker is as follows:

- The social worker offers 3 groups per year = 66 hours; **24 unique clients**; **168 direct contacts**
    - 1022 hrs for direct care – 66 hours for group work = 956 hrs remaining for visits
- Assumes 70% of the caseload is for counselling and/or psychotherapy @ 6.5 hrs per client
    - 956 x 70% = 669 hrs
    - 669 hrs ÷ 6.5 hrs = **103 unique clients**
    - 103 x 6 visits = **618 direct client contacts**
- Assumes 30% of the caseload is for Instrumental Concerns/Advocacy (3 hrs per client)
    - 956 hrs x 30% = 287 hrs (286.8 hrs)
    - 287 hrs ÷ 3 hrs per client = **96 (95.6) unique clients**
    - **96 x 3 visits = 287 direct client contacts**

To summarize (Table 1), 1 FTE Social Worker providing 3 groups per year (# unique clients = 24) with remaining hours split between instrumental/advocacy @ 30% (# unique clients = 96) and counselling and/or psychotherapy @ 70% (# unique clients = 103) will see **223 new clients** per year with approximately **1074 direct client contacts.** In addition, the social worker will have **64 unique clients carryover caseload** from the previous year with **255 direct client contacts;** 223 new clients + 64 carryover clients = **287 clients;** 1074 new direct contacts + 255 carryover clients direct contact = **1329 direct contacts.** 1 FTE Social worker will see 287 clients per year with approximately 1329 direct client contacts based on a split of 80% for direct patient care activities and 20% indirect patient care activities.

**Table 1**

| Unique Clients | | Direct Client Contacts |
|---|---|---|
| 24 | Group Work (n=3) | 168 |
| 96 | Instrumental/Advocacy | 288 |
| 103 | Counselling/Psychotherapy | 618 |
| **223** | Total | **1074** |
| 64 | Carryover Caseload Added | 255 |
| **287** | Total | **1329** |
| **1 FTE Social worker will see 287 clients per year with approximately 1329 direct client contacts** | | |

### *10. Number of FTE Social Work Positions- Tertiary Cancer Centre*

To calculate the number of FTE MSWs for a tertiary cancer centre based on the framework provided in the previous pages, we estimated a number of unique cancer cases that may be referred to a tertiary cancer centre in one year, the estimated prevalence of distress and the estimated workload for one FTE social worker:

- New unique cancer patients referred to a cancer centre; e.g. n = 2,000
- Distress @ 35% minimum of oncology patient population to be referred
- 2,000 unique cancer patients x 35% distress = 700 patients require a professional intervention
- A social worker can see 223 new patients based on a calculated caseload for new referrals
- 700 potential new patients experiencing distress ÷ estimated social work caseload capacity of 223 = 3.1 **FTE social workers**

A summary of these calculations is provided in Table 2 that permits to adapt the formula if required. The full time equivalent staffing estimations based on 80% and 20 % split between direct and indirect patient care activities are found in Table 3. We redid the calculations based on 75% and 25% split in direct and indirect patient/client care activities for easy reference provided in Table 4.

**Table 2. Summary of calculations for MSW staffing formula-Tertiary Cancer Centre**

| |
|---|
| ***Defining the work hours:***<br>• 1 Full time social worker (1FTE) = 1950 hours (hrs) per year based on 37.5 hrs of work per week, 7.5 paid hrs per day.<br>  • Employees are usually at work 8 hours per day; two 15 minute breaks are unpaid therefore we started calculations on paid hours 7.5 hours<br>• Assumes 4 weeks of holidays (37.5 X 4 = 150 hours) on average for someone starting a new position<br>• Assumes 12 statutory holidays (12 X 7.5 = 90 hrs) on average<br>• 1950 hrs – 150 hrs – 90hrs = 1710 hours of work in 1 year<br>• 1710 of work hrs available ÷ 7.5 hours = 228 days of work available<br>• 228 days x .5 hrs for paid lunch break = 114 hrs |
| ***Defining the split of direct and indirect patient care services***<br><br>• 80% for direct patient care: 1596 potential work hours x 80% = 1277 hrs<br>  • **Total direct patient care hours available 1277**<br>• 20% for indirect patient care: 1596 potential work hours x 20% = 319 hrs<br>• **Year total indirect patient care hours 319** |

***Estimated time per referral:***

Instrumental concerns:

- New consult: 1.0 hour
- Follow-up 1 hour x 2 visits = 2 hours
- 1 Client for instrumental concerns = 3 hours
- It is estimated that instrumental concerns represent 30% of the individual/couple/family sessions

