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**Partnerships between Hospitals and Community: A
Qualitative study on Collaboration for Spiritual Care in
Healthcare**

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THESIS/DISSERTATION

Submitted to Waterloo Lutheran Seminary

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The Doctor of Ministry in Spiritual Care and Psychotherapy

Wilfrid Laurier University

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Partnerships between Hospitals and Community: A Qualitative Study on Collaboration for Spiritual Care in Healthcare

Abstract:

Hospital-Community Collaborative (HCC) arrangements for the provision of spiritual care have been brokered in certain Ontario hospitals with varying degrees of success. The current study investigated how a community based organization could effectively partner with a healthcare institution to ensure spiritual care support for hospital patients. It asked the question: What factors are essential to make a hospital-community collaboration function well as a model for the provision of spiritual care? Qualitative research was conducted with four hospital corporations with HCC partnerships to ascertain the key factors which enable these arrangements to work, noting also the benefits and the challenges of hospital-community collaborations. A brief survey of the acute care hospitals in Ontario was conducted to ascertain the general type and prevalence of hospital partnership arrangements in the province, specifically, identifying the number of hospital-community collaborations.

Results. In-depth interviews and focus groups were conducted with 56 participants, including healthcare managers, hospital chaplains, board members of the partnering community-based spiritual care organization, and community faith leaders. Three key factors were identified as necessary for collaborative arrangements for spiritual care to work effectively: **Leadership** (support from the senior hospital managers, community leadership, and chaplain skill set); **Shared Responsibility/Cost** (between the hospital and community); **Relationship Building and Communication** (with hospital management, faith leaders, and all funding partners). The survey found that in Ontario, between 8-10% of acute care hospital corporations, mostly in small population centres, have a hospital-community collaborative where funding and governance for the spiritual care program is jointly held. An additional 13% of acute care hospitals, mostly in medium to large population centres, have a partnership arrangement by contracting for chaplaincy service with a religious denomination.

Implications. Creating a partnership between the healthcare institution and a community organization can be an effective means of ensuring professional spiritual care to all patients, under certain conditions. Hospital-Community Collaborative's (HCC) tend to function cohesively in small to medium sized population centres and when senior hospital management is fully committed to joint funding and shared decision making in the spiritual care program. As healthcare continues to face fiscal restraint, those attempting to initiate a new spiritual care program will need access to sustainable models of spiritual care. Partnership between hospital and community is a creative and viable model and may be most applicable in smaller or rural based hospitals.

Acknowledgements

I am deeply grateful to the board members who serve the Hospital-Community Collaborative under which I work as a healthcare chaplain and to our partnering hospital corporations. It has been a tremendous joy to create a chaplaincy program that reflects the needs and the vision of both the hospital staff and the community. I have had the privilege of getting to know fine leaders and for their support, wisdom and friendship I will always be indebted.

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Chapter One: Introduction

It is midafternoon and a nurse from the intensive care unit pages for me to come immediately. A patient with malignant carcinoma has had a massive cardiac event, expired, and now his substitute decision maker would like an opportunity to talk with a spiritual care provider about next steps. Translation: *A man, who is a husband and father, has unexpectedly died, not of the disease from which he was ailing, but rather that his heart has given out. His family did not expect this sudden death. His wife is in shock and she is grieving. She needs someone to come alongside of her and support her.*

I introduce myself to the wife, who is already outside of the patient's room and has her coat on. "Our children are driving here but won't arrive for five hours. Would you be able to come tonight and be with us so that they can see their dad one last time? The nurse said you could do a viewing in the chapel – nothing religious though. I am not a religious person." Translation: *"I can't believe Bob is dead. We just did not see this happening so fast. My kids need to see their dad for this to be more real to them. We are not the church going type. I don't know anything about you and I do not want you to push religion on me or say some spiritual platitude. Would you just come and be with us?"*

I agree to return that evening and she leaves immediately. The nurse turns and says, "Thank you so much for coming right away. I offered your services earlier but they declined." Translation: *"When the patient was not doing well physically we wanted to offer more support to the family. The ICU is so busy we just cannot spend the time that is needed at the bedside and are so grateful that the Chaplain can come and support families. We offered to page you but the family seemed uncomfortable at the mention of spiritual care and I did not want to upset them."*

Healthcare professionals and religious leaders share a long history of partnership in caring for the sick. The motive for the medical doctor and for the priest is the same: both desire to provide effective, evidence-based, physical, emotional and spiritual care to the patient for the purpose of facilitating a return to health or to comfort the dying and their family members. The language of the medical professional and the spiritual professional are quite different, though. Translation of medicalese is often needed so that patient and family members can understand what is happening to the patient and what the healthcare team can offer (diagnosis and prognosis). The divergent languages employed by healthcare professionals and spiritual leaders are indications that they reside in different cultures. The healthcare culture in North America is a

pharmaceutical, interventionist, technology-based, outcome-oriented culture. In providing wholistic care for the patient, medicine encounters a spiritual culture that values meaning-making, practices rituals, offers comfort, and promotes hope in that which is unseen and sacred by a wide variety of religious and spiritual traditions. Vastly different cultures are often ill at ease with one another and the same can be said for healthcare and religion.

The religious experience and spiritual awareness of healthcare professionals and the patient population influences the kind of care they anticipate a religious professional will provide in the hospital environment. The opening scenario presented a glimpse into a familiar life and death encounter in the intensive care unit of a hospital. The nurse was aware of the emotional and spiritual needs of the patient and family. She recognized the severe limitations on her time and the boundaries of professional competence and therefore offered the service of an additional member of the healthcare team – the chaplain. The patient's spouse did not want anything religious but desired the support of the chaplain to facilitate a viewing of her deceased husband. The scenario exemplifies the now common suspicion of religion and uncertainty of what the person who represents religion might offer. Language can empower and can restrict. It can draw close or repel. The relationship between healthcare and religion is at the heart of the matter. If one discipline values and respects the other discipline, it is possible to collaborate in caring for the sick. The healthcare team needs to know and understand what the chaplain, also called a spiritual care specialist, does and can offer or they simply will not make a referral.

Despite the linguistic and cultural variances, religious and healthcare professionals seek to ensure spiritual care support is available for hospital patients. The Chaplain promotes religious support by attending to requests for prayer, sacraments or ritual, talking about one's relationship with God, or connecting people with representatives from their own faith community. Spiritual

needs are supported as chaplains help patients make sense or meaning in the crisis while identifying some inner resources that will help get them through this difficult time (Vandecreek and Mooney, 2002). Spiritual care targets the common human experience and is inclusive; it is offered to all persons who would like support regardless of their religious, ethnic or cultural background (Handzo, 1996). Therefore, spiritual needs are addressed from the patient's perspective and chaplains themselves represent a wide variety of faith traditions and perspectives, including Christian (Protestant and Catholic), Jewish, Muslim, Buddhist, Hindu and Humanist (Koenig, 2007).

Healthcare is populated by regulated professions each working within a specific scope of practice. Yet, the assessment of spiritual needs is shared by many professions, including physicians, nurses, occupational therapists, social workers, and mental health workers (Pargament, 2007). Spiritual care interventions in hospital settings are more commonly provided by those who have specific training, including religious faith leaders and healthcare chaplains. Institutions that have a spiritual care specialist or chaplain on the healthcare team together create a hospital culture that values spiritual care (Holst, 1996). Not all hospitals have a designated spiritual care representative (Flannelly, Handzo and Weaver, 2004). The omission of a spiritual care specialist is due in part to the diffusion of responsibility for spiritual care across professions and also due to a general lack of appreciation for the contribution of spiritual care to patient recovery. Economics also plays an important role in determining the hiring of healthcare chaplains. A gap in the provision of spiritual care within some hospitals has led to the formation of partnership arrangements between religious institutions or community organizations and their local healthcare corporation to fund the position of a healthcare chaplain.

Religious leaders and healthcare administrators have united in partnership arrangements to address the common goal of attending to the spiritual needs of patients (Koenig, 2004). Their willingness to dialogue has fostered collaboration between hospitals and community.

Partnerships can take many forms. For example, a partnership is created when a religious organization provides money for the hospital to hire a chaplain. Other partnerships occur when a religious organization places one of their own paid religious professionals within a hospital to provide spiritual care to patients. A third form of partnership is called Hospital-Community Collaboration (HCC) (Poland, Graham, Walsh et al, 2005). In an HCC arrangement for spiritual care there is a balancing of power between the community-based association and the hospital through the formation of a joint governing board. The chaplain position is funded and managed/overseen by the joint hospital-community board (with membership from the religious community and healthcare sector). Both pay and both therefore have decision-making responsibilities.

The research presented here investigates the Hospital-Community Collaboration form of partnership. I dialogued with medical professionals and hospital administrators, religious leaders and healthcare chaplains, as well as community leaders about their experience of working with a collaborative arrangement. Research participants were asked: *“What factors are necessary to make the Hospital-Community Collaborative function well as a model of partnership for spiritual care?”* Participants went on to describe what they found to be the essential building blocks of their collaborative arrangement for hospital spiritual care, noting factors that helped or hindered the development of the partnership. I was intrigued to learn how these medical professionals and community leaders, many of whom were local Christian clergy, were working

together to ensure that spiritual care is available for patients despite different cultures, languages and suspicions. My research hoped to identify how they made it work.

A case will be made in the chapters ahead for why it is important to consider collaboration in general as part of spiritual care in healthcare. And that the HCC model can work well under certain conditions and in smaller population centres. Current research has identified that hospital patients want access to spiritual care (Balboni, et al, 2007) yet many hospitals have not made spiritual care professionals a priority due to funding constraints and lack of awareness of the benefits of spiritual care to patients. Furthermore, collaboration with community is now part of the strategic plan of many healthcare corporations. In an era of fiscal restraint, healthcare and community need to join forces and develop creative solutions to ensure access to professional spiritual care. Collaboration builds the bridge and brings together some times unlikely partners who share a common purpose (Wagner and Fernandez-Gimenez, 2008). The result or outcome of collaboration is a spiritual care program that has broad ownership by both the healthcare system and the local community. The emphasis on dialogue and creating a win-win solution is the development of a program uniquely tailored to the needs of hospital patients, staff and faith community. The Hospital-Community Collaborative model changes how spiritual care is delivered because it is a rethinking of the system of care and not merely an opportunity to find money to support spiritual care programming.

Collaboration between hospital and community leaders to support the spiritual care of patients is a grassroots movement. It has an organic quality. Leaders begin with informal conversations, build trust and assess the unique needs within their hospitals before formalizing agreements. Often there is an event or crisis that provides motivation and energy for joining together and seeking a solution. I am the Healthcare Chaplain for a Hospital-Community

Collaboration in the Grey Bruce Region of Ontario. The impetus for dialogue between the community leaders and hospital personnel came about when the hospital chaplain position was eliminated in a round of budget cuts in the mid-1990s. The community clergy were outraged at the unilateral cut of the chaplain position. They demanded an opportunity to meet with the hospital administration and came out en masse to express their discontent. The hospital administrator who faced the crowd of angry clerics said that day she stood on a burning platform and knew the only way off way to agree to dialogue further. The religious leaders expressed to the hospital that they needed an advocate within the hospital who would promote an atmosphere that welcomed spiritual care. A business plan was created where the community and the hospital would share the funding of a chaplain position and would also share the governing of the spiritual care program.

Conversations which involve healthcare dollars inevitably turn to economics and the sustainability of funding. Healthcare is a dominant budgetary item for most provincial (state) and federal governments. As costs continue to escalate, healthcare administrators are forced to balance the budget in one of two ways: cut services or find healthcare efficiencies. The distinction between the two economic perspectives employed to balance budgets is important. Reducing costs by eliminating healthcare chaplain positions has occurred across Canada and will be discussed more fully in Chapter One. Locating healthcare efficiencies is a more effective alternative. This ‘doing more with less’ concept promotes a fresh look at the current systems in healthcare. Efficiencies can often be found when the pathway to care is reconsidered instead of simply cutting a service or personnel. The Hospital-Community Collaborative model is an excellent example of finding healthcare efficiencies by rethinking how spiritual care can be provided in the hospital. This study investigates four different hospital corporations in Ontario

that utilize a hospital-community partnership for spiritual care. In each case, a new chaplain position was established in a corporation that had never had a paid spiritual care provider. The partnerships that developed between community members and hospital leaders in the HCC model did not develop to save an existing chaplaincy position but to establish a new position. This allowed a thorough reconsideration of a standard chaplain job description and how the system of spiritual care could be delivered in light of the needs and desires of the partnering groups.

Too often, ideas about how to address spiritual needs within healthcare are exchanged among faith leaders and chaplains in isolation from healthcare administrators. Hospital administrators deal with the bottom line – does spiritual care benefit the patient? Is this program effective (clear, measureable benefits) and does it run efficiently? Most chaplains are religiously trained people and have not been taught to think in terms of tangible outcomes. Spiritual care professionals may resist quantifying the sensitive care that is offered. Yet all other professions within a hospital system are being required to translate the kind of care they offer patients into measurable terms so that their programs can be evaluated. Spiritual care professionals need the wisdom and support of other healthcare professionals to speak the language of healthcare in order to secure the program within the hospital budget. To initiate a new program in an era of healthcare restraint is challenging. Healthcare administrators may be quick to say ‘we simply cannot afford to begin a spiritual care program.’ However, if healthcare administrators, entrusted with casting the vision for a healthcare organization, are provided with evidence of effective means of funding and governing chaplaincy, an opportunity to rethink the funding problem may be created.

The desire to conduct research on the collaboration model of spiritual care grew out of my direct and on-going experience as a Healthcare Chaplaincy Coordinator in Southwestern Ontario. The Hospital-Community Collaborative model, under which I work, arose in the Owen Sound Regional Hospital in the mid-1990s. In the newly established program the hospital and the community shared the cost and the responsibility for overseeing the work of the chaplain. Then as now, the Ontario government was strongly encouraging local hospitals to amalgamate with one another to form new corporations as a cost-saving measure. The Owen Sound Regional Hospital joined with six other hospitals to form a multi-site healthcare corporation – Grey Bruce Health Services. I was hired to coordinate the collaborative spiritual care program which now covered a wide geographic area with seven hospital sites, all approximately thirty miles from one another.

The sharing of power between the community and the hospital, so critical to the success of the new spiritual care program, was evident in my job interview which was conducted by the vice president for clinical services, two senior hospital managers, and several community clergy. These people were members of a joint hospital-community board called the Grey Bruce Healthcare Chaplaincy Council (GBHCC) to whom the chaplain would be responsible. The position description did include patient visitation but it was much broader. The hospital wanted spiritual care support for their staff and educational in-services. The religious community wanted the chaplain to consider the systems of care so that the community clergy could locate their people with ease. They also wanted basic spiritual care skills training to be offered to pastoral care teams in local churches and special training for faith leaders. Speaking about chaplaincy in the local community was encouraged. Assisting the GBHCC board to communicate with the funding stakeholders was also expected. Funding was split 50/50 between the hospital budget

and community fund-raising (mostly by soliciting funds from local faith communities). Over the course of the next five years, three more healthcare corporations came under the GBHCC board for a total of four corporations (twelve distinct sites) and one chaplaincy coordinator. Again the model continued to develop to suit the distinctive needs of the community and the hospital sites. Individual hospitals wanted their own local part-time chaplain who would be supervised by a Coordinating Chaplain. Today we have fourteen part-time chaplains and myself, a full-time coordinator and fulfill the GBHCC slogan of ‘spiritual care for every hospital’ in our region.

Managing the provision of spiritual care to four separate corporations all under the Hospital-Community Collaborative model ignited a research question. I wondered why the relationship worked so well in some corporations and was so challenging in others. I wondered if it was possible to identify the necessary factors that make the partnership between hospitals and faith organizations work well. Around the board room table some struggles occurred. For example, the healthcare professionals advocated for communicating with ‘stakeholders’, a term that the religious leaders resisted using due to both its foreignness and comments by clergy of the negative historical associations of burning heretics at the stake. The Grey Bruce Healthcare Chaplaincy Council was approached by five additional hospital corporations in Ontario for assistance to initiate a chaplaincy position in their hospital. None of the five corporations had ever had a professional spiritual care provider. The Chaplaincy Council decided to provide information and guidance on how to create a partnership between the community and hospital leaders but not to further expand their own oversight. Three of the five healthcare corporations established a collaborative model for spiritual care in their hospitals but two did not get off the ground. I wondered why some partnerships took root and flourished and others did not.

I have approached the research on hospital-community collaboration following years of experience partnering with area hospitals and communicating with leaders about how spiritual care programs function. The personal, academic and vocational history of each researcher also influences how research is approached, including the kind of questions that get asked and how data is interpreted. My family of origin valued and modelled three things: a deep love of God, a commitment to community involvement, and an entrepreneurial spirit. Given this history I am open to the concepts of collaboration and community leadership within chaplaincy. Furthermore, I grew up in the small population centre of Hanover, Ontario which gives me intimate knowledge and respect for rural, small-centre dynamics. Small population centres thrive on the interconnectedness of relationships for the promotion of events and projects. It is not uncommon for the mayor to be a member of a local congregation, see the CEO of the hospital in the grocery store, or sit on a community board with someone from healthcare circles. Inter-relatedness can build trust, respect, and fosters social capital.

In rural and small population centres, it is often helpful to build credibility based upon the social capital of relationships. It is essential to talk with the front line people to gain their respect and listen to their ideas. Furthermore, it is important to move slowly and ensure that the majority support a new initiative. Rural, small centre healthcare has a rich history of innovation. Since these corporations often have limited access to resources their leaders learn to create novel solutions. The Hospital-Community Collaborative model is one solution to the question of how to initiate and fund a chaplaincy program. Many chaplains in Ontario are more familiar with the funding model where spiritual care professionals are paid solely through the hospital operating budget (and in Ontario this is by the public purse). However, in an era of fiscal restraint it is essential to consider alternative models. In particular, small population centre acute care

hospitals have few beds and limited resources. They need access to evidence-based models that demonstrate effective and efficient use of hospital funds for spiritual care.

Before I began my work as a hospital chaplain I was a marriage and family therapist and adjunct faculty for a liberal arts Christian university. Family therapy is a systems-based approach where problems are not considered in isolation but rather in light of the whole system within which the issue resides. Collaboration for the purpose of spiritual care requires systemic thinking in order to include all of the key players and to create sustainable chaplaincy programs. A chaplaincy program placed within the system of healthcare is much broader than a single chaplain visiting patients. Systemic thinking can also broaden the funding base for the spiritual care program. Years of teaching solidified my belief that education and skills-based training should be accessible to all. The best way to improve quality is to focus on the knowledge base of all who provide care – from the volunteer to the faith leader to the healthcare professional. In more recent years I have embraced the solution-focused, future oriented, strengths-based perspective of Steve de Shazer's Solution Focused Brief Therapy (SFBT). SFBT builds on health and what is working within a system (de Shazer, 1991). A solution-focused perspective asks what is enabling these positive things to happen and encourages the client or system to do more of what is working. In chaplaincy there is a need to consider the system of care as well as models of care in order to sustain the future of the profession.

The Canadian Association for Spiritual Care (CASC), once known as CAPPE, is the national organization that oversees the training and certification of spiritual care professionals in Canada. I am a Certified Spiritual Care Specialist with CASC. There are ten core competencies expected of certified hospital chaplains (www.spiritualcare.ca/competencies). Two of these competencies are central to my research: 'Collaboration and Partnership' and 'Leadership'. The

Collaboration and Partnership competency envisions the healthcare chaplain as accountable to the general public, to the faith communities that serve the local hospital, and to the employees and professionals within the healthcare corporation. Accountability is manifested when chaplains build working relationships with the members of the inter-disciplinary healthcare team and with the representatives of the faith traditions that visit their congregation members in hospital. Accountability is also demonstrated when the chaplain considers the system of spiritual care within the structure of the hospital. The system represents everything from the collection and dissemination of patient spiritual care information, to the referral process, to education of staff to increase their awareness of the value and benefits of spiritual care. The national spiritual care association is encouraging all chaplains – really, *expecting* all chaplains - to engage actively in a collaborative process with healthcare personnel and community faith leaders both to build relationships and educate.

The CASC competency of Leadership is also pertinent to the current study. Chaplains are encouraged to take a leadership role within the culture of the hospital corporation. At the core of this competency are the ideas of advocacy and support for patients, family members and staff. Advocacy and support includes the assurance that appropriate spiritual care resources and facilities are available within the healthcare institution. Clinical consultation is another form of advocacy. The CASC Certified Spiritual Care Specialist competency of Leadership is also demonstrated through the development of a strategic plan that integrates spiritual care within the corporate culture. As in the Collaboration and Partnership competency, chaplains are expected to demonstrate Leadership both within the organization and in the community. The two competencies of Leadership and Collaboration and Partnership anchor the present research within the expected skill set of Spiritual Care Specialists.

Prior to commencing the current research study, I conducted a preliminary, related piece of research on the hospital-community collaborative in Grey and Bruce Counties in which I work – the ‘Grey Bruce Study’. This study was part of a syllabus requirement in an advanced research course required by my doctoral program. Although the data from the Grey Bruce Study has not been included, the research results arising from it provided a foundational understanding of the hospital-community collaborative model. Eight factors emerged in this preliminary research as necessary for making partnerships work: effective leadership from the hospital and community, a win-win focus, shared partnership, relationship building among stakeholders, mutual respect among disciplines, training and education, accountability, and prayer. Comments by my research colleagues noted the close association between the role of researcher (me) and the success of the hospital –community collaborative I lead. They wisely cited that perhaps I was underestimating my abilities as an administrator and community leader as the real reason for the effectiveness of the Grey Bruce collaborative model. In the Grey Bruce Study I knew each of the thirty-three research participants as healthcare administrators, community clergy, or chaplains. I went to great lengths not to taint the data, yet I still wondered if the HCC model was working effectively due to an outlying variable such as rural dynamics or due to my own personal commitment.

The research presented here in the following study was birthed from the need to investigate HCC models where I did not have an affiliation or a relationship with the participants in order to either substantiate the aforementioned results or provide an alternative understanding of hospital-community collaboration. The results of the current research are summarized in Chapter Four. It is worth noting the obvious similarity of the top three factors that emerged as they parallel with the earlier results: Effective Leadership (top hospital administration,

community and chaplain), Shared Cost and Responsibility, and Relationship Building with Communication. The absence of the remaining four factors from the earlier Grey Bruce Study may be indicators of factors that are unique to that collaborative arrangement (an emphasis on accountability, training and education, respect between professions and prayer). The chapters ahead will unpack the literature on hospital chaplaincy, the methodology of the current study, and the research results followed by an informed discussion of the findings in light of solution focused therapy and organizational theory. A theological reflection of the collaborative model of spiritual care will also be provided.

Chapter Summaries

Chapter One summarizes the long history of partnership between religious organizations and healthcare institutions and notes the uneasy relationship between the medical and religious professionals that has grown up especially over the last century. A case is made for why it is imperative that we have spiritual care professionals on the healthcare team. The mantra in healthcare is ‘patient-centered care’ in the context of ‘evidence-based’ practice. The research literature is reviewed focusing on what hospital patients want in terms of spiritual care and how patients use religion to cope with illness. I present evidence that hospitalized patients want access to spiritual care and experience the current level of spiritual care as insufficient. If economics is based upon supply and demand, it follows there is more demand for spiritual care than is currently being supplied. Some of the barriers to the placement of spiritual care professionals on the healthcare team are discussed as well as a newly-acute problem: How do we increase the number of spiritual care positions in a time of budgetary restraint? One answer among many is to form partnerships with organizations or individuals who also are passionate

about spiritual care for the sick. Variations on religious-healthcare partnerships exist but the current study is interested in a specific form of partnership that balances the power and shares the responsibility between both the hospital corporation and the community called a Hospital-Community Collaborative (HCC) model for spiritual care.

Chapter Two presents the methodology behind the qualitative research. Four hospital corporations in Southern Ontario that employ an HCC model were investigated. In qualitative, ethnographic research the participants are studied in their own environment. One corporation was in a large population centre of well over 100,000 (identified by statistics Canada 2011 census as a city), and three were in small population centers under 30,000 (identified as towns) but each serve large regional populations (www.citypopulations.de/canad-ontario.html). All interviews and focus groups were conducted in the environment familiar to the fifty-six participants – their hospital, worship centre or home. My position as a hospital chaplain familiar with hospital-community partnerships may have facilitated access to the participants. I was both participant and observer. In all four hospital-community collaborations there were many people who were eager to tell the story of their partnership, including how it formed, what helps the collaboration to work and what hinders it, as well as the benefits and the challenges they were experiencing in this model for funding/governing a spiritual care program.

Chapter Three places the HCC model into the distinctive settings within which they developed. Hospital-Community Collaboration is not a ‘one size fits all’ model. This chapter acquaints the reader with the context of four healthcare corporations under study by providing details about the hospital community setting and historical information on how their specific collaboration originated. The broader context for this research is the province of Ontario. As participants told the story of their HCC experience they also mentioned encountering other

partnerships for spiritual care. I discovered more partnership arrangements than I had first anticipated. A search was conducted (albeit unsuccessful) for published data on the prevalence of partnerships for hospital spiritual care in Ontario. An addendum to the qualitative research was made in the form of a brief survey of the acute care hospitals in Ontario to determine the number and quality of partnerships. The results are included in Chapter Three because they support a sub-question that emerged out of the research question asking: “*What is the prevalence of partnership arrangements in Ontario?*” The survey data informs a contextual understanding of chaplaincy in Ontario and colours the discussion of the results from the research on hospital-community collaboration.

Chapter Four summarizes the research results from the qualitative study of hospital-community collaboration. As noted earlier, the current research sought to understand why the hospital-community partnership was working well for one corporation while another struggled. I identified three key factors as necessary for collaborative arrangements for spiritual care to work effectively: **Leadership** (support from the senior hospital managers, community leadership, and chaplain skill set); **Shared Responsibility/Cost** (between the hospital and community); **Relationship Building and Communication** (with hospital management, with faith leaders, and with all funding partners). The factors are inter-related such that a removal of one factor will cause the partnership to falter. The benefits to both the hospital community and to the faith communities of the HCC model are expressed through the voices of the participants. This model encounters some specific challenges, not the least of which is the need to fund-raise to generate community support. However, the most significant difficulties encountered in the HCC model have to do with personnel: finding a chaplain who has the skill-set necessary to facilitate a

collaborative spiritual care model and the stress of the continual change in leadership within the hospitals and on the chaplaincy boards.

There is an emphasis in the research community on discussing the results of qualitative and quantitative inquiry within existing theoretical frameworks. Chapter Five places the findings of the necessary factors for effective functioning of the HCC model in the context of Solution Focused Theory and Organizational Theory. The latter expounds the concepts of collaboration and social capital. The discussion section also reflects upon the research results within the context of chaplaincy as a developing profession. The need for hospital administrators and spiritual care professionals to talk together about how chaplaincy is funded is emphasised. To that end, the various models of funding hospital chaplaincy that exist in Ontario and around the globe are presented in more detail. Finally, recommendations based upon the research findings are offered.

Theological Reflection is a way of making sense of an experience or event by re-considering it from both a theological standpoint and one's experience of God or the divine (O'Connor and Meakes, 2008). In this case, the event is the research at hand. Killen and de Beer (1994) have developed a series of steps to take one through a theological reflection. They describe this kind of reflection as a means of "exploring individual and corporate experience in conversation with the wisdom of a religious heritage. The conversation is a genuine dialogue that seeks to hear from our own beliefs, action, and perspectives, as well as those of the tradition." (pg. viii) In Chapter Six, I offer a theological reflection on the research results, in particular, the idea of building a sustainable chaplaincy program. The Spiritual Wisdom model of Killen and de Beer is explained and then the reader participates with the researcher in reflecting upon the

research by engaging in a conversation about what matters most to chaplains and the HCC model. Some final thoughts are presented following the Theological Reflection.

Chapter Two: Review of the Literature

Hospitals are much more than institutions designed for treating and healing diseased or injured bodies. Hospitals are reservoirs of immense hope; patients hope for a restoration of health or the courage to face an uncertain future, patients hope for comfort in dying and strength for their loved ones. The experience of illness awakens the patient's sense of vulnerability and is a reminder of the fragility of life. Deep questions may surface while in hospital about living, dying and the meaning of it all. Hospitals are much more than biological garages repairing broken or damaged parts (VandeCreek and Burton, 2001); they are centers of hope. The role of the spiritual care provider or chaplain is to help connect patients with the deep source of hope that resides within them.

