



Pastoral Care Consultant Agreement

Evaluation of the Pastoral Services Partnership: 2001-2003

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Congratulations on the successes you created as part of this impressive collaboration.

L. Parizeau

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Executive Summary

Hospital pastoral care consultants benefit the community, patients, and staff at both personal and organizational levels. In 2001, St. Thomas-Elgin General Hospital (STEGH) had difficulty recruiting a part-time pastoral care consultant. In response to this difficulty, they contacted the nearby academic health sciences centre, London Health Sciences Centre (LHSC), to discuss ways in which resources might be shared. As a result, the two hospitals developed a Memorandum of Understanding to meet the identified need, through the recruitment of a pastoral care consult by LHSC, who would work at STEGH.

This evaluation reviews the impact of this voluntary partnership, and the outcomes resulting from the unique relationship. The evaluation was also seen as an opportunity to provide evidence to support replication of this model in other areas or at other centres.

The evaluation consisted of a qualitative survey, delivered in an interview format. Participants answered a series of general questions, as well as questions related to their specific involvement in the agreement. Thirteen participants represented four different hospital roles at the two hospital sites: human resources, management/administration, occupational health, and pastoral care.

Respondents brought forward different indicators of success, including: recruitment of the consultant, expanding the mandate of the position, lack of conflict, positive feedback. Overall, participants viewed the agreement as successful, consistent with the mission, values, and goals of their respective organizations, and as meeting the original need of the partnership. In general, the partnership has done an excellent job of increasing awareness, reducing insularity, and building trust between the two hospital organizations.

Many of the strengths of the partnership could extend to other relationships, particularly situations where there is a lone practitioner, or a small hospital seeking expertise but lacking resources. The potential exists for the partnership to serve as a model for other regional collaborations. However, identified issues relating to human resource issues and management concerns need to be addressed before that happens. The majority of the limitations cited through this evaluation involve administrative rather than service delivery concerns. A slightly modified relationship that capitalizes on the benefits to service delivery while reducing administrative concerns may resolve liability issues, while continuing the healthy and positive alliance.

In terms of the future, it is recommended that clear and consistent communication at all levels be continued, and improved upon. Further research and identification of “red flag” issues is recommended, particularly increased awareness of liabilities and risk management, union and non-union issues, and human resources challenges. It is also recommended that the service delivery portion of the agreement continue to be explored. Whether the agreement is renewed in its current form, or the model is adapted, a second, follow-up evaluation would provide useful information about the longer-term success of this partnership.

1.0 Introduction

Why Pastoral Care is Important

The Joint Commission on Accreditation of Health Organizations (JCAHO), in the United States commented, “Patients have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychological, and spiritual values,” (VandeCreek and Burton, 2001). Spiritual care and healthcare should be closely linked; patients have a right to spiritual care services, especially when dealing with palliative care situations (VandeCreek and Burton, 2001).

The benefits of hospital pastoral care consultants are pervasive, in that they can impact patients, family and staff. Patients receive assistance and emotional support for coping with distress. Employees benefit from the existence of a “healthy organizational culture.” Spiritual care helps staff members cope with moral and ethical workplace concerns (VandeCreek and Burton, 2001). And by supporting patients and their families, pastoral care workers allow other staff members to focus on their obligations as healthcare professionals (VandeCreek and Burton, 2001). At an organizational level, chaplains help administrators consider ethical and moral issues, and develop the hospital’s mission, values and vision (VandeCreek and Burton, 2001; LHSC and CHWO, 2003). The community benefits through the maintenance of the continuum of spiritual care (VandeCreek and Burton, 2001).

1.1 Background

In 2001, management at St. Thomas-Elgin General Hospital (STEGH), a community hospital in Elgin County, identified a need in their Pastoral Services department. Specifically, the hospital had difficulty recruiting a part-time Pastoral Care Consultant (Consultant) to their organization. In response to this situation, STEGH contacted the nearby academic health sciences centre, London Health Sciences Centre (LHSC), to discuss ways in which resources might be shared. As a result of the conversations that took place, the partners decided to help meet the identified need through the recruitment of a Pastoral Care Consultant or chaplain by LHSC, who would work at STEGH. In order to formalize the relationship between the two organizations and guide on-going collaboration, a Memorandum of Understanding was developed. The voluntary agreement was “based on the principles of mutual respect, trust, and a shared commitment to providing the best pastoral services possible.” (MOU, 2001).

Initially, the term of the MOU was three years, ending in November 2004. However, the MOU was amended on May 5, 2003 in order to reflect a change in the employment status of the Pastoral Care Consultant from part-time to full-time. The amendment provided an excellent opportunity to evaluate the first phase of this innovative partnership.

Purpose of this Evaluation

The purpose of the evaluation is to review the impact of the partnership, and the outcomes resulting from this unique relationship. In addition, the partnership between these two organizations may represent a useful model for other programs, as it demonstrates one way of addressing the staffing shortages experienced by some facilities.

The evaluation may provide evidence to support replication of this model in other areas or at other centres. The MOU does allow other partners to join this agreement, provided the signing partners agree.

A Cautionary Note

This is an evaluation of the agreement, not the role of the Consultant. The focus of the evaluation is the relationship between the two hospitals, and the effect it has had on solving the original difficulty. This evaluation should not be interpreted as a “performance evaluation” of the Consultant, nor is it necessarily reflective of the effectiveness of the role.

2.0 Methods and Findings

2.1 Materials and Method

In order to evaluate the existing agreement between LHSC and STEGH, a framework for a qualitative survey, to be delivered in interview format, was designed in July 2003. The design and implementation of the evaluation was left to the discretion of the investigator, with comments and suggestions provided by a manager involved in the development of the MOU. For a detailed description of the methodology, please see **Appendix A**. For a list of interview questions, and a copy of the initial contact letter please see **Appendix B** and **C**, respectively.

2.2 Population

Thirteen people were surveyed for the Pastoral Care Consultant Agreement Evaluation, representing four different hospital roles at two hospital sites: Human Resources (six people), Management/Administration (five people), Occupational Health (one person), and the Pastoral Care Consultant (one person). For more details see **Appendix A**.

2.3 Confidentiality/Ethical Issues

Due to the nature of the evaluation and the small number of people involved, confidentiality could not be assured. Participants were informed of the risks to confidentiality prior to commencement of the interview, and were aware of their ability to refuse or withdraw their participation without penalty or jeopardy (see **Appendix D**). Consent was obtained by asking the question, “Do you still wish to participate?”

The investigator was the sole reviewer of the collected survey responses. Hard copies of the data are secured in the investigator’s private files, and after an appropriate time period, will be destroyed.

2.4 Limitations

Biases may result if an investigator conducts the interviews inconsistently. For the most part, interviews were conducted one-to-one and face-to-face. However, when circumstances dictated otherwise, responses were received by fax or phone (using the same template as the in-person interview) or people were interviewed in groups of two. Due to limitations in the length of time a respondent was available for an appointment, in

one situation a participant was interviewed on two separate occasions. The location varied depending on the site the person was employed.