Counselling and/or Psychotherapy

- New consult: 1.5 hours
- Follow-up 1 hour x 5 visits = 5 hours
- 1 patient/client for counselling and/or psychotherapy = 6.5 hours
- It is estimated that counselling and/or psychotherapy represents 70% of the individual/couple/family sessions

Group Work:

Based on a social worker offering 1 group per year

- Based on average 8 participants joining a group
    - 1/2 hr per participant to screen = 4 hrs (8 direct contacts)
    - 3 hrs per group x 6 weeks = 18 worked hrs
        - Prepare content 0.5 hours
        - Set up room 0.5 hours
        - Facilitate 1.5 hours
        - Notes for the group 0.5 hours
    - 8 participants x 6 weeks = 48 direct contacts
    - Total *worked hours* for 1 group: 4 + 18 = 22
    - Total direct *client contacts* for 1 group: 8 + 48 = 56

    Based on a social worker offering 3 groups per year
    - Total *worked hours* for 1 group: 22 x 3 groups = 66 hrs
    - Total direct patient/*client contacts* for 1 group: 56 x 3 groups = 168

Formula can be adjusted as needed

***Carryover caseload from previous year:***

- It is estimated that 20% of the possible work hrs (n = 1277) will be directed to the carryover caseload going into the next fiscal year.
    - 1277 hrs x 20% = 255 hrs allocated to carryover caseload
    - 255 hrs ÷ 4 hours per unique patient/client = 64 clients
    - ***64 clients for carryover caseload***
    - ***255 direct contacts for carryover caseload***
    - Total work hrs remaining: 1022 hrs

***Full Caseload of Social Worker***

- Based on:
  - 3 Groups per year = 66 work hours; 24 unique participants; 168 direct client contacts
    - 1022 work hrs available – 66 hours for group work = 956 work hrs remaining
  - Assumes 30% of the caseload is for instrumental concerns/advocacy (3 hours per client)
    - 956 hrs x 30% = 287 hrs
    - 287 hrs ÷ 3 hours per patient/client = 96 unique patients/clients
    - 287 direct client contacts
  - Assumes 70% of the caseload is for counselling and/or psychotherapy @ 6.5 hours per client
    - 956 x 70% = 669 hours
    - 669 hours ÷ 6.5 hours = 103 unique clients
  - Assumes 24 participants for group work + 96 unique clients for instrumental concerns + 103 clients for counselling and/or psychotherapy = 223 new unique clients referred in a fiscal year.
  - 1074 new direct contacts + 255 carryover contacts = 1320 contacts
  - ***1 FTE Social Worker providing 3 groups (n = 24 participants) per year with remaining hours split between instrumental/advocacy @ 30% (n= 96 unique clients) and counselling and/or psychotherapy @ 70% (n=103 unique clients/patients) will see 223 new clients/patients per year with a carryover caseload of 64 unique clients for a total caseload 287 unique clients and 1329 direct contacts in one fiscal year.***

***Number of FTE Social Work Positions -Tertiary Cancer Centre***

- 35% of oncology patient population will experience distress
- New cancer cases referred to a cancer centre e.g. n = 2,000
- 2,000 unique patients x 35% will experience distress and need professional intervention = 700 patients
- 700 potential new patient experiencing distress ÷ new referrals caseload capacity of 223 = 3 FTE social workers; carryover caseload of 64 unique clients factored in formula for total of 287 unique clients

## Table 3: Number of FTE Social Work Positions – Tertiary Cancer Centre

| This Table is based on 80% Direct Patient Care & 20% Indirect Patient Care 3 Groups provided per year | | | | | | |
|---|---|---|---|---|---|---|
| **a) New cases referred to tertiary cancer centre for fiscal year** | b) 35% prevalence of distress [a x 35%] | c) Social Work caseload capacity for new referrals [formula Table 2 n = ] | d) Social Work FTEs [b ÷ c = ] | e) Carry-over caseload [formula Table 2 n = ] | f) Total Caseload [c + e = ] | Total Caseload for PSO Program [f x d = ] |
| **2,000** | 700 | 223 | 3.1 | 64 | 287 | 890 |
| **3,000** | 1050 | 223 | 4.7 | 64 | 287 | 1,348 |
| **4,000** | 1400 | 223 | 6.3 | 64 | 287 | 1,808 |
| **5,000** | 1750 | 223 | 7.8 | 64 | 287 | 2,215 |
| **6,000** | 2100 | 223 | 9.4 | 64 | 287 | 2,698 |