Spiritual care is the provision of support through listening, presence, and meaningful religious actions intended to offer comfort and connection to a person's source of spiritual strength. Professional Chaplains are spiritual care specialists who have theological, clinical and cultural training to assess the spiritual needs and beliefs of the patient (Piderman, 2010). Spiritual care may be provided by any member of the healthcare team but only one professional has broad religious training to discuss spiritual and existential concerns in the context of the patient's belief system (Handzo, Flannelly, and Murphey, 2008)). Chaplains listen to the concerns of the patient, walk with them as they wrestle with questions of meaning, and help patients tap into their sources of strength. The healthcare chaplain ministers in the thin places where earthly matters and eternal concerns touch for illness impinges upon what matters dearly to us.

In the pages ahead an overview of the relationship between religion and healthcare will be discussed noting both the historical separation of healthcare from its religious roots and the

recent research emphasis on the impact of patient spirituality upon their health. Of particular importance is the research on how patients cope with illness. Many patients turn to their faith to help them through the stress of illness and desire access to a spiritual care provider during this time, a desire which is supported by healthcare studies. The chaplain is the trained spiritual care provider on the healthcare team. But ensuring funding for sufficient access to chaplains is challenging in an era of fiscal restraint. Chaplains are working to translate this research in a way that those who hold the healthcare purse strings – healthcare administrators – can hear. Healthcare administrators want evidence of effective (working) and fiscally efficient models. The variety of funding models for hospital spiritual care will be discussed with particular emphasis on the hospital-community collaborative model.

Brief History of Religion and Healthcare

In the West, the rise of the hospital as a place to attend to sick and injured persons from the general population was yoked with the spread of Christianity in the 4th Century. Christian teachings (Matt 25:36,40) promote charitable actions towards those who cannot care for themselves – the sick, the poor, and the hungry. St. Basil, Bishop of Caearea, established the first hospital in Asia Minor in 370 AD (Koenig, King, and Carson, 2012). The ‘Rule of St. Benedict’ guided much of the medical tradition from 500 – 1200 whereby monestaries became the primary centers for medical care with monks and nuns caring for the sick – body and soul (Amundsen, 1998). By 1300, the separation between religion and science was promoted by the church authorities to stop clergy from practicing medicine to the exclusion of religious duties and to prevent monetary gain. The long association between priest and physician was severed and medicine developed as a secular discipline (Koenig, King and Carson, 2012) furthered by the

great promoters of the scientific method in Francis Bacon and Rene Descartes. The later taught that the world operated according to mechanical laws alone. The emphasis in medical teaching to focus on the observable and what could be known and studied distanced medicine from the spiritual concepts of meaning and purpose.

Despite the growing division between the roles of priest and physician, healthcare institutions in the Western world remained partnered with religious organizations to provide both physical and spiritual care to patients for six more centuries. Porter (1993) emphasised this vast connection between the hospital and religious orders recounting that by 1789, in France alone, there were 426 hospitals established and run by the Sisters of Charity. Religious leaders, both Catholic and Protestant went on to establish medical schools, nursing schools and hospitals throughout Europe, the United States and Canada. The intertwining of healthcare and faith was still prominent at the dawn of the twentieth century. Canadian Dr. William Osler, the first professor of medicine at John Hopkins Medical School, penned his famous essay on the benefits of faith entitled, “The Faith that Heals” (Osler, 1910) and religious based hospitals cared for over a quarter of the in-patients in the United States (Koenig, King and Carson, 2012). Dr. Christina Puchalski states in *Making Health Care Whole*, that “Historically, spirituality was an integral part of the mission and practice of health care institutions and providers” (pg. 11, 2010). Prior to the 1900s those who entered the healthcare professions did so out of sense of calling to care for others. Care of the patient encompassed care for the whole person, not just their body. Throughout the establishment of hospitals in the Western sphere, designated spiritual care professionals have provided spiritual care for the sick and infirmed (Swift, 2009). Historically, these chaplains were either agents of the hospital institution charged with caring for the souls of

the sick, or they were assigned by their denomination or faith group to provide spiritual care to hospital patients.

The secularization of healthcare in the twentieth century reduced ties to religious bodies and diminished the association between medicine and spirituality. The technology focused biomedical model that emerged in the twentieth century promoted ‘cure’ as the dominate goal for Western medicine. The separation of medical treatment from its spiritual roots led to a rise of healthcare institutions without designated spiritual care providers for patient care. Today chaplains in the US are present in only 54-64% of hospitals; chaplains are most likely to be found in large urban hospitals, in religiously affiliated hospitals, and in the ‘not for profit’ hospital sector (Cadge et al. 2008). Comprehensive data on the prevalence of chaplains in Canadian hospitals is needed. Medicine, during the last century has emphasised the mind-body connection to the exclusion of the soul but the tide may be turning again. The World Health Organization in 1998 reported, “This reductionist or mechanistic view of patients is no longer satisfactory. Patients and physicians have begun to realise the value of elements such as faith, hope, and compassion in the healing process”, (pg 3, cited in Williams, 2008). Today, 90 percent of the medical schools in the United States offer a course in spirituality and medicine (Koenig, Hooten, Lindsay-Calkins, and Meador, 2010) and healthcare professionals (physicians and nurses) dominate the field of research on spirituality and health.

The role of spirituality in healthcare is gaining significance once again through quality research targeting the health outcomes of spiritual and religious support during recovery. Excellent summaries of quantitative and qualitative research supporting the association between health benefits and spirituality are available (Puchalski and Ferrall, 2010; Koenig, 2007; Koenig, King and Carson, 2012; VandeCreek, 1995). Before the year 2000 there were over 1200 research

studies purporting a link between spirituality and health for various conditions such as, heart disease, cancer, HIV, depression and anxiety (Piderman, Marek, Jenkins, Johnson et al., 2010; Sagueil, Fitzpatrick and Clark, 2011). Correlations have been demonstrated between higher levels of spirituality and lower rates of medical utilization, lower healthcare costs and decreased risk of death (Byrd, 1998; Koeing et al. 1999). Methodological flaws and lack of rigor in the early studies of spirituality and health outcomes led to concerns regarding the validity of these associations (Sloan, Bagiella and Powell, 1999) and to the replication of numerous studies (Koenig, 2007). Current research has reaffirmed the results of many earlier studies, including evidence that a higher level of spiritual well-being is associated with lower depressive symptoms (Cotton, Larkin, Hoopes, Cromer, and Rosenthan, 2005); spiritual beliefs predict greater longevity and protect against cardiovascular disease (Powell, Shahabi, Thoresen, 2003); and patient care satisfaction is higher in those that receive spiritual care (McClung, Grossoehme, and Jacobson, 2006). The importance of providing patients with access to spiritual care providers during their recovery from serious illness also has been demonstrated (Vanderwerker, Flannelly, Galek, et al., 2008; Lichter and O’Gorman, 2009).

The majority of Canadians (82%) and Americans (93%) believe in a God or a higher power (Bibby, 2011, and Gallup, 2008 cited in Grossoehme et al 2008 , respectively). When facing a significant illness, many turn to their spiritual beliefs as a means of coping and support (Saguil, Fitzpatrick and Clark, 2011). By engaging in prayer and rituals patients may gain a sense of strength from beyond their own personal resources (Jankowski, Handzo and Flannelly, 2011). In his book, *Spirituality in Patient Care*, Harold Koenig cites research with medical patients in the Midwest. Over 90% stated that religious beliefs and practices were an important means of coping with their illness, and for 40% of respondents, religion was the most important factor that

helped them through their illness (Koenig, 2007). There is solid evidence that patients across cultures use religious coping to help them through an illness (Tzeng and Yin, 2003; Zehnder et al, 2006).

Recent studies that investigate the association between religious coping and health outcomes in specific populations have not produced clear results. Pargament and colleagues (2004) found that ‘seeking support from faith leaders’ as a form of religious coping predicted improved cognitive functioning. However, these researchers also noted that other forms of religious coping such as ‘seeking religious direction’ or ‘seeking religious conversion’ was associated with worse physical functioning. The complexity in the spiritual coping research literature may reflect the paradox of illness and health outcomes - those who are most ill are more likely to rely on religious coping as a means of support in the later stages of their illness. Furthermore, patients have different levels of spiritual needs and ability or awareness of how to access spiritual resources. Fitchett (1999) described patients as being at spiritual risk when they have high spiritual needs but low spiritual resources. Jankowski et al (2011) stated that “patients with high spiritual risk are likely to experience negative health outcomes should they develop negative coping or spiritual struggles.

There have been a plethora of studies measuring religious coping but few studies ensured access to a spiritual care professional to support the patient’s spiritual care concerns during their illness (Cotton, Puchalski et al, 2006; Sherman et al, 2005; Phelps et al, 2009) . Balboni et al (2007) addressed this concern in their research with stage IV cancer patients (Balboni, Vanderwerker, Block, Paulk, Lathan, Peteet, and Prigerson, 2007). The religious coping of 230 patients was assessed in relation to access to religious support from the healthcare team or from the patient’s religious community. The results suggested that patient’s quality of life was greater

when they had spiritual support. However, almost half (47%) of the patients reported that their spiritual needs were not met or only minimally met by their religious community. Even more significant was the result that 72% of these advanced cancer patients reported that their spiritual needs were not met, or only minimally met, by the healthcare team. Balboni's research underscores the need for patients to have access to spiritual care professionals while in hospital.

Literature demonstrating that patients want contact with a spiritual care provider or chaplain is mounting. In the Press Ganey National In-patient Priority Index (satisfaction survey) of 1.4 million patients in the United States, hospitalized patients indicated that the most important area for hospitals to focus on regarding quality improvement was to meet the spiritual and emotional needs of patients (Clark, Drain, & Malone, 2003). Piderman (2010) surveyed 1600 patients from Minnesota, Florida and Arizona and found that 70% (1105 patients) wanted to be visited by a chaplain while in hospital, 43% were visited, with 81% of these patients indicating that the visit was very important. The authors concluded that "The results of this study suggest the importance medical and surgical patients place on being visited by a chaplain while they are hospitalized" (Piderman, 2010, pg 1002). Respondents indicated that they wanted a chaplain to visit as a salient reminder of God's care and presence during their illness, and secondly to receive a spiritual care intervention such as prayer and scripture reading. Spiritual care resources are stretched thin in many hospitals; therefore, chaplains target critical areas of patient care or only respond to spiritual care referrals despite the evidence-based desire by the majority of patients to receive a spiritual care visit by a chaplain during their hospitalization.

Patient satisfaction research is important because it identifies the potentially negative effect of unmet spiritual needs upon patient health and recovery. Pearce, Coan, Herndon, Koenig and Abernethy (2011) surveyed 150 hospitalized patients with advanced cancer. The research

focused on whether spiritual care was desired and received, quality of life and overall patient satisfaction. 91% of the patients indicated they had spiritual needs and the majority both desired and received spiritual care from one of three places - members of the healthcare team, their faith leader or a hospital chaplain. However, one third of these very ill patients received less care than was desired. In addition 35% stated that more attention to spiritual needs would improve their overall satisfaction with care. The negative impact of insufficient provision of spiritual care was noted, “those receiving less spiritual care experienced higher depressive symptoms (CES-D) and less meaning and peace (FACIT-Sp subscale)” (*Crossroads*, January 2012, pg. 1). Pargament et al (2001) found a correlation between patients who experienced religious struggles, most of whom did not receive spiritual support, and an increase in mortality within two years following discharge.

University of Chicago medical researchers explored the question of whether patients wished to have religious concerns discussed as part of their care plan (Williams, Metzger, Arora, Chung and Curlin, 2011). They found 41% of in-patients wanted spiritual and religious concerns related to their healthcare issues to be addressed while in hospital. The significance of this research is that patients were not just identifying that they were spiritually oriented and would appreciate spiritual care – patients were identifying that they had religious and spiritual concerns and wanted a member of the healthcare team to address these concerns during their hospitalization. Only half reported having a discussion. These researchers concluded that in-patients desire spiritual care conversations related to their health crisis and that such attention would improve patient satisfaction. Ellis, Thomlinson, Gemmill and Harris (2012, abstract only) similarly found that 30% of in-patients reported religious struggles related to their

hospitalization. Half of these patients did receive spiritual support from a chaplain or their faith leader.

Patients utilize a variety of healthcare professionals, including chaplains, as well as members of their own faith traditions and family support in meeting spiritual needs. The chaplain, however, is the specific member of the healthcare team who has the training and certification for the provision of spiritual care during a healthcare crisis (VandeCreek, 2009; Piderman, 2008). Physician and researcher, Christina Puchalski et al. (2006) describe the unique contribution of the chaplain to the healthcare team, “The chaplain, unlike other healthcare professionals, has no agenda to explain, cure or eliminate disease. The chaplain seeks only to engage the sufferer and ...to provide indepth spiritual counselling. The chaplain attends to the person not the disease.” (Puchalski, 2006, pg 410) Many Chaplains in Canada and the United States have a master’s degree, theological and psychological training, provide care to persons of all faith traditions, have clinical training within a healthcare setting – up to 1600 supervised hours of Clinical Pastoral Education (CPE), and are certified through a national organization (Canadian Association for Spiritual Care; and in the U.S.A., Association for Professional Chaplains; National Association of Catholic Chaplains; National Association of Jewish Chaplains; and the Association for Clinical Pastoral Education). Chaplains adhere to a code of professional ethics and complete annual continuing education requirements. Their specialized training enables chaplains to employ spiritual resources or spiritual counselling based on the patient’s spiritual beliefs. The role and status of the chaplain is summed up by Puchalski (2006, pg. 398), “The Chaplain is the trained spiritual care expert on the team.”

Translating Evidenced-Based Research into Funding for Spiritual Care

In the field of health sciences, the best practice for patient care is based on research (Koenig, 2008). There has been a vast accumulation of research demonstrating the important relationship between spiritual care and health, religious coping during illness and patient desire for spiritual support (Frenk, Foy and Meador (2011). Why is the healthcare industry not heeding the research and ensuring access to spiritual care professionals? The short answer may be ‘money’! Healthcare in Canada and the United States is in an era of fiscal restraint. Escalating costs are forcing many healthcare administrators to question their ability to fund spiritual care departments (Trogden, 2009). Evidence of the elimination of hospital-based chaplains continues to occur in Canada, such as the termination of twelve spiritual care directors by the Fraser Health Authority in 2009 (Todd, 2010). The elimination of hospital chaplain positions, outsourcing, and increasing reliance on volunteers or community clergy (not paid by hospital) to provide spiritual care in U. S. hospitals is described by Koenig (2008). The issue of fiscal restraint is particularly relevant in Ontario, Canada where 40% of the Canadian population reside and almost half of the provincial tax revenue is spent on healthcare costs (Stewart and Thomson, 2012). Despite decades of trimming healthcare fat and increasing efficiencies, Ontario hospitals need to find further healthcare savings (Drummond, 2012). The susceptibility of spiritual care programs to cost-cutting measures has been widely discussed in the chaplaincy literature (VandeCreek, 2009). Hospital chaplaincy positions may be particularly vulnerable if the role of the chaplain is deemed an inefficient use of healthcare dollars.

The long answer as to why healthcare management is not acting on evidence based research (that has demonstrated a positive relationship between spiritual care and health and the importance of access to spiritual care professionals during recovery) may be ‘uncertainty’ and

‘suspicion’. Healthcare professionals and administrators may be unclear or unaware about the role of the healthcare chaplain and how to justify the value of spiritual care in measurable terms. Moreover, a lingering suspicion regarding the place of spirituality in a scientific institution devoted to the rational care of the sick may construct a further barrier to paying attention to the literature on spirituality and health. Even the healthcare administrators in religious hospitals express this uncertainty. In 2007, a Pastoral Care Summit was held in Omaha Nebraska with over 50 representatives from Catholic healthcare systems. Participants asked basic questions about spiritual care; ‘What does a chaplain do? How does spiritual care contribute to the mission of the organization? What productivity measures are in place for chaplains? How is quality measured?’ (Lichter and O’Gorman, 2009). The healthcare administrators were holding the profession of chaplaincy to the same standards as all other healthcare professions. They wanted to know the role, the value and the productivity of the healthcare chaplain. Healthcare administrators and managers are less likely to fund spiritual care if they are unclear of the value of spiritual care.

Lyndes, Fitchett, Thomsaon, Berlinger and Jacobs’ (2008) research illuminates the disconnect between chaplains and healthcare administrators. Healthcare chaplains in the study described their service as valuable when they listen and support patients through their healthcare crisis. Healthcare administrators, however, understood value in numerical terms and were interested in productivity measures, such as cost per visit, and want high patient satisfaction scores. If an important part of the chaplain’s role is to support patients and families as they face a healthcare crisis, thereby allowing physicians and nurses to attend to other patients, the numerical emphasis on value presents a huge challenge (Jacobs, 2008). The chaplain’s ‘one’ four hour visit in an ICU to support a family while the healthcare team remove life support from their

loved one does not capture the value of the contribution to the whole healthcare system. Neither will it be picked up by the patient satisfaction survey since the deceased patient will not be completing the survey.

Spiritual care research asking North American hospital administrators to identify the information they need to determine funding for chaplaincy is scarce. In Israel, however, an interesting study was recently conducted with healthcare administrators to investigate attitudes toward spiritual care and the conditions under which they would fund a spiritual care program (Bentur, Resnitzky and Sterne, 2010). The healthcare administrators cited the following barriers: lack of knowledge of spiritual care, fiscal constraint, concerns about the professional credibility, and (important for the current research) administrators wanted access to research on spiritual care programs that demonstrated effectiveness and efficiency. These authors state, “This information is important since directors and policy makers often serve as “gatekeepers”, deciding whether services will be established, developed, financed and recognized. Consequently, their attitudes play a key role in decisions...” (Pg 14). Considering the economic value of the work of spiritual care is challenging for chaplains. Most chaplains are focused on meeting the needs of the patient. Their attention is not necessarily trained on how to translate their work into dollars and cents. Bentur et al (2010) conducted their research in a country without a history of professional spiritual care programs. It challenges advocates of spiritual care to consider what factors are necessary to implement a spiritual care program where one has never existed before. Moreover, their research challenges those who desire to start a chaplaincy program to think like a healthcare administrator. The concept is not new. Twenty five years ago McSherry (1987) led a rallying cry for chaplains to conduct research “of major economic and/or clinical importance for top-hospital administrators” (pg 33). Sociologists Raymond De Vries and Wendy Cadge (2008)

collaborated with healthcare chaplain Nancy Berlinger to develop a series of articles on the current state of the chaplain's role in health care. They conclude that chaplains need to consider how to translate "the meaning and value of their work into terms which hospital administrators and others in decision-making positions can understand" (page 27).

Translating spiritual care work into something that top administrators understand may help to establish and maintain spiritual care programs. However, a further barrier for spiritual care in hospitals may exist. In 2006, Flannelly, Handzo, Galek, Weaver and Overvold conducted a national survey on the attitudes of hospital directors (nursing, medical and pastoral) regarding the role of chaplains in healthcare. These researchers found that the importance that directors attributed to the various functions of a chaplain (such as end of life care, prayer, emotional support, religious services) was influenced by two factors – the spiritual beliefs of the hospital director and whether the institution had a religious affiliation. There is an undocumented belief among spiritual care professionals that if the top administrator is supportive of spiritual care, then the program will be initiated or protected. The converse attitude may prevent a spiritual care program from being initiated unless solid research can demonstrate an effective and efficient means of delivering spiritual care.

Hospital Spiritual Care Delivery Models

Professional spiritual care delivery models can be classified as hospital funded or partnership funded. Research is beginning to be conducted on various models of chaplaincy programs and how they are funded to demonstrate efficiency and effective contribution. In 1999, the Journal of Healthcare Chaplaincy devoted an entire issue to highlighting examples of contract chaplaincy in the United States. Contract chaplaincy is one form of partnership where a

healthcare corporation purchases spiritual care services from an external organization. The journal describes numerous examples of chaplaincy programs based in the contract model with information on how these partnerships originated and how they are financed.

Hospital funded professional chaplains are financially compensated through the hospital operating budget. In public hospitals, the operating budget is gained through government tax dollars. In private hospitals, the operating budget is from revenue sources including patient reimbursement. The chaplain is a hospital employee and treated as a fellow professional on the healthcare team. The hospital funded chaplain is perhaps the dominant model in Canadian and American hospitals although complete data is unavailable. This model is less common in Australia where only 32 % of hospital chaplain positions are funded through the operating budget (Newell and Carey, 2000). The alternate modality for funding hospital chaplains is partnership between the hospital corporation and another organization. Partnership occurs in one of three ways: contract chaplaincy, faith-based chaplaincy, or hospital-community collaboration. In contract chaplaincy, the hospital purchases chaplaincy services from an external agency. The work of spiritual care is outsourced to a religious organization. The chaplain is hired by the external organization as a contract service worker or employee and provides spiritual care based on the service agreement. Several examples of contract chaplaincy include The Healthcare Chaplaincy in New York (Handzo et al 1999) and The Lutheran Chaplaincy Service in Cleveland, Ohio (Warger, 1999). Contract chaplains may become integrated with the healthcare team if it is delineated in the service contract. The external chaplaincy organization often has charitable status and may receive funds from the hospital but not all of the cost may be fully covered. Hence, these organizations may also fund-raise with faith groups, create spiritual care endowments or host revenue generating events.

A second form of partnership occurs when a religious organization or denomination provides a chaplain to the hospital at no cost. The faith-based chaplain sees patients who adhere to that particular faith group. The faith-based chaplain is on loan so to speak to the hospital. Agreements are minimal and these healthcare chaplains tend to not become integrated with the healthcare team. For example, in Ontario, Canada the Roman Catholic Church has a number of full time priests designated solely to hospital spiritual care. The hospital receives the full benefit with no cost. In some countries this is the dominant model; an example is found in Winter-Pfandler and Flannelly's (2011) description of the Swiss hospital chaplaincy service provided through the official Roman Catholic and Protestant churches.

The current research is focused on a third form of partnership between the hospital and the community to finance the chaplain's position called hospital-community collaboration (HCC). In this model, the hospital corporation intentionally joins with the community (represented by a spiritual care association or a pastoral care committee) to fund and govern a spiritual care position or program. An example would be the Grey Bruce Healthcare Chaplaincy Association (GBHCC) in Ontario which is a charitable, community based organization with membership from both the hospital and the community. Community chaplaincy associations receive funding through local faith communities, grants, fund-raising events, and hospital foundations. The chaplain is either an employee of the hospital or the community association with the non-employing organization contributing financially to the budget of the employing organization. The chaplain is responsible to both the hospital and the community. Decision-making is collaborative and the spiritual care program is managed through the joint board.

The benefit of forming a partnership between hospital and community is not just economic. Partners from different work sectors bring unique expertise in their specific area.

Forming a chaplaincy board with healthcare professionals, religious representatives and interested community members develops trust between medical personnel and religious leaders and helps each group to see spiritual care through the lens of the other. Medical personnel know how to navigate the healthcare system. Religious leaders understand the spiritual language and needs of patients facing a health crisis and have wide community networks. By combining expertise, the resulting partnership creates new resources and could improve the quality and efficiency of spiritual care service.

Hospital-community collaboration models may take many forms but in each there is a formal agreement that outlines roles and expectations for both the hospital and the community. The intent of the hospital-community collaborative model is to create sustainable spiritual care services in combination with providing an economic rationale for funding chaplaincy to healthcare administrators. The HCC model requires a strong commitment from both members of the healthcare team (including administration) and also the local community. The result is a potentially wide integration of chaplaincy services throughout the healthcare system and a far-reaching commitment to spiritual care from the organization and the community ensuring sustainability. In the shifting healthcare landscape in North America, healthcare administrators are attempting to reign in budgets while improving access and quality of care. This has produced a degree of openness to investigating other modalities for providing spiritual care. The development of partnerships between hospitals and community has occurred to fill the gap and ensure the provision of spiritual care to patients.

The Strength of Collaboration

In his book, *Bowling Alone*, Robert Putnam (2000) states the purpose for creating a partnership with another organization is to achieve a goal that neither could accomplish without the other. In a collaborative arrangement two or more organizations agree on a common goal and work together to attain that goal through shared decision-making and accountability. Each organization also experiences benefits which makes their participation worthwhile. Putnam noted that when services cannot be provided alone, or issues cannot be addressed singly, then they need to be addressed jointly (McKinnon, 2009). The common goal in the HCC model is access to quality spiritual care for all hospital patients (regardless of hospital size) in the most efficient and effective manner. The motivations by each partner for wanting the same outcome may be different but are equally valid. Partnership between organizations and people enable common goals to be achieved. Crowther and Trott (2004) note that “the question to ask is not, ‘Do partnerships work?’ but rather, ‘What can a partnership achieve?’”.

Cross-sector partnerships (i.e. business and non-profits) are increasing. Crowther and Trott (2004) discuss three global shifts that have occurred in the last thirty years which have motivated diverse groups of people to come together to form partnerships. The first shift occurred in the political arena. Since the 1980s there has been a downloading of social responsibilities from the federal government to provincial/state governments, and from provincial/state governments to municipalities, community organizations and religious organizations. Economic forces produced the second shift by exerting pressure for leaner budgets. Survival for some organizations may only be possible with partnership. The third motivation is the social force of collaboration which has produced a significant change in how organizations relate to one another and how people within corporate structures manage.

Decision-making within an organization is changing from top down (hierarchical) to collaboration among key stakeholders (Fitkin, 2011). For example, at the beginning of a new project, managers ask ‘Who needs to be at the table’? and they make an effort to include those who have expertise, an investment in the outcome, and those who will be impacted along the way. Decision-making is based in the team versus an individual. This powerful social force is promoting collaboration between government and business (often called Public-Private Partnerships); business and non-profits; and all sectors of society. Different work sectors form partnerships to reach a goal not possible without collaboration, but also to gain access to unique resources, to reduce costs, to increase the relationship between the organization and their community (Crowther and Trott, 2004).

Why would a healthcare institution want to collaborate with another organization? Entin (1994) spoke to the American situation stating that the “American Hospital Association (AHA) and numerous others have urged hospitals to collaborate with ...businesses, schools, and community organizations to improve access and quality and to reduce the precipitous rise of health care costs” (Pg 2). Collaborations can assist both patients and staff members. Dewolf (1992) evaluated a hospital community partnership in Cedar Rapids Iowa created to achieve a common goal - day care services for hospital and school employees. The mutual benefit was employee retention. The success of this partnership was “attributed to several factors including careful planning, good communication, a clear delineation of roles, ... services provided complemented the mission of both (organizations)...and the partners demonstrated an ongoing commitment to collaboration in all planning and decision making activities” (p2). The history of collaborative relationships between U.S. healthcare institutions and religious organizations is described in Harold Koenig and Douglas Lawson’s book ‘Faith in the Future’ (2004). They

describe successful partnerships between non-profit religious groups and hospitals to prevent disease, promote health, and provide basic medical attention to those without Medicare.

The push for Canadian hospitals to collaborate with their community has been equally important as a means to do more with less healthcare dollars, reduce duplication, enhance service coordination, and tap into the community's ability to address complex healthcare issues (Poland, Graham, Walsh, Williams, Fell, Lum, Polzer, Syed, Tobin, Kim, and Yardy, 2005). An example of collaboration occurred in Oshawa, Ontario. The Home First program was developed between Lakeridge Health (hospital corporation) and two community organizations, Central East Community Care Access Centre (CECCAC) and Community Care Durham, to support patients who were no longer needing an acute care bed but for whom a Long Term Care (LTC) bed was not yet available. The Director of Home First explained in the hospital-community newsletter that "Its primary goal is to develop safe and timely discharge plans from the hospital and also give patients time to make informed decisions about long term living arrangements" by having transitional medical and hygiene care in their own home (Community Connection, 2010). An example of the flattening of the decision-making structure and the developing relationship between the hospital culture and community occurred in Kingston, Ontario. The Kingston General Hospital has taken a leadership role in Canada in demonstrating how collaboration with community can be effective means of management and have put former patients onto all new project task forces to ensure that all stakeholders have a voice.

Research Question

Poland et al (2005) note that despite significant promotion of hospital-community collaboration (HCC) by all levels of government there is a lack of analysis regarding what makes

these partnerships work effectively. These Canadian researchers investigated the working relationship between hospitals and community organizations to identify the factors that enabled or hindered the partnership arrangement. Although results indicated a high prevalence of collaborations across the Canadian landscape, successful HCC's were dependent on the presence of a hospital management champion and one in the community. The hospital's institutional culture posed the most significant barrier to effective management of the partnership. Commitment by Canadian hospitals to collaborate with local community organizations is appearing in hospital mission statements and strategic planning documents. An example would be the Muskoka Health Strategic Plans for 2012 which states, "A strong healthcare system is one that is built on a foundation of partnerships. Engagement with community and health systems partners is an on-going priority for MAHC. The role of community has been and will remain crucial to our ongoing success." (pg. 7, Strategic Action Plan, viewed August 12, 2012 www.mahc.ca/en/about/resources/StrategicPlan2012-2014-Final.pdf). Woodland and Taylor (2010) conducted research on the Canadian chaplaincy context. They noted that the concept of partnerships aligns with the strategic objectives of healthcare institutions by linking community spiritual care and hospital care to provide continuity of care: "Spiritual care benefits the larger community through partnership for continuity of care" (pg. 6). The community benefits from the partnership by having access to spiritual care support groups, opportunities for education on healthcare and spirituality topics, and connection to community faith providers who could care for patients returning to community.