The surveys received by fax or filled out by phone were generally not as comprehensive as those resulting from the in-person interviews. The group interview format happened twice. In the first situation, although both participants appeared unaffected by having a colleague present, at times only one person responded to the question. In the second situation, answers from one participant may have been limited due to the presence of a manager. The participant whose interview was spread out over two days may have provided more or different information than if only interviewed once, but since the interview would have otherwise been considered incomplete, it was necessary to continue on a second day.

A few participants did not receive copies of the interview questions prior to the meeting. As a result while most participants had the opportunity to prepare their answers in advance, a few did not. It is suggested that this oversight did not significantly affect the results, since most of the participants who received the questions in advance acknowledged that they had not had time to review them.

Finally, although every effort was made to maintain the confidentiality of the participants, the potential of identification remained comparatively high due to the small sample size and relative uniqueness of the positions within the participating organizations. While choosing to take part, it is possible that some participants were more guarded or selective in their responses than if their anonymity had been guaranteed.

2.5 Findings: Overall Agreement

Roles Fulfilled

Participants were asked whether their organization felt they had fulfilled their shared and respective roles in the agreement, and whether the agreement was equitable for both organizations. Four people felt this question was outside of their purview and did not respond, and two stated the agreement was not equal from a cost perspective, although they acknowledged the relationship may have been more equitable depending on what aspect of the partnership was being discussed. The remaining seven respondents felt the agreement was fair for both parties.

"The agreement is fair for both parties, and responsibilities are in the right place."

Agreement Modification

During the interview, participants were asked whether the agreement had been modified since the relationship began. The purpose of this question was to determine their awareness of the agreement. Eleven (11/13) people were aware that the contract had been modified (to reflect the Consultant's change from part- to full-time status).

Perceived Effectiveness

Interviewees were asked a question about the effectiveness of the relationship. Six (6/13) stated the question was not applicable to them and seven (7/13) commented that the

relationship was effective. Some respondents based their statements on the fact that STEGH had succeeded in recruiting a Pastoral Care Consultant, and had in fact expanded the mandate for the position. Others based their evaluation of the relationship's effectiveness on the lack of conflict or lack of issues arising from the relationship, and the positive feedback received. One participant saw the Consultant's level of satisfaction with the arrangement as a good outcome indicator.

Communications

Participants were asked to describe the communication between the two hospitals surrounding the partnership. Of the thirteen answers received, four indicated limited communication, four stated the level of communication was acceptable, and five responded that they did not know or could not comment on the communication between the two hospitals. Reasons given for the perception of communication as limited included:

- The partners do not proactively meet (resulting in the suggestion by one participant that there be more meetings between the higher management levels at both sites);
- Those not directly involved are unaware of the benefits of the partnership (evidenced by the suggestion by STEGH to end the agreement after the change to full-time); and,
- The majority of communications only happen through the Consultant.

When communication was identified as acceptable, reasons included that the partnering hospital responded quickly, that email enabled easy management of requests and responses, and that individuals communicated when necessary.

Identified Need

"Needs have either been met or eclipsed by the partnership."

Regarding the identified need that prompted the partnership, nine people stated this question was not applicable to their involvement in the agreement. Two commented that the need (to recruit a Consultant for STEGH) had been met, and two agreed that while the original need had been met, the need is now different. One person stated that the need is now different, and did not clarify whether the original needs had been met.

i. *Strengths*

- a) *Overall Benefits.* In terms of the general or overall benefits of the relationship, participants identified three general strengths:
- Building the relationship between the two partnering hospitals (3)¹;
 - Providing support and a peer group for a sole practitioner (7); and,
 - Administrative benefits for STEGH (3).

Specific benefits from the strengthened relationship between the hospitals included the opportunity to network and work collaboratively with another peer organization and the sharing of resources (particularly the educational opportunities available at a larger hospital). The Pastoral Care Consultant

“All benefit from this mutual learning opportunity and sharing of gifts.”

represents a “department of one” at STEGH, which was identified by one respondent as a “lonely role.” The hospital partnership provides the Consultant with a peer group and a collegial relationship that may support the unique role of a Pastoral Care Consultant in a

community hospital. A further benefit to this support was that the connection to a department allows the sole practitioner to provide more comprehensive and improved services. With respect to administrative benefits, STEGH is relieved of some payroll administration by LHSC. The HR departments must work together to support an on-going relationship with the employee, strengthening their awareness of each other.

- b) *Benefits: Own Organization.* Participants were also asked to identify what benefits they saw for their own organization. Of those who answered from LHSC the relationship with STEGH was seen as a benefit (2 respondents). The partnership was seen as reducing insularity, and showed that LHSC was sensitive to the needs of a community hospital in the region. The comment that the partnership helps LHSC to prepare to be “region-ready,” and to be in a position to share resources across the region was also mentioned (by 2 respondents). From the same regional perspective, this formalized partnership between the teaching centre and the community hospital may lead to further collaboration, an exchange of information, and consistency between the two centres. The final strength identified was that the pastoral care department of LHSC benefits from this relationship.

Of the representatives from STEGH (including the Pastoral Care Consultant), improved access to resources was stated as a benefit (6), and one person commented on the ability to access the pastoral care services of LHSC if there was a crisis, or the Consultant went on vacation. The resources identified as being available through the teaching facility were: improved access to continuing education, more research opportunities; and access to recruitment resources (which was the expressed need for the original agreement).

¹ The numbers in brackets refer to how many times a response was given.

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- c) *Benefits: Partnering Organization.* In order to examine the relationship from both sides, participants were asked to identify the benefits they saw for the partnering or “other” organization. From the LHSC perspective, three comments related to administrative benefits to STEGH; one identified the professional support for a sole practitioner; and one related to the educational opportunities provided. The administrative benefits referred to a reduced workload for human resources at the community site; reduced costs (some are absorbed by the tertiary site, and some are reduced due to the large size of the teaching centre); and reduced time and support required to bring a new person on staff. With respect to educational opportunities, one participant referred to both the educational resources and research capabilities of the teaching hospital, and also to the reduction of insularity provided (through this partnership STEGH develops a better understanding of what is going on in LHSC).

When STEGH was the responding organization, six comments were provided. Three identified better communication and awareness of the community environment as a benefit to LHSC; two were not sure of benefits realized by LHSC; and one saw no benefits to their partner by the arrangement. Regarding the link with STEGH, respondents felt this would improve referrals and increase collegial contacts, as well as increase awareness of the unique services (both programs and staff development) offered at a community hospital.

ii. Limitations and Issues

Not all of the participants identified limitations to the overall agreement or had issues with the agreement in general. Of those that responded to this question, three felt there were no limitations, and three identified limits that applied to specific areas. Distance (between the two hospitals) was stated as a problem for the Consultant (“an ‘arm’s length’ member of the team at LHSC”) and a manager. One person commented that changing the terms of employment is more challenging in this situation.

