CREATIVE MODELS OF SPIRITUAL CARE

As Healthcare Delivery Changes, Pastoral Care Departments Must Explore Alternative Staffing Approaches

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To prosper in a reformed healthcare system, pastoral care departments must be innovative and cost-effective and be able to demonstrate the connection between spiritual and physical health. Finding fresh approaches to the complex task of assembling a pastoral care staff will be critical to achieving such performance.

SPENDING MORE TIME SUPPORTING STAFF

The roles of staff chaplain are expanding as healthcare becomes less departmentalized and more focused on integrated delivery networks, continuous quality improvement, clinical pathways, and product lines. In this changed environment for healthcare delivery, the chaplain will be a member of care teams, committees, and quality improvement groups. These new roles require skills and training in addition to those necessary to prepare for one-on-one visiting.

As the healthcare system changes, some pastoral care staff will find the new environment unacceptable personally. To ease the transition, pastoral care directors may need to spend more time counseling their staffs. At the same time, staff turnover can also provide an opportunity for directors to change the staff's skill mix, establish new roles within the department, and collaborate with staff to set a new vision.

Directors themselves must reflect on whether they find such changes personally threatening or liberating. We cannot lead where we do not want to go. Directors will also need to work with administrators to ensure that assessing how a program meets clients' spiritual needs is a part of program development.

ALLOWING CHAPLAINS FLEXIBLE SCHEDULES

Using more part-time staff can be helpful in many situations, although there are drawbacks as well. Part-time positions can meet some employees' needs and be less expensive for a facility. Also, the more part-time employees on staff, the greater the opportunities for splitting on-call duties. A chaplain who is on "casual" status can work during high-census times, between clinical pastoral education (CPE) quarters, and during staff members' vacations or illnesses. A reliable person in this role can take the staffing headaches out of managing a pastoral care department. Unfortunately, however, part-time employees are often not as available or as invested in the team as are full-time staff.

Summary Recognizing changes are coming to the healthcare delivery system, pastoral care departments are developing a new vision of spiritual care. As they educate and hire staff, many directors are finding that alternative staffing approaches can help them make the transition.

Flexible schedules for pastoral care professionals improve the care they deliver and enhance morale. Restructuring responsibilities within the department and giving some patient populations priority can be helpful. Some facilities share chaplains' time to minimize on-call burden; others are increasingly using supervised volunteers.

Pastoral care givers who are specialists in areas such as mental health and chemical dependency can often perform certain functions traditionally performed by other professionals. By assigning chaplains to a product or service line, pastoral care departments can improve the continuity of care patients receive. As parishes' role in the healing ministry takes on new meaning, healthcare institutions' pastoral care staff can help initiate and develop new parish services or provide assistance that complements existing parish efforts.

Sharing Chaplains with Other Organizations

In-house chaplain coverage for evening and night hours is declining. However, patients are so busy during the day that requiring chaplains to spend a certain number of evenings per week on campus seeing patients may be necessary to provide adequate patient and family pastoral care. Some hospitals are collaborating to provide on-call night coverage. One chaplain is on call at both facilities, and another acts as backup in case of greater need. The goal is to minimize on-call burden so staff are more available for other necessary tasks.

Cross-Training

Pastoral care givers who are specialists in areas such as mental health and chemical dependency can often be assigned to these areas. In this context, they can perform their traditional pastoral care roles and provide care that addresses spiritual issues (e.g., grief, 12-step work, finding meaning in life) which usually are addressed by other specialists.

Staff with cross-training—such as a chaplain trained in imaging, massage, or art therapy, or one who is a licensed counselor—can also be a plus. In mental health programs, pain management clinics, and outpatient settings, chaplains with dual specialties, especially those who are licensed, might be better qualified for a certain position than a professional specializing in only one area. These options integrate pastoral care staff into the patient care team while keeping overall service costs down.

Taking a Service- or Product-Line Approach

An institution that has adopted a service- or product-line approach should consider assigning chaplains by product line. For example, one of

FAIRVIEW RIVERSIDE MEDICAL CENTER

As director of the pastoral care department at Fairview Riverside Medical Center, Minneapolis, I have instituted some alternative staffing approaches to help the department meet patients' needs. Fairview Riverside is a tertiary care medical center with 917 staffed beds. Thirteen chaplains are part of the pastoral care department—4 working part time and 9 full time. All are certified or in the certification process.

Volunteers

Fairview Riverside has developed a cadre of volunteers. A retired deacon volunteers as a staff chaplain half time. And four volunteers assist the pastoral care secretary (15 hours per week) with everything from calling parishes with admission and discharge information to typing projects.

Hospitality volunteers, all retired nurses, visit patients who have just been admitted, offering a number of amenities and services, including a pastoral visit. Volunteers then make the appropriate referrals to pastoral care.