Hospital-community collaborations exist to provide a wide range of patient care services and numerous hospitals are forming partnerships with community organizations and religious denominations or faith groups in order to fund a spiritual care department. Research is needed to

ascertain the prevalence of these partnerships. As cited earlier, hospitals have been partnering with religious bodies to provide spiritual care to patients from the beginnings of institutional medicine (Koenig, King and Carson, 2012). Research is needed to determine how partnerships between hospitals and community organizations or faith groups can work effectively and efficiently for the provision of spiritual care to patients. A significant benefit of the hospital-community collaboration model is that the community in which a healthcare institution is located has an opportunity to guide and develop a spiritual care program tailored to the unique needs of the community. The HCC model enables spiritual care services to be developed in small population center hospitals as well as medium-sized population centers. The model ensures access to spiritual care for all patients. Although Canada wide data is needed, the current research focused on hospital chaplaincy partnerships in Ontario, the largest province in the country, specifically investigating the prevalence of hospital-community collaborations for spiritual care. Four healthcare corporations that utilize an HCC were evaluated to ascertain what people negotiating and managing a hospital-community collaborative need to know and do so that their partnership will be successful. Or more succinctly - What factors make the partnership work effectively and what are the benefits and challenges of the HCC model?

Chapter Three: Methodology

An Overview

To conduct a systematic inquiry into a topic of interest it is essential to choose a research design that corresponds to the research question (Merriam, 2009). The current study asked: “What essential factors enable the Hospital-Community Collaboration (HCC) model to function effectively for the provision of spiritual care?” A qualitative ethnographic research study was conducted to access the culture of a HCC, noting the relationship among the healthcare corporation, the community, and the chaplaincy board/pastoral care committee. The qualitative paradigm is particularly suited to the collection and analysis of data from a defined context with the goal of eliciting meaning from the data. To this end both in-depth interviews and focus groups were conducted. Qualitative research investigates how people make sense of what is happening to them or around them and attempts to clarify the meaning people attach to their experiences. The statements in the interviews were coded and analyzed to identify chunks of meaning. Related chunks of meaning were gathered into themes and the themes were presented in the results section.

The methodology utilized in this study was also ethnographic. Ethnography is both a research method and also a way of looking at the world of data (O'Reilly, 2012). Ethnographers seek to immerse themselves into the culture of study so that they can not only observe but also interact with the human subjects. This form of data collection is called participant observation. The aim is to get to know the population under study in their own setting to gain a more intimate knowledge of that culture. This emic perspective, or insider point of view, allows the researcher to participate in the life of the culture under study while also observing and describing the

culture. I entered into the culture as the researcher but I am also a chaplain who works under a separate HCC model. I had a moderate level of participation and needed to balance my insider role with the outsider, observer role. In ethnographic research it is common to gather data from a variety of sources. In the following study information was gathered from interviews, focus groups, meeting minutes, historical documents, phone conversations, reflections on the board meetings, and other observations I made in the field (field notes).

Ethnography seeks to “find patterns of regularity in the complexity of human interactions, (and) moves from descriptive reporting to cultural interpretation. It accomplishes this goal through analysis of detailed descriptions of contexts, events, behaviors and conversations.” (pg. 139, Tubbs and Burton, in Editors Sprenkle and Piercy, 2005) Healthcare has a distinct culture as do religious organizations. The qualitative ethnographic methodology was employed to elicit the dynamics of the culture and the perceptions of participants in order to identify how they saw the partnership working or not working (and how they understood this reality). The current study was micro-ethnographic in that it did not look at all aspects of the healthcare and religious cultures but rather examined one specific slice, namely, where the two intersect to partner for the purposes of funding and governing a spiritual care program (O’Connor, 1999).

Selection of the four hospital corporations. The researcher selected the four corporations utilized in the study because all use a HCC model for spiritual care. Each are located in southern Ontario and therefore were accessible for the researcher (within a day’s driving distance). One corporation was identified to the researcher by a colleague and three of the corporations had contacted the researcher in previous years to inquire how to initiate a hospital-community

partnership. Almost all participants were unaware that the researcher had a historical consultative role with their HCC.

Initial Request for Participation in the Research. The Chairperson of each Chaplaincy Association or the Chair of the Pastoral Care Committee was contacted by phone or by e-mail to discuss the possibility of the partner organization participating in the research. Professional information about the person of the researcher and the nature of the research was provided. Each chaplaincy association/ pastoral care committee was asked to vote regarding willingness to participate in the research and to provide membership contact information to the researcher. A motion was made to participate in the research by three of the committees (the fourth chose to decide participation on an individual basis). The Chair provided the e-mail list of the board members (following consent of members) and provided contact information for the chair of the local ministerial association. The Chair also provided the name and contact information of the chaplain following consent by the chaplain. A description of the research was sent to all board members, ministerial association chairs, and to the chaplains through e-mail. The Chairperson played a significant advocacy role also with the hospital corporation by encouraging the current manager to whom the chaplain reported and former managers to participate in the research.

Each hospital corporation was contacted to request an interview with the healthcare manager responsible for spiritual care and the employed hospital chaplain(s). All four corporations required internal research approval. A 'Request to Conduct Research' application was submitted to the Research Ethics Committee of all four corporations. A copy of the Research Ethics Approval from Research Ethics Board of Wilfrid Laurier was included in the hospital applications as well as a description of the study and all required documents. Approval was

granted by three of the corporations. The fourth corporation would not allow research to be conducted within the corporation unless it was initiated by a staff member or a staff member was willing to partner with the researcher. Numerous, unsuccessful efforts were made to align with the manager of this fourth corporation to request support for the research application. Healthcare managers were interviewed from the other three hospital corporations but not the fourth. The chaplain for this corporation, also employed by the Chaplaincy Association, participated following board approval.

The local clergy were contacted through the chairperson of the area ministerial association. A description of the study and a consent form was sent to the chairperson followed by a phone call. After ascertaining approval from the ministerial association, a request to participate in the research (with a description of the research) was sent to each member. In areas that did not have a ministerial association, the internet was used to research the name and phone number of the area faith leaders and they were contacted directly.

Participants. Selective sampling was employed. Participants were affiliated with one of the four hospital-community partnerships in Ontario selected for this study. They met the participant criteria by falling into one of four categories:

1. Healthcare manager
2. Chaplain
3. Member of partner organization (Chaplaincy Assoc. or Pastoral Care Committee)
4. Community Faith Leader/ funding donor.

The criteria ensured that all those who are members of the hospital-community collaborative, or immediately affected by the HCC model, had an opportunity to share their experience.

Participants were interviewed from the four categories of each hospital-community collaborative with one exception. The manager responsible for spiritual care in one corporation could not be interviewed due to lack of research consent from that corporation. Additional participants were contacted during the study in order to add missing data and history to which current managers, chaplains, or community partners were not privy. This included making contact with a former chaplain from a corporation under study and interviewing chaplains whose hospitals still have some form of community collaboration for hospital chaplaincy.

All participants were contacted by e-mail or phone and then sent by e-mail a description of the research and an informed consent form. Participants were asked to either join a focus group that would be held in their community or engage in an individual interview in their home, office or local hospital. The members of the Chaplaincy Board / Pastoral Care Committee and the Ministerial Association for most sites offered to designate their monthly board meeting as a time for a focus group to ensure a strong attendance. The researcher spent approximately three days in each community to provide a variety of times for the focus groups and interviews. The fifty-six participants included four healthcare managers/ or hospital executive members with spiritual care in their portfolio; nine hospital chaplains; twenty-three board members of the spiritual care organizations partnered with the hospital; and twenty community clergy/funding partners. All participants signed an informed consent and a release for quotations.

All participants identified themselves as Christian. There was a significant range of denominations. The majority of participants were from relatively conservative Christian faith traditions (nine participants were Baptist, eleven were Evangelical Missionary, and seven were Pentecostal) or from denominations that have a long history of promoting hospital chaplaincy (ten participants were Anglican and six were United Church of Canada). The remaining

participants were from the following denominations: Wesleyan, Salvation Army, Presbyterian, Free Methodist, Christian Reform, Nazarene, Lutheran, Apostolic, Brethren, and five identified themselves as Other or non-attending.

Interview format. A semi-structured interview format was used for all interviews and focus groups (See Appendix A) and each were audio-taped. The open-ended questions sought to elicit information about how these collaborative arrangements came about and the processes or factors that help to maintain the partnership. It was important to hear the history of how the partnership arrangement was initiated. Participants were also asked to identify some of the benefits and challenges of working with a hospital-community partnership for the provision of spiritual care. The focus groups were one and one half hours in length and the individual interviews ranged from 25 minutes to one and one half hours. Six focus groups were held and twenty-six individual in-depth interviews were conducted. Interviews and focus groups were conducted until the point of data saturation (no new content).

Transcription and Coding of Data. The audiotapes were transcribed verbatim by the researcher using Dragon 11 speech recognition software. Each Participant was given a number to identify the speaker without the name attached to the comments. There were over 4200 lines of interview comments. The transcripts were read through three times. The first read was to get a sense of the content as a whole. Upon the second read codes were identified that were both descriptive (e.g. benefits to hospital of HCC model) and interpretive (e.g. accountability). Each sentence was read and a code was labelled to identify the description or interpretation by the speaker. If it took several sentences to complete the thought only one code was identified. Saldana (2009) defines a

code as short phrase or sentence that attempts to capture the essence of the thought or is summative.

For example: “I can tell you the relationship between the on-call chaplains and the hospital has really increased over the last four years. The staff were tentative at first. It has taken a long time and it is still improving.” [P26]

Code 1– Stronger Relationship

Code 2– Hospital Benefits

If one sentence contained several codes, both were labelled. During a third read of each transcript the codes were categorized according to emerging themes. Coding is therefore like a step ladder linking the first floor of data to the second floor of data analysis. Code 1 identified above was placed under the theme of Relationship Building and Code 2 under the theme of Benefits to Hospital. The transcripts were analyzed for themes using the constant comparative method. This continual process of categorizing and re-categorizing, sorting and re-sorting, would occur as the data was re-read and new themes emerged which served to further guide data collection and analysis. The constant comparative method helps to refine the themes as they emerge and enables the researcher to then interpret findings in order to build a useful theoretical framework in which to understand the area of study.

Sources of Data. The bulk of the data was gathered in the form of transcripts from in-depth interviews and focus groups. Data was also gathered from informal phone conversations, minutes from board meetings, newsletters and publications from the chaplaincy organization and also the hospital corporations, annual reports, strategic plans, websites, and the field notes of the researcher. Data triangulation was employed between the transcripts and written documents from the hospital-community partner organizations and their annual reports.

Data Compilation and Analysis. Once the broad themes of the research had been identified, the data was then organized into a table. The participant number or focus group number was listed across the top of the table and the theme along the left axis. The researcher returned to the transcripts and recorded a tally for each theme beginning with participant one. Each time a theme had been labelled, a tally was indicated in the corresponding box in the table. The number of tally marks per theme was then computed and the larger the tally indicated the prominence of the theme. It was Anselm L. Strauss who said “any researcher who wishes to become proficient at doing qualitative analysis must learn to code well and easily. The excellence of the research rests in large part on the excellence of the coding” (Cited in Saldana, 2009, pg viii). Hands on, repeated interaction with the data in combination with using the constant-comparative method was deemed to be an effective means of data analysis in this study for it kept the researcher continually interacting with the primary data sources.

Chapter Four: Context

The research question asked “What factors are essential to enable HCC’s for spiritual care to work effectively?” A sub-question flows from the research query: “Why does the partnership function well in one context and experience challenges in another setting?” To understand the necessary factors that enable a hospital-community collaborative to work well requires exploration into the context in which the partnership arose. Communities, boards, and organizations, have personalities and histories. Some aspects of a community can welcome or prohibit partnership between religious leaders and hospital personnel. If a moderate or strong pastoral presence already exists in a hospital (for example, a pastoral care committee, or volunteer chaplaincy, or on-call provision by local faith leaders) there is a foundational relationship between the religious and healthcare disciplines potentially producing a hospital environment respectful of spiritual care. The soil would already be tilled to plant a partnership. The following chapter briefly explores the origin of each HCC and notes the presence of a foundational relationship between the faith leaders and the healthcare corporation. Care has been taken to protect the identification of the actual hospital so as not to contravene the participants’ confidentiality agreement.

A firsthand account of the initiation of the hospital-community collaborative for Corporation #1, #2, and #3 is provided because I was the consultant. Representatives from these three communities contacted me to provide information on how they could commence a partnership between their hospital and community. There had been no contact with two of the three corporations since this initial consultation provided years ago, until my request for interviews for the current research. I have provided on-going consultation to the third corporation

for several years. I did not have prior knowledge of the fourth corporation under study and located members of the original pastoral care committee of Corporation #4 to hear how their chaplaincy program started.

The broader context for these four hospital-community collaborations is the Province of Ontario. All healthcare corporations in Ontario are funded by the Ministry of Health and Long Term Care with tax payer dollars. All hospitals are required to demonstrate provision for the spiritual and religious care of patients, no matter how minimal. Each corporation may individually interpret the level of spiritual care and by whom spiritual care will be provided. There is considerable variability regarding the level of chaplaincy in Ontario healthcare corporations. Some hospitals do not have a designated spiritual care provider but merely expect that local religious providers will be available upon request. By contrast, many hospitals have indeed allocated hospital operating dollars to pay for a spiritual care professional. While conducting the interviews and focus groups I discovered that there were a variety of forms of partnerships for the provision of spiritual care occurring in Ontario hospitals and, noteworthy for the current research, that there was a considerable level of collaboration between community and hospitals occurring across the province. Most of these partnerships seemed to be occurring in isolation from one another. Many members of the hospital-community collaborations thought they were the only example of a partnership model. As data was gathered further questions arose about the number of hospitals that have collaborations for chaplaincy in Ontario. I had assumed there were only a handful of such collaborations and discovered several more plus some historical HCC's that transitioned to hospital paid chaplains. To understand the context of the collaborative model further research was conducted to investigate the prevalence of the hospital-community collaborations in acute care hospitals. This survey data has been included in this

chapter. Discussion of the data will occur in Chapter Five by integrating the results on prevalence with the focus of this study – factors that help hospital-community collaborations to work.

The Context of the Four Healthcare Corporations

All four healthcare corporations in this study are acute care hospitals with in-patient medical and surgical beds. Some sites have additional designated long term beds or a separate long term care facility associated with their corporation. All have active emergency room departments that run 24/7. All provide healthcare services to a much wider area than the specific city or town in which the hospital is located. And finally, three of the four serve the local populations plus an influx of visitors in the summer and winter months for recreational purposes.

Statistics Canada, the federal governmental agency, defines an urban area as having a population of at least 1000 people and a rural area as having a density of less than 400 people per square mile. This definition masks the differences between small towns and large urban cities. Statistics Canada recognizes that the rural-urban divide is more of a continuum representing concentrated versus dispersed populations that range from low densities to very high densities. To address this challenge, it is introducing new terminology (www.statcan.gc.ca). Small population centres have between 1000-29,999 people, medium population centres have between 30,000 – 99,999 people, and large population centres have over 100,000. The new distinctions provide a better description of the actual population concentration and may improve the interpretation of the Canadian urban-rural differences.

Corporation # 1

Located in what Statistics Canada defines as a small population centre, Corporation #1 was established 125 years ago to support Great Lakes sailors who needed medical attention (www.citypopulations.de/Canad-Ontario.html). Today this single-site hospital serves a regional population of 60,000 people with 2.5 million annual visitors (<http://www.canadian-universities.net>). The emergency department is consequently very busy and it was here that the need for a staff chaplain was identified. The local faith leaders were providing a free on-call chaplain service to the hospital and noted the tremendous demand upon the emergency department and the high acuity of the medical issues. A small group of clergy offered to volunteer in the emergency department, a few hours a day, in order to evaluate the need for chaplaincy services. Once the demand for service was defined and reported to the hospital Pastoral Care Committee a discussion began with the hospital administration about hiring a part-time chaplain.

Initially the discussion was shut down with the ‘no money in the budget’ rationale. The pastoral care committee began discussing further options and approached another local hospital, with a Hospital-Community Collaborative, to learn about the HCC model. The pastoral care committee and the hospital administrator developed a business plan based on the HCC model and submitted it to Corporation #1’s hospital board. The board approved the concept. To honor the funding partnership Corporation #1’s board asked its hospital foundation to cover their portion of the financial commitment. An ad was placed in the local newspaper, interviews followed and a hospital chaplain was hired. The partnership was formed six years ago and continues to have solid support by the hospital and the community churches as evidenced by the high number of faith communities that contribute annually (over 87% as of November, 2012).

The hospital sends out a letter each fall to all of the faith communities with a pledge form attached. The faith communities return the pledge form and the finance department invoices the church for the amount of the pledge. The pastoral care committee continues to oversee the work of the chaplain and maintains communication with the area churches. Membership on the pastoral care committee of this hospital includes hospital staff and community clergy. The chaplain reports to the Vice President of Clinical Services and to the Regional Chaplaincy Coordinator. The hospital also provides 'in kind' financial support for the chaplain position with a spiritual care office, phone, computer, signage, access to administrative support and a small budget for memorial services, training and educational events.

Corporation #2

Corporation #2 is an acute care hospital with a continuing complex care facility at a separate site. The hospital was established over 100 years ago by a group of local women who were alarmed at the large distances people were required to travel in order to obtain medical care. At the time the community of Corporation #2 was very small; but the women conducted a large, successful fund-raising campaign to raise the money needed to start a hospital. Today the primary facility is located in a small population centre (www.statscan.gc.ca). The hospital has over 100 beds and serves a regional population of 135,000 (<http://www.canadian-universities.net>). Like the hospital of Corporation #1, this hospital had no history of professional chaplaincy, but did have a pastoral care committee and an active volunteer chaplaincy program. The community clergy and trained laity offered both 24/7 on-call emergency chaplaincy and took turns coming into the hospital each day to provide care to patients and staff. Training for the volunteer chaplains was provided by the community clergy. The volunteers were appreciated by

the hospital, and the staff wanted the volunteer chaplaincy program to continue. However, hospital staff and managers noted the need for a designated person (a chaplaincy coordinator) to train and oversee the volunteer chaplains.

A small group of healthcare managers and nurses approached the hospital Chief Executive Officer (CEO) about the prospect of hiring a professional chaplain. The answer was no because of a lack of funds. Undaunted, this team spoke with the hospital pastoral care committee about other options and became aware of a program at another hospital where a partnership existed to help fund and govern the chaplaincy department. A hospital delegation (human resources and vice president of clinical services) from Corporation #2 arranged to meet with the chaplaincy coordinator of this other program. They were provided with the resources they would need to initiate a hospital community collaborative. Information was taken to the Corporation #2's hospital board and approval was granted. An operating plan was developed by the pastoral care committee. Once the community funds for the first year were in place the CEO of Corporation #2 gave permission for the pastoral care committee to commence a search for a chaplaincy coordinator.

Over a decade has passed and this program continues to receive support from both the hospital and the community churches. Similar to Corporation #1, the accounting department of the Corporation #2 receives the community donations directly from the local supporting faith groups and provides the pastoral care committee with a monthly financial statement. The pastoral care committee oversees the generation of funds from the community, including an annual fundraiser, and supports the work of the chaplaincy coordinator. The majority of the Christian churches contribute and non-Christian faith communities also donate. The chaplain of Corporation #2 officially reports to its Manager of Clinical Services. The hospital provides 'in

kind' financial support with a spiritual care office, phone, computer, access to the hospital information system, and a small operating budget.

Corporation #3

The third healthcare corporation included in the research has two sites, Site A and Site B, located in different small population centres, with approximately sixty beds in each hospital. The corporation serves a recreational area with a high number of seasonal visitors and a fairly dispersed permanent residential population of about 46,000 located in three nearby towns (www.citypopulations.de/Canad-Ontario.html). The two hospital sites underwent the process of amalgamation at the same time as dialogue was occurring about initiating a chaplaincy program. The local community clergy of hospital Site A were frustrated with the lack of patient religion information that they received and experienced the hospital culture as resistant to spiritual care. Numerous members of the ministerial association had clinical pastoral education and communicated the benefits of a professional spiritual care provider to the local community clergy. A delegation of the ministerial approached the CEO of Site A who stated they simply did not have the funds to hire a chaplain. Moreover, this CEO informed the clergy that the hospital was in discussion with another local hospital, Site B, about merging the corporations. Numerous changes in hospital management occurred. It became increasingly difficult for the community clergy to ascertain to whom they should be addressing the need for a hospital chaplain and the value of chaplaincy. Hospital amalgamation shifted the chief operations to Site A. The partnering corporation, Site B had had a well-functioning pastoral care committee and volunteer chaplains, both were lost in the process of amalgamation. As frustrations arose, the clergy from

all surrounding communities became more resolved than ever to establish a hospital chaplaincy program and reactivate a pastoral care committee in the newly-formed corporation.

A separate chaplaincy association was formed to both fund-raise and dialogue with the newly amalgamated hospital corporation about hiring a chaplaincy coordinator. They had heard of another hospital that had a partnership arrangement between the faith communities and the hospital and sent representatives to learn about the model. Next, a Consultant was invited to Corporation #3 to meet with the hospital pastoral care committee and senior hospital management to discuss the partnership model. Although numerous hospital representatives had agreed to attend, only one manager was present. Nevertheless, the chaplaincy association was successful in raising funds and continued to do so over the course of several years while negotiations proceeded with the hospital about the need for professional spiritual care. The hospital management would not agree to financially support the chaplaincy program during this time. The energy for this initiative was exterior to the hospital. The chaplaincy association eventually raised enough money to hire a part-time chaplain entirely without the hospital's financial assistance. An agreement was struck between the chaplaincy association and the hospital to hire a part-time chaplain, paid for by the community, with a hope that the hospital would contribute financially in the future. At the time of this writing, the hospital chaplain position has been going six years and there is no sign of financial commitment for the chaplain salary by the hospital. The community is finding it difficult to carry the financial load on its own. The hospital does contribute financially 'in kind' by providing a spiritual care office, phone, computer, signage and some administrative support.

Corporation #3's hospital pastoral care committee (distinct from the area chaplaincy association) today only meets sporadically. Faith leaders who were aware of a once successful

volunteer chaplaincy program find it difficult to support the idea of hospital chaplaincy when they lost what was of benefit to them – their regular pastoral care committee, the opportunity to volunteer for spiritual care emergencies, and patient religious information. Within the vast geographic area that this hospital corporation serves there are three large community clergy ministerial associations which function independent of one another. The topography contributes to the lack of cohesiveness among the regional faith communities and this has made wide-spread support for the hospital chaplaincy program to be challenging. In addition, amalgamation seems to have hindered the dialogue between the hospital and the chaplaincy association. As leaders changed they took the knowledge of the chaplaincy program with them.

The Chaplaincy Association that is partnered with Corporation #3 continues to be a strong and viable entity. It has representation from area clergy, mental health representatives, and hospice/palliative care people. The hospital clinical manager is identified as a member of the organization. Initially the hospital clinical manager attended the monthly meetings with some regularity, but upon her retirement the connection between the community organization and the hospital has been greatly reduced. The chaplaincy association has had tremendous success in the placement of a chaplain, the integration of the chaplain within the healthcare system, and in fund-raising. The lack of awareness of the ‘partnership’ by senior hospital staff has been detrimental. The interviews for this research were welcomed by the chaplaincy association members and the community clergy as an opportunity for them to process what was working and what was not, and to evaluate what they needed to do to strengthen the partnership between the hospital and the community chaplaincy association.

Corporation #4

The fourth corporation included in the current research study is located in a large population centre with over 400,000 residents (www.citypopulations.de/Canad-Ontario.html). This hospital corporation is an amalgamation of three acute care hospitals, Site A, B and C, and one specialty hospital, Site D. Some of the sites within this corporation have hundreds of beds and other sites have less than 100 beds. The merger occurred in 1998. Two of the hospital sites in this corporation were established in 1910 and the other two hospital sites were incorporated by mid twentieth century. Although each of these corporations had a pastoral care committee prior to amalgamation, only two committees have continued post-merger.

Forty years ago, a ministerial association within the catchment of the largest of the hospitals, Site A, began an internal dialogue about their experience as faith leaders coming into the hospital. They provided volunteer on-call emergency chaplaincy to the regional hospital. The clergy agreed that a professional spiritual care provider was needed to coordinate the spiritual care service between the hospital and the area ministers. They had a vision of a chaplain who would offer spiritual care training to community faith leaders and the lay persons who provide pastoral care to congregation members. They also wanted to establish a volunteer chaplain program in the hospital. A community chaplaincy association was formed with participation from significant hospital leadership and community faith leaders. They agreed to fund the chaplain position jointly. The chaplaincy association replaced the hospital pastoral care committee of Site A, and met monthly in the hospital to enable hospital staff to regularly attend. As the size of Site A grew, today it has over 300 beds, so did the number of chaplaincy staff. The chaplaincy association continues today with representation from both the community and the

hospital corporation. The hospital and the community chaplaincy association are currently reviewing how to strengthen their partnership.

Prior to the hospital merger of Corporation #4, the pastoral care committee of hospital Site B heard about the hospital-community collaborative of Site A and requested information on how to commence this model. A part-time chaplain was hired as a hospital employee of Site B. The community churches in the catchment of Site B continue to give annually to the hospital to support this position. Amalgamation has brought some logistical challenges. Site A and C have several chaplains who answer and are funded by both the chaplaincy association and Corporation #4. Site B has a chaplain who is a hospital employee but supported by a pastoral care committee who raises community funds. Site D has a hospital paid chaplain. All of these chaplains and pastoral care committees are now part of the same corporation. Today, despite being part of the same amalgamated corporation there is minimal dialogue between the external chaplaincy association (serving Site A and C) and the internal pastoral care committee (serving Site B).

One of the general consequences of amalgamations is that the number of hospital staff positions decrease. In the newly-formed Corporation #4 the director of spiritual care position was eliminated. The chaplains no longer reported to upper management but were put under the Manager for Volunteer Services. Amalgamation decreased the managerial oversight provided to the chaplains and the availability of other hospital disciplines to be represented on the pastoral care committee or the chaplaincy association. Post amalgamation, the Manager of Volunteer Services is the only hospital representative on these committees and is spread among all four hospital sites. Therefore there has been a significant reduction in the amount of connection that Corporation #4 has to the pastoral care committee of Site B and the chaplaincy association of Site A and C. The regular hospital support had once stabilized the partnership arrangements and

it seems to be waning under the burden of amalgamation. There is an initiative to have only one chaplaincy committee for all four sites. A consequence could be the loss of connection and communication with local community churches and their funding. Hospital amalgamation and the rapid growth of the population have impacted the partnerships.

Corporation #4 also contributed financially ‘in kind’ to the spiritual care program by providing a multi-room department and chapel in the largest of the three sites with phone, computer and furnishings. A spiritual care office was provided at each of the other sites.

Context of Hospital Chaplaincy in Ontario

During the research interviews participants described some of the other partnership arrangements that they had encountered in Ontario Hospitals. To understand the context of hospital-community collaboration it became necessary to also be able to delineate the prevalence of this model in the province. The researcher designed a brief survey to gather data on the number of acute care hospital chaplains and how these chaplains are funded. The goal was to determine the frequency of partnerships for hospital spiritual care and identify the subset of a specific form of partnership, being the Hospital-Community Collaboration for spiritual care. The survey was conducted with representatives from all of the 134 acute care hospitals in Ontario (www.ministryofhealthandlongtermcare.on.ca). The Wilfrid Laurier Research Ethics Review Board was contacted to inquire if this addition could be made to the prior approved ethics proposal. After consultation with the official REB representative, a second research ethics application was deemed unnecessary for the proposed survey fell within the boundaries of the previously approved research ethics application.

Methodology for Survey

A census is an official count of a particular population. In this study the research population is the acute care hospitals in Ontario with specific attention to the prevalence of chaplains and how they are funded. Probability sampling was not employed in the data analysis since the complete data set had been obtained. The data has been presented in simple format in order to not obscure unique occurrences within the data.

Hospitals included in the data set. Hospitals in Canada are categorized according to the number of hospital beds and the function of the institution. Research data was obtained from acute care hospitals in Ontario that are identified by the Ministry of Health as Group A, B and C hospitals. Group A hospitals are teaching centers located in large population centers and affiliated with universities and medical schools. Group B hospitals have more than 100 acute care beds. Group C hospitals have less than 100 acute care beds and are often in small population centres. Due to facility amalgamations, many hospital corporations are multi-site and some have additional long term care, mental health, and/or rehabilitation beds. In the data set there were 15 hospital corporations in Group A, 45 hospital corporations in Group B, and 74 in Group C for a total of 134 hospital corporations.