Relationship Issues

When asked about issues that arose from the relationship, four participants stated there were no issues, and two abstained from answering the question (due to indirect involvement in the relationship). One participant discussed management issues. Human resources issues, and payroll or administrative issues were mentioned as a problem five times.

- a) *Management.* One concern raised by STEGH was that LHSC may have different management priorities, resulting in a differing view between organizations of who had management responsibility for the Consultant (the respondent stated that this concern was unnecessary, due to the supportive nature of the partnership).
- b) *Payroll.* The payroll or salary issues identified included difficulties making salary adjustments. More specifically, STEGH is not bound to honour funding adjustments or percentage salary increases made at LHSC. Denying payroll changes would result in the Consultant being taken off the LHSC payroll template, in

comparison to those of an equivalent role. If the Consultant does not move ahead on the scale at the same rate, human resources must handle the file manually, which is outside of the norm and is more time-intensive. Challenges also exist in that the two organizations have different levels of salary and benefits. In addition, dealing with the Consultant's invoices can be time-consuming at STEGH, because they also need to process the information manually ("work outside the system").

iii. Suggestions for Changing this Relationship

The recommendations received regarding the future of the relationship can be broadly categorized into four groups: a) funding, b) administrative issues, c) the agreement, and d) decision-making.

- a) *Funding.* One suggested funding change was to address the salary adjustment issue (i.e., defining which hospital's template the Consultant moves on), either by developing a system to keep the Consultant on-stream at LHSC or by changing the funding model so that LHSC is no longer the paymaster. Also, it was suggested that the benefits package be investigated. Since the benefits offered by LHSC are more costly, STEGH needs to evaluate if savings from the agreement (realized elsewhere) balance against this added expense.
- b) *Administrative.* Administrative issues raised included the need to increase awareness at both sites of the functions of a paymaster relationship, and the resource constraints associated in being able to support integrated partnerships of this type. Also, it was suggested that the relationship between the two hospitals should be more clearly defined with respect to the Pastoral Care Consultant (i.e. does LHSC function as the Consultant's employer, or just as a payroll provider?).
- c) *The Agreement.* The suggestion that the relationship should be continued focused on the benefits of the support for the Consultant, the satisfaction expressed with the Consultant, and the opportunity to explore the partnership further.
- d) *Decision-making.* One interviewee suggested that those directly involved be allowed to determine whether the benefits of the agreement warranted its continuation. A related suggestion was that more information was needed before being able to determine the usefulness of the partnership (being only 18 months into the agreement at the time of the interview).

iv. Suggestions for the Future

- a) *Broadening this Relationship.* Ten participants provided answers to the question of future possibilities for this type of collaboration. Three people envisioned this type of relationship expanding to other areas, for sole practitioners, specialized areas and under-serviced departments. Three saw the future of these collaborations as opportunities to further share resources (education and access to expertise), and two commented on the possibility of building relationships and networks to strengthen ties between professionals, teams, and program areas. One person envisioned LHSC becoming a payroll provider, so that STEGH would be able to access the same

knowledge and systems they currently are, but at less cost to LHSC (assuming the role of payroll provider), and without confusing the employee/employer relationship.

- b) *Relationship as a Model.* Participants were asked to elaborate whether they thought the partnership was a model for other organizations or programs. In general, eight people responded affirmatively, and three stated they believe there is at least potential for the relationship to be used as a model elsewhere. In particular, the agreement was seen as a model in situations involving lone practitioners or single person departments; small community hospitals seeking expertise and lacking resources; and, when there is a need to further regionalize or share regional resources. The agreement was seen as potentially working to break down prejudices, or perceptions of power imbalances. As a cautionary note, further research and identification of “red flag” issues was recommended. It was noted that there needs to be an increased awareness of liabilities and risk management, union and non-union issues, and human resource challenges before entering into agreements of this type in the future.

2.6 Findings: Human Resources (HR)

In total, six people were interviewed from human resources (both payroll and salary administration). Three people were interviewed from LHSC, and three from STEGH.

At the time of the evaluation, LHSC had acted as paymaster in other situations, and the comparisons are similar, although not exact. STEGH representatives did not know of any other positions in their facility resulting from similar agreements.

Representatives from human resources at LHSC noted a slight impact from the relationship on their department, although they were able to absorb the additional workload. They noted that the impact would be greater if there were multiple positions of this type, but that the impact would be lessened if there was more clarification in the agreement around human resource issues and who is responsible for human resource problems. From the perspective of STEGH, after the initial contract was finalized, there was very little impact on their HR department.

LHSC was asked about any challenges in communication with an off-site employee. The consensus was that communication was almost entirely issues-based, and they responded whenever the Consultant contacted them. They noted that communication might become an issue from a corporate perspective, because the Consultant, being located in another organization, was not part of LHSC’s e-mail or computerized payroll systems.

“All in all, a very positive experience. The two departments tried to work together, and to understand one another’s limits and time constraints.”

In terms of collaboration between human resource departments at different hospitals, the representative from LHSC who had contact with their colleagues at STEGH felt that the experience had “opened a door,” providing them with a contact and allowing them to “work in a collaborative fashion with a peer. “ The LHSC representatives who had not

had contact with the partnering department were concerned about confidentiality restrictions, stating that STEGH had the option to refuse to release necessary human resource information to LHSC, although this had not been a problem. STEGH representatives who had worked with their peers at LHSC found the experience very positive.

i. HR Services

- a) *Benefits.* The funding for the Pastoral Care Consultant comes from the Medical Program budget at STEGH, which is funded from the global budget. Just prior to the commencement of the evaluation, the role of the Consultant changed from a part-time to a full-time position, with the expected change in benefits. STEGH examined the difference in the benefits, and did a cost comparison. A breakdown of the costs was provided by LHSC, and it was determined that the increased costs would remain within the program budget. While moderately time-consuming, this change presented no real challenges. From the perspective of LHSC, the effort required to change the status of the Consultant was minimal, absorbed by the department, and was not a challenge from an administrative point of view. All that was required was that the necessary paperwork from STEGH be completed on time. However, the representatives from LHSC felt these changes could become a workload issue if there were multiple relationships.

When questioned about the policies and procedures related to benefits, those that responded seemed understand the situation. That is, LHSC offers a benefits package that is more comprehensive than the package offered at STEGH, and the Consultant receives the same benefits as a chaplain of similar seniority at LHSC. From LHSC's point of view, the Consultant is governed by the same policies and procedures as on-site employees. At STEGH, the payroll department is sent a bill for the cost of the benefits and remits the amount to LHSC. However, when paying benefits, LHSC pays for both the benefits and an associated administration fee. While STEGH pays for the premiums, it is too challenging at this time to back-bill them for the usage fees.