Flexible Scheduling

One staffing approach Fairview Riverside has found helpful is splitting the call day. One chaplain's call responsibility is 6:30 AM to 11:30 AM, Monday through Friday. This assignment, which includes coverage for surgery, frees the rest of the staff for uninterrupted patient care team rounds, meetings, group sessions, and clinical pastoral education (CPE), most of which are scheduled for mornings. One of the principles of such an arrangement is that everyone shares equally in the work, but equal effort does not mean the same responsibilities. If a department tries to function with everyone splitting all tasks evenly, creativity is stifled.

Three chaplains at Fairview Riverside take four weeks' leave of absence each year when census is down or extra CPE students are available. These employees get full benefits, but they are effectively eleven-month employees. Nine-month positions are another possibility.

Chaplains determine which hours and the number of hours they will work each day. Such an arrangement allows them to be present when their patients and families are available and for special needs as they arise. Each week chaplains note on a bulletin board when they will be in so they can be contacted if necessary. This flexibility increases staff morale and matches pastoral care staff availability to time of need.

Specialists

Fairview Riverside has a large adolescent chemical dependency program with a twelve-step philosophy, a spiritually based approach to treatment. The facility is therefore able to justify 4.6 full-time equivalents (FTEs) in pastoral care for approximately 100 inpatients and clients at three outpatient sites.

Chaplains with training in adolescent development and chemical dependency provide traditional pastoral care, as well as counseling, step work, lectures, and group therapy. In most programs these tasks are handled by chemical dependency counselors. Although the last two ministers I hired for this area had no CPE, they had extensive experience working with kids on the street. Traditional chaplaincy training alone does not prepare one to work effectively with badly wounded adolescents.

These five chemical dependency chaplains function as a team separate from the rest of the department, with one member as supervisor. Another chaplain works full time in a medical outpatient program off campus. The entire department meets twice a month to discuss business and for educational sessions. On alternate weeks each of the two subgroup meets separately.

our staff is assigned to cardiology. He sees all cardiac catheterization and cardiac surgery patients at the preoperative stage, maintains contact with the family during surgery, and follows patients' progress during the postoperative phase in the intensive care unit. He also covers the coronary care and cardiac rehabilitation units. In an integrated delivery network, the chaplain would also serve the patient in such outpatient settings as the physician's office and wellness clinic.

The advantages of this approach include providing patients with continuity of care, integrating pastoral care staff into the care team, and making other staff more aware of pastoral care.

A product-line manager usually supervises the chaplain's involvement in the program. However, if the product-line manager has total control over the chaplain full-time equivalent (FTE), the next budget reduction may mean reducing the pastoral care FTE disproportionately. Another danger is that a product-line manager might want all the chaplain's time. This would leave the central pastoral care department without that person for call rotation and other department responsibilities. Also, chaplains need professional supervision by a pastoral care director. Giving product-line managers programmatic control while keeping professional supervision in the pastoral care department is one solution.

PASTORAL CARE TRENDS

Although pastoral care had in the past been relatively immune to staffing cuts, a Catholic Health Association (CHA) survey reveals that 22.7 percent of respondents experienced downsizing at some point in 1990 or 1991 (*Survey Report of CHA-Member Pastoral Care Departments*, 1992). The finding suggests that pastoral care staff must continue to document the value of their services and that directors must carefully consider options to make the best use of their personnel.

As healthcare employment trends grow more volatile and the pool of diocesan priests continues to shrink, more institutions are recruiting and hiring priest chaplains. In 1988—the last year CHA completed such a survey—39 percent of priest chaplains were appointed by the diocesan bishop to the Catholic hospital, but in 1992 only 26.1 percent of priest chaplains were diocesan appointments. In addition, fewer dioceses now limit the salary available to Catholic clergy (21.1 percent versus 25 percent in 1988). Nearly one-fourth of respondents said the priest shortage was affecting their ability to provide sacramental ministry.

The percentage of certified pastoral care staff increased slightly from 1988 to 1991 (from 47 percent to 51 percent), but 69.4 percent of survey respondents indicated they did not equate certification with competency. Many said they were finding it increasingly difficult to obtain certified staff because of new certification requirements and lack of access to training centers.

The survey results also indicate that pastoral care departments may be putting too little emphasis on outpatient services. Currently, pastoral care staff spend 14.1 percent of their time serving outpatients, whereas 41 percent of overall healthcare activities in the United States focus on outpatient care. These numbers suggest that pastoral care departments may need to shift their priorities, considering which services might be given up to free time for outpatient activities and consulting the literature for successful models for delivering high-quality outpatient pastoral care.