Data Collection. A list of all of the acute care hospitals in Ontario was obtained from the provincial Ministry of Health website accompanied by the phone number and bed total for each hospital. A representative from each corporation was contacted by phone or e-mail. Representatives fell into one of three categories: the spiritual care representative (chaplain), the

manager responsible for spiritual care, or a human resources officer. They were asked if the hospital employed/ or utilized a designated spiritual care professional and if so, how the chaplain(s) position was funded. The hospital identified if their chaplain was funded through the hospital operating budget, a religious denomination or religious organization, or if compensated by a partnership between the hospital and the community. The hospital identified if the chaplain was full time or part-time. Data on Full Time Equivalents (FTE) in Pastoral Care exist in the public domain and can be accessed through a freedom of information request to the Ministry of Health (MOH). These numbers were not utilized because partnership arrangements would not be identified in the data set. The only means of accurately identifying the existence of a partnership arrangement and the nuances of funding within the arrangement was to speak directly to each corporation.

Table 4.1: Acute Care Hospitals in Ontario

Hospital Category	# of Corporations	# of beds
Group A – Teaching Hospital	15	10345
Group B – More than 100 beds	45	15285
Group C – Less than 100 beds	74	3783
Total	134	29413*

*Some corporations have amalgamated with long term care facilities and although the hospital is categorized as acute care it has long term beds or rehabilitation beds in their total bed count.

Hospital Chaplain Funding Survey Results

To determine the prevalence of partnerships between acute care hospitals and religious organizations in Ontario it was necessary to first obtain data on the number of professional

hospital chaplains (Full Time Equivalents, FTE) and the sources of funding for all positions. In Ontario, there are 183.1 FTE in acute care hospitals representing approximately 240 chaplain positions (See Table 4.2). Numerous positions are part-time and in these cases two or more chaplains represent 1.0 FTE. The majority of these positions are in teaching hospitals (50%) and in acute care hospitals with more than 100 beds (46%). Only 4% of chaplain positions are in hospitals with less than 100 beds.

Group A, B, and C hospital corporations represent 29,413 beds in the 134 corporations (many of which are multi-site) (See Table 4.1). There is an average of one FTE for every 160 beds. However, there is tremendous range in the chaplain to bed ratio. For example, two 600 bed facilities provided very different levels of spiritual care. One hospital corporation was faith or religious-order based and had 9 FTE (average of 67 beds per chaplain) and the other 600 bed hospital corporation employed one FTE (average of 600 beds per chaplain). Further research is needed to compare the level of access to spiritual care in religious versus non-religious hospitals in Ontario.

Table 4.2 compares the size/function of the hospital with the percentage of professional chaplains to illustrate where the majority of hospital chaplains are employed. In Ontario, 70% of the acute care hospitals have some level of access to a spiritual care professional. 100% of teaching hospitals have professional chaplains and 88% of the Group B (more than 100 acute care beds) hospitals provide access to a chaplain. In those hospitals with less than 100 beds (Group C) only 23% have professional chaplains (see Table 4.2) and most of these positions are .2 - .5 FTE. Although Group C represents the largest number of hospital corporations (74) it has the least access to professional spiritual care. This finding has important implications for the hospital community collaborative model for delivery of spiritual care services to small center

population hospitals. Group C has the smallest number of acute care beds (See Table 4.1) so it is not surprising that many of the chaplain position FTE's are quite small. The predominance of chaplain positions in the Group A and B hospitals could lead to the conclusion that there is a high level of spiritual care in Ontario hospitals.

Table 4.2: Percentage of Hospitals with Paid Chaplains in Ontario (Group A,B,C)

Hospital Category (MOH)	% with Pd chaplains	Total FTE	% of total FTE
Group A	100%	92	50%
Group B	88%	83.8	46%
Group C	23%	7.3	4%
Total	70%	183.1 FTE **	

** It is important to note that the total number of FTE's does not indicate the total number of hospital chaplains. Numerous positions are part-time and in these cases two or more chaplains represent one FTE. Employed hospital chaplains (including paid on-call chaplains and residents) are approximately 240 (for Group A, B and C corporations).

In Ontario, hospital chaplains are funded through the hospital operating budget or through a partnership arrangement with an external organization. Those chaplains funded through partnerships include denominationally (faith-based) funded chaplains and hospital-community collaboration funded chaplains. The data provided information on the size of the facility where chaplains work, how they are financed, and identified the prevalence of hospital-community collaborative arrangements (HCC). Table 4.3 shows the funding sources for the professional chaplains. Teaching hospitals (Group A) employ the majority of hospital chaplains through the hospital operating budget, 90% (82.5 FTE) but also have an additional 10% (9.5 FTE) paid through a partnership arrangement with a religious denominations/or religious agency (For example, Roman Catholic denomination or a Jewish Social Service Agency). Likewise, in

Group B hospitals, the majority of chaplains (70% of FTE) are funded through the hospital operating budget, with an additional 25% of the chaplain FTE paid from religious denominations. Most of these partnership agreements are between the hospital and a Christian denomination or faith based social service agency. Some positions are fully funded by the denomination while others share funding between the faith group and the hospital i.e. 50/50. Denominationally funded chaplains provide care primarily to patients who are members of that specific faith group and not to the global patient population, although there was a unique occurrence where a denomination funded more than one chaplain to serve the entire patient population.

The remaining 5% of Group B hospitals have a hospital-community partnership arrangement to jointly fund and manage their spiritual care program. In the HCC agreement, the spiritual community does not just write a cheque to support the chaplain position but also contributes to the management of the spiritual care program. In addition, these chaplains provide care for all in-patients regardless of faith tradition. It is the shared management and shared funding model that is the focus of this study. The category of hospital corporations that have the most Hospital-Community Collaborations (HCC) is the Group C (with less than 100 acute care beds in the corporation). In Group C, only 23% of the hospital corporations have a professional chaplaincy. In these seventeen corporations, 68% of the FTE's are hospital employees paid through the operating budget and 32% of the FTE's exist due to collaborative arrangements where the hospital and community have formed a joint partnership, sharing management and funding of the chaplain positions (See Table 4.3). Since many of these positions are very small, the 2.3 FTE translates into 14 very part-time chaplain positions under the HCC model in level C hospitals. These findings demonstrate that hospital-community collaborative arrangements for

the provision of patient spiritual care exist in both Group B and Group C hospitals although they are more prevalent in the latter.

Sources of Funding for Ontario Hospital Chaplains

Table 4.3: Funding Sources for Ontario Hospital Chaplains

Hospital Category	Total Chaplaincy FTE (Paid Hospital Employee)	Total FTE from denominations (% of Total FTE)	Total FTE from community
Group A	82.5 (90%)	9.5 (10%)	0
Group B	59 (70%)	20.3 (25%)	4.5 (5%)
Group C	5 (68%)	0	2.3 (32%)
Total	146.5 (80%)	29.8 (16%)	6.8 (4%)

The information in Table 4.3 illustrates that in Ontario the majority of hospital chaplains (80%) are funded through the hospital operating budget and that 16% of the total FTE are paid through the chaplains religious denomination (with no contribution by the hospital). Overall, a very small percentage of hospital chaplains are paid through hospital-community partnerships (4%) and most of these partnerships exist in small population centres in the Group C hospitals. It is often helpful to look at the data from another angle. By considering the total number of hospital corporations that have partnership arrangements the picture changes somewhat. Many chaplains are part-time. To ascertain the actual prevalence of collaborative models the number of corporations with a designated spiritual care professional were counted and the numbers were converted into percentages (See Table 4.4).

Table 4.4: Partnership Arrangements for Funding Hospital Spiritual Care in Ontario

Hospital Category	Percent of corporations with denominationally paid chaplains	Percent of Corporations with hospital-community partnerships to pay/govern chaplains
Group A	40% 6/15	0
Group B	24% 11/45	9% 4/45
Group C	0 0/ 74	8% 6/74
Total	13%	8% **

*An additional 2% of corporations receive community funding for chaplaincy supplies and expenses but do not fund the FTE. These dollars are contributed annually due to a previous partnership to fund the chaplaincy position.

Teaching hospitals (Group A) and those hospitals with more than 100 acute care beds (Group B) encompass the majority of hospital beds in Ontario (See Table 4.1) and enable the most patient access to a professional spiritual care provider. The results presented in Table 4.4 highlight that many of the teaching hospitals and larger urban hospitals are able to provide this high level of access since they are engaging in partnerships arrangements. 40 % of teaching hospitals have entered into partnership arrangements in order to ensure patient access to spiritual care. In Group B hospitals, 24% of these acute care hospitals with over 100 beds are able to provide spiritual care in part due to partnership agreements with religious denominations (i.e. Catholic or Salvation Army). These results indicate that partnership arrangements are well integrated into the hospital system within Ontario and area worthy of further research exploration. These partnership arrangements reflect professional chaplains who are paid through their religious denomination or through a religious organization, such as Jewish Community

Services. The majority of those chaplains paid by their denomination are Roman Catholic priests. In addition there are Anglican, Pentecostal, Salvation Army, and Presbyterian funded chaplains.

The prevalence of chaplains associated with hospital-community collaborations kept was separate from the denominational/religious organizational chaplain data. Table 4.4 demonstrates that 8 % of the hospital corporations in Ontario are utilizing the HCC model and have partnered with a community organization to fund and manage the spiritual care program. The ten hospital corporations that provide spiritual care through the hospital-community collaborative model encompass twenty-one hospital sites, and as mentioned, are supporting fourteen part-time chaplains. Several additional corporations had utilized an HCC model years ago. Although the community in these cases no longer have an active role in the managing of the spiritual care program they continue to assist with the funding of resources for the spiritual care department. The FTE's for these chaplain positions were allocated to the 'hospital funded' category and were not allocated to partnership or HCC. However, these churches or religious communities continue to contribute thousands of dollars each year to their local hospital. This money is not used by the hospital to fund the chaplain position but is said to fund some of the supplies and resources for the chaplain. If these corporations were included in the HCC funded data the number of hospital-community collaborations would increase to 10%.

Summary

In Ontario, hospitals (including religious-based hospitals) are funded through the Ministry of Health and Long Term Care. There are three levels of acute care hospitals called Group A (teaching hospitals), Group B (more than 100 beds) and Group C (less than 100 beds). Two Group B hospital corporations were included in the qualitative data set and two Group C corporations. The context for the qualitative research study on hospital-community collaboration

has occurred in corporations that are mostly in small population centres (three out of the four corporations) and one was located in a large population centre. The small population centre component of the contextual quantifiable data is worth highlighting. Most of the corporations in Group C with less than 100 beds are located in small population centres in Ontario. These hospitals are vital to their local community. 77% of the hospitals in this category do not provide any professional chaplaincy to patients and rely on volunteers or community clergy to offer spiritual care to their own members. In those Group C corporations that do employ a professional chaplain, one third are able to do so because of a community-hospital partnership. The HCC model is able to ensure access to a professional spiritual care provider even in small rural hospitals so that the majority of chaplain positions are not just in hospitals located in medium and large population centres.

Partnerships between religious organizations and Ontario hospitals were more prevalent than anticipated. The data for chaplains funded through a denomination or religious organization was distinguished from those associated with a hospital-community collaboration. In the HCC model a partnership is formed to share both the funding and the management of the spiritual care program/chaplain. The contextual data demonstrated that 20% of the FTE's in Ontario exist due to partnership arrangements and are not funded solely through the hospital operating budget. Across all three groups (A, B and C) 21% of the total number of hospital corporations in Ontario have partnership arrangements (13% of these hospital corporations have a partnership with a religious denomination and another 8% of the corporations utilize an HCC model.) Partnerships for the provision of spiritual care seem to have a significant place in the hospital chaplaincy landscape of Ontario healthcare.

Chapter Five: Hospital-Community Collaborative Research Results

Overview of the Qualitative Research Results.

The research question asked what factors promote an effective hospital-community collaborative model for hospital spiritual care. The interview transcripts from the six focus groups (n= 30, average of five per group) and the individual interviews (n= 26) were coded according to content and categorized under one of four generalized headings: 1. Catalyst or reason why the partnership was sought out; 2. Factors that helped to create a sustainable, effective, community-hospital partnership; 3. Benefits of community-hospital partnerships; and 4. Challenges of initiating or maintaining this form of collaboration for spiritual care. These headings corresponded to the Interview questions (See Appendix One). The participant statements were analysed for concepts and ideas which in turn generated themes. Related themes were then combined.

For example, participants spoke about the specific qualities they wanted in the chaplain who worked under this model and how they expected this chaplain to provide leadership. The concepts or codes, such as organizer, administrator, volunteer manager, were grouped together under the theme of chaplain skills. Participants spoke about the need for strong support from community members who would commit volunteer hours. These comments became grouped under community support. Many statements by participants centered on the necessity of having official support from the hospital management team and the need for active involvement from a senior hospital staff member. These were coded as hospital backing, or vice president support, and became grouped as hospital leadership. The three themes of chaplain skills, community

support, and hospital leadership were combined to form the overarching principal factor of ‘leadership’.

A Catalyst Initiated the Partnership.

Each hospital-community collaborative (HCC) developed in response to a series of difficulties that either the community clergy or the hospital staff was experiencing. The challenge or difficulty had prompted a group to form to begin to address the problem and seek a solution. In all four HCC’s under study, the solution was to hire a professional spiritual care provider who would work with both the hospital and the community faith leaders. The initial proposal to hire a healthcare chaplain came from the community faith leaders in three of the four HCC’s. The reason cited was that the faith leaders were experiencing a common difficulty. Each hospital had a system for providing patient religion information prior to establishing the chaplain position; however, this system was described as not functioning effectively. Parishioners expect their pastor to visit them when they are sick and in hospital. “There is a file folder (at the hospital switchboard) that I could go and check but I had no confidence in it being up to date.” [P25] “...there were three forms for eighty patients.” [P21] They cited a lack of access to patient religion information as a major source of frustration.

- “The clergy were feeling really frustrated because they could not go into the hospital and find out which of their parishioners were staying in the hospital unless the parishioner or the family had directly asked the hospital to contact the minister.” [P16]
- “It was just hard to see folks from our congregation,” stated one minister. [P25]

- “Even with our own people you feel like you have to be a detective to find out who’s in hospital and what has happened to your people.”[P26]

In one healthcare corporation, it was the hospital management team who decided they needed a chaplain. The healthcare managers wanted a professional chaplain to manage the growing volunteer spiritual care program and oversee the community faith leaders and laity who were visiting patients in hospital. They wanted a person who was a hospital staff member, accountable to the hospital and aware of the corporation’s policies and procedures. “We needed somebody (working) from the hospital perspective who answered to the hospital...who would manage the volunteers.” [P2] The catalyst for this hospital corporation was a personality clash and a need to standardize the screening and supervision of the spiritual care volunteers and community clergy. “There had been some issues between personalities and churches and all that stuff.” [P2] The hospital management wanted to improve access to professional spiritual care but were concerned about the cost. They looked for a partnership model so that the cost of the program could be shared. “The hospital said they could not afford it on their own.” [P17]

In the three corporations where the proposal for a chaplain position came from the community faith leaders, following dialogue with senior administration of the hospital, a separate charitable organization was formed to manage the emerging partnership. The fourth corporation continued with the pre-existing hospital pastoral care committee. Early on the discussions though, for all four corporations, the community faith leaders identified that they were willing to join in the funding for a chaplain if this person would also provide spiritual care training to community members, pastoral care team members, and volunteer chaplains. “We wanted patient access and training. We did not have either.” [P24] Lack of access to patients who were

requesting spiritual care became a lightning rod that ignited action but a further barrier cited by participants was hospital culture itself which seemed to alienate the community clergy. One minister described his experience as follows, “When I went into the hospital I felt very much like an outsider. I was treading on someone else’s territory and I often did not feel welcome there.” [P38] The clergy believed that if a chaplain was working within the hospital system on their behalf that the hospital would be more welcoming to spiritual care. They hoped staff would grasp the benefits of spiritual care by seeing a chaplain in action and that access to parishioners would improve. “When you enter a hospital that has a chaplain there is a lot that helps (the clergy and faith leaders). The chaplain works with the nurses and with the administration. As clergy we can go in and find our people.”[P3]

The partnership agreement that developed was unique to each community. In one HCC the chaplain was designated as a hospital employee and in two HCC’s the chaplain was made an employee of the chaplaincy association. In the fourth, the chaplain had two employers and was paid a half-time salary from both the hospital and the chaplaincy organization. In three of the four corporations the charitable organization that was formed was called the “‘insert name of area’ Chaplaincy Association”. The role of these boards was to oversee the chaplaincy program and to fund-raise for a portion of the chaplain’s salary. Membership on the chaplaincy board came from the faith leaders, the community and the hospital staff. The hospital initiated HCC did not form a separate association but utilized a pre-existing hospital committee for spiritual care. The pastoral care committee had been meeting monthly and had clergy representation from the major local churches as well as volunteer chaplains and staff. Their role was expanded and they functioned quite similarly to the chaplaincy association boards.

In all four HCC's:

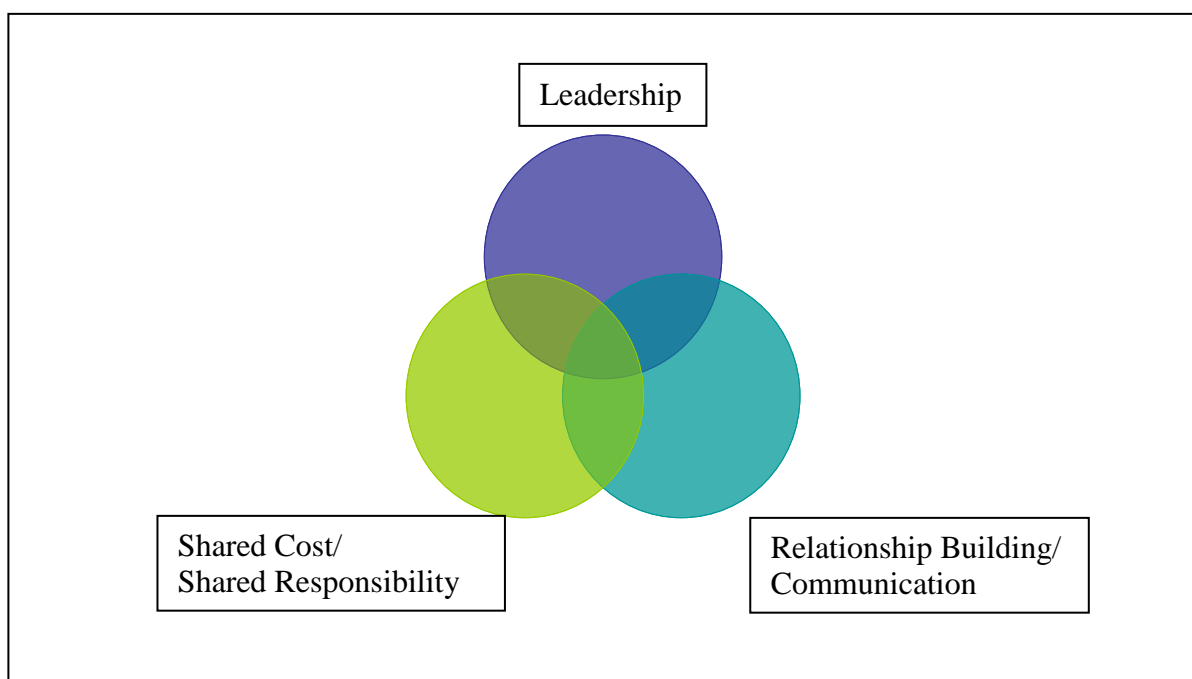
1. The chaplaincy boards/pastoral care committee was expected to oversee the spiritual care program, communicate with the funding stakeholders, monitor the receipt of community funds, and provide a liaison with the community for issues that arose.
2. A contract was devised to acknowledge the partnership or define the parameters of the partnership agreement.
3. The community churches in their local area were sent a letter each fall to request annual financial support for the chaplaincy partnership program. Donations were made to the newly formed chaplaincy association or directly to the hospital (on behalf of the pastoral care committee). "We do a church letter to (request) supporting the chaplaincy... We also do a fund-raiser concert each year." [15]
4. The annual community dollars ranged from \$10,000 to \$35,000 depending on the HCC.
5. The money raised in the community was matched by the hospital or hospital foundation. Note: One corporation did not contribute funding for salary.

Factors that Enable Hospital-Community Collaboration for Spiritual Care to Work Effectively.

Three overarching themes emerged from the in-depth interviews and focus group discussions to identify what makes hospital-community collaborations work well. The first key factor is 'Leadership'. This theme encompasses the necessity of strong leadership by senior hospital management, community leaders and the chaplain themselves. The second theme of

‘Shared Responsibility’ demonstrated through Shared Funding, Shared Decision-making and Resources, and Shared Vision is the second factor. The third principal of ‘Relationship-Building’ reflects the themes of building trusted relationships among stakeholders and maintaining on-going communication among those who fund the chaplaincy program and those who manage it. Communication needs to be both in person, which fosters the relationships, or can be through newsletters, websites, phone calls, and presence at meetings. In two of the healthcare corporations in this study, the partnership between the hospital and the community is working effectively. In the remaining two corporations under study, the partnership is struggling in the area of shared responsibility. One HCC struggled with shared cost and the other wrestled with the sharing of decision-making power. One corporation is in the midst of reassessing what is necessary to improve the partnership. The other is reassessing if they can make the partnership work at all. The three themes, Leadership, Shared Responsibility, and Relationship Building, are consistently evident in the partnerships that are working well.

Figure 5.1: Essential Factors that Enable Hospital-Community Partnerships Work



Factor #1 Leadership

Participants cited leadership as coming from one of three sources: 1. Senior Hospital Management; 2. Community Members/ Faith Leaders; 3. Hospital Chaplain. All three were presented as necessary for this model of chaplaincy to work effectively but the need for official support to come from the top leadership of the hospital management team and from the chaplain were most frequently cited. (See Table 5.1).

Table 5.1: Participant Statement of Themes

Factors That Promote Effective Hospital-Community Collaboration	No. of Participant Statements	Percentage
LEADERSHIP	215	36%
Senior Hospital Management	79	13%
Community Leaders	47	8%
Chaplain	89	15%
SHARED RESPONSIBILITY	245	41%
Shared Vision	20	3%
Shared Funding	80	13%
Shared Decision-Making and Clear Agreement/Expectations	145	24%
RELATIONSHIP-BUILDING	139	23%
Building trusted relationships with staff and community	62	11%
Communication	77	13%

Senior Management Leadership.

For the collaborative model of hospital chaplaincy to work, senior hospital management needs to be both supportive of spiritual care and involved in the oversight of the spiritual care program. The participants from all four corporations and regardless of status (chaplain, healthcare manager, or community leader) all affirmed the necessity of top down support right from the beginning conversations. “You have to have hospital leadership on board before you start,” stated one founder of a chaplaincy program. [P23] “Senior administration must understand and value spiritual care. They must have ‘buy in’ or it is not possible to have a partnership.”[P57] “It is important to have a VP (vice president) ...it says they want to be directly involved.”[P39] “Look for the energy within the healthcare system to make this model work; the hospital needs to buy in.”[P7] Lack of leadership from the hospital management was seen as detrimental to the spiritual care program. “Unless the leadership of the hospital is on the ball and supportive of chaplaincy then the chaplain is unable to do a lot and will be limited in what can be accomplished.”[P23] The presence of the senior manager regularly at the chaplaincy association or pastoral care committee meetings was emphasised. “We do have a member of the hospital staff (manager) who sits on the board for chaplaincy. I think that’s very important... She is our liaison with the hospital.”[P4]

One hospital manager noted that the size of the hospital may be a contributing factor. This participant stated that the majority of their hospital staff live within the hospital catchment and are integrated into the community. “We support spiritual care because it is a small community hospital and when you know people personally it is easier to obtain ‘buy in’ and support from the hospital leadership as compared to a larger hospital.”[P45] It was stated that this may be true for other Level C hospitals in small population centers. Participant statements

articulating the need for senior leadership were imbedded with the concept of investment or ‘buy in’.

Support from the top of the healthcare hierarchy communicated to the hospital culture that the administration valued spiritual care and backed the development of the program. One community member participant gave an example of what they wanted from the hospital administration in terms of support and backing. The local long term care facility (LTC) asked the ministerial association (interdenominational group of faith leaders) to come and meet at their facility. The LTC facility offered to host the ministerial in order to build a relationship with the faith leaders who were coming in and out of the facility offering spiritual care to residents. The minister described the LTC administration as clearly presenting their expectations of the faith leaders but wanted input from the clergy on their views on how to support the spiritual care of residents. The administration asked and listened; they created a collaborative discussion. Some comments regarding the need for collaborative discussions initiated by the hospital leadership follow:

“The ministerial now meets with the staff at the local LTC facility. I find those meetings are better because what we are talking about is clearer. The administration is clear about what they are after. They are very concerned about pastoral care and spiritual care for their residents. They drove the process requesting that we get together. They asked the clergy to come and discuss how they could better support the residents.”[P20]

“If it’s (HCC) just beginning, my recommendation is to get everyone together at the table to talk about this. At the table you need senior representation from the hospital, including human resources, and representatives from the area ministerial, and also whoever the candidate is for the chaplain. These are the key people.”[P4]

Community Leadership.

Leadership from significant members of the community including the faith community was stated as essential to the establishment, the support and the management of the partnership.

“We had a member of the community who had a vision for an in-house chaplain. She was a real instigator. She collected some lay and local clergy and formed the chaplaincy association.”[P18]

“You have to have good leadership.”[P19] A community clergy stated, “I think we all had a part in championing this idea of the chaplain in the first place. When I was on the pastoral care committee we worked long and hard to bring this together.”[P30] A hospital manager noted that the work accomplished by the community chaplaincy organization in this model is essential to its effective management, declaring, “Without the chaplaincy association we would not have a chaplain. I am so grateful for their work. This is all volunteer from the faith communities. They got together and did the fund-raising, the interviewing, they link with the hospital.”[P17] This sentiment was affirmed by a community member who stated, “The chaplaincy program would not have happened without the letter writing, the networking and the fund-raising. It is a lot of administrative work and public relations.”[P10] The necessity of both hospital and community leadership at the planning table and continuing during the program management is summed up by in the following statement, “without both, there is no partnership.”[P12]

Chaplain Leadership.

The leadership from senior hospital managers and community members was viewed as critical but participants also repeatedly commented on the importance of the skill set, personality, and leadership skills of the chaplain. In each corporation a chaplain was hired at the beginning of the HCC partnership. Table 5.1 contains a breakdown of the percentages of the comments and the need for leadership from the chaplain slightly edged ahead of senior hospital management leadership (15% and 13% respectively). Interviewees spoke about chaplain leadership in terms of the competencies they saw as necessary in order to facilitate and manage the HCC model of

chaplaincy. They highlighted administrative, relational, communication, and entrepreneurial skills.

- “You have to be comfortable with chaplaincy work, you have to be very, very organized. Relational skills are huge; public relations skills; and you have to be a dynamite volunteer coordinator. The faith leaders are a diverse group of people and come from different theological backgrounds. You need to value them.”[P1]
- “The strengths of the chaplain for this particular model are absolutely key. This model requires networking ability (with staff and community) ...through training the chaplain can expand the role by having many more hands to do the work, liaising, politics...figuring a way to make it work.”[15]
- “The personality of the chaplain is a big thing. You would not want someone with an adversarial personality to be involved here. You need someone with the ability to get along with hospital staff, and the chaplaincy board. “[P4]
- “Our chaplain is always available to the community clergy if they have any issues. They can reach out to her and she to them... our chaplain has been available for staff support and consultation...she takes time to educate staff and steer them to recognize that this is a support for them. The chaplain needs to be outgoing and get themselves onto the team.”[P17]

The expectations upon these chaplains are diverse and encompass bedside spiritual care as well as volunteer management and networking both within the institution but also with the variety of religious groups in the local community. One chaplaincy association board member affirmed, “Having someone who can devote some time to coordinate the lay chaplains, and liaise

with the hospital, and build up the profile of spiritual care in the hospital has resulted in a big change.”[P5] The model requires the chaplain to break new ground. Each of the institutions had no history of a chaplaincy program and so it fell upon the chaplain to create an atmosphere where the purpose and value of spiritual care was understood. This entrepreneurial spirit and work was not described as easy but rather quite challenging. One participant summed up the leadership abilities necessary in the chaplain in order to establish a new spiritual care program, “The chaplain is a pioneer in this (model). You have to have a lot of personal initiative. A hospital can be a very intimidating place. You have to make sure that your personality is strong enough.” [P7] The chaplain also needs to embrace the concept of the hospital-community collaborative model and be supportive of it. A healthcare administrator recognized this ability in their chaplain and stated, “(Our chaplain’s) had a really good vision of the chaplaincy partnership right from the get go. (The chaplain) is able to understand how the day to day challenges will speak to the vision and will help.”[P2] The chaplain keeps focused on the big picture of maintaining the partnership.