- b) *Payroll.* With respect to payroll, LHSC treats the Consultant the same as everyone else in a non-union, full-time position. However, LHSC is assuming hidden costs that are not part of the operating budget, such as the time it takes to implement changes to the Consultant's payroll. STEGH assumes responsibility for remittances to LHSC based on hours worked. At STEGH, this results in extra work in order to confirm hours.
- c) *Revenue Canada.* From the point of view of Revenue Canada, the Consultant's time would only represent an issue if the hospital responsible (in this case, LHSC) was not submitting the necessary deductions. However, Revenue Canada is getting the appropriate deduction per Gross dollar, and the T4 is created at LHSC. It was suggested that Revenue Canada might look more closely into who is the actual employer if issues arose, such as a need for severance.

ii. Limitations and Issues

- a) *Legislative.* One potential issue raised from a legislative perspective was that LHSC and the Consultant might be bound by employer/employee legislation. In other words, although from a functional perspective the Consultant is an employee of STEGH, from a legal perspective LHSC may be obligated to provide severance and WSIB return to work and leave costs, in the event STEGH “walks away” from the agreement. Such a situation is extremely unlikely in this “good faith” agreement, but is possible. There are also potential legal implications or complications with unions, and with labour relations or patient risk management if there is ever a problem with the way the Consultant performed any professional duties.
- b) *Financial: Administrative.* An administrative complication arose at LHSC in that the Consultant does not automatically move “on-scale” at LHSC with respect to salary increases; movement is dependent on approval from STEGH. If the Consultant does not receive salary increases at the same level as counterparts at LHSC do, payroll cannot use a corporate template for the employee and must update the file manually. This increases the hours necessary to support the role. Effective communication can help with this problem, and is particularly important because, as noted earlier, the Consultant is not on the internal system (i.e. email) at LHSC.
- c) *Financial: Hidden Costs.* Limitations also exist with respect to hidden costs, which are absorbed and managed by LHSC. Representatives from LHSC raised concerns that the Consultant’s “benefits experience” affects the non-union life insurance, medical benefits, and WSIB rates. These hidden costs can influence the premiums paid by LHSC, which are based on experience and the number of people who make claims. Other costs related to this partnership include a fee per employee charge from the payroll provider, costs for T4s at year-end, and charges for manual cheques (if they are required). The Consultant is non-union, but in a relationship involving a unionized employee, there would be costs for any benefits administered by the union group. Participants suggested that if this type of relationship were to expand, these hidden fiscal costs should be built into the budget in order to cover off the cost of support staff. Furthermore, it was suggested that the hospital set a common policy so that employees in this kind of a relationship can be dealt with as a group, rather than individually (which is time-consuming).

iii. Suggestions for the Future

Recommendations for the future provided by human resources representatives can be summarized into three general themes: a) research, b) communication, and c) the relationship.

- a) *Research.* Specific suggestions related to research included the need to: examine the capacity of LHSC to handle these relationships; complete a business analysis of the clinical benefits compared to the human resources demands; and, investigate the payroll provider versus employer/employee relationship.

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- b) *Communication.* Representatives from STEGH emphasized the need to increase the level of communication, stressing the importance of keeping everyone “in the loop”. Specifically, representatives felt that everyone should be copied on all related emails, and that phone conversations should be summarized in email to all participants when negotiating or revising the agreement. From STEGH, the point was made that clear and complete communication is key. In the future, representatives from human resources encouraged increased communication between facilities to ensure the relationships and responsibilities are clearly defined, and the associated risks are understood.
- c) *The Relationship.* The general suggestion was that the relationship be continued, but adapted. This reflected the belief that there will be more resource sharing in the future, and that there needs to be a system or model in place to support that practice. The only additional comment was that there needs to be clarity from the Consultant as to which facility they identify with personally. This is important to ensure that the appropriate institution provides recognition events (such as long service awards), and that the Consultant is kept aware of, and is involved in ongoing initiatives at their host organization.

2.7 Findings: Management/Administration

Five people were interviewed in the management or administration hospital role: three from STEGH, and two from LHSC. From the perspective of involvement with the relationship, two participants (one from each centre) can be viewed as having direct participation in the partnership, relating directly and with some frequency with the Consultant. The other three have a more indirect role with respect to their association with the Consultant.

When asked about other positions in their facility resulting from similar agreements, the managers from LHSC knew of similar positions in psychiatry and management. In STEGH, there were no positions exactly like this, although the Regional Geriatric Assessment Centre and the Regional Cancer Centre were cited as potential areas for comparison.

i. Supervision and Support

- a) *Management.* Of the management participants interviewed, those indirectly involved in the relationship reported that this relationship resulted in no changes to their staff meetings or communications. Those directly involved in the management portion of the relationship reported some changes in their meetings. The manager from LHSC stated that the Consultant is included in communications (mailing and distribution) and team functions, but aside from the additional management time spent, there are no other changes. From the perspective of the manager at STEGH, there are regular formal and informal meetings with the Consultant, but no change to the system of communication compared to regular on-site employees. No

“It’s a painless arrangement from my distant perception.”

changes were made to the management structure at either site with the inclusion of the Consultant as an employee.

- b) *Supervision and Mentorship.* Regarding the provision of supervision and mentorship, those indirectly involved reported no changes. The direct manager from LHSC reported time spent interacting with the Consultant as a change, (although the time demand is not as much as for the Chaplains located on site). The manager from STEGH stated that the Consultant had more mentorship and support specific to the discipline (provided by LHSC) because of the relationship, than if the Consultant was solely an employee of STEGH.

The consensus of the managers was that the Consultant receives adequate support from the pastoral care group at LHSC. One manager from LHSC went on to clarify that the Consultant does not receive supervision, but instead collegial and team support. The relationship is not seen as being authoritative, but as a reciprocal and mutually beneficial relationship.

"I'm getting the sense that a healthy, collegial relationship is developing."

When asked about the provision of direction and leadership by LHSC towards the development of a model of pastoral care at STEGH, managers with direct involvement felt the role of LHSC was supportive, rather than directive. The manager from LHSC stated that initially their department provided assistance in developing a job description at STEGH, in addition to providing professional attention, opinion, and opportunities for challenge. Presently, LHSC provides support, and the manager "acts as a sounding board," for the Consultant. As for the direction and supervision provided by STEGH, all managers who responded stated that STEGH provides "whole-hearted" support at several different levels.

- c) *Professional Development.* All managers felt that the Consultant was able to participate in several educational opportunities for professional development. Specifically, LHSC provided access to community education sessions, and invitations to conferences and retreats. STEGH provides access to the Internet, and funding to attend two conferences a year.
- d) *Appropriate Resource Allocation.* When asked if the resource allocation associated with this partnership was consistent with the mission, values, and goals of their organization, all five participating managers stated this was the case. One STEGH respondent clarified that the Consultant provides visible and available pastoral care to patients and families, which is consistent with the significant value the hospital places on being "customer focused." From LHSC, participants stated the relationship is consistent with their mission to work with the region, and the values of partnership and building community relationships.

ii. Role Definition

a) *Perception of Function.* To determine whether everyone had similar expectations of the Consultant, representatives were asked to define their perceptions of the functions of the Consultant. General themes cited by those with indirect participation in the relationship included:

- Responding to the needs and requests for spiritual support from patients, family and staff;
- Providing leadership in pastoral care, ethics, and values; and
- Coordination of community services and resources.

