How Many Chaplains Does Our Hospital Need? The GRASP Model for Pastoral Care Staffing

Orin Newberry BCC

Orin Newberry PhD BCC serves as director, pastoral care, at Grant Medical Center and Riverside Methodist Hospital, Columbus, OH. An ACPE supervisor, he is endorsed by the Alliance of Baptists.

newbero@ohiohealth.com

Determining pastoral care needs and securing full-time equivalencies (FTE) to staff them appropriately are ongoing challenges for professional chaplaincy. This article discusses both the contractual and ratio approach to staffing with particular attention to the latter. The author details a ratio model, the Grant-Riverside acuity staffing process (GRASP) that he developed with colleagues at Grant Medical Center and Riverside Methodist Hospital, Columbus, OH. The article includes specifications for this process and an example of its application.

PASTORAL CARE STAFFING IS ONE OF THE MOST CHALLENGING issues chaplains face. This is evident when chaplains seek to convince hospital administrators to retain or to add staff. The challenge also surfaces in making assignments. How may pastoral care staff be assigned in a manner that insures appropriate levels of coverage across multiple settings? How do chaplains assess the equity of workload in departments with more than one chaplain? How do pastoral care departments determine staffing levels that insure adequate pastoral care to patients and their family members? This article explores two basic approaches to staffing: ratio and contractual.

This discussion begins with two important working assumptions. First, the issue of pastoral care staffing is far too complex to be approached from only one perspective. The focus of this article is on ratio and contractual approaches with particular attention to a ratio model, but it is not the intention of the author to argue for one approach over the other. Also, this does not preclude the possibility of other approaches.

Second, pastoral care at its best is integrated into the institution rather than being considered an optional resource to be called upon when needed. To illustrate the difference, consider pastoral care as a continuum. On one end, the focus is primarily on pastoral care as a resource for the medical unit or hospital to draw upon when requested by staff members or patients. The understanding or contract between the institution and the pastoral care department is one of "we will call you if we need you." At its most extreme, this approach is restricted to either on-call pastoral care coverage alone or a limited number of staff whose primary focus is responding to crisis calls.

At the other end of the continuum is an approach to pastoral care staffing in which chaplains are integrated into the institution's day-to-day operation. Integrated pastoral care departments have staffing levels and a mindset that make them valuable and visible *partners* with other hospital staff to provide care beyond ministry in crisis situations. This consistent pastoral care presence enables the chaplain to establish stronger relationships with staff and to develop a better understanding of the patient population s/he serves. This model paves the way for chaplains to support both the medical unit staff and the patients/families, such as the following: participation in interdisciplinary rounds/case conferences, providing staff development programming, hospital committee membership such as ethics or quality improvement. In addition, increased visibility on the medical units opens doors to regular referrals for patient ministry as well as ministry to hospital staff.

Integrated pastoral care departments may develop services that not only provide these valuable ministries but also translate to cost savings that even skeptical administrators will appreciate. For example, a growing number of pastoral care departments have developed comprehensive protocols related to death and dying that not only provide direct pastoral care to family members at the time of death but also attend to the oversight of many regulatory and paperwork issues related to death. Though hospital administrators may not fully comprehend the ministry of presence, they usually understand the critical importance of regulatory compliance and the time chaplains save nursing personnel. Clinical staff members value the expertise provided by chaplains as the hospital's experts on matters of death and dying. In addition, time-pressed nurses appreciate having chaplains perform these tasks. Thus, integrated pastoral care departments are in a position to become leaders in the provision of spiritual and emotional care within the institution.

The contractual approach

The contractual approach to pastoral care staffing begins with a series of questions:

- What are the institution's mission and strategic goals?
- What role does pastoral care play in supporting these goals?
- What services does the institution expect from the chaplaincy team?

In short, what is the contract, whether explicit or implicit, that the institution has established with the chaplain or pastoral care department that defines the scope of services to be provided? Often this contract is implicit and informal having evolved between the chaplain and the person the chaplain reports to in the institution. Though this contract has a significant impact on decisions related to pastoral care staffing, its utility extends far beyond this issue. Indeed, it guides day-to-day ministry priorities and becomes the basis for the administration's evaluation of pastoral services.