The first necessary factor for creating and maintaining effective hospital-community collaborations for spiritual care is strong leadership from three sources – senior management, community faith leaders/chaplaincy board members, and the chaplain. The second factor reflects the shared nature of partnership arrangement. Participants stated that in order for the collaboration to work effectively there needed to be a shared vision, shared financial responsibility for funding the chaplain position, shared decision-making power in the management of the chaplaincy program (by both the hospital and the community), and shared responsibility for providing tangible resources to support the work and place of the chaplain

within the hospital system. It is the sharing of both the financial and the management of the spiritual care program that ensures the voice of all the stakeholders.

Factor #2: Shared Vision, Funding and Responsibility

Shared Vision.

The need for a common vision for the chaplaincy program was emphasised by participants. Interviewees stated that their common goal was the provision of spiritual care to patients. But they went one step further and suggested that both the hospital and the community are intricately linked in accomplishing this goal for they share the same mission. “Care for the sick is in line with the ministry goals of the faith community.”[P40] By sharing a common vision and mission, the hospital through the help of the community was seen by participants as able to highlight the place of spiritual care in healthcare. A hospital administrator commented that “This model of partnership promotes a deeper understanding in the community that the hospital is a place for physical healing but also spiritual healing. The hospital is not just a place that fixes body parts but there is a spiritual component in each person and with the community involved they keep this piece from being ignored.”[P45] A community clergy supported this understanding by stating, “Having community clergy and the presence of a chaplain reminds the healthcare givers of the spiritual involvement in healthcare.”[P40]

In three of the four hospital community collaborations, the model was seen as helping the hospital to establish a relationship with community faith leaders which in turn helped both the hospital and the faith community to provide effective spiritual care to in-patients. “Partnership with community is part of the hospital profile. In this model the chaplain maintains a relationship with community faith providers and then the relationship between the hospital and the

community is enhanced and the community profile is maintained – this is good for the hospital.”[P57] One chaplain summed up the benefit of hospital/community connection, stating, “When the community invests there is a relationship between the community and the hospital. This makes a stronger chaplaincy because the community then knows what we do as chaplains in terms of spiritual care.”[P52] The hospital and the faith communities share a common vision of being responsible for spiritual care of patients and the mission of both support the idea of partnership. One chaplain did not connect with the ministerial association(s) and this was a point of contention for the community clergy and the chaplaincy board.

Shared Funding.

The model of collaborative chaplaincy, as described by participants, requires both partners (the healthcare corporation and the community) to contribute on-going financial support to fund the chaplain position. The hospital corporation contributes out of its operating budget or through hospital foundation dollars designated for spiritual care. One astute participant commented, “The degree of financial support from the hospital is indicative of their level of support for spiritual care. If spiritual care is important then ‘show me the money’!”[P50] Participants viewed the shared aspect of funding as essential to what makes the partnership work. “Without funding there is not the ownership.”[P22] Money seemed to communicate commitment to spiritual care by the stakeholders. “If the top administration believed that spiritual care is important, they would set some money aside.” [P49] Participant comments on the need for the hospital to provide funding occurred with tremendous frequency.

- They need to put funds on the table [P21]
- (Funding) would be a huge indicator that they are interested in working with us [P20]

- We are looking for them (hospital) to invest [P16]
- To have a partnership work it is all about the money [P15]
- I believe they must commit financially in order to feel a full part of this model [P4]

The faith communities were also responsible to contribute financially. Some described this in terms of a natural outgrowth of Christian ministry. In centres where the community leadership had waned, the expectation of community funding was stated as a source of difficulty. “Thirty years ago the (church) climate was different. Today churches are stretched too thin financially.” [P41] This will be presented more fully under challenges of the model. Participants described the value of contributing financially as both enabling the possibility of chaplaincy and also as a means of establishing a connection between the local faith leaders and the hospital chaplain. “If the community no longer paid anything for the chaplains I think that the relationship between the chaplains and community would be lost because the connection would be less.” [P52] Further in the same interview the participant articulated some of the mutual benefits for both the hospital and the community that result when the faith community contributes financially. “When the community invests there is more interest shown by the churches in the hospital and this helps the on-call chaplaincy and the volunteer chaplain relationships. I think the risk is that if churches are not financially contributing then they will fall away and not give attention to the hospital spiritual care program. The financial partnership makes us as chaplains not overlook the community clergy.” [P52] The faith communities financial contribution strengthened the relationship between the religious leaders and the hospital, built a relationship between the chaplain and the local faith representatives, increased knowledge of the role of the chaplain and the benefits of spiritual care, and increased access to volunteer chaplains.

Some participants saw the shared aspect of funding as opening the door to a hospital chaplaincy program that would not be possible otherwise. “It is definitely a solution for smaller hospitals because they cannot afford what the big hospital can.”[P7] Participants articulated the financial designation as a means to creating a deeper partnership and a deeper understanding of spiritual care. “Collaboration is more than money. It is developing a spirituality of unity, it is relationships.”[P1] “Having a partnership with the hospital is about more than the hospital getting financial support. It’s about helping them to understand spiritual needs of patients.”[P50] One participant sounded a warning of what can happen if the funding is not shared from the beginning, stating, “We expected that the hospital would kick in dollars after a few years if we just got started. The expectation never came to fruition. If the dollars are not there on the table to begin with they are probably not going to be forthcoming.”[P18] The lack of shared funding in one HCC was expressed with frustration and also some resentment that they were being taken for granted. “We are not just a partner in the funding – we are the funding.”[P21] “That’s the hospital’s big non-involvement – No Money.”[P20] The need for the funding to be shared equally was discussed from both the perspective of the hospital and also the community. One community participant recounted, “In my previous pastoral charge it was the same situation except it was the reverse. The hospital was paying their share but it was the community churches that were not.”[P22]

Shared Responsibility

In an effective collaborative model of chaplaincy both the financial cost of the chaplain position or spiritual care program and the management of the program/position are shared. The research participants described a wide range in terms of how the healthcare corporation in

conjunction with the local chaplaincy association shared the management of the chaplaincy program; or shared power. Some partnerships displayed and verbalized a balance of power in governing. For example, one hospital manager described their partnership by stating, “This model causes us to be innovative – by managing and overseeing the spiritual care area together and needing to fund raise - this helps us to be more of a team and to collaborate.” [P45] In other partnerships the decision-making power seemed to lie mostly with the position of the chaplain or under the authority of the hospital. The chaplaincy association or the pastoral care committee provided a sounding board or a consultative role without any real power. The relationship between one pastoral care committee and a chaplain was described in the following manner, “When I was hired it was presented to me that we are your advisory committee. We are here to support you and the program in whatever way we can. I think some of the clergy had the idea that if we are giving money to this program then we control the program.”[P1] In another HCC, where community money was contributed, the decision-making was no longer shared at the level the chaplaincy association considered acceptable. The hospital management did not seem to be aware or sensitive to the dynamic. A participant stated, “The hospital sometimes sees the chaplaincy association as a thorn in their flesh. The association feels they have a right to be heard because they are helping to pay for the spiritual care program. The hospital wants to be in charge... sometimes the chaplaincy association has ‘told’ the hospital what they want and this has not gone over well.”[P52] Sharing the management of the chaplaincy program seemed to work better when the roles and responsibilities had been clearly defined at the beginning of the partnership and were reviewed from time to time to reset the balance of power.

Establishing clear expectations between the hospital and the community organization seemed critical for sharing responsibility of the chaplaincy program. Table 4.1 presents data on

the number of times a statement or set of comments expressed a theme. One quarter of the all of the statements made by participants (related to the three dominate themes of leadership, shared responsibility and relationship building) concerned the need for a clear partnership agreement that delineated the structure and expectations. “Define the nature of the relationship.”[P41] Participants described the need for the mission statement to be on paper and to negotiate the balance of power in a written agreement. One interviewee stated they needed to develop “a statement of responsibilities, terms of reference and fund-raising guidelines.”[P54] Another commented on their planning for the future: “We did our strategic plan two years ago.”[P41] Many of the statements concerning a desire for clear agreement came from participants who were experiencing the stress of an HCC that was not working effectively and they expressed that if there was a clear agreement they could use their time more effectively.

- “In my mind the purpose of the meeting was unclear. So let’s be clear on what we want to accomplish together.”[P20]
- “We created a chaplaincy association because we were not willing to send dollars to the hospital. We could not be sure where that money would go and how it would be used.”[P46]
- “Need clear definition of the (chaplains) role... You have to have your policy and procedure clearly outlined.”[P17]

The limits of the decision-making power of the partnering organization needed to be clarified or tensions could arise and balance of power could be tipped. “Some tension developed between the hospital corporation and the community association over what each felt the chaplain should be doing... it was hard to balance.”[P57] To be an effective partnership, the hospital

corporation needed to understand that the mandate of the chaplaincy association was more than just raising funds but also had a management role. One organization described their struggle with lack of role delineation, “We are confused regarding what the chaplaincy association is responsible for and what the hospital is responsible for.”[P50] Participants wanted clarity on who is responsible for communication about chaplaincy through pamphlets, training of volunteers, scheduling of on-call, fund-raising, and deciding the level of community presence by the chaplains. It should be noted that in those partnerships where the hospital management supported and appreciated the shared management of the chaplaincy program, that the agreement for roles and responsibilities was seen as more fluid. The organizations that felt unappreciated or valued by the hospital recommended a clear contract to outline roles, responsibilities and expectations of all partners and the chaplains.

A final aspect of shared responsibility that was described in the interviews and focus groups was the need for the hospital to provide physical resources for the chaplain to accomplish their job and to ensure organizational support was available to establish the spiritual care program within the hospital system. Participants described the list of necessary physical resources in detail. “The hospital needed to provide a space for the chaplain and a phone and computer access and to welcome her into the group. The hospital needs to promote... and clearly outline the responsibilities and how you will work with this person.”[P17] Participants enumerated the essential supports for the work of chaplaincy: an office, a desk, a computer, a phone, integration with the internal hospital phone system and computer e-mail, access to a photocopier, software needed to develop pamphlets, a resource or book budget, travel expenses, continuing education budget, and access to administrative support. [The summaries of essential

supports identified above were voiced by the following participants – P1, P2, P45, P11, and P17.]

Organizational support articulated by interviewees included official recognition by the hospital, chaplain attendance at management meetings, and integration into the hospital quality improvement plan. A chaplain stated, “The hospital welcomed me when I first started. They sent a message around on the computer, and I was written up in the newspaper. I was invited to meet with the senior hospital managers and gave them a presentation on chaplaincy.”[P10] Integration also included representation on key teams that intersect with spiritual care, such as, ethics committee, palliative care rounds, diversity equity/cultural sensitivity group.

One manager summed up the necessity for integration of the chaplain into the hospital system and structure: “The chaplain would have no credibility if not listed on the organizational chart.”[P2] The organizational chart displays the all key positions and the accountability structure. If the chaplain position is not on the chart, it does not officially exist.

Factor #3: Relationship Building and Communication

The third factor identified by participants as essential to making the partnership work involved building relationships and maintaining communication among all of the stakeholders. The bond between the concept of relationship building and communication was indivisible for interviewees described the two themes often in the same sentence. Therefore, the themes of building relationships and promoting communication were combined. The importance of developing a relationship with the community faith leaders will be presented first and then the significance of developing relationships among hospital staff members will be discussed. Listening to the participant comments it was not always clear ‘who’ they felt was responsible for

developing the relationships. It seemed that although the goal was for the chaplaincy association or the pastoral care committee to assume this responsibility, in fact, it often fell to the chaplain alone. Most boards consist of volunteer members and although their agreements might indicate that it is the role of the board to communicate with funding partners, communication was often voiced as the task of paid staff, be it the chaplain or the person to whom they report.

“Communication or an invitation is supposed to come from the manager responsible for spiritual care.”[P21]

Relationship Building with Community Faith Leaders.

Relationship building with community faith leaders was described as essential and voiced repeatedly by the community clergy participants. “There needs to be a personal connection. In order for this model to work the chaplain needs to build a relationship with the community faith leaders.”[P14] “The chaplain is building a relationship, building communication, showing the hospital the value of the faith groups.”[P27] A chaplain termed their role as networker, supporter, and peer. “I think one of the reasons our program has been so successful is that I work really hard to keep a good relationship with the area ministers and faith leaders. I support them, and attend their ministerial,..you have to be proactive. Relationship building is huge.”[P1] The chaplain went on to describe the natural benefits that come from the close relationship between hospital chaplain and community faith leaders. “So when I send out a notice saying that I’m recruiting more volunteer chaplains there is trust there. They will put the announcement in the bulletin and I get applications.”[P1] When there is a new clergy in town the chaplain takes the initiative to contact them and invite them to be oriented at the hospital. “As a chaplain I networked with the community by being a member of the local ministerial. I went to their

monthly meetings. I was a part of their team and they were a part of my team by being willing to be on-call. When a new minister came to town I would seek this person out.” [P51] One chaplain stated their familiarity with the Salvation Army, noting that their organizational structure is to build relationships with community, business, other faith groups, and with members of the public. A chaplain summed it up by saying: “It is all bridge-building.”[P1]

Building a relationship takes time and requires face to face interactions and also communicating about the chaplaincy program through other means, such as newsletters, e-mail, and websites. “Communication can be a challenge so we are trying to increase the communities’ awareness of the Chaplaincy Association.”[50] In the hospital-community collaborative model letters to community faith leaders are sent out annually to request funding. These letters communicate the nature of the partnership arrangement and serve to remind the community faith leaders that the chaplaincy program exists because of their financial support. The relationship between the faith community and the hospital is also valued in the letters and reinforces to the community faith leaders that they too are a significant part of hospital spiritual care. A chaplain noted, “You have to develop the attitude that we’re in this together in order to provide spiritual care. The message is that you are a partner in providing the spiritual care in the hospital...not just with money but also with prayers.”[P1]

One community leader participant linked the importance of building a relationship with community clergy to their willingness to provide financial support. “The chaplain needs to understand the faith community. People put their money where their trust is. Money follows confidence...”[P27] Not building a relationship with the community faith leaders leaves them bereft of knowledge of the chaplaincy partnership and willingness to fund. This circumstance was noted by one faith leader, “I do not know anything about the chaplaincy. I never got a letter.

I have been here for years. Even just a phone call would help.”[P14] The need to build a relationship between the chaplaincy association and the community clergy was also underscored by participants. An interviewee articulated that the union or partnership is not just between the chaplaincy association and the hospital but that the faith communities are an equal partner as well. This participant went on to describe his vision of the relationship among the three partners: “The three need to be part of the grassroots and understand the role that each can have and should have - so that no one is excluded. It needs to be a team approach. If you try to bring in one of the three later it may already be too late.”[P12]

Participants suggested that in fulfilling the partnership arrangement it was not just the chaplain who was responsible for building relationships with the community faith leaders but the responsibility of the chaplaincy association. “The Chaplaincy Association needs to build a relationship with the community clergy and have regular communication.”[P13] A wonderful example of communication was described by the chaplain of one HCC:

“When we hit the hundred thousand mark of what the churches had given to the hospital, about two years ago, I wrote an article, and the hospital communications manager edited it, and we sent it out as a press release. One of the local newspapers picked it up. You see in the paper all the time that some organization has made a \$5000 donation to some charity. I said, you know it is \$100,000 that the area churches have invested in their local hospital. A lot of the ministers commented on it. They like the fact that the hospital was recognizing their contributions. So the hospital and the chaplaincy association get the benefit of this PR thing. It enriches the community. It gives them an opportunity to know that spiritual care is being provided in the hospital.”[P1]

Relationship Building with Hospital Management.

Initially building a relationship with staff members prior to establishing the chaplain position seemed to require finding like-minded people already in the hospital system willing to join the chaplaincy association. “There were two individuals who were hospital employees who

saw a need for a paid chaplaincy program and they were willing to work alongside of the pastoral care committee. Right from the beginning...there was energy within the system in order to make it (the model) work.”[P7] Once the chaplain position becomes established, participants described the importance of having a regular connection between the chaplaincy association or the pastoral care committee and senior management. A participant told a story of a new CEO coming to the hospital and the executive of the Chaplaincy Association asking for a fifteen minute meeting in the CEO’s first week on the job. They wanted to briefly articulate the partnership to the new CEO and establish a personal relationship with this senior hospital official. The need for the chaplain to also establish and maintain a relationship with senior management was stated, “The person who is the CEO started as the professional practice person and was a peer. Now it is easy to approach her. She is so supportive.”[P1]

In three healthcare corporations under study, a senior manager was officially a member of the chaplaincy association or pastoral care committee. In the fourth corporation a senior manager was historically on the committee but after major corporate restructuring spiritual care was placed under a middle manager. The regularity of the manager’s attendance determined the depth of the relationship. In some organizations the senior manager endeavoured to attend most or all of the chaplaincy association meetings. This manager was able to clearly articulate the concept of the partnership model. In some healthcare corporations there is a close but somewhat looser association between the healthcare manager and the chaplaincy association or pastoral care committee with occasional attendance and regular reading of minutes. “My manager attends the Pastoral Care Committee once in a while and receives the minutes. If there is something in our minutes that needs hospital approval I will give her a heads up.”[P1] The manager remained accessible to the chaplain and had semi-regular one-on-one meetings with the chaplain. In other

organizations, particularly when the manager was new, maintaining a relationship with the partnering organization was not given priority. “I have minimal contact with the chaplaincy society. I attended one meeting when I first began so I could extend good faith. I was stepping into a new role and wanted to know who they were and what they did. Since then all of my contacts have just been with the chaplain.”[P44]

Participants described the relationship between the senior manager and the chaplain as an important way of validating the new chaplain position. “You have to have a manager welcome them into the healthcare team.”[P17] The chaplain is extended credibility by nature of the healthcare manager’s position and authority. “It is a problem when doctors are not sure what that person is doing in there and the nurses are wondering how much they can tell the chaplain. That has to be really clearly explained (by the manager)... You need to help staff to know the advantages of including the chaplain in the patient’s care plan.” [P17] One community partner mentioned the relevance of the manager building a relationship with the chaplain is so that they can be an effective advocate for the chaplain. “They have to notice and give attention and advocate that the chaplain is important.”[P23]

The manager’s presence at the chaplaincy board table helped to bring wisdom in how the chaplain could navigate the healthcare system. The key seemed to not just build hospital relationships in order to establish the chaplaincy but was necessary to maintain them. Specific attention to the relationship was needed from the hospital chaplain and members of the chaplaincy association. Without a personal connection between hospital management and the chaplaincy association the partnership is greatly hampered. Those partnerships where the hospital designated key hospital personnel to sit on the chaplaincy association board were experiencing the greatest sense of relationship and success. “We have a hospital manager who

sits on the board for chaplaincy...I know she cannot always be here because of other commitments but our chaplain communicates with her regularly.”[P4] The manager’s bring knowledge of what is currently happening in their facility. They are able to trouble shoot on behalf of the chaplain. “So when an issue comes up, they will correct the problem and carry on.”[P57]

The chaplains’ efforts to communicate with hospital staff members also seemed to build the relationship between the healthcare providers and the spiritual care program.

“Communicating about chaplaincy to the hospital is very important.”[50] Communication took many forms: attendance on committees, in-services, one to one support for staff members. One clinical manager commented:

“(The chaplain) has been important for the professional development of our staff. Our staff has been able to recognize that we don’t just get the patient’s blood ready, we don’t just do their surgery, we don’t just get their oxygen going, we have to care for the whole person, and that includes their spirit. So the (chaplain) has helped from that perspective to broaden everybody’s vision of how important we can be with our patients and their care.”[P2]

Some communication also came from the hospital management to the staff about the chaplaincy program. “The hospital sends out newsletters periodically, or news articles that go into the papers. They state the value of chaplaincy now and then.”[P4]

A chaplain stated the benefit of building relationships with staff members: “Collaboration works because it forces you to get to know your partners. Then you know the people you can count on. You know the people who you can refer to when you need them.”[P1] The participants who were chaplains described the plethora of ways that building relationships with staff paid off in unexpected ways. One told of the hospital computer expert suggesting a system of automatic spiritual care referrals in order for volunteer chaplains to know which patients would prefer spiritual care. Another chaplain recounted how he is referred to by the physicians as

‘The Chaplain’ and regularly receives palliative care referrals from them. A third mentioned how relationship builds knowledge of what the chaplain does and increases a sense of respect for spiritual care. One day while supporting a patient, the healthcare team member entered the room and saw that the chaplain was already engaged with the patient. The staff member simply greeted the patient and said that they could see they were with the chaplain and would return when the chaplain was finished. By building a trusting relationship, the chaplains seemed to have gained the respect of the staff.

Relationship building and communication among all of the key stakeholders (community association, the hospital management, and the faith community) is critical; But not in isolation from one another. All three groups of stakeholders need to participate in the development and maintenance of the partnership. Linked with building relationship is the concept of communication. “The whole role of communication between us and the hospital is important.”[P22] When there was an absence of relationship and an absence of communication the partnership dwindled and comments about a lack of partnership were voiced: “The hospital is not partnering.”[P22] When participants were asked who is responsible for communication, most often both the hospital and the community association viewed this as part of the chaplain’s job description with the help and support of their hospital manager.

Benefits of the Hospital-Community Collaborative Model

Participants stated many benefits of the HCC model and emphasised that the benefits are an important reason for why they joined the partnership; sustained benefits keeps them at the table. The perceived benefits to the community will be presented separately from the benefits to the hospitals.

Three major benefits to the community faith leaders were stated:

1. Increased Respect Extended to Faith Providers by the Healthcare Team.
2. A voice at the table (for such things as facilitated access to find their congregants).
3. Spiritual Care Education and training.

Three distinct benefits for the healthcare corporations were cited:

1. Spiritual care available for all patients.
2. Increased awareness and understanding of spiritual care by staff.
3. Financial help to fund the spiritual care program.

Other benefits of the HCC model experienced by the community and the hospital, too numerous to include, were stated. However, the concepts of figurehead and ambassador were mentioned with some frequency as well as the desire for supervision over the volunteer spiritual care providers and faith leaders.

Benefits to Community Faith Leaders.

In three of the four HCC under study it was not difficult to obtain ‘buy in’ from the community clergy to support hospital chaplaincy because they perceived numerous benefits for the community. In the fourth corporation a group of community clergy continued to resist supporting the chaplaincy program because the proposed benefits never materialized in their hospital. The following descriptions of benefits are primarily from participants in three of the four hospital-community collaborations.

Community Benefit #1 - Increased Respect.

The most often cited benefit for community clergy is an increase in respect from the hospital staff for the faith leaders and respect for the spiritual care they are offering to patients. The presence of a chaplain on the healthcare team was thought to have taught the staff about spiritual care so that when the community faith leaders came to see their own parishioners the staff had a greater sense of how significant their support could be for the patient. One faith leader commented, “I believe that (the chaplain) has set out the groundwork, and that his presence there (in hospital) is a presence of spiritual care. So when we walk in, because he has a positive influence with most of the staff, he lays a path for us that we can walk in on and benefit from.”[P27] The community faith leaders described now having a relationship with the staff. “You do not feel like an outsider here, you feel like you are part of the team.”[P38] “When I come onto the floor now as community clergy I feel there is a connection with the nurses and that it’s okay that I’m here. I have a real sense that I’m part of the team. That has been huge.”[P7]

Community faith leaders also have a relationship with a member of the healthcare team, the chaplain, who is their advocate and can trouble shoot on behalf of the faith leaders. “I know I can talk with the chaplain and ask him to look into it for me and he will take care of that or come back with an answer as to why. It is nice to have somebody there from our perspective.”[P35] The benefit of advocacy was linked with the benefit of respect by one chaplain: “I am here advocating on their behalf so when they come into hospital they are treated with respect. They say they’re part of the team.”[P1] One clergy recounted being called by a family to come to the hospital immediately for their child was gravely ill. The clergy arrived at the pediatric unit and was told by staff that they were not allowed to visit the child or the family

because their name was not listed on the chart. The clergy, knowing the chaplain, called and asked the chaplain to advocate. Within minutes the barrier was lifted. Staff trusted the chaplain. “The chaplain could say – this clergy has gone through an orientation and has been vetted by the hospital and they are part of our team.” [P40] The family had been unaware of the struggle to get into see them. The clergy was so grateful to have an inside advocate.

Community Benefit #2 - A Voice at the Table and Access.

Community clergy and Faith Leaders come to their local hospital with regularity to visit their congregation members. As participants described the act of coming to hospital, it was linked with how they were welcomed by the staff, the level of difficulty finding their person, and the benefit of having a voice in terms of spiritual care in the hospital. “This model gives us a voice so we supported it.”[P35] Later in the same focus group, this faith leader added, “I have to visit hospitals in Toronto and Barrie and it really does feel like you are intruding on everybody else’s territory. Whereas here, we are a part of the process and it is important for the churches to have a strong, visible voice in the hospital.”[P35] Community faith leaders wanted a voice to improve access so that they can know how to find their parishioners quickly. They perceived this as an integral benefit of the hospital-community collaboration. A chaplain summarized, “Part of my job with community clergy is to keep them happy, to make sure that it’s easy for them to come in and see patients but working within the implications of privacy and confidentiality.”[P1] The needs of the community faith leaders are taken into consideration because they are helping to fund the spiritual care program. “It is not just churches sending in money. They have to have a voice. We always listen although we may not always agree. But the community churches are listened to.”[P1]

In the one hospital-community collaboration, the clergy were not able to identify many community benefits. Lack of access to the patient religion information for their own churches was described with strong emotions. “Today clergy cannot find out if their person, their congregant, is in hospital. They only find out if the family calls them. And if it is an emergency there is no time to call. Therefore, many patients do not receive care from their own minister.”[P50] Another focus group member described the kind of beneficial experience he was hoping the chaplaincy program was going to bring:

“About a year ago I was down in Sick Kids Hospital in Toronto. As soon as I walked in and went the nurse’s station the nurse showed me immediately to a private room where the family was gathered. We had total privacy. Probably one of the things that brings me to this focus group today is that I find when I go into a room in the local hospital here, whether it is a ward or semi-private...I can be having a word of prayer with the patient and the staff will just barge right in. That says to me that they don’t care about the spiritual care of patients.”[P11]

Community Benefit # 3 - Education and Training.

Interviewees from all four corporations under study stated that an important benefit of the collaborative model was the provision of spiritual care education in the community. Having a local expert who could teach others about how to provide spiritual care and who could increase the communities awareness of spiritual care was shared as a benefit of the partnership. “Our vision is for the chaplain to do teaching in the community and train others in spiritual care...One of the functions is to educate and build people’s understanding and knowledge (of Spiritual Care).”[P18] “What the faith community can learn from the chaplain is how to care for the sick when in hospital.”[P57] The benefit of community education was described as important by both the recipients (the faith communities) and the hospital administration as well. One manager commented, “Another role that the chaplain has branched into...is education in the community. The chaplain has gone to church groups and gatherings to explain the role of spiritual care.”[P17]

There was wide variety in the amount of spiritual care education that was available to the community members between the hospital-community collaborations. This seemed to depend on the unique needs of the community and the ‘voice’ of the community (what they were requesting). One chaplain described a more extensive spiritual care education:

“I trained people who came through a lay pastoral visitor program and the lay visitors could then visit their own congregants. We then decided to offer a second level of training where the lay pastoral visitors would be able to visit patients in the hospital on a particular ward. A third level of training was started. These volunteer chaplains could be available anywhere in the hospital. Some would become on-call chaplains.”[P51]

Further Collaboration. Participants described a further benefit of the collaboration model is that community faith leaders have learned themselves to collaborate; to build something together where they are not divided by their theologies or faith perspectives. “Partnerships help to break down barriers. Churches had to learn about each other.”[P2] The added benefit is that one partnership begets more partnerships. In one community, following the establishment of the chaplaincy by the faith leaders, they next collaborated with a community group to establish a foundation for good works in the community. They recognized that they could do more together than separately. “Because we learned to work together in one area we learned we could work together in the second area. I think barriers got broken down.”[P2]

Hospital Benefit #1 - Spiritual Care for All.