The two managers with direct participation in the relationship were able to provide more detailed perceptions. Responsibilities cited by these managers included:

- Direct care of patients;
- Facilitation of spiritual care of patients by others (particularly community clergy);
- Education of the health care team (including administrative support and training); and,
- Care for the soul of the institution (i.e. medical ethics, palliative care, and ensuring patient-centred care).

b) *Development of Role.* Only three of the managers (one indirect, two direct) responded as to whether STEGH works with the Consultant and LHSC to ensure effective communication and understanding of the role of the Consultant. The consensus of those that responded was that there is acceptable communication, with the Consultant acting as a facilitator or conduit between the two organizations.

iii. Integration and Collaboration

a) *Integration.* From the perspective of all of the hospital managers, the Consultant has been well integrated into STEGH organization. The general impression is that the Consultant is integrated as much as necessary or appropriate at LHSC. One participant went on to specify that minimal integration into LHSC is appropriate in order to support the philosophy of collaborative, mutual partnerships, rather than give the illusion of a controlling or dominating partnership.

b) *Collaboration.* When asked about the collaboration between the organizations for the purpose of developing a model of spiritual and religious care, the four managers who responded confirmed that some collaboration happens through the Consultant. One manager from LHSC emphasized that the contribution of the LHSC pastoral care department was consultative, and was more about a philosophy than providing a specific model. The direct manager from STEGH commented that the Consultant had taken the lead on collaboration, and was the most involved in developing the model of spiritual and religious care at the institution.

2.8 Findings: Occupational Health

Only one Occupational Health representative, from LHSC, was interviewed. As the Consultant is on LHSC's payroll, it is this organization that is legally responsible for managing occupational health issues. The representative from Occupational Health was not aware of any other similar agreements.

i. Office Safety

The off-site position of the Consultant presents more challenges to managing office safety concerns than an on-site position. For example, LHSC is responsible for addressing the Consultant's physical office concerns, but the office is located on someone else's site. LHSC is in the position of being able to make recommendations, but is not able to ensure the recommendations are followed. Although safety concerns are addressed by STEGH's policies and procedures, there remains a question of logistics, because of the responsibilities of LHSC.

ii. Workplace Safety and Insurance Board (WSIB)

Regarding the Workplace Safety and Insurance Board (WSIB), responsibility rests with LHSC. If the Consultant received a workplace injury, the procedure from the manager's view would be that the injury would be reported to occupational health at LHSC, and then the department would collaborate with STEGH to provide rehabilitation. LHSC must report any accident to the WSIB within 72 hours. If the Consultant is in long-term rehabilitation, it might affect LHSC's rebate from the WSIB. Even though STEGH is reimbursing LHSC, any health-related issues would have an impact on LHSC (since the Consultant is their employee). Another safety issue is that of the requirements for annual retraining, such as those for fire safety or WHMIS. Also, the employee needs to know where they can access certain services, such as the Employee Assistance Program.

iii. Ergonomic Assessments

Ergonomic assessments also represent a logistical issue. For example, if the Consultant returned from a long-term disability leave, an ergonomist would be required to do a Physical Demands Analysis (PDA). With the limited resources of the Occupational Health department at LHSC, it would be a strain to send their ergonomist out to STEGH site.

iv. Return to Work/Leave Costs

LHSC is responsible for any return to work or leave costs, which would have an impact on their experience rating. In other words, STEGH would not be affected by an injury occurring to the Consultant on their site in this capacity; LHSC would feel the effect. Furthermore, if the Consultant was unable to continue working due to a temporary or permanent disability, LHSC might be responsible for accommodating the employee and dealing with any barriers or limitations. LHSC would collaborate with STEGH to assist the employee, but the ultimate responsibility would rest with LHSC (provided the Consultant was found to be LHSC's employee). A related issue is that if the Consultant remains on long-term disability, LHSC would be responsible for backfilling the role at STEGH.

The policy at LHSC is that if an employee misses more than five days of work, they must be cleared with Occupational Health before returning. Enforcing this policy presents a logistical challenge in the situation of the Consultant.

v. Performance Development

Further issues may arise if there are attendance problems; guidelines need to be clear on who would manage this issue. Similarly, it was suggested that there needs to be clear guidelines on how to manage attendance enhancement and performance development programs. It was pointed out that if STEGH wants to manage these issues that is not a problem from LHSC's perspective; it is just necessary to have a mechanism for communication on these issues (since for example, chronic absenteeism could impact on LHSC's human resource department).

vi. Suggestions for the Future regarding Occupational Health

The Occupational Health manager recommended the development of clear reporting guidelines. A system should be established with the on-site provider, so that LHSC can ensure they can submit claims on time.

The manager also suggested using a separate WSIB rate number to isolate off-site employees and identify the costs related to them. Looking at this issue is necessary to identify a way to reduce LHSC's risk. These issues become a bigger problem the more relationships there are; there is no problem currently.

There needs to be a solution developed to address retraining issues. For example, there could be an arrangement with the on-site hospital to provide the necessary retraining courses. For one person, these issues are small, but become more complex if the hospital undertakes more of this type of collaboration. The manager also suggested that the Consultant attend LHSC's Corporate Orientation, to receive information on programs such as the Employee Assistance Program, and find out ways to access Occupational Health.

Regarding the Return to Work policy, it would be beneficial to set up a process whereby STEGH would send information to LHSC in situations where an employee had returned to work after an absence of five or more days. The clearance should be done at STEGH, with the results being forwarded to LHSC. These issues are not significant in and of themselves; they just need to be recognized, and guidelines need to be set.

2.9 Findings: Pastoral Care Consultant

When asked about the accuracy of the job description, the Consultant said the balance as described was correct (50% coordination, training of volunteers and administration; 30% direct care and support of patients, family and staff; and 20% networking in the hospital and community). As a way to document appropriate allocation of time, the Consultant has developed a statistical tool based on the percentages identified in the job description.

Role Definition

The Consultant defined the function of a Pastoral Care Consultant as follows: “to provide for the spiritual and religious health of the patients, family, and staff in the hospital.” The Consultant is involved with program development, building relationships with community clergy, and participates on the Ethics Committee, in addition to working with palliative patients, responding to referrals and urgent needs, and providing worship services. As the role has developed, it has been indicated that the “Consultant” role, as classified in the structure of STEGH, is not an accurate description of the complexity of what the Pastoral Care Consultant actually does.

ii. Integration and Support: Tertiary Centre

The Consultant discussed integration at both facilities. In both circumstances, the Consultant felt integrated as appropriate to the circumstances: very welcomed and integrated at STEGH, and integrated into the Pastoral Care Group at LHSC, but not the broader organization.