Collaborating with Local Parishes

Local parishes and hospital pastoral care departments could collaborate to provide continuity across a variety of settings. As the emphasis on networks of care increases, parishes' role in healing will expand. The parish-hospital relationship can affect the staffing priorities of the pastoral care department. Parishes can develop lay ministry and parish nurse programs, as well as other services such as the following:

- Health and wellness classes
- Health-risk appraisals
- Task assistance
- Respite care programs
- Transportation services
- Bereavement follow-up calls

Healthcare institutions' pastoral care staff can initiate and develop new parish services or provide assistance that complements existing parish efforts. Such collaboration will be especially valuable as institutions focus more on cooperation with community groups to achieve healthcare goals. *Healthcare Facilities and the Parish* (see **Box**, p. 61) is a good resource on the parish-facility relationship.

Making Pastoral Care Available

Rather than setting a goal that pastoral care staff will *see* all patients, the department should strive to make pastoral care *available* to all patients. One way to do this is to give new patients a pastoral care admission brochure that tells them how and when to contact the pastoral care department. Also, the department can place racks of high-quality reading material (with the pastoral care department telephone number stamped on it) in patient lounges and waiting rooms. Auxiliaries and foundations may help pay for reading material and brochures.

Staffing levels in some pastoral care departments require them to emphasize some areas more than others, limiting coverage of lower-priority areas to referrals only rather than giving inadequate coverage to all. Chaplains can also work with nurses to set priorities on which patients to visit. And they can prepare other care givers who, as they do their jobs, can provide

empathy and spiritual support to their patients. All new program proposals, especially those regarding outpatient services, should address how spiritual needs will be met.

Using Volunteers

Facilities are increasingly using volunteers in their pastoral care departments. Volunteers can serve as extraordinary ministers of the Eucharist, can make initial visits and referrals to staff chaplains, or can help secretaries with office work and admission and discharge calls to parishes.

Trained volunteers can be particularly effective in providing pastoral care in longer length-of-stay areas such as rehabilitation, where they can maintain continuity of care without making daily rounds. They are also valuable in very short length-of-stay settings (like routine obstetrics, where one visit is all that is possible). Volunteers can also be effective in waiting rooms in surgical and critical care areas and in other areas where a ministerial presence is the primary need. The critical first step in any volunteer program is to screen new volunteers and arrange for their ongoing supervision.

Restructuring Responsibilities

Adequate secretarial support is critical to effective department function and efficient use of staff chaplains. Increasing a skilled and experienced secretary's responsibilities to include managing everyday questions, adjustments, and scheduling can free the director for other tasks and decrease his or her interruptions. In this model the secretary functions in many ways like an office manager. This is particularly helpful when many volunteers and CPE interns are involved because they often have questions, dilemmas, and schedule changes that the secretary can deal with. Maximizing the use of priest chaplains may require minimizing their management functions and eliminating some liturgies that are not well attended.

Other Staffing Opportunities

CPE interns provide a significant amount of direct patient care, but they should be teamed with a chaplain who can take on more difficult situations and maintain the department's relationship to the care team. Because these students cannot do professional assessments, plans, interventions, and evaluations, they cannot replace qualified staff. If chaplains want to be recognized as the equal of others on the care team, they cannot assign an intern sole responsibility for direct patient care and still defend their role with any integrity.

ADDITIONAL READINGS

Carole A. Griswold, "Pastoral Partners," *Health Progress*, March 1990, pp. 71-73

Healthcare Facilities and the Parish: A Relationship between Two Healing Communities, Catholic Health Association, St. Louis, 1989 (An expanded version of this text will be pulished later this year.)

Harold G. Koenig, et al., "Religious Perspectives of Doctors, Nurses, Patients and Families," *Journal of Pastoral Care*, Fall 1991, pp. 254-267

David B. Larson and Susan S. Larson, "Religious Commitment and Health: Valuing the Relationship," *Second Opinion*, July 1991, pp. 27-40

Gregory A. Stoddard, Adele H. Sheffieck, and Gail Leonard, "The Science of Caring," *Health Progress*, March 1990, pp. 66-70, 79

Survey Report of CHA-Member Pastoral Care Departments, Catholic Health Association, St. Louis, 1992

Larry VandeCreek and Damain Smith, "Measuring the Spiritual Needs of Hospital Patients and Their Families," *Journal of Pastoral Care*, Spring 1992, pp. 46-52

Other creative staffing approaches include job sharing; using the hospital clerical pool for large typing projects; and establishing a team of chaplains, students, and volunteers to be responsible for a number of patient care areas within the healthcare facility.

Problem areas to watch for when using creative staffing approaches in a healthcare facility's pastoral care department include communication breakdown within the department, with other departments, or with the patient care areas; a loss of continuity of care; or the need for excessive supervisory time. All staffing approaches should be evaluated for their impact on quality, staff morale, quantity of services provided, and cost effectiveness. Any changes should be initiated for a trial period and then reevaluated.

Creative Options

The next few years will bring radical changes to healthcare. As healthcare changes, spiritual care must become cost-effective and make a difference in health outcomes. To meet the challenges ahead, spiritual care providers will need to develop creative models of care that promote patients' healing and maximize resources across the continuum of care. □