The most frequently cited benefit of having professional hospital chaplaincy was the availability of spiritual care to all patients, family members and staff. Since many patients may not have a specific church affiliation or religious community they would not have a designated person to come to hospital and provide spiritual care support. Participants cited the need to have

a chaplain on the healthcare team who would ensure that all patients had access to spiritual care as they so desire. “We looked for a paid chaplain because there was a real need for the chaplain to meet the spiritual care needs of the patients; to give the patient’s total care.”[P39] “We have to care for the whole person and that includes their spirit.”[P2]

The chaplain was described as the one spiritual care specialist who has training to be able to minister to persons from all traditions. This was cited as important in a culture where fewer people are members of a particular religious community but still have a personal faith and spiritual needs. “A chaplain listens to people from all faith perspectives (and of no particular faith affiliation). In a healthcare crisis people start asking life’s big questions and increasingly, people have no religious affiliation. Yet they still have questions. So I think it is really important to offer avenues for people to explore that even though they might not be part of a traditional religious community.”[P25]

Providing all patients with access to a spiritual care specialist was described by the hospital representatives as consistent with holistic care and evidenced-based patient care. “Our hospital believes in patient-centered holistic care – and the interconnection of mind/body/spirit... Our patients benefit and research demonstrates the benefit of spiritual care when patients have access spiritual care 24/7.”[P45] The presence of a chaplain was seen as a tremendous support to staff. “Our chaplain has been a real resource to our staff. She is someone that they recognize that they can go to and get advice, or vent, or ask questions, or help explore their own spirituality. That has been a huge asset to the hospital.”[P2] A healthcare manager stated, “I see the staff talking with the chaplain. She is very approachable. When they have a crisis I know they can talk to her...Someone to vent to. She’s very supportive to medical staff.”[P44] A chaplain commented, “When they see me around the halls and get talking or see me in the

emergency, they also have a sense of relief. They appreciate having a chaplain figure around. They know who they can go to if there is an issue.”[P26]

Hospital Benefit #2 - Increased Knowledge of Spiritual Care by Staff.

A second benefit is the education for staff and volunteers concerning spiritual care, thereby, increasing the collective knowledge and awareness of the importance of spiritual care in healthcare. “There is a far greater understanding for what spiritual care is about and acceptance for spiritual care now in the hospital.”[P1] A board member of a Chaplaincy Association stated, “Her role is to raise awareness of the spiritual dimension of the person.”[P23] There is a qualified person to screen, train and supervise the plethora of faith group leaders and volunteers who come into hospital to offer spiritual care during patient illness or to support them through a crisis. One manager summed up this sentiment, “You have to have someone body to manage them.”[P2] The emphasis on volunteer development increased the quantity and quality of care that could be provided. One chaplain stated, “By building the volunteer chaplain team we have increased sevenfold the number of patients who are seen in the hospital.”[P1] Participants described the stress today on nurses to accomplish all levels of care (physical, emotional and spiritual). “Staff are so busy and it is easy to lose sight of the person of the patient and their social and spiritual needs...chaplaincy benefits staff because it helps them connect with a hospital approved resource.”[P45]

Hospital Benefit #3 - Financial Support to Fund Spiritual Care.

The third most commonly cited benefit to the hospital of the hospital-community collaboration was the provision of financial support. Revenue for a clinical program, in the

hospital in an age where funding for new programs is difficult to find, was cited as a key benefit for the hospital.

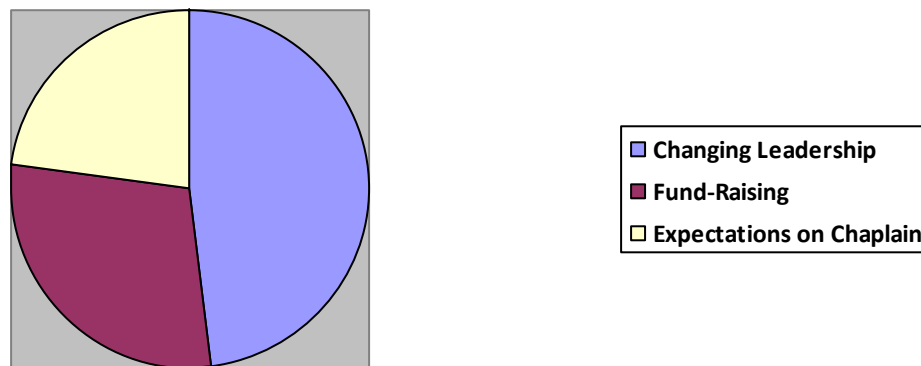
- “The hospital was reluctant to finance the chaplaincy by themselves and felt the religious community should also help pay. By involving the community to work with the hospital they were not alone in providing the service.”[P51]
- “Looking at increased demands in the future on hospital budgets this partnership is a good thing – it protects the chaplaincy from being cut or decreasing the service in order to find savings. Every component in healthcare is being looked at.”[P45]
- “The hospital benefits financially from the commitment from the faith community.”[P4]
- It was a money issue for the hospital and they wanted to figure out how to make it work.”[P7]

Challenges and Drawbacks of the HCC model for Spiritual Care

Three common challenges emerged from the participant discussions. The most cited difficulty of the HCC model, due to its reliance upon volunteer board membership to provide leadership, concerned the turnover of persons affiliated with the chaplaincy program or within the hospital itself. The pie graph below (See Figure 4.2) displays data that almost 50% of the comments on the challenge of the HCC model referred to the continual change of leadership personnel. The second common hurdle expressed by participants related to the stress of raising funds in the community with 29% of the challenge of the model comments. The third challenge involved the tremendous number of expectations upon the chaplains who serve in HCC models. These comments accounted for the remaining 23% of concerns or difficulties experienced or observed by those who use the HCC model. Two further challenges were noted albeit

infrequently by participants – the difficulty of defining the work of spiritual care to healthcare professionals and secondly, the lack of recognition by the hospital for the communities contribution to the spiritual care program.

Figure 5.2: Challenges of the HCC Model from Participant Statements



Challenge - Constant Leadership Change.

The most significant challenge cited by participants was the continual change in leadership from within the hospital and on the board of the Chaplaincy Association or Pastoral Care Committee. A champion within the hospital would be found and integrated into the chaplaincy association and then the hospital would amalgamate, restructure, or the person would move or retire. “We have had trouble with turn over...lack of continuity on the corporate side. The structure keeps changing and chaplains get shuffled to whom they report.”[P54] One chaplain stated, “I have had five different managers in ten years.”[P1] Another chaplain commented, “I used to meet with my manager once a week. When she left there was a six month vacuum. The new person just did not have any extra time. Now I report to someone who does not have any understanding of spiritual care.”[56]

Changes in the organization also meant changes in the staff member designated to participate on the chaplaincy association. Knowledge of the partnership would get lost. The historical relationship and balance of power would be strained. One board member articulated the new challenge, “Now there is some tension between the corporation and the community association. It’s between what each feels the chaplain should do. It’s hard to balance. The corporation wants us to raise money but we feel we are being shut out of the conversation.”[54] If the chaplaincy association worked in isolation from the hospital leadership their ability to advocate for the chaplain and be a partner in the program was severely hampered. The balance of power to manage the chaplaincy program would shift with the changes in leadership because new hospital personnel or new community members did not yet have a full grasp of the partnership. “The disadvantage is if the chaplaincy association (no longer) understands how to work with the hospital and how to be appropriately political without being demanding.”[P52] The community was willing to fund-raise because they wanted a voice at the table and did not want to just be revenue generators.

The flattening of the organizational structure was viewed as an impediment to building relationships with significant leaders in the hospital. “It is harder to negotiate because it is challenging to know who to talk to. Even worse, it is difficult to advocate for spiritual care with a hospital manager who does not have responsibility for the budget.”[P57] As hospitals re-organize spiritual care seems to go lower in the organizational structure. In one corporation under study, the spiritual care department was eliminated and the chaplains were placed under a department where the manager had limited power in the organizational structure to advocate for the chaplaincy program. “(The manager) does not have the same clout as the predecessor in the organizational structure. We do not have power people on the committee anymore and so we

have lost power to affect change.”[P54] The challenge of the changing hospital structure was summed up in the following statement:

“A challenge is that hospital’s reorganize and spiritual care goes lower in the organizational structure. For example, one Toronto area hospital restructured and had spiritual care reporting to dietary services. This was protested and changed but it is not uncommon for chaplains to be placed under Volunteer Services or Patient Activation. The sobering conversation is where the hospital views spiritual care in the organizational structure.”[P57]

Community leadership changes also occurred regularly on the chaplaincy association board since faith leaders would be transferred to other congregations outside of the hospital catchment. “Leadership is a big problem. You have a keen person who is a leader and then they move away and the next one does not have the same commitment. ‘[P52] Significant effort needed to be made by the chaplaincy association to build its membership and do succession planning so that the executive could provide strong leadership and focus on the mandate. The danger of not doing so was cited by one board member, “There has been a leadership vacuum (on the chaplaincy association) for the last number of years...things are starting to fall apart.”[P52] Good leaders also implied giving attention to the organizational structure of the organization and understanding “how to work with the hospital.”[P1]. The changes in leadership also seemed to impact the delicate balance of power that is achieved when leaders know one another and work for a common goal. Related to leadership changes was the problem or a changing work ethic in the new board members. One chaplaincy association member stated, “The new members do not want to do any work... Even getting volunteers to help on the board is difficult now.”[P41]

Challenge - Community Fund-raising.

The second challenge articulated by participants was raising funds within the community and sustaining the momentum of annual financial commitments. The significant number of community faith leaders on the Chaplaincy Associations and on the Pastoral Care Committees meant that the necessary skills for fund-raising may not be present on the board. “We have mostly had community clergy on the chaplaincy board and they prefer the program side of things and not the fund-raising.”[P16] “Our biggest challenge is financial. We believe passionately in spiritual care but we are not fund-raisers.”[P25] “You have to have someone who is comfortable fund-raising. Being clergy, we had people who did not want to fund-raise.”[P18] One board member on the Chaplaincy Association or Pastoral Care Committee said, “It is a challenge to raise our portion of the funds. It has gone up and down. It is a big part of what we do.”[P8] Many faith leaders noted the economic stress that is felt in their own congregations yet felt some level of financial contribution was essential to maintain their voice within the hospital spiritual care program:

“There is a lot of variation in the faith communities (as to what they can afford). Attendance is down in many churches and costs are going up so monies are not necessarily available all the time. We encourage everybody to be involved even if it’s at the \$100/year level. We want them to feel that their contribution is equal to the larger contribution because of their stake in the partnership is important.”[P4]

Community dollars can come from a variety of sources other than the faith communities. Fund-raising for endowment dollars is a methodology advocated by some American hospital systems in order to access philanthropic dollars and create a development fund for sustainable chaplaincy in the hospital spiritual care department (DeLong, 1992). Some participants in the current study mentioned their desire to encourage bequests but were told that this encroached on the hospital foundations work. “The pastoral care committee feels constrained because the

foundation does not want us to interfere with their fund-raising so we just raise funds from the church community – issue to fund-raising territory.” [P54] This challenge then limits the places and the means of accessing funds. Because they are a partnership there is a need to respect the hospital fund-raising practices and find sources that do not conflict with the hospital’s capital campaign projects or memorial donations.

If the community does not want to do the fund-raising, the chaplains felt that they were then responsible for ensuring the community portion of the financial partnership. “The chaplain has spoken to me about feeling somewhat responsible for raising the dollars for his/her own salary, which is an awkward position to be in.”[P2]

Participants associated with HCC models that were experiencing some internal struggles were the most vocal as to the stress of raising funds and conducting fund-raisers. In several HCC that were functioning well the following comments were made in regard to finances:

“Asking the churches for money is not a challenge. We send out an annual letter asking for support to churches. We have an annual luncheon each fall during Religious and Spiritual Care Awareness Week and that’s when I present to people how much money we have raised, and how much is needed, and how the program is run. It is an opportunity for the community clergy from the whole area to come together. The community donates 10% from the Lenten Lunches which is about \$1000. We do not do a fund-raiser. There has never been a need to do one.”[P1]

Challenge - Expectations of the Chaplain.

The third challenge stated by participants related to the expectations of the chaplain. Each stakeholder had specific ideas of where they would like the chaplain to spend their energy. The community clergy wanted help with access and training, the hospital wanted direct spiritual care to patients, and the association wanted help with administration. On top of everything the chaplain was expected to build relationships in hospital and maintain communication. The

chaplains felt stretched to capacity. “It is tough for the chaplain for it is a big job organizing everything and this takes (him or her) away from direct pastoral care.”[P20] “So the chaplain became more and more involved in the hospital administration because the chaplain was an employee of the hospital. This felt to us as ministers that there was less and less involvement of the chaplain into the community...the chaplain became more involved in hospital meetings.”[P22] The chaplains that had well-functioning chaplaincy associations with clear agreements felt they were supported. Essentially the chaplains are serving two masters – the hospital and the community. “They are trying to stand between the jetty and the boat and trying to ensure that they represent community and also advocate in the hospital, reminding all that spiritual care is important.”[P54] A chaplain summed up the internal pressure she was experiencing, “It is very different being funded by a charitable organization. I think you have a greater sense of obligation to give them their monies worth. Whereas, if you are funded by the hospital budget you would not work any less, it’s just you would not feel as pressured to have performance results.”[P10]

Chapter Six: Discussion

The research of Poland et al (2005) on Hospital-Community Collaborations in Canada (for patient oriented services) noted that further analysis was needed to determine what makes these partnerships work effectively. The current study on Hospital-Community Collaboration for Spiritual Care sought to identify the factors that help HCC models (as applied to hospital and religious communities) to work well. The results provide evidence that the HCC model works effectively when attention is given to the three principal themes of Leadership, Shared Responsibility, and Relationship Building, as well as the identification of critical benefits for each of the partners. Application of the conclusions is quite practical but more helpful if the results are considered within a theoretical framework. The themes or factors that promote productive partnerships coincide with the basic tenets from Solution-Focused Therapy and Organizational Theory. Solution-Focused Therapy asks the question, “How did you do that? How did you make that (HCC) happen?” Organizational Theory expounds on the principals of collaboration and social capital. The HCC model works because it is solution-focused and collaborative (brings together key stakeholders and gives them a voice); builds through social capital, and produces a tremendous sense of ownership by both hospital personnel and community members (due to diversified funding contributors): ‘We are better together’.

Partnerships bring together organizations that share a common interest and enable them to achieve a goal that was not possible on their own. Such collaborations do not always occur between similar groups of people. Cross-sector partnerships arise between two very different partners and can be successful when there is respect and trust between the organizations. The

historical partnership in healthcare between local hospital corporations and religious organizations has been to achieve the common goal of access to quality spiritual care for patients. In the last century, this example of cross-sector partnership has experienced a measure of distrust. Yet partnership as a means to ensure provision of spiritual care to patients continues to exist as a model in healthcare.

In Ontario, partnerships account for 20% of the hospital chaplain positions in the province and are present in 21% of the corporations. Hospital-Community Collaboration (HCC) is a unique partnership model where hospitals and a community organization share the funding and the responsibility for managing the hospital spiritual care program. HCC partnerships account for 8-10% of the partnerships and most of these are in rural or small population center hospitals. The HCC model brings together unlikely partners – religious leaders and hospital management. By building a relationship, forming a bond of trust, these partners are able to then develop a spiritual care program tailored to the unique needs of the healthcare institution and the community. There are ten Hospital-Community Collaborations in Ontario acute care hospital corporations. All initiated a spiritual care program in an institution without a chaplain. Nine of the ten had no history of professional chaplaincy within the organization. It is a beginning point to say the HCC models works because of committed leadership, the sharing of resources and a commitment to the building up of relationships and regular communication. The next step is to place the results within a broad understanding or theoretical context and ask – why is it so?

Solution-Focused Perspective Underpinning Collaborative Model of Chaplaincy

In the late 1970's Steve de Shazer and Insoo Kim Berg developed a therapeutic model called Solution-Focused Therapy (later called Solution Focused Brief Therapy or SFBT). This goal-directed, future oriented form of therapy concentrates attention on potential solutions rather than on a person's problem (The Institute of Solution Focused Therapy, 2011, de Shazer, 1985). The emphasis within the therapeutic encounter is shifted from attention to what is wrong in someone's life and the roots of problem development, onto identifying what is right and healthy in a person's life. Therapy focuses upon identifying strengths and empowering clients to access their unique skills and resources. Solution-focused therapists ask, "What would your life be like without this problem?" (de Shazer, 1988) In hospital chaplaincy the problem is often identified as unwillingness in healthcare to fund a spiritual care program, or a tendency to cut the funding to exiting chaplaincy programs. Solution-focused therapy contends that we can get so stuck in examining the problem and the reasons for its occurrence that we become problem-saturated. A solution focused perspective points to the possibilities of what can be done to provide sustainable funding even in an atmosphere of fiscal restraint.

Today the influence of Solution Focused Brief Therapy (SFBT) has stretched into business, education, social policy and even the criminal justice system. The Hospital-Community Collaborative Model of Chaplaincy is based on a solution-focused perspective. Like SFBT, the collaborative model is a practical and goal-driven paradigm. Key stakeholders come together to identify clear and realistic goals and work together to ensure the success of the development of the spiritual care program. As healthcare continues to face budget restraint it would be easy to focus upon the problem – loss of spiritual care programs or the lack of funds to initiate a new spiritual care program. The HCC model is practical because it is economically

resourceful. It is goal-driven because the key leaders mutually decide the shape of the spiritual care program and the job description of the chaplain. The HCC model provides one of many possible solutions in sustainable funding for spiritual care.

Solution Focused therapy emerged out of family systems perspective. The solution is viewed from the perspective of the whole system in which the solution resides – a change in one area of the system will necessitate change in other areas (de Shazer, 1991). A hospital functions as a system and bringing quality solutions to spiritual care will have a lasting effect if we work with the system as a whole. HCC works because the key leaders from the hospital management and significant religious leaders are at the same table and both are able to share how their ‘system’ works. Medical leaders are present to help the hospital chaplain navigate the complex hospital system, to advocate for projects and integrate spiritual care within the hospital culture. Having the religious and community leaders on the board membership provides important spiritual information to the hospital regarding the spiritual needs of patients and the need for continuity of care from hospital to home. Working systemically means more people are involved and once positive change is in motion it produces more constructive changes. In family therapy, the whole family participates in the therapeutic process to find workable solutions, not only the identified patient. The family represents the system in which the person lives, so to effect change the whole system (family) needs to be supportive and part of the solution. In Hospital – Community Collaborations for chaplaincy, key influential people are essential during program development and maintenance. When key persons are present to manage a program there is ‘buy in’ from the whole system.

An example of the systemic ownership for spiritual care occurred in the Grey Bruce HCC which covers four separate healthcare corporations. The executives of the three corporations

meet regularly and noted the complexity of updating spiritual care policies for all three corporations. Without initiation of the chaplaincy coordinator the executives decided to allow one set of spiritual care policies to be adopted by all three corporations. They created a solution to a more workable chaplaincy system by seeing the program as owned by all and all responsible for making it work. A further example occurred following a terrible car accident that killed five teenage boys. The morgue services were overwhelmed and the physicians were distressed at the inadequacy of the environment for supporting the grieving parents. A group of emergency department physicians approached the chaplaincy coordinator to create a space in the hospital where loved ones could view their deceased family members rather than in the morgue – physicians, emergency nurses, transportation services, and the chaplain worked out a policy and procedure for utilizing the chapel as a place for the family members to gather and take time with their deceased relative with the support of an on-call chaplain. What developed was more than a collaborative policy, rather, it was the creation of a system of care that is now owned by the physicians, the switchboard operators, the emergency department nurses, the environmental service transporters, and the team of on-call chaplains.

A significant aspect of solution focused therapy is that the client is considered the expert and has the best understanding of what would help them. In the Hospital-Community Collaborative model the stakeholders, both hospital personnel and the community (faith leaders and other) together have a voice as to what would work in their community, from the form of the chaplaincy, to where time and energy of the chaplain is targeted. The stakeholders know their community, they have the relationships with key personnel, they understand the challenges to establishing a spiritual care program, and they are in the best position to identify the potential solutions. They need a model that has flexibility to take into account the unique variables of their

community. They also need a model that is supportive to allowing the voices of others who have an investment in spiritual care to be heard. Too many chaplains work in silos, isolated from other chaplains, not integrated with the community faith leaders, and sometimes isolated from staff when not considered a full member of the healthcare team. Spiritual care and chaplaincy needs to be part of a larger solution.

Currently chaplains dialogue within their professional journals and at conferences about the future of the profession. To find effective solutions for sustainable spiritual care programs, or solutions to initiate a chaplaincy program, chaplains need to have input from the whole healthcare team but also from the religious leaders in their community. It is the client's vision of the solution that drives the therapy in SFBT. In the HCC model, if the vision is shared, built collaboratively between the community and the healthcare system it will be owned by more people than just the individual chaplain. The result is a chaplaincy program where the chaplain feels tremendously supported by both hospital management and also the faith community. In the HCC model the chaplain does not work in isolation but as part of the team – the program managing team – and integrated into the healthcare team.

Organizational Theory and the Concept of Collaboration

Neumann (2010) contends that effective collaboration is not 'reorganization' but promotes a new system of care "to develop optimal, sustainable solutions that are widely supported" (Pg 314). The HCC model has been used to initiate a new spiritual care program and not to just reorganize an existing program. It has worked because the leaders chose to develop the chaplain position by first listening to the vision of those around the table – hospital staff and religious leaders. The community did not simply propose to give the hospital money for a

chaplain position nor did they offer to provide a chaplain free of charge to visit members of their faith community. In the HCC model, the partnership is developed with all funding partners getting a voice as to what the spiritual care program should look like and an opportunity to identify their needs in order to achieve specific benefits. The leaders do not lose sight of their purpose – what it is they hope to accomplish together. The new system of care is one based on common goals and mutual benefits. The new system offers substantial support to the chaplain position to ensure the chaplain becomes integrated into the hospital system. Neumann's comments are that collaboration not only creates a new system but the solution is widely adopted by the whole system. This last point is significant. If the hospital management feels ownership for the spiritual care program they will promote it among other managers on the healthcare team. Ownership means they will be supportive and will advocate as necessary. Ownership can also mean financial protection from funding cuts.

Collaboration theory advocates that mutual goals can be accomplished when there is representation from all of the essential stakeholders at the table. If crucial stakeholders are not brought into the system, or if all parties are not sufficiently represented, then the partnership may be destined to fail. Effective collaboration can only work in an atmosphere of trust and respect. 'Self-interest' can bring about a quick death to an organization struggling to achieve unity and balance. Members need to have an equal ability to make decisions and influence the direction of the program. Membership includes hospital management, community and religious leaders, and the chaplain. Decisions are not made in isolation but collaboratively. Sharing decision-making does not come easily for a hospital corporation. In the HCC models that were working well, there was trust among the hospital management, the community, and the chaplain, in the shared decision-making. In fact, the hospital corporations welcomed the collective wisdom where the

community religious leaders felt they had a voice in the hospital, and the chaplain felt supported. However, in one HCC model in this research there was a sense by participants that they were contributing money but did not have a sufficient voice in how the spiritual care program was being restructured. Collaboration for decision-making directly impacts the work of the chaplain in the HCC model and the objective of supporting the work of the chaplain must be emphasized.

Table 5.1 summarized the three necessary factors to make an HCC arrangement work effectively with 36% of the comments referring to the leadership theme, 41% of the statements noting the theme of shared responsibility, and 23% of the statements commenting on the need for relationship building and communication. The majority of comments in the shared responsibility section encompassed statements about the need for shared decision making and clear agreements (145 of the 245 statements). Two of the collaborative arrangements under study were experiencing frustration with their partnerships. In one HCC, the distress was due to the lack of shared funding and in the other the frustration was a perceived lack of decision-making power. One HCC was in the midst of re-evaluating how to go forward as a partnership. The volume of statements noting the need for clear agreements reflects their need to voice what would improve their respective situations. It is important to note that the solution for both was to say they needed partnership guidelines on paper so that when troubles arose they would have had something to ground their discussions. The continual turnover of hospital leaders and chaplaincy board members meant that those who held the knowledge of the agreement and were invested in the continuance of the chaplaincy program were no longer present within the hospital system and no longer advocated for spiritual care.

Neumann (2010) contends that effective collaborations are possible with clear agreements that state mutual benefits of working together, have a common goal, and are based

on a win-win relationship between the parties. The HCC model keeps the benefits of a spiritual care program for the hospital and the community at the forefront. If the community does not feel they are benefiting they will no longer support it. McKinnen (2009) describes some of the potential pitfalls when healthcare institutions attempt to partner with the private sector, foundations and non-profit organizations. Partnerships fail when time is not taken to understand what motives each group, power dynamics, world views and the unique contributions of each group. For an HCC to work effectively, time and attention must be given to the voices, views, and vision of each partner. The three dominant themes in the HCC model of Leadership, Shared Resources and Relationship building make the model effective because they are in line with the principals of collaboration from organizational theory.

The Relationship Between Social Capital and the HCC model.

To provide a theoretical framework within which to understand why the hospital-community collaborative (HCC) model works it is important to consider the power of social capital in the development and maintenance of the model. Social capital “is the relationships of trust, norms of reciprocity, and networks among individuals that can be drawn upon for individual or collective benefit” (Wagner and Fernandez-Gemenez, 2008). The intentional building of relationships turned out to be a critical asset of the HCC model. Relationships and regular communication between the chaplain and the community clergy, the chaplain and the chaplaincy board, the chaplain and the hospital staff, the hospital management and the chaplaincy association...and so forth, were pivotal to making this a success. The interplay of the leadership, relationship building and communication was evident – it took leadership to initiate relationships and leadership to invest time in communicating about the chaplaincy program to all

of the stakeholders. Putman (1993) described social capital as a resource that enables stakeholders to accomplish goals that would otherwise be unattainable because it provides access to other forms of capital, like financial (grant, hospital Foundations funds), or human resources (insight into how healthcare systems operate and what gets the attention of the purse keepers). Most significantly, social capital can assist a group to “come up with innovative solutions to problems, manage risk, and adapt to change” (pg. 325, Wagner and Fernandez-Gemenez, 2008). Social capital increases the effectiveness of collaboration and as said by a research participant “Success builds upon success.”

A hospital manager described how social capital aided in establishing the spiritual care program in their hospital. The community clergy had approached the hospital to fund a chaplain position and had brought a workable business plan. The hospital board was intrigued but worried about adding to their current operating expenses. Members from the hospital board, a senior official and some community clergy met with the Hospital Foundation Director. The hospital was saying that they were behind spiritual care but needed a creative way to fund it. The Foundation Director approached a person who lived in the community who agreed to make a very significant donation to the hospital so that the interest from the investment could be used specifically to fund the spiritual care program. The Foundation Director knew where to look for money. The hospital knew who to go to for help in financing. The community clergy knew to approach the senior hospital officials. Social capital helped to make a chaplaincy program possible in this corporation.

A further example of the power of social capital occurred in another locale when community clergy approached their hospital CEO to advocate for a part-time hospital chaplain position. The CEO asked for a business plan and they presented a plan based on the HCC model

of shared funding and shared responsibility. The CEO was impressed with the well thought out plan and the management support and accountability but what he commented upon was the great number of community clergy who showed up for the meeting! He said it spoke volumes to him that so many professionals would take time out of their day to attend the meeting. He invited two representatives to come to the hospital board meeting to present the Hospital-Community Collaborative model. At the hospital board meeting the HCC model and business plan was presented and the board members noted that the CEO was fully behind the adoption of the HCC model. They voted to designate operating funds to spiritual care. Social capital brought together significant religious leaders to form a plan. A wave of social capital bowled over the CEO and helped him to support the spiritual care program. The establishment of the new chaplain position was possible because the board members trusted the CEO and his leadership. The hospital staff accepted and supported the new chaplain because the decision was supported by the hospital management. Social capital opened doors and facilitated the success of establishing the hospital-community collaborative model.

Social Capital is possible where there are trusted relationships. The HCC model may be successful in small cities and in small to medium population centres where community members are inter-connected. A member on a hospital board may also be the member of a local congregation. They may be aware that their pastor is advocating for a local hospital chaplain. Staff members from the healthcare team may be more willing to participate in the development of the chaplaincy program because they know some of the key leaders. Social capital starts with relationships but then it provides access to further resources because of those trusted relationships. One chaplain experienced the power of trusted relationships when obtaining sponsors for a fund-raising event to cover the cost of the musical group. A community clergy

who was on the chaplaincy board had told the local funeral director and two local businesses that he frequented that the hospital chaplain would be calling them looking for financial sponsorship for the annual fund-raiser. The chaplain made the calls and immediately had the financial support...social capital opened doors. Sociological research into where spiritual care programs were located in American hospitals was conducted by Cadge et al in 2008. They found that chaplains were not represented in small rural hospitals. The HCC model may be a solution for increasing access to spiritual care in small city and rural hospitals.

Strengths, Challenges and Limitations of the HCC Model:

Handzo (2006) encouraged spiritual care providers to consider the unique needs of their hospitals and to develop spiritual care programs that dovetail with the mission, vision, and strategic plan of the hospital. Partnerships between religious organizations and hospitals work because all share a common mission – to care for the sick. Collaboration, between community leaders and the hospital management, to form a spiritual care program ensures that spiritual care is part of the vision of the institution. Working with community organizations to accomplish hospital goals is evident in many hospital strategic plans. The HCC is an effective model for providing spiritual care when, and only when, there is strong leadership from both the hospital and the community. Active leadership from the top administration of the hospital, from the community faith leaders and from the chaplain themselves forms a balanced three legged stool upon which the program can build. Deficiency in any one of the three forms of leadership would bring instability for the chaplain's position or promotion of the program.