- a) *Professional Support.* Regarding supervisory and team support at LHSC, the Consultant views the relationship between professional practice leaders in their respective institutions as collegial (aside from the supervisory role the organization had in the hiring process). The Consultant approves of and values the collegial relationship, believing a directive approach--with LHSC trying to manage pastoral care at STEGH--would result in friction and hinder establishing trust with STEGH staff.
- b) *Professional Development.* LHSC provides opportunities for professional development. The Consultant has been included in planning retreats and a review of the teaching program for medical students, and has been given the opportunity to attend educational and professional building days. In addition to providing educational opportunities, LHSC has acted as a resource and sounding board, and has provided a level of expertise that would otherwise not be available. The Consultant has received collegial and team support towards the goals of creating an on-call roster of community clergy, developing a training program for community pastoral volunteers, and developing a program for staff regarding “caring for the caregiver.”

iii. Integration and Support: Community Hospital

a) *Professional Support.* The support from the management at STEGH has been excellent, and the Consultant feels STEGH is both appreciative and supportive of the role. STEGH has provided absolute and appropriate direction and leadership in assisting the Consultant with developing and implementing a model of spiritual and religious care. The Consultant brings forward ideas, suggestions and concerns, and even presented a vision of pastoral care to the STEGH Board of Governors. The management, at different levels within the organization, has actively sought ways to support and include the Consultant. In terms of office space, there were some delays

in finding appropriate secretarial support, but STEGH worked to resolve this problem once they were made aware of the Consultant's needs.

- b) *Professional Development.* STEGH has been responsible for providing money for educational opportunities, although the question of financial responsibilities for professional development has been debated.

"I'm very impressed with the support from management. Anywhere I've gone to raise issues or offer support has been great."

iv. Suggestions for the Future

With respect to professional development, there is potential for conflict concerning which institution is responsible for the financial cost of educational opportunities. The two organizations need to share a clear understanding of the agreement in this regard. Related to this, the Consultant has suggested that the language of the agreement be reviewed, in the light that LHSC has no managerial authority over the Consultant.

3.0 Conclusion

As a whole, the majority of participants were aware that the agreement was modified from a part-time to a full-time position. This indicates that those interviewed for the evaluation had a fairly up-to-date knowledge of the partnership. Furthermore, those respondents who were asked about the function of the Consultant seemed to hold similar and accurate views as to the roles and responsibilities of the position.

The respondents brought forward different indicators of success, including recruitment of the Consultant, expanding the mandate of the position, lack of conflict and positive feedback. Overall, participants seem to view the agreement as successful, consistent with the mission, values, and goals of their respective organizations, and as meeting the original need of the partnership. The Consultant was appropriately integrated at both sites, and although the integration was to a different degree, it supported a mutual, rather than directive, partnership.

In general, this partnership has done an excellent job at increasing awareness between the two hospital organizations. Despite original concerns held by both hospitals, and initial hesitation in working together, participants overcame these challenges and have developed a positive and productive working relationship. The Pastoral Care Consultant agreement is a useful example of the benefits of collaboration, and seems to have successfully encouraged other collaborations in an atmosphere of increasing trust.

3.1 Relationship as a Model for Partnership

Many of the strengths of this partnership could extend to other relationships, particularly situations where there is a lone practitioner, or a small community hospital seeking expertise and lacking resources. The agreement helped to build the relationship between the two hospitals, providing an opportunity to network and work collaboratively with a peer organization. Working collaboratively in this manner may help to reduce the

insularity of the participating organizations, assisting each to become more sensitive to the demands of the other's environment, and potentially improving referrals. The relationship also provided a peer group for a sole practitioner, and allowed for sharing of resources, increased collegial contacts, and increased awareness of services.

When looking at the agreement as a model, it is important to note that not all parties saw the agreement as being uniformly equitable. For example, from a financial perspective LHSC seemed to be absorbing more of the cost. At a more individual level, there was some concern that the Consultant was receiving benefits and salary comparable to employees in a teaching hospital, while equivalent colleagues at STEGH may be compensated at a lesser rate. Although no specific examples of co-worker jealousy were noted, the potential for conflict does exist. In terms of managerial conflict, this model did result in initial concerns from STEGH that LHSC could exercise a dominating managerial style and attempt to assume managerial responsibility for the Consultant in an effort to try to "take over" pastoral care at STEGH. This did not materialize. An additional concern is the demands this relationship placed on the human resources department of LHSC. Although the extra workload was minimal in this specific agreement, it was made clear that the department would require additional resources to be able to manage multiple employees of this type. The extra workload at STEGH was also minimal, but it was recommended that in future a cost-benefit analysis be undertaken before proceeding with duplicating this model. Similarly, although LHSC was able to absorb the 'hidden' costs of processing this employee, those costs may become prohibitive with a larger number of similar agreements.

Based on the identified successes of the Pastoral Care Consultant Agreement, the potential does exist for it to serve as a model for other regional partnerships. However, administrative issues were identified that need to be addressed before using this relationship as a model. There are also administrative issues that should be examined before renewing this agreement.

3.2 Administration vs. Service Delivery

When examining the limitations of the agreement, a general theme appears. There seems to be a marked difference between the administrative perspective, and the views of those in the capacity of service delivery (in this case, direct provision of pastoral care). The majority of the limitations cited have to do with administrative (i.e. human resources or occupational health) issues, rather than service delivery (i.e. the provision of pastoral care). The operational functioning of the agreement seems to have been very successful, while the administrative challenges still need to be addressed.

In order to capitalize on the benefits to service delivery, while reducing the administrative concerns the opportunity now exists to develop a slightly modified relationship or Memorandum of Understanding. Originally, the need that prompted this relationship required the Consultant to be an employee of LHSC. However, with the role now being filled on a full-time basis and a solid alliance having been formed between the two organizations, the need is different, and is now more focused on providing support to a lone practitioner. If the partnership at the frontline level—between LHSC's Pastoral Care

department and the Consultant at STEGH—is maintained and supported, but the Consultant is placed on STEGH’s payroll as a full employee at that site, most of the liability issues would be resolved, while continuing the healthy and positive alliance between the participating organizations.

4.0 Suggestions for Future Consideration

4.1 Communications

The importance of clear and consistent communication at all levels in a relationship between two organizations cannot be overemphasized. If the relationship is to continue in the current form, it is suggested that management representatives from both organizations connect on a regular basis to discuss any issues and to dispel any arising concerns. Additionally, representatives from human resources at both hospitals need to continue to work together to support the employee at both sites. These meetings will assist in increasing the awareness of the agreement, and improve the collaboration between the two organizations.