## Table 4: Number of FTE Social Work Positions – Tertiary Cancer Centre

| This Table is based on 75% Direct Patient Care & 25% Indirect Patient Care 3 Groups provided per year | | | | | | |
|---|---|---|---|---|---|---|
| **a) New cases referred to tertiary cancer centre for fiscal year** | b) 35% prevalence of distress a x 35% | c) Social Work caseload capacity for new referrals (formula Table 2 replicated n = ) | d) Social Work FTEs b ÷ c | e) Carry-over caseload (formula Table 2 replicated n = ) | f) Total Caseload c + e | Total Caseload for PSO Program f x d = |
| **2,000** | 700 | 209 | 3.3 | 60 | 269 | 898 |
| **3,000** | 1050 | 209 | 5 | 60 | 269 | 1,345 |
| **4,000** | 1400 | 209 | 6.7 | 60 | 269 | 1,802 |
| **5,000** | 1750 | 209 | 8.4 | 60 | 269 | 2,260 |
| **6,000** | 2100 | 209 | 10 | 60 | 269 | 2,690 |

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**LITERATURE SEARCH** **Appendix 1**

A literature search was conducted in February and March 2019 by a librarian in databases: PubMed, CINAHL, MedLine and Health Business Elite, as well as some sources for Grey Literature

- MeSh Subject Headings:
    - Workforce
    - Medical oncology/standards
    - Social work/statistics & numerical data
    - Health personnel/standards
    - Workload
    - Benchmarking
    - Social Work
    - Reference Standards
- Secondary MeSh Subject Headings: Staffing ratios; psychosocial

Keywords: Oncology; psychosocial; staffing; standards; workforce

**Results:**

- 6 articles identified from the literature search
    - 4 articles excluded as the content was not relevant to staffing ratios/social work discipline
    - 2 articles summarized (see Table 1)
    - Inter-rater consensus achieved between two members of the Clinical Advisory Committee
- 3 articles identified from other sources (grey literature)
    - 2 articles excluded as the content was not relevant staffing ratios/social work discipline
    - 1 article summarized (see Table 1)
    - Inter-rater consensus achieved between two members of the Clinical Advisory Committee
- 14 abstracts identified from the literature search
    - 9 abstracts excluded as the content was not relevant to staffing ratios/social work discipline
    - 5 abstracts identified as possibly relevant
    - 5 articles obtained and reviewed
    - 5 articles excluded as the content was not relevant to staffing ratios/social work discipline
    - Inter-rater consensus achieved between two members of the Clinical Advisory Committee

## Table 1 Articles Summarized

| Year | Author(s) | Country | Background | Method | Results |
|---|---|---|---|---|---|
| 2012 | Cartmill<br>Corman<br>Clark<br>Ash<br>Sheppard | Australia | • Underutilization of professional competencies identified by the Australian Productivity Commission<br>• Aim of review was to identify what workforce ratios have been used in nine allied health professions (AHPs)<br>• Identify whether these measures would be useful for planning allied health workforce requirements<br>• Not specific to PSO | • Systemic literature search using relevant MeSH headings for business, medical and allied health databases and relevant grey literature<br>• 2000-2008<br>• Wrote to professional bodies for the nine allied health disciplines in question (including social work) | • 12 papers identified<br>• 6 papers had reached consensus through working groups or committees vs observation<br>• Concluded not possible to use workforce ratios to plan for AHPs based on evidence |
| 2018 | Wilde<br>Lesniak-Walton<br>Knapik<br>Brigden | Canada (Alberta) | • Describe the design and functioning of the oncology social work (SW) program in a busy community cancer program (Jack Ady Cancer Centre) | • Scope of practice defined<br>• Distinction made between SW working at tertiary cancer centre vs | • Tertiary cancer centre (2 sites) 12 FTEs<br>• Regional cancer centres (4 sites) 4.0 FTEs |

| | | | | | |
|---|---|---|---|---|---|
| | | | | SW working at community clinic<br>Tertiary: resource social workers and clinical social workers<br>RCC: provide both resources and counselling<br>CCC: resources and counselling mostly via phone and virtual connections | Community cancer centres (11 sites) 1.3 FTEs<br>Number of patients per FTEs not described |
| 2012 | Zebrack, Burg, Vaitones | United States | • Social work always played a critical role in major client/patient care<br>• Need an approach to respond to distress screening | • Not described. Quotes "social work department heads" (reference is J. Zabora, personal communication March 28, 2012) | • Oncology social workers can manage 10-12 highly distressed patients a month, in addition to maintaining activities related to current caseload (n=120 per month)<br>• Conclude that approximately 30% of all newly diagnosed patients are high-distress; based on this calculation need one social worker for approximately 400 newly diagnosed patients/year (e.g. 30% x 3,600 newly diagnosed patients = 1080 divided by 120 = 9 social workers.<br>• Unclear how the 10-12 ca pts. per month was determined |