Support from the top level of the hospital administration and participation by the senior managers for clinical care were cited as essential to making this model of chaplaincy work.

Endorsement from the top communicates a message to staff that the hospital values spiritual care. As a result, the chaplain becomes an accepted member of the healthcare team. Participation by senior hospital managers on the chaplaincy board (or the Pastoral Care Committee) models that this is an important use of management time, provides opportunity for the manager to hear and advocate for spiritual care concerns, and builds a relationship with the faith leaders.

Attendance at the monthly meetings or a minimum of four times a year seems to maintain the continuity between the community and the hospital. Time and endorsement by senior management mirrors for the hospital culture the image that spiritual care is valued within the institution. Senior hospital leadership was present at the bi-monthly chaplaincy board meetings in two of the HCC's under study. In another HCC, the senior manager met regularly with the chaplain but not regularly with the chaplaincy board. In fact, many board members had not met the new healthcare manager. In the fourth HCC, a middle manager was responsible for overseeing and advocating for the spiritual care program for all four hospital sites in this corporation and this was in addition to her full-time responsibilities for another department of the hospital. Hospital endorsement and support for spiritual care is evidenced by allocating time for managers to be present at meetings.

Senior management leads by example. The experience of one healthcare manager is described below. A hospital chaplain had joined the organization (through an HCC) and was visiting patients but the healthcare team was reluctant to make spiritual care patient referrals or have the chaplain join the inter-disciplinary rounds. The clinical manager decided to address the problem head on:

“I told the staff, remember watching those old shows like M*A*S*H? They would have a chaplain on the show. The chaplain was not directed toward any particular religion but was there for everybody. It was someone to talk to, and to vent to – and that person is called the chaplain. You can talk with them about your feelings, and patients, and reactions. The staff used to be

unsure of her role but now they have begun to make referrals. I have talked about what her basic role is and now she is involved in the multi-disciplinary rounds. She is part of our team so I tell staff to include her.” [P44]

This manager went on to describe further modelling of support for spiritual care by walking the chaplain around the hospital to introduce her to all of the senior administration.

Community leadership was the second leg of the Leadership stool. Community leadership was evidenced by volunteer commitment on the Chaplaincy Association board for several terms and active participation in the promotion of the chaplaincy program. The community leaders were most often community clergy or active laity in religious congregations. They demonstrated leadership by being conduits of information about the chaplaincy program and the work of the chaplain with their local ministerial associations, church boards, and denominational groups (Presbytery, Deanery or Cluster). The mandate to care for the sick is shared many faith traditions. Community faith leaders are willing to participate on the chaplaincy associations because they view pastoral care of the sick as a logical extension of the work of the church (local outreach) and want to ensure benefits of access and spiritual care training for the community. In each community the faith leaders already had an established pattern of working collaboratively on community related projects or services. Religious leaders from a variety of Christian denominations met regularly in ministerial. They were used to one another, had relationships built on trust, and were open to supporting a chaplain who would represent faith in the hospital system.

The third leg of the Leadership stool cited by participants was the person of the chaplain. Participants described the role of the chaplain in the Hospital-Community Collaborative model as different from the traditional job description for spiritual care providers. It was the matrix of skills necessary to facilitate this model that required strong leadership abilities. The chaplain was

expected to not only have effective spiritual care skills in order to provide quality bedside care, but in addition they needed to have skills in administration, teaching and training, public speaking, and volunteer management. The chaplain had to accomplish their work often on a part-time salary and do extensive networking with the community faith leaders.

Those interested in creating a Hospital-Community Collaborative in their region would be wise to note the importance of the theme of chaplain leadership. The ability to demonstrate spiritual care competencies accompanied by a hospitable personality is central to all chaplaincy positions. However, the skill mix for the HCC model requires a person who has strong collaborative abilities, administrative/management skills, community leadership qualities, hospital leadership aptitude, and can be a welcoming presence to hospital staff and community members. The chaplain needs to see themselves as a bridge and a broker for spiritual care. The continuity of care between hospital and home (or LTC) must be advocated. The chaplain needs to embrace the tenets of the model and facilitate its success. The HCC model is perhaps highly dependent upon the skill set of the chaplain more than other models for funding chaplaincy for the chaplain is quite visible in this model. Not unlike an ambassador, the chaplain becomes the ‘go to’ person for spiritual care by both community members and hospital staff.

The theme of Leadership, encompassing senior hospital managers, community faith leaders and the chaplain, required a time commitment from all three in order to effectively manage the program. Together, the leaders cast a vision for the development of the chaplaincy program and the role of the chaplain within the hospital and the community. The leaders needed to respect the different perspective that each partnering organization brought to the boardroom table. Their reasons for entering the collaboration may be different; for example, the hospital may want financial help and the community may want spiritual care education and an advocate

in the hospital for community faith leaders. However, effective partnership means working together towards the common goal while respecting and supporting the unique benefits for all stakeholders.

The energy that is needed to both develop and sustain a hospital-community collaborative seemed to come from a catalyst event or difficult spiritual care related circumstance faced by either the community or the hospital. In many cases in the current research it was the lack of access to patient religion information and hence the inability to find their parishioners that mounted frustration in community clergy and necessitated a solution. One hospital corporation also cited their difficulty managing community members who wanted to provide spiritual care and some personality conflicts and power struggles concerning access to patients. If all had been going well there would not have been a need to develop a new spiritual care program. If the community faith leaders had experienced a reasonable level of access to patient religion information allotted to faith leaders under the privacy legislation and had not felt alienated by the hospital culture; if the hospitals had not needed to have someone to manage the spiritual care volunteers and screen, train and supervise all those who offer care in their hospitals...if these pressures had not increased to such a level that action had to be taken, there would not have been the energy or inertia to spend the tremendous amount of volunteer energy to develop the proposal for a chaplain position and participate on the board. One pastor summed up his experience, “We worked long and hard to bring this together.” [P30]

By sharing the financial load the hospital experiences support from the community and social capital is fostered among partners. The comments from the participants emphasised that money equals commitment but more importantly, money follows trust. The financial contributions from stakeholders are not just to ensure patient access to spiritual care – the

community also would like to see a return on their investment. What makes the hospital-community collaboration work well is the ability to share decisions regarding the management of the spiritual care program. Establishing a clear agreement, sharing decision-making and respecting the boundaries of the partners accounted for 24% of the participant responses in terms of the factors that make the partnership work. A well-defined agreement with a balance between partners for guiding program development is the foundation of collaboration. Sharing management is challenging for hospital culture and requires trust between the stakeholders. The community value the opportunity to have a voice in the development of the spiritual care program. The hospital can experience the benefit of having access to the energy and wisdom of the community. Sharing funding and sharing responsibility for the management of the spiritual care program deepens the sense of ownership in hospital staff and in the community.

Partnerships require a win-win experience for all stakeholders and the Hospital-Community Collaborative model delivers positive outcomes to all when there is strong leadership, shared funding and shared resources and when regular attention is given to building relationships and maintaining communication among stakeholders.

The unique contribution of the HCC model for spiritual care is the increased sense of ownership for the chaplaincy program by hospital staff, administrative leadership, and among community members. In this model the chaplain is not working in isolation. Rather, the chaplain is part of the hospital management team, integrated into the healthcare teams on designated in-patient units, and is also connected to the community through the chaplaincy association (with both hospital and community members). The chaplain works with patients but is also connected to the community clergy and builds relationships with faith leaders, staff and hospital administration.

Participants cited that the sense of ownership is strengthened by the increased knowledge of spiritual care and awareness of the chaplaincy program. Hospital staff and community faith leaders/ community members were represented on the chaplaincy association board. Their role was to bring information and spiritual care issues to the board and members were responsible to problem solve and take spiritual care information back to their respective hospital departments or ministerial association. The result was a broad recognition by hospital staff and community members of the importance of spiritual care. Participants perceived that the HCC model ensured that more staff and community members were aware of the availability of chaplaincy services and could describe the kind of care provided by a chaplain. Further research is needed to investigate this perception by participants. Bentur et al (2010) research and Trogden (2009) underscore the need for more people in healthcare to understand what spiritual care actually is, and what a chaplain uniquely offers. Increasing the awareness of spiritual care within the hospital culture and in the community ensures that more people grasp the importance of patient access to spiritual care while in hospital.

Community knowledge of the chaplaincy program can support patient access to spiritual care. One chaplain spoke of being contacted by a family member of a dying patient to come and support the family and the patient. It was the community funeral director who told the family about the availability of the chaplaincy service. A nurse spoke about the broad sense of ownership for the hospital-based chaplaincy program saying that she appreciated that there were now so many volunteers that you no longer had just one chaplain but rather many qualified volunteers. She knew who to contact as the Healthcare Chaplaincy Coordinator but experienced a greater level of support knowing there were on-call volunteers and volunteer chaplains who were trained and supervised.

The HCC model can bring financial stability for a chaplaincy program since there is not a single source of funding. Shared funding spreads the load which is helpful in times of fiscal restraint. Moreover, shared funding means many more people are involved in the financial well-being of the spiritual care program. Before unpacking the inherent benefits of diverse funding a caution of the HCC model of shared funding will be offered. The HCC model is not an opportunity for the healthcare corporation to become a ‘free-rider’, experiencing all the benefits of shared funding and shared management with none of the responsibility. The hospital management needs to be kept aware of the amount of money that is contributed annually by community into the hospital for the support of the spiritual care program. Sharing decision-making is a means of ensuring shared management and prevents the free rider phenomenon.

A tremendous benefit of the community fund-raisers is the increased profile of hospital spiritual care in the broader (non-religiously affiliated) community. The members of one chaplaincy association board in this study described their annual community musical event. A talented community choir of seventy plus members offers a concert annually during the Christmas Season in several venues with all proceeds going to support hospital chaplaincy. The board members were tremendously encouraged that a non-faith based choir would commit their time and energy to support spiritual care. The hospital chaplain also speaks during the intermission to illustrate the work of spiritual care and to put a face to hospital chaplaincy. The board members felt that the wider community came to understand the importance of access to spiritual support during illness through these events. Visibility, promotion of spiritual care, and community profile, all interact with the goal of fund-raising. The implicit message to the community is that we are all responsible for continued spiritual care.

Diversified funding with broad ownership can mean the position of the chaplain is no longer one stroke away from being eliminated during economic downturns. A funding mix helps those who manage the budget to adjust to the changes that occur within communities. The HCC model is rooted in collaboration. Many foundations that offer grants have a requirement for collaboration within the application process. Despite the benefits of fund-raising, the idea of raising money seemed to be a source of angst by many board members on the chaplaincy associations. They felt inadequate as fund-raisers and expressed worry about whether they would be able to continue to uphold their end of the financial arrangement. Those boards that maintained close relationships through newsletters, e-mails, orientations or meeting with community faith leaders expressed more confidence in obtaining annual community financial support for their chaplaincy program.

The challenge of the HCC model for spiritual care is not unlike the challenges experienced with many partnerships – it takes on-going volunteer time and energy. If the leadership wains, if the will to fund-raise ceases, if communication breaks down, if the chaplain does not build relationships with community faith leaders, if the chaplaincy association works in isolation from the hospital or vice versa and relationships between the two are not tended to, then the partnership begins to weaken. At the conclusion of the interviews many participants volunteered their perspective on collaboration. They emphasised that the hospital chaplaincy partnership program enabled them to offer professional spiritual care; without the partnership this would not be possible. Participants noted the tremendous amount of work that was required and then spoke of the equally gained benefit. “Collaboration works because it forces you to get to know your partners. It implies commitment, it implies ownership and it brings with it accountability. Collaboration forces those three things to take place” [P1]. Keeping an eye on

the mutual goal was essential; “Both have to believe in the cause, which is spiritual care for the patients.” [P23]

In those collaborations where there was strong leadership from both the hospital and the community, shared funding and responsibility, relationship building and communication, there was a collective sense that this model was not only effective but a better model than having the hospital chaplain work in isolation from community. One participant stated that they had experienced other hospital spiritual care programs and had never felt so integrated within the healthcare team, so valued by the community, and so supported by both the hospital and the faith communities. Another chaplain stated, “I absolutely think that collaboration is the best model in the world if it is set up to work. Then the chaplain does not belong to the hospital or to the community alone but belongs to everyone who needs them. It’s the patient that matters.” [P16] One healthcare administrator underscored the need to think through the needs of the hospital and the ability of the community to work together before entering the partnership. The administrator stated that “Collaboration works if people all believe in what you are doing. The question you need to ask is not ‘should we’ but is it the right thing to do? If it is the right thing to do then figure out how make it work. Don’t talk about what you can’t do, talk about what you can.” [P2]

Summary of Limitations of the HCC Model

The Hospital Community Collaborative model seems to be reliant upon the presence of several critical factors before discussions about a possible partnership can commence:

- A crisis that provides energy to motivate people for change
- A hospital culture that is welcoming of spiritual care due to a previous positive experience of spiritual care (i.e. a volunteer chaplaincy program)
- A stable hospital organizational structure that is not undergoing major organizational transition

- The presence of a strong, united ministerial association that is in agreement to proceed with this HCC discussions

Other limitations of the HCC model have been scattered throughout the discussion and will be summarized here accompanied with some further observances by the researcher. The HCC model seems to work in smaller communities where there is one local hospital and the community (religious leaders) frequents that one hospital. A clear limitation of the model is that in medium to large population centres there are numerous hospitals and the deep sense of connection with the local hospital, necessary for this model, does not exist. A further limitation of the model is that we are speaking of ‘hospital in – patient chaplaincy’ when the future of hospital acute care may mean a continual decrease in the number of acute care beds with more healthcare being provided at home thorough community nursing organizations and homecare support – allowing for more out-patient surgery and less hospital days (Self, 2000). This model may be transferable to a community chaplaincy model or a focus on out-patient services.

The kind of collaboration made possible in an HCC could be due to the ‘like-mindedness’ of the participants. Each HCC in the current study was located in a culturally homogeneous region of Ontario and all participants were Christian. Jackson and Olive (2009) researched ethics committees in rural hospitals and found that one of the reasons they work so well is because the committee members share similar opinions. The van Loon (2005) study of partnerships between faith communities and healthcare recounted that although projects may start out as inter-faith, in the Australian experience, it was only the Christian faith communities that remained in the partnership. A limitation of the HCC model may well be a need for a homogeneous faith community. This model may not work with a religiously diverse community.

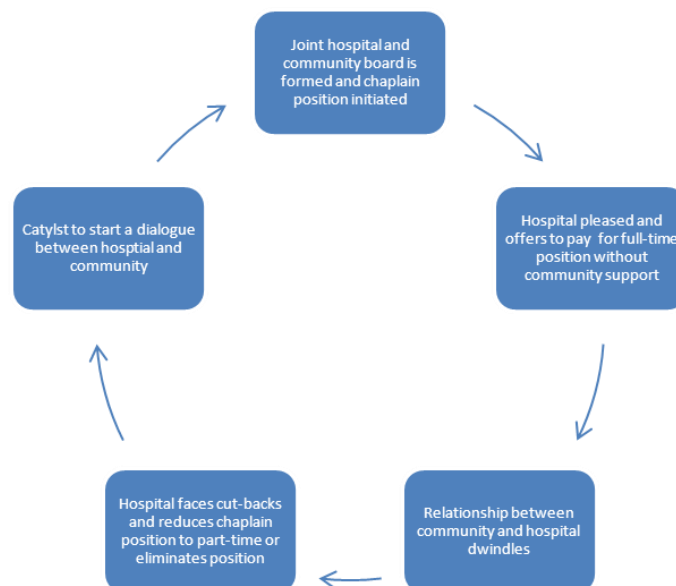
A big limitation is that the model requires a significant amount of work and networking to be done by unpaid personnel and as one chaplaincy board chair mentioned – “Some members do not want to do any work! Even getting volunteers to help on the board now is difficult.” (P41) But the more pressing issue for volunteer organizations today is the ever increasing expectations upon charitable organizations to create and maintain good governance practices and stringent financial accounting procedures. Volunteer charitable organizations in Canada must have a board of directors, terms of reference, by-laws, be registered with either the province or federally, hold regular and annual meetings, provide annual financial documentation to the Canadian Revenue Agency and follow all CRA accounting practices. Boards have the additional financial weight of liability insurance in order to protect the board members. The organization will benefit from being incorporated which means expenses for lawyers. Volunteer boards often need a part-time secretary to manage their activities and communications. If all this is left to the chaplain then it overburdens the work of the chaplain in this model.

This model is limited to centers where there are clear leaders in both the hospital and in the community who are deeply passionate about spiritual care, for the time and energy it takes to initiate an HCC is tremendous. The voices of the participants seemed to say it was worth it all. Even those facing challenges were quick to say how committed they were to the model due to the broadening of ownership of spiritual care throughout the hospital and into the community. Yet the reality of healthcare today is that the time available to managers, let alone senior managers is stretched very thin. The hospital needs to ensure that they are committed to ensuring their continuing presence and support at the chaplaincy board meetings.

Finally, a limitation of the HCC model is that when those who started the partnership retire, new energy and commitment must be found. This requires succession planning so that a

new generation of leaders can take the HCC to the next level. In the contextual research it was noted that a few historical HCC's in Ontario were identified. Each had gone through a similar cycle over a twenty to thirty year period (See Figure 6.1) – a catalyst occurred to begin a discussion, the HCC commenced with a financial/ governance partnership and a part-time chaplain was hired. Over the years, the hospital appreciated the work of the chaplain and offered to take over the funding of the chaplain position and make it a full time position. The need for the community board waned and eventually ceased to exist. The pattern of annual giving was sustained by a number of churches even if unsolicited. Eventually the hospital faced budgetary constraint and reduced the chaplain position to part-time or eliminated the position. The relationship with the community was lost in the intervening years. The HCC model does not need to follow the cycle but if community partnership wanes than ultimately the relationship is lost and if the hospital downsizes the chaplaincy position there is no longer the community to advocate on behalf of the chaplain.

Figure 6.1 Potential Cycle of an HCC if Partnership is not Maintained



Noting limitations provides an opportunity to see where this model might be most effective and assists in strategic planning by the chaplaincy boards to avoid the pitfalls.

Models of Funding Chaplaincy

Globally, hospital chaplain positions are funded through one or more of the following means: government tax dollars, private foundations, faith groups/denominations, spiritual care corporations, community grants, or volunteer/self-employed. Kofinas (2008) contends that the tremendous variety of how healthcare chaplains are funded is determined by how a region or a country understands spirituality in relation to its government. The variety of funding has produced many different spiritual care delivery models and each has implications for how spiritual care is integrated into the institutional system.

Orton (2008) summarized the systems for delivering spiritual care in healthcare settings in England, Scotland, the United States and Australia. In the U.K., chaplaincy is publicly funded and “professional chaplains are employed directly by the hospitals to provide a spiritual-focused multi-faith service” (pg 4). There has been a shift in recent years away from chaplains employed through state churches (the Church of England and the Church of Scotland) who received government funding to support denominationally based chaplaincies. Currently, the delivery of service is through the National Health Service Foundation Trusts, who are accountable to the UK government standards but have local discretion to serve local needs (National Health Service, 2006). UK funding for hospital chaplaincy is similar to Ontario, Canada, where individual hospitals decide upon the services they will fund and if spiritual care is included. Chaplaincy departments benefit from public funds with their chaplains serve as hospital employees.

In the United States, hospital chaplains are paid using funds from public sources, private foundations (including faith groups), spiritual care corporations, and from patients (reimbursed care model/fee for service) (Warnock, 2009). There are many examples of creative chaplaincy solutions built through partnerships between hospitals and religious organizations called contract chaplaincy (VandeCreek, 1999). There are numerous hospital systems in the U.S.: Government; Non-Government Not-for-profit; Investor-Owned; Faith-Based; and Veterans (Cadge et al, 2008). The American chaplain group is perhaps the largest in the world with estimates of over 10,000 chaplains working in hospitals and healthcare institutions (Weaver, Flannelly, Koenig, and Smith, 2004). Carey and Cohen (2008) provide evidence to support an emerging chaplaincy in Australia. Staff chaplains in Australia are employed through “the hospital, government, churches, or mixed funding” (pg 29, Carey and Cohen, 2008). Orton (2008) promoted that research is needed in Australia to determine how chaplains are funded and cited one study done in the city of Melbourne found that 2/3 of the hospital chaplains were paid through the hospital operating budget and 1/3 are church funded. However, the source of funding for the hospitals and whether it consisted of mixed funding was not teased out. Newell and Carey (2000) had previously found that 24% of hospital chaplains in Australia are hospital funded and stated “to put it bluntly, this means that a majority of hospitals are receiving a service with someone else footing the bill!” (pg 43). Spiritual care programs have recently been started in Israel through funds from several American Jewish philanthropic organizations (Benzur et al, 2010).

The predominant model in Ontario, Canada is the hospital (or healthcare institution) employed chaplain similar to other healthcare professionals. Positions are funded through the operating budget of public hospitals. Ontario has both public hospitals and a faith-based, religious-order based healthcare system (Roman Catholic) but both receive tax dollars for their

operating budget. As a hospital employee, chaplains are extended the same rights and privileges afforded to all members of the healthcare team and held to similar standards of professionalism and accountability. The contextual survey attached to this study found that 80% of Ontario acute care hospital chaplains are funded through the public purse. Canadian professional chaplaincy organizations have worked hard to promote the place of the chaplain as a full member of the healthcare team. The hospital is solely responsible to hire and manage the chaplain position (or department). Numerous hospitals have spiritual care committees that welcome community input into the spiritual care program but at the end of the day the decision-making power remains with the hospital administration. Additional funding does not come from grants, community religious organizations or foundations. The chaplain is able to focus on direct patient spiritual care and may have no requirements in the job description to network with faith communities or provide community education. Given the clear advantage of simplicity in this model why would partnership models even be considered let alone promoted?

In Ontario, chaplain positions dependant on single source government funding have been vulnerable to elimination as hospitals seek to balance their healthcare budgets. A minority of chaplain positions are funded through denominational grants, 13%, and hospital-community collaborations 8-10%. Comprehensive study of the current state of chaplaincy is needed in the Canadian context. It is important to note what partnerships can do; what they can achieve. Partnerships help to ensure access to a spiritual care professional where such access has previously not existed and partnerships help to increase the level of spiritual care support in our hospitals. The data on chaplaincy in Ontario provided in this study hints that there is tremendous variability in the percentage of patients who receive spiritual care while in hospital. The religious-order based hospitals seemed to provide a substantially higher ratio of chaplains to in-

patients. More research is needed to accurately determine the level of hospital spiritual care in Ontario and across Canada. The research on patient satisfaction confirms that patients want access to a qualified spiritual care provider while in hospital. In addition, partnerships are able to create a system of spiritual care that is remarkably different because it is solution focused and based on the needs of all of the stakeholders. Partnership enables two organizations to provide a service that would not be possible otherwise.

One form of partnership is the contract model. The hospital contracts with an external agency to purchase spiritual care services. This outsourcing for chaplaincy has the advantage of stabilizing funding outside of the institution. Although the chaplain is not a staff member, they can become integrated with the healthcare team. A second form of partnership occurs when the healthcare institution receives spiritual care services free through a denominationally funded chaplain (i.e. Roman Catholic Priest), a national trust (such as the National Health Service Fund in the U.K.). The disadvantage is that when a hospital receives spiritual care service free the chaplain is often not fully integrated into the healthcare team but rather remains on the outside looking in. The current research has focused on a third model of partnership where the healthcare institution collaborates with a spiritual care corporation to both fund and govern the spiritual care program. In the hospital-community collaboration (HCC) model the healthcare institution does not make unilateral decisions affecting spiritual care but rather works in partnership with the community to address needs of patients and those who provide care. Moreover, a partnership with shared decision-making means that the chaplain position is no longer vulnerable to unilateral fiscal decisions. Healthcare administrators view the chaplaincy program as sustainable because it is a revenue generating program. Institutions partner for economic reasons, to build a chaplaincy program that would be impossible without the contribution of each partner.

Are partnerships interfering with establishing chaplaincy as a profession?

Partnerships abound but does their existence pose an inherent risk to the development of chaplaincy as a profession? The quest of professional chaplaincy has been for the healthcare system to recognize the unique and vital contribution of chaplains in the process of restoring patients to health or assisting patients and family members at end of life. Chaplains have worked hard to replace their perceived volunteer/good works image with an established profession with credentials, competencies, and professional accountability. The road has not been smooth. Unlike more recent healthcare professions such as Social Work and Occupational Therapists which are recognized as registered healthcare professionals with their own college, chaplains awkwardly straddle the fence between the psychotherapy camp and that of their religious roots. Having a foot in two camps has split the profession and caused confusion to the healthcare partners who are looking for a clear definition of spiritual care, standardized education, specific role definition, and identified competencies.

Spiritual care specialists are in a quandary. They desire to be recognized for their evidence-based, unique contribution to patient care and be accepted as a full member of the healthcare team. Moreover, as professionals, spiritual care specialists want to be paid through the same system that pays all other health professionals, be that a government funded system or a private healthcare corporation. To open the door to allowing funding through other sources, namely, a religious organization is perceived by some as a setback for the profession and undermining the fight for professional recognition and status. Yet partnership models are the dominant source of funding in other countries where their chaplains are also engaging in the establishment of professional standards and credentialing (Newell and Carey, 2000).

Returning to the question at hand – would the funding of spiritual care specialists from an outside source (not the corporate operating budget) undermine the continued development of chaplaincy as a profession? The answer is no – based on the research with hospital-community funded chaplains – most healthcare professionals assumed that the chaplain was a hospital employee (some are) and paid by the hospital. What was critical was the hospital’s endorsement of the chaplain as a full member of the healthcare team – attendance at patient care rounds, charting privileges, integration with various teams, and membership at the management table. The other healthcare professionals did not care how the chaplain was paid – what they cared about was whether the person was well trained (certified), demonstrated a high level of spiritual care skill, and supported the other members of the healthcare team and was accountable to a governing organization. Preference may be given to having healthcare chaplains paid through the healthcare institution, the same as nurses and respiratory therapists. To not consider partnerships though negates the opportunity for smaller hospitals to obtain professional spiritual care. The provision of spiritual care, or access to the provision of spiritual care by those patients who request it, is a requirement of hospital accreditation and has been identified as essential by the World Health Organization.

A further concern is that if we open the door to consider other forms of funding (other than hospital operating budget), then during a healthcare pinch, hospital managers might balance the budget by assuming that the community or religious denominations will pick up the financial slack and fund spiritual care. Hence the fear is that hospitals might eliminate chaplaincy positions as a cost saving measure anticipating provision through other means. The qualitative research did not bear witness to this concern. Research with the four healthcare corporations discovered that in all four corporations there had not been a chaplain position at the hospital and

one was created in response to the advocacy from the community following the establishment of the partnering organization. Conversations with other hospital corporations that utilize the HCC model revealed that a chaplain position had not existed prior to the initiation of the partnership. The HCC model is not about handing over money to the hospital to fund chaplaincy. Rather, the HCC model is founded on the principals of collaboration among key stakeholders to reach a common goal, ensuring mutual benefits, and changing the system of care rather than simply supplementing the spiritual care program.

Although the partnership model is a minority, among acute care hospitals in Ontario, it should be noted that these partnerships for the provision of care exist as part of the solution for sustainable chaplaincy. The majority of positions created by religious denominations are again filling a gap in spiritual care. For example, the Roman Catholic and Anglican denominations have recognized a need to provide care to their members during significant healthcare crises that are attended to in our large teaching hospitals. These positions did not arise because the hospital perceived that the ‘church’ would just pay for spiritual care. Rather, the denominations actively sought out the creation of these positions to fill a need.

Ontario’s healthcare system and hospitals are acknowledging the coming economic crunch (OHA, 2011) and the need to prepare through a coordinated strategy. Healthcare in Ontario is the single largest expense for the provincial government. The OHA position statement October 2011 on funding and capacity planning predicts Ontario hospitals will need to implement aggressive reductions in order to balance budgets in the coming years. In 1995, the Ontario government made large funding cuts to healthcare without first planning for restructuring and estimating the fallout from those cost-cutting measures. The absence of a coordinated strategy to achieve spending cuts resulted in service disruption and gaps. “Ontario’s

current situation is much more challenging than in the 1990s” and “there are plans for real-dollar cuts to the health budget” (OHA, 2011, Page 3). Throughout the 1990s and early 2000s hospitals worked hard to find all possible material efficiencies and reduced staffing. The result is that there is little room for cuts without reducing beds and Ontario bed occupancy already exceeds 90%.