4.2 Suggestions for Evolving Pastoral Care Partnership Model

As the relationship has evolved, it seems advisable to change the Consultant to STEGH’s payroll. Before doing so, however, consideration should be given to how this changeover would affect the Consultant (i.e. with respect to seniority, benefits, salary, etc). To determine the best course of action a discussion between all parties involved is recommended.

“It’s not necessary to have the formal financial relationship to form healthy alliances.”

If the Consultant remains as an employee of LHSC, the salary adjustment issues brought forward by human resources need to be addressed. Further research and identification of “red flag” issues is recommended, particularly with respect to increased awareness of liabilities and risk management, union and non-union issues, and human resource challenges. There also needs to be clarification of confidentiality and privacy restrictions. The capacity of LHSC to handle the administrative requirements of these relationships should be researched. It could take the form of a business analysis of the administrative costs and benefits.

If the relationship continues in its current form, it is suggested that the wording of the agreement be revised to reflect the collegial-style relationship that has developed. The participating organizations also need to resolve who is financially responsible for professional development.

The participants also need to address Occupational Health issues. While LHSC does not need to actually perform certain tasks (i.e. WHIMIS), it does need to receive documentation that the training has occurred. The hospitals need to develop clear reporting guidelines. One additional suggestion, from the Occupational Health representative, is to investigate the development of a separate WSIB rate number for employees working in this situation.

Regardless of whether the Consultant remains as an employee of LHSC, it is recommended that the service delivery alliance portion of the agreement continue to be explored, to determine if there are opportunities to realize any additional benefits to the participating organizations.

4.3 Other Applications

With the further investigation, the relationship could expand to other areas with sole practitioners, specialized areas and under-serviced departments. Based on the input to this evaluation, it is proposed that agreements of this type will build relationships and networks, strengthening ties between professionals, teams, and program areas.

4.4 Future Evaluations

Whether the agreement is renewed in its current form, or the model is adapted, a second, follow-up evaluation would provide useful information about the longer-term success of this partnership. The format should be changed slightly, so that participants identify goals and indicators of a successful partnership prior to the evaluation. A representative from Occupational Health at STEGH site should also be interviewed in any future evaluations, and the participant list should be reviewed to ensure there are no gaps in representation. The agreement should be reviewed prior to being renewed, and an evaluation could be considered in two years time.

5.0 References

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VandeCreek, L. & Burton, L. (Eds.) (2001). *Professional Chaplaincy: Its Role and Importance in Healthcare*. The Association for Clinical Pastoral Education; The Association of Professional Chaplains; The Canadian Association for Pastoral Practice and Education; The National Association of Catholic Chaplains; The National Association of Jewish Chaplains.

Appendix A: Methodology

Stakeholder groups that were involved in the evaluation included representatives from Human Resources, Management and Administration, Occupational Health, the Pastoral Care Consultant (Consultant). All stakeholder groups were asked the same set of thirteen general questions at the beginning of the interview. They then responded to questions specific to their area of expertise (see **Appendix B**). The questions were open-ended and qualitative in nature. An open-ended, person-to-person interview approach was used in order to obtain detailed feedback and find out why people were satisfied or dissatisfied with the agreement (Myers, 1999). The interviews took place from July 23rd, 2003 to September 4th, 2003.

Initially, the list of participants was derived from those involved with the development and approval of the amended agreement, and suggestions from that core group. The list was further expanded based on recommendations from those initial contacts, resulting in the final sample size of 13.

Participants were contacted by e-mail; initially as a group with a letter outlining the intent to undertake the evaluation (see **Appendix C**), and then individually, to book times for in-person interviews. In most cases, once a time was confirmed, participants received copies of the questions they would be asked in order to give them an opportunity to prepare.

Information for this report was collected systematically. All interview questions were asked in the same order they appeared on the written survey. Participants were contacted at work, and the interviews took place at their home hospital site. The investigator recorded the responses on a hard copy of the survey. Participants were given ample time to respond, and encouraged to indicate when they were prepared to answer the next question. Time to complete the interview was in most cases limited to an hour, but the actual length depended on how much time the respondent had available.

After the final interview, all responses (thirteen) were compiled into a table to aid in analysis and comparisons of data. Of the thirteen people interviewed, six were from LHSC, six represented STEGH, and one was an integrated position that self-identified as belonging to STEGH site (the Consultant). Their participation in the agreement varied considerably: some had direct involvement in the front-line application of the partnership (three of thirteen); others (particularly in the administrative or human resources areas) were involved indirectly in the partnership (eight of thirteen). Finally, some of the informants approached knew very little about the agreement, as their involvement was quite removed (two of thirteen).

Appendix B: Interview Questions

General Questions

1. Under the roles and responsibilities of the agreement, it states that the participants will work together to fulfill their shared and respective roles. Do you feel that this has taken place? Can you elaborate? Do you feel the roles and responsibilities are appropriate, fair and equitable for both organizations?
2. What is your role in the partnership? What has been your participation in this agreement?
3. To your knowledge, has the application of the contract been modified or adapted in any way since the relationship began a year ago?
4. What are the strengths and limitations of this relationship from your point of view?
5. Have you noticed any issues arising from this relationship? If so, please elaborate. (For example, have you noticed any disruptions in the pattern of activity in your department?)
6. In your opinion, what benefits are there to your organization resulting from this relationship?
7. What benefits do you perceive for the “other” organization in this relationship?
8. From your point of view, do you feel that this relationship has been effective? Can you give examples of its effectiveness? How do you judge the effectiveness of this relationship? (I.e. Why do you think it is effective?)
9. How would you describe communications between the two hospitals surrounding this partnership? Do you have any suggestions for improvement?
10. Is the identified need that prompted this partnership with STEGH still the same, and is it being met by this arrangement?
11. What would you recommend for the future regarding this relationship?
12. Do you think this partnership is a model for other organizations or programs? Can you elaborate how?
13. What future possibilities do you see for this type of collaboration?

Questions Specific to Human Resources

1. How has this arrangement affected policies and procedures, with respect to:
 - a. Benefits? Are the benefits received by the Pastoral Care Consultant equivalent to those at an equivalent seniority at LHSC (Chaplain, Pastoral Services) or STEGH?
 - b. Payroll?
 - c. Revenue Canada?
2. How has this agreement affected your department?
3. Are there other positions in your facility resulting from similar agreements, either with these two partners or with others?
4. What type of funding is used to pay for this position (i.e. part of hospital's global budget, supplement by faith groups or similar organizations)?
5. What challenges arose when providing the Consultant with FT benefits after the change from her PT position? How were these challenges resolved?
6. How is communication with this off-site employee? Any suggestions for improvement? (Problems due to when department at LHSC closes and STEGH employee needs to drop things off?)
7. Are there any issues resulting from working with the HR department at another hospital? Can you elaborate? How has this altered your collegial relationship with the other hospital in the partnership?
8. Do you have any suggestions as to how to deal with the logistics surrounding this type of relationship agreement in the future?
9. Were there any issues with working out the logistics of the contract change?
10. If future changes were to be made to the contract, would you suggest or recommend that anything be done differently?
11. Additional Comments?

Questions Specific to Management and Administration

1. Has this arrangement affected policies and procedures with respect to:
 - a. Staff meetings and communication? (If yes, how?)
 - b. Management structure? (If yes, how?)
 - c. Supervision/mentorship/support? (If yes, how?)
2. Is the resource allocation associated with this agreement consistent with the mission, values and goals of the organization? If so, how?

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3. What do you perceive the functions of a Pastoral Care Consultant to be?
 4. To your knowledge, has the Pastoral Care Consultant been integrated well into both organizations?
 5. To your knowledge, does LHSC provide supervisory and team support to the Pastoral Care Consultant on an on-going basis?
 6. Is the Pastoral Care Consultant provided with opportunities for professional development and growth? Can you provide examples? (LHSC)
 7. Has LHSC has provided the Consultant with direction and leadership to ensure she is able to fulfill her role to STEGH, and develop/implement a model of spiritual and religious care that is appropriate, addresses the needs of patients and makes the best use of the resources of the hospital and community?"
 8. To your knowledge, does STEGH provide supervision and direction that will enabling the Pastoral Care Consultant to function effectively?
 9. To your knowledge does STEGH "work with the Pastoral Care Consultant and Pastoral Services of LHSC to ensure effective communication and understanding of the role of the Pastoral Care Consultant throughout the hospital and community?"
 10. In your view, Has STEGH "work[ed] with the Pastoral Care Consultant and Pastoral Services of LHSC to collaboratively develop and implement a model of spiritual and religious care that is appropriate, addresses the needs of patients and makes the best use of the resources of the hospital and community?"
 11. Are there other positions in your facility resulting from similar agreements, either with these two partners or with others?

Questions Specific to Occupational Health

1. How does this position (Pastoral Care Consultant at STEGH) differ from the Chaplains at LHSC with respect to the following:
 - a. Office safety?
 - b. WSIB?
 - c. Ergonomic Assessments?
 - d. Return to work/Leave Costs?
2. Are there other positions in your facility resulting from similar agreements, either with these two partners or with others?

-
3. What are the issues/challenges surrounding this relationship with respect to:
 - a. Office safety?
 - b. WSIB?
 - c. Ergonomic Assessments?
 - d. Return to work/Leave Costs?
 4. Any other OH issues associated with this position? Any additional comments?

Questions Specific to the Pastoral Care Consultant

1. Do you feel you have been integrated into the two organizations you are involved with?
2. Has the supervisory and team support you've received from the management at LHSC been sufficient? Do you feel that you fit into the department there? Can you elaborate/provide examples?
3. Do you think that the management at STEGH supports your role? Can you elaborate as to why or why not?
4. Has LHSC has provided you with opportunities for professional development and growth? Can you elaborate/provide examples?
5. Do you feel LHSC has provided you with appropriate direction to provide care directly and by facilitating care through volunteers/laity? Do you feel you have accomplished this goal as specified in the agreement?
6. Do you feel LHSC has provided you with direction and leadership to assist the STEGH to develop and implement a model of spiritual and religious care? Correspondingly, has STEGH worked with you to collaboratively develop and implement this model?
7. Did STEGH provide appropriate office space and related services?
8. Does STEGH provide "supervision and direction that will enable the [you] to function effectively in the role?"
9. Do you feel that your job description (50% Coordination, Training of Volunteers and Administration, 30% Direct Care and Support of Patients, Families and Staff, and 20% Networking in the Hospital and Community) was accurate? If not, what is the actual balance? Could you describe some of these activities?
10. Do you feel that you, STEGH and LHSC work together to ensure effective communication and understanding of the your role throughout the hospital and community?"
11. What do you perceive the functions of a Pastoral Care Consultant to be?

Appendix C: Memo of Intent for Pastoral Care Evaluation

Pastoral Care Consultant Agreement

To: Janice McCallum, Manager, Medical Care, Family Medicine and Palliative Care, LHSC; Linda Millard, Vice President, Patient Services, STEGH; Anita Grant; Graham Bland; Mary Turner; Laura Pavilonis; Joanne Smith; Adele Miles
Date: May 6, 2003
From: Laura Parizeau, Administrative Resident, ISAN;
RE: LHSC and STEGH Pastoral Care Consultant Agreement – Proposed Evaluation

Further to our recent email communication, I am pleased to provide you with documentation of our intention to undertake an evaluation of the Pastoral Services Partnership between London Health Sciences Centre (LHSC) and St. Thomas-Elgin General Hospital (STEGH).

The recent amendment to the Agreement increasing the employment of the Pastoral Care Consultant from part-time to full-time indicates an excellent opportunity to evaluate this innovative partnership. The evaluation may clarify some of the needs served by the Partnership, and the outcomes resulting from this unique relationship. Furthermore, the evaluation may be used in the future to assist in developing the role of the Consultant.

With the ongoing participation of all involved, I expect the evaluation to be completed by early August. I appreciate any suggestions or comments regarding the evaluation. In terms of the demands of the evaluation on participants from LHSC and STEGH, interviews with all participants in this partnership are likely necessary, in order to ensure all experiences are appropriately represented.

If there is a specific completion date that would be more beneficial to either organization, or you have any additional questions, please do not hesitate to contact me at (519) 685-8500 ext. 77735 or by email at Laura.Parizeau@lhsc.on.ca Also, if there is anyone else who should be copied on this communication please let me know.

Appendix D: Confidentiality Information Provided to Respondents

Pastoral Care Evaluation St. Thomas-Elgin General Hospital and London Health Sciences Centre

The recent amendment to the Agreement increasing the employment of the Pastoral Care Consultant from part-time to full-time indicates an excellent opportunity to evaluate this innovative partnership. The evaluation may clarify some of the needs served by the Partnership, and the outcomes resulting from this unique relationship. Furthermore, the evaluation may be used in the future to assist in developing the role of the Consultant.

The unique partnership between London Health Sciences Centre (LHSC) and St. Thomas-Elgin General Hospital (STEGH) may represent a useful model for other programs, as one way of addressing the staffing shortages experienced by some facilities. The evaluation may add evidence to support replicating this model in other areas.

Stakeholder groups that will be involved in this evaluation include representatives from Human Resources, Management and Administration, Occupational Health and the Pastoral Care Consultant. All four groups will be asked the same set of thirteen general questions at the beginning of the interview; questions specific to their area of expertise will follow.

Although names will not be used in the final report, due to the nature of the evaluation and the small number of people involved, confidentiality cannot be assured and in most cases participants will be identifiable. At any point in the interview, please feel free to ask questions, or to withdraw your participation without penalty or jeopardy.

Do you still wish to participate? Yes No

Name: _____

Position: _____

Date: _____