The lack of margin to find continued efficiencies in Ontario hospitals could mean that further cuts are possible by looking at services deemed non-essential to the provision of care. Conversely, Ontario hospitals could promote systemic changes – changes in the way we go about providing a service, rather than cutting the service. The HCC model is based on a systemic change in how chaplaincy service is both provided and funded. The OHA position paper is advocating that Ontario hospitals learn the lessons of the 1990s and become active planners for how to restructure prior to the implementation of the coming budget cuts. Chaplaincy must also heed the writing on the wall. For professional chaplaincy to thrive chaplains and the healthcare team (and community) must be proactive and seek out a variety of funding model alternatives. Next, chaplains need to research the effectiveness of these models for the provision of quality care and the model’s sustainability. And thirdly, chaplains need to ensure that they are doing this work in tandem with the hospital leadership. A major learning was stated by one participant, “The Chaplaincy Association can have all the goodwill we want, and do all the right things, but if the leadership of the hospital do not know we exist and do not care that we exist, and if the hospital leadership do not know what spiritual care is and they are not willing to embrace it, then I think there is no way for it to go forward.”[P23]

The link that professional chaplains provide between the healthcare institution and the community needs to be integrated into the development of new models. Handzo and Wintz

(2006) open an article on community health innovations by summarizing the diversity and complexity of the role of the healthcare chaplain:

Professional chaplains play a key role in an organization's ability to meet the emotional and spiritual needs of patients and their families. Through supporting patients' religious/spiritual beliefs and practices, professional chaplains enhance coping mechanisms and care for families (reducing demands on staff). Professional chaplains can provide patient support and spiritual guidance to healthcare staff and help the organization increase customer and staff satisfaction, which are critical goals in a healthcare organization. In addition, chaplains are actively involved in their communities by organizing wellness events, providing leadership during a crisis or disaster, and serving as a point person for other religious leaders who may have a member of their congregation in the hospital system. (P38)

The qualitative data in this study confirmed that faith leaders would like chaplains to take a leadership role and provide spiritual care education in the community. They viewed the chaplain as the local spiritual care expert who could help train the spiritual care teams in faith communities. The faith leaders also saw the chaplain as either the enabler or the preventer of access to patient religion information. Under the Ontario Privacy Legislation (Personal Health Information Protection Act, PHIPA) community clergy have access to the name and address of in-patients who belong to their denomination. This study demonstrates that chaplains need to ensure ease of access within the boundaries of PHIPA so that community faith leaders can visit their parishioners while in hospital. Hospital funded chaplains may find some significant insights within the HCC model. One significant contribution from the data was that when a chaplain intentionally builds a relationship with the community faith leaders the spiritual care program is strengthened and the relationship between the hospital and the community is enhanced.

Finally, the HCC model is rooted in the conceptual foundation of Solution-Focused Therapy and the ideas of collaboration and social capital from Organizational Theory. The key leaders are invited to envision a hospital system where spiritual care is working. This research provided clear evidence that the initiation of an effective spiritual care program needs the active

support of top hospital administration. Hospital leaders and community can come together by identifying the common goals and balancing the mutual benefits, by building trust among very different partners, by fostering social capital, a unique model of hospital chaplaincy is developed. The current research investigated four healthcare corporations that implemented a hospital-community collaborative model of chaplaincy in large and small population centers (noting that the small centers became medium sized by serving regional and recreational populations). The data suggested how they made this form of chaplaincy work - Leadership, Shared Financing and Shared Responsibility, and Relationship Building with Communication. Each partnership arrangement was unique and based on the community needs and hospital requirements. Yet there was remarkable similarity between the voices of management, chaplains, and the members of the partnership committee as to what was required to make these collaborations work effectively.

The implication of this research is that as chaplains, religious leaders and hospital managers consider how to establish sustainable chaplaincy in their hospital - this conversation would be more effective if it happened together rather than in isolation. Chaplains need to pursue conversations with hospital administrators if creative solutions are to be found. Moreover, the local faith leaders need to be brought into the discussion. Social capital teaches us that others have access to resources that we did not even know existed. Perhaps by joining with others we can move our immovable mountains. Through collaboration we can create a spiritual care program that was not possible without the support of both community and the hospital itself. By focusing on what it is that we want to happen, what life would be like without the problem of fiscal restraint, perhaps chaplaincy in healthcare can flourish.

Recommendations based on the Research:

There are several recommendations I would like to highlight from this research. First, all hospital spiritual care providers can manifest the core competency of collaboration by networking with the community clergy and faith leaders that frequent their hospital. A partnership mentality can foster further collaborations and support the work of the chaplain in yet unimagined ways. Too often local faith leaders feel alienated from the hospital environment and do not experience the local chaplain as their advocate. Networking is manifested when chaplains offer hospital pastoral care orientations for faith leaders, attend the local ministerial association, and invite the faith leaders to an education seminar on care for the sick in hospital. The core competency of leadership also encourages chaplains to build relationships within the hospital and the community. Hospital staff benefit from knowing who the chaplain is (by name) and what they do. Leadership is exemplified when the spiritual care professional is part of the hospital new staff (and new physician) orientation schedule. A spiritual care e-learning module tailored to the specific chaplaincy program could be developed. Leadership can be as simple as showing up! Show up for interdisciplinary rounds, ask to be on accreditation survey teams, join the local palliative care network. Leadership, as envisioned through the HCC model also encourages hospital chaplains to speak about spiritual care in local faith communities as part of the worship service or at service club meetings.

A second recommendation is to develop a forum for creative funding strategies. A conversation about alternative funding models (other than government) does not mean that spiritual care professionals will lose the ground gained in establishing chaplaincy as a profession. The reality is that creative funding strategies abound and discussion at the national level needs to be supported. (For example, offering sessions at the annual conference of the Canadian

Association for Spiritual Care or at the Ontario Hospital Association annual conference). We have much to learn from one another. A funding strategy that is wonderfully effective for a Level A hospital may not work well for a Level C. However, some effective principles may be transferable. Within our healthcare system there is much diversity. In small and medium sized population centres approaches that work are often community driven because there is energy to bring about a solution that is suited to the local community. Hospital chaplaincy could benefit from learning more about small centre strategies across Canada as well as medium to large population center solutions. Furthermore, chaplains need to be prepared to participate at the start of the discussion of Healthcare Hubs in Ontario for rural and small population centres. The Local Health Hubs report (due to be released by the Ontario Hospital Association in 2013) promotes the linking of all health related services under one umbrella in order to improve patient access (OHA President's Report, August – October 2012). It will be essential for both faith leaders and spiritual care specialists to request a seat at the Healthcare Hub table and communicate their pivotal role in supporting continuity of spiritual care from hospital to home.

As acute care beds decrease and community healthcare increases, the discussion on the future of spiritual care integration into healthcare needs to consider the role of the community chaplain. Healthcare dollars in Ontario are funnelled through Local Health Integration Networks (LHIN's). This second recommendation of a forum for discussion needs to highlight the development of chaplaincy positions under the LHIN's (including community positions with an emphasis on palliative care support). The focus of the current research is upon hospital chaplaincy; however, spiritual care professions tend to be a wide and diverse group and dialogue among those who work in long term care facilities, in the federal and provincial Correction

System, in educational facilities, as well as industry, could promote cohesiveness to the profession.

A third recommendation from the research is directed at those who are considering a Hospital-Community Collaborative for their hospital. A HCC partnership requires attention to the skill set of the chaplain hired to manage the spiritual care program. The key factors of Leadership, Shared Responsibility and Relationship are necessary, but for this model to work well it requires a chaplain who has significant organizational abilities, networking/communication skills, and is willing to embrace the tenets of the model. For many years the training of chaplains has focused on the development of excellent bedside skills. The majority of the core competencies advocated by CASC (Spiritual Care Assessment/Intervention; Self-Awareness; Theological Reflection and Spiritual Formation; Multi-dimensional Communication (Listening); Brokering Diversity; Ethical Practice and Documentation) affirm the role of the chaplain with patients and family members. Two of the competencies, Collaboration/Partnerships and Leadership are essential competencies required by the chaplain to facilitate this model effectively.

Further Research Stimulated from this Research

In the previous pages, a mantra has been peppered encouraging chaplains to research a variety of models of spiritual care delivery so that hospital administrators can make evidence based decisions on what are effective and efficient means of providing spiritual care to patients. The current research looked at only one form of funding – the HCC, and specifically how to make the partnership arrangement work effectively. There are many other aspects of HCC's to

still investigate. This study researched what people negotiating and managing a hospital-community collaborative need to know and do in order to have a successful partnership. A flaw in the methodology was to only speak to the manager to whom the chaplain reported. It would have been valuable to have interviewed the CEO, nurses, or other healthcare professionals to truly assess the hospital perspective on the partnership arrangement. Further research is needed to discover how the hospital culture perceives their partnership with community.

The concept of shared responsibility, specifically, shared cost sharing and shared decision-making also needs further investigation since this is the area of tension identified by the participants. Sharing governance seems destined to create tensions in a hospital-community collaborative since the service is being provided on the hospital premises. In addition, Poland et al (2005) noted that the institutional culture of the hospital provided many challenges for hospital-community collaboratives. The current research study did not unpack this dynamic and further research is needed to help joint boards navigate the sharing of decision-making power. As an observer at chaplaincy board meetings I noticed that the community did not appear to be asking for a 50/50 split of shared decision-making but clearly wanted their concerns addressed.

There is a need to expand the data from the regional study of chaplaincy in Ontario and funding models to the wider Canadian context. Each province has a distinct approach to funding spiritual care providing opportunities to learn from the variety of strategies or partnership models that have been developed. The data included in this study suggests that religious-based hospitals, although funded by the public, seem to fund a greater number of chaplains. This may well have to do with the values and mission of the hospital corporations. Further research is needed to investigate if differences exist between religious-based hospitals versus secular hospital corporations and what can be learned about the valuing of spiritual care. If indeed this trend

exits, it may be possible to investigate the benefit of lower chaplain to bed ratios. Such research would provide further evidence for hospital administrators to fund chaplaincy.

Conclusion

Researching Hospital-Community Collaboration for spiritual care encourages all the key stakeholders – the community faith leaders, chaplains, and hospital administrators, to consider a solution-focused perspective when they tackle the question of how to fund spiritual care in an era of fiscal restraint. The existence of HCC's is a wonderful example of the creative human spirit to find unique ways of making the impossible possible. The HCC model is one model in a world of many types of partnerships but shines as an example of what is possible when we collaborate, for we truly are 'better together'.

In the highly technological world of healthcare, there are sometimes very few reminders of the spiritual reality that also surrounds us. Healthcare providers want to provide the best care for patients and yet spiritual care can get pushed to the side as obsolete or unnecessary. The patient though is asking for our hospitals to take into account their emotional and spiritual needs; patients are requesting access to spiritual care providers to support them through difficult phases in their healthcare crisis. The presence of spiritual care providers on the healthcare team remind health professionals that the spiritual dimension of living and recovery is important. There is a great need for further study to determine effective models for providing spiritual care to in-patients. Rachel Naomi Remen, a Jewish physician and educator, writes that physicians and health professionals need to be reminded of the spiritual reality. Or they, like the image of the dancing Shiva, will be "so caught up in the study of the material world that (they) do not know that the living god is dancing on (their) back." (p xiii, Puchalski and Ferrell, 2010)

Chapter Seven: Theological Reflection

Researchers tend to investigate an area of study about which they feel passionate. Passion does not bias the data; rather, it provides energy for the researcher to explore the topic because it matters to them. The passion that drives the current research is a desire to ensure that there are paid spiritual care providers available to support people when they are sick and in hospital. In other words, ensuring that there is funding for spiritual care matters to me personally. The Christian tradition encourages adherents to theologically reflect upon what is taught, believed, experienced, and written. Passion may be considered from a personal perspective and also from the view point of the theological understandings of sacred texts. There are many forms of spiritual reflection but I have chosen a model that moves the participant toward insight by spending time reflecting upon what matters deeply. The Spiritual Wisdom model is rooted in passion.

The spiritual wisdom style of theological reflection was developed by Patricia Killen and John de Beer (Killen and de Beer, 1994). These authors believed that humans are meaning makers and seek to understand both ourselves and our world. When something significant happens to us in our lives (or in our culture) we need to make sense of the event. According to Killen and De Beer, the event will stay with us until we have had time to process it. Spiritual wisdom occurs when we connect our everyday experiences with the sacred writings, doctrine, religious history and collective wisdom from our religious tradition. Theological reflection is the conversation that occurs when we slow down and intentionally reflect upon our experience and think about what our tradition may speak into that experience. The goal of “exploring individual and corporate experience in conversation with the wisdom of a religious heritage” (pg. viii) is to

move towards insight so that there is congruency between what we say we believe and our actions (our 'walk' and our 'talk').

The conversation between experience and religious tradition is critical. Without reflection our actions may not align with our beliefs. For example, if Christians say they believe we are to care for the sick and then do nothing to actively support the spiritual care of the sick then beliefs and actions are incongruent. The world calls this hypocrisy and Christians lose credibility. Killen and de Beer (1994) call people of all faith traditions to live congruent and authentic lives so that faith informs actions and actions inform faith. The hospital-community collaborative model is a wonderful example of the faith of both community members and hospital personnel being lived out by creating a spiritual care program together. The church and faith communities are able to ensure support for the care of the sick which is congruent with an essential part of a living Christian faith.

The Spiritual Wisdom model has four steps in the process of theological reflection. Step one involves thinking about the experience (in this case it is the desire to fund hospital spiritual care to ensure access for patients) but suspending judgements. Next, the participant is called to reflect upon the feelings and images that may emerge which symbolize the experience. Listening to the inner voice is critical at this stage. One is listening for a central issue or a question that emerges out of the feelings or images. Killen and de Beer (1994) refer to this as getting to the heart of the matter. Sometimes when we reflect we can get to this stage and encounter unsettling questions or uncomfortable emotions which prompts us to shut down the whole process of reflection! These authors call us to not stop when we have identified the heart of the matter but move further into the conversation between experience and the wisdom of your religious tradition.

Step three is the conversation between the lived experience and religious tradition. Delving deeper happens by asking reflective questions about the images, feelings and thoughts that are emerging. The seeker of spiritual wisdom is encouraged to listen for the theological themes or big life questions. The fourth and final step is to identify any new learning's from this reflection and put them into practice. So Step Four is a call to action, to implement the insights that have been gleaned with the support of prayer.

While reflecting upon the research, the voices of the interviewees, and the place of spiritual care in our hospitals I became aware of the anxiety that is shared by many chaplains. Their angst is rooted in the fear of further elimination of chaplain positions propagated as a cost cutting measure. Many chaplains work as the sole professional spiritual care provider in their institution. This can leave the chaplain in a position of collegial isolation. The changes in healthcare structure have meant the removal of numerous pastoral care department heads and placement of remaining chaplains under clinical or non-clinical managers, such as social work and volunteer services. These changes have reduced the ability to advocate for spiritual care positions. The spiritual wisdom model of theological reflection calls the participant to stay with the feelings and see if an image emerges to symbolize the experience. The image that came forth for me was the building of a house. My husband and I recently renovated our home by adding an upper story. In order to sustain the weight of the new roof twelve pylons or pillars were poured deep into the ground and joined up to the new roof. I thought about what these pylons represented in terms of hospital chaplaincy and what is needed to create and sustain a hospital – community partnership for spiritual care. As I reflected upon the Christian scriptures a parable came to mind.

There is a parable, or teaching story, in the Christian New Testament Scriptures (Bible) about wise and foolish builders. The power of this simple story lies in its ordinariness. The imagery is familiar to us all. The story-teller is Jesus and he states that a wise person builds their house upon a rock or solid foundation. Storms may inevitably come with fierce wind and rain but the builder does not need to fear because the house will be safe. It will not collapse because the house has been built on a sure foundation. Next the story turns to describe the foolish builder. The fool takes the easier route and builds the house on sandy soil. When the waters rise and the winds blow this house will simply collapse. (NIV Matt 7: 24-27)

A Hospital-Community Collaborative is a construction; it has to be made or created. It is a model for the provision of hospital spiritual care that is built. The challenge for many hospital chaplains is isolation. Chaplains may be the sole employee responsible for spiritual care or may work as part of a spiritual care team. The danger for all though is when the chaplain(s) becomes isolated from the community faith leaders that serve the hospital and/or isolated from other healthcare professionals within the corporation who have the ability to ensure the continuance of professional spiritual care for patients. The presence of a pastoral care committee can help with issues of advocacy but there is a need for senior hospital leadership to have membership on these committees. If the winds of change blow and the rains of budget cutbacks fall, the chaplaincy position may be in jeopardy. Numerous pylons of competent spiritual care may have been placed by the chaplain(s) to secure the foundation of this house. For example, the chaplain may have excellent spiritual assessment skills, competence from a healthy self-awareness, strong spiritual and personal formation, and willingness to broker diversity, documents as necessary, all of which are spiritual care competencies. But the winds and the rain may prove to be too great. More pylons are needed to be sunk down into the rock to anchor the house into a solid foundation.

These pylons include community connection with the faith leaders that serve the hospital; the establishment of relationships between chaplains and senior hospital executives; and in some cases, the sharing of responsibility and resources for the continuance of spiritual care between the faith communities and the hospital. The spiritual care competencies of Collaboration and Leadership support these pylons in particular.

The Hospital-Community Collaborative model is just one example of a house that has been built on a solid foundation; built to withstand the winds of change and the rains of fiscal restraint. The text was spoken by Jesus and He was suggesting that people who hear His words and put them into practice are like sensible and wise builders. The HCC model is built upon prayerful and respectful listening. For community faith leaders it means listening to their God for wisdom and guidance about their role in building a hospital chaplaincy program. For hospital staff members it means listening to the spiritual needs that are vocalized by patients and attending to the voices of staff members, community, and all those who talk of caring for the whole person. Collaborative efforts are not top down, ego driven initiatives. Partnerships are formed when we take time to listen to one another, build respect and trust, and dream together of what can only be possible when we join together.

The wise builder chooses carefully where to build the house. The land needs to be amenable to construction and the weight of the proposed building. If a hospital administration stubbornly refuses to see the value of spiritual care and declines to build a spiritual care program with the community then the foundation will be built on sandy soil. It would be better to wait and find a more secure site for construction. The wise builder often does not build alone – but starts with a team of experts who develop a blueprint of what the builder hopes for. The wise builder also judiciously chooses who will help erect the building. These leaders bring energy, insight,

and skill. Together this team can accomplish much for they bring a diversity of knowledge and an appreciation for the gifts and talents of one another.

Home owners know that you cannot just build a house and leave it. Houses require ongoing attention and maintenance. Repairs will be necessary. Additions may occur. The HCC model assembles a chaplaincy program that is suitable to their own region – they know their land. The leadership of the group with representatives from both the hospitals and the community form a team of experts who listen to the goals of each and create a model that offers benefits for both the patients and staff members but also the community members. Construction is not started until the team has taken time to build relationships among themselves and taken into account the common vision of spiritual care for patients. But what makes the HCC model withstand the wind and the rains which cause stress and strain is the solid foundation upon which the spiritual care program has been built. The foundation of the house has driven down pylons deep into the rock which has so secured the house that when the winds of change come and the rains of budget cutbacks arrive the house will stand firm. The pylons are the tri-fold factors that enable partnerships for spiritual care to be effective: leadership, from senior management, community and the chaplain; shared responsibility, for creating a common vision, sharing the financial cost, sharing decision-making and resources; and relationship building and communicating about the model and spiritual care.

The winds of change will come, and leaders will come and go from the chaplaincy association or the pastoral care committee but solid succession planning can coordinate the skills that will be necessary to maintain the next phase of the build. Without succession planning cracks will eventually appear in the foundation which could destabilize the collaborative spiritual care program. Without strong leadership, the rains of financial restraint could seep into the

foundation and further erode what was once a strong and well-built foundation. Even a spiritual program that has been built upon rock is not impervious to the elements. Vision casting and strategic planning are necessary. The HCC model requires on-going attention to leadership, shared responsibility and relationships for its continued success. Without such attention to on-going maintenance of the HCC the foundation could erode such that the building could sag or even collapse.

The rains of cut backs will continue to happen in healthcare but our healthcare system is looking for places of revenue in hospital programs and opportunities to collaborate with community organizations in order to provide better and more efficient use of resources. The management team is less likely to make a unilateral cut to a program when there is a strong partnership with accountability to a community organization and relationships among stakeholders. When senior leaders understand the value of spiritual care they are willing to work to maintain and not eliminate spiritual care programs. When the community has invested financially in the spiritual care program they feel some ownership and will work hard to ensure its continuance. When a hospital corporation creates a program together with community and places significant hospital managers to participate in the governance of the program, then a strong voice has been created within the hospital. The hospital staff themselves will express the value and necessity of the program for it is theirs, they too have ownership. The house of Hospital-Community Collaboration can only be built by a team who constructs on a foundation that is agreeable to establishing a spiritual care program. This house is not built quickly but rather takes years to construct. The blueprint may need to be redrafted from time to time. The pylons of leadership, shared responsibility and relationship-building are sunk with the strong contributions from both the senior hospital staff and the leaders in the community. Hence, the

house is anchored to withstand the storms that will inevitably blow. The house has been built on a foundation of rock by hearers of the Great Architect.

Theologian Stanley Haueraus (2006) describes this story in the Gospel of Matthew as an illustration of what it means to be a follower of Jesus. I have used the story as an analogy of what it means to build a spiritual care program. The theological context of this scripture passage within the Christian tradition is that a believer will be careful to do what they have been taught to do as Christians. This passage is often called the parable of “Hearers and Doers” (Albright and Mann, 1971). Haueraus contends that it is not enough to call Jesus Lord; we also need to do His will. He states, “Those who hear his words and act on them have lives founded on the only foundation capable of weathering (the difficulties found in) the world.” (pg. 91, Haueraus, 2006).

The fourth step in Killen and de Beers model of theological reflection is the action stage. New insights are put into action and lived out in one’s life but insight only leads to action “if we are willing” (Killen and de Beer, pg. 21). These theologians contend that the Christian way is not merely a promotion of increased awareness and understanding. Rather, the Christian tradition is incarnational. We receive truth or insights so that we can embody love and virtues in the world that benefit and change the world for the better. Insight leads to actions that impact us personally as well as corporately. I began to wonder how I have been changed through the course of this research and what the call to action will look like in my own experience as a healthcare chaplaincy coordinator of a Hospital-Community Collaborative. The research results compel me to focus on the relationships which undergird the partnership and to designate time to reinvesting in those essential relationships and their understanding of the nature of the partnership model.

A further personal insight is to anticipate the coming of the wind and the rain. Schweizer (1984) states that the passage from Matthew predicts that crisis will come. The passage may be

directly commenting on the final judgement or upon the difficulties of life but either way it counsels the reader to not be caught unaware that difficulty will come. Action can take the form of planning ahead, building relationships with senior management and community faith leaders today so that when the day of difficulty comes alliances will already have been made. A third personal action could be to establish a supportive network for the ten Hospital-Community Collaborative models in Ontario so that we can learn from one another and support one another in our commitment to partnership. When we have strong relationships we know who to turn to when the wind blows and waters rise.

Killen and de Beer's model of theological reflection promotes action stemming from insight for the purpose of changing our world for the better. An example of a positive action is the equipping of chaplains and faith leaders on how to have the spiritual care conversation with healthcare leaders and administrators who hold the purse strings. Such education can take the form of seminars at national conferences but it is essential that collaborative and systemic thinking become incorporated into the training of chaplains. Many spiritual care providers have master's level theological training from accredited seminaries and many gain clinical education through supervised pastoral education internships. The profession of spiritual care could be furthered if post-secondary educational institutions developed graduate training programs specifically targeting the skill set of the healthcare chaplains that included administrative, collaborative and leadership skills as well as the spiritual care and counselling skills. In Ontario it is important for the development of such programs to be done in tandem with the credentialing specifications of the newly established College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario (www.collegeofpsychotherapists.on.ca). Action resulting from insight from the research would be to include community clergy/faith leaders, healthcare

and a community chaplain, in emergency preparedness planning exercises. The sacred and the secular too often function as if they are independent when in reality there is significant overlap. We need to be observant of opportunities for dialogue between the religious and the medical traditions.

According to these authors, three things are required for us to make the leap from insight into action: prayer, planning and people. I would be remiss in this research if I did not state that those healthcare administrators that were supportive of the chaplaincy programs also were adherents to a faith tradition. The Hospital-Community Collaboratives were possible not just because they proved to be efficient and effective but because people of prayer were undergirding them. In the introduction I shared that part of my wonderings that led to this research concerned why some HCC's became established and others did not, why some flourished and some seemed to falter. Prayer, planning and a focus upon people are all connected to the action of making the impossible possible.

Final Thoughts

Research studies often produce some unanticipated research results that have significant implications. These are called the surprises of investigation. In an ethnographic study the researcher explores a culture and continues to gather data until the content becomes so saturated with similar messages that no new data is forthcoming. As I spoke with hospital chaplains across the province involved in some form of partnership for spiritual care I was amazed at the creativity and the plethora of the forms of partnership. What surprised me was the tremendous number of partnerships between hospitals and denominations or community organizations in order to ensure the availability of spiritual care to patients and family members in Ontario's healthcare system. Hospital-community collaboration is just one form of partnership. A further surprise was that the majority of those facilitating a partnership work in isolation from other chaplaincies facilitating a partnership. There is a great need to learn from one another and to grow stronger with one another. The governmental healthcare system is predominantly unaware of the extent to which community is investing in spiritual care in our hospitals, albeit in an isolated but coordinated fashion. It would be a travesty for the healthcare system to interpret these partnerships as an opportunity to simply off load (more commonly called downloading) spiritual care and expect religious organizations to pick up the tab.

At the writing of this paper the federal government in Canada eliminated financial reimbursement to all part-time non-Christian chaplains who provide services in federal prisons. This is a prime example of how governments or businesses find savings without consultation. With a stroke of a pen a spiritual care service is lost. In this recent case the government assumed that Christian Chaplains could cover all prisoners regardless of faith tradition. Government

officials missed an opportunity to collaborate or build a partnership with faith leaders where they could have learned the best way to proceed, together. Partnership brings a relationship between the faith traditions and the administration. When a relationship is created the lack of understanding for the value of spiritual care is bridged. In the healthcare system we need partnerships between hospital administrators and religious organizations to increase the dialogue, reduce suspicions, provide spiritual care education, and to value the contribution of spiritual care to patient centered care. A partnership does not have to be financial. The present study focused on how partnerships have formed in order to establish spiritual care services and to ensure sustainable funding of hospital chaplaincy. However, the overarching message is that ‘partnerships’ are important (financial, educational, relational, service) and partnerships protect the presence of spiritual care in our healthcare system.

There is a story of a wise old man in African who was dying. He asked his wives and children and grandchildren to come to his bed so that he could share his final thoughts. The man asked each member to go and get a stick. They did and when they returned he told them to try to break the stick in half. All were able to do so with ease. “When we are alone, we are like these sticks and we are easily broken. Now go and gather another stick” he requested. They went and gathered a second stick and returned to his bed. “Take your sticks and bind them together in groups of two and three” said the old man. His family obediently tied their sticks together in small bundles of two and three sticks. Again he asked them to break the bundled sticks in half. None were able to break their bundle. “When we join together we are strong and we are not easily broken.”

Spiritual care and healthcare has been joined for centuries in the mission of providing care for the physical, emotional and spiritual well-being of the sick. We can be better, stronger

together. Chaplains need to actively seek out collaborative relationships with the community faith leaders and the hospital administration so that those invested in the provision of spiritual care is owned by many. Those chaplains managing partnership based spiritual care programs need to dialogue with others who manage such programs to support one another and share wisdom. The community chaplaincy organizations that facilitate a local hospital spiritual care program also need opportunities to gather and learn from one another. We are better together. Collaboration and leadership are essential to a strong chaplaincy program.

Appendix One:

Interview and Focus Group Questions 2011/12

1. What is your name, and what is your connection with the chaplaincy program i.e. a board member, a chaplain, hospital staff or funding partner?
2. The hospital chaplaincy program in your hospital began as (or transitioned to) a partnership between the community and the healthcare corporation. How did this come about and who was involved? How did you (they) make this happen?
3. What kind of structure for spiritual care was created and how is maintained? Any specific steps along the way that helped development? (Structure)
4. What factors do you think help this partnership between the community and the hospital work? What are some of the necessary elements to make your partnership successful? (Why it Works or Doesn't)
5. What are some benefits of having the community partner with the hospital corporation in order to provide spiritual care? (Benefits)
6. What are some of the challenges of this arrangement? Were there some big hurdles along the way and how were they overcome? (Challenges)
7. Any significant insights that you would like to pass along to other people interested in initiating a partnership for their hospital spiritual care program?
8. In a 10 second sound bite - Why does collaboration work (or not work)?

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