One example of such a contract is ministry in the area of maternal and infant care. At one institution, the contract may designate the chaplain as primary coordinator of most, if not all, services to families who have experienced a fetal or infant death. In this case, the chaplain's ministry would include a wide spectrum of services beyond the provision of pastoral care to the patient/family, e.g., tracking and completing much of the paper work related to the death. At another institution, the chaplain's contract may be limited to providing direct pastoral care.

It is important to clarify the contract with administration for pastoral care services and to demonstrate alignment between the institution's mission/priorities and the work of pastoral care. Susan Wintz and George Handzo[1] provide an excellent overview of how to assess or survey a hospital as part of the development and presentation of a pastoral care business plan. This article provides an excellent starting point for establishing an explicit pastoral care contract with one's institution.

The ratio approach

The ratio approach to pastoral care staff does not attempt to address the larger question of the scope of pastoral care services. Rather this approach establishes a chaplain-to-patient ratio as a way to guide staffing decisions. The concept of staffing ratios is well established within the health care setting. Hospital administrators rely on ratios when addressing staffing issues for a variety of disciplines. Historically, pastoral care professionals, using their best judgment, have established staffing ratios. Wintz and Handzo provide an excellent review of some of these.[2]

Though the ratio approach has significant potential, it has several limitations with respect to pastoral care – especially as it has been used historically. First and foremost, there are few if any nationally recognized and accepted benchmarks for pastoral care ratios. For example, the Spiritual

Care Collaborative (SCC), an international group of professional spiritual care organizations, has not established benchmarks.[3] Second, the ratios that have been developed tend to take a "one size fits all" approach. That is, one ratio is established for use across all institutions and/or patient populations. This fails to recognize the diversity of settings, the diverse needs of patients within a given institution and the diversity of roles that chaplains play.

In an effort to address staffing issues, chaplains at Grant Medical Center and Riverside Methodist Hospital developed a staffing model for the medical/surgical hospital setting. The Grant/Riverside acuity staffing process (GRASP) model assumes an integrated pastoral care department and establishes a chaplain-to-patient ratio based on a pastoral care acuity assessment of each hospital inpatient unit. GRASP does not preclude the simultaneous use of the contractual approach. Indeed, both are necessary.

The GRASP model establishes a chaplain-to-patient ratio for daytime inpatient coverage only. It assumes that staffing in outpatient settings, e.g. emergency departments, hospice programs, and freestanding or same day surgical centers as well as coverage during evenings, nights and weekends will be determined through a contractual approach. That is, in collaboration with hospital administration, the pastoral care department assesses the hospital's mission, goals, scope of services and priorities to determine the extent of inpatient *on-call* and outpatient pastoral care coverage. The limitation of the GRASP to inpatient coverage points to the importance of integrating both the contractual and ratio approaches.

An example at this point may be helpful. Given its mission, priorities and scope of services, a smaller hospital located in a suburban area with relatively few deaths may determine that an on-call arrangement with chaplains or community clergy responding from home is sufficient during night and weekend hours. On the other hand, an urban hospital, which is a level 1 trauma center, may determine that having a chaplain in house overnight and on weekends is an important expression of its mission and scope of services.

Overview of GRASP

GRASP begins with a unit-by-unit pastoral care acuity assessment. There are a variety of ways to conduct this assessment, and the process will be shaped, in part, by how the results will be used. The chaplaincy team which developed the GRASP model maintain that it is important to utilize a process that draws on both the perspective of the chaplain who has responsibility for a specific unit and on that of other chaplains or professionals who are not assigned to the unit but who are familiar with most of the other inpatient units. Including professional disciplines such as nursing gives additional objectivity and credibility to the process.

This objectivity and credibility is of particular importance if the assessment is intended to justify current staffing levels or to request additional staffing. If the assessment is to be used to support a request for additional staffing, it is advisable to convene a multidisciplinary pastoral care advisory committee or taskforce to conduct the unit assessments as well as to collect and analyze the data gathered. In addition to increasing ownership of the assessment beyond the pastoral care department, these individuals also may be in a position to advocate on behalf of the department.

If the assessment is only to be used within the department, e.g., to allocate staff, a less comprehensive process may suffice. In this instance, the department manager or a departmental taskforce would conduct the unit assessments as well as to collect and analyze the data gathered. It is, however, still advisable to have chaplains who are not assigned to a given medical unit involved in the assessment process for that unit. The average daily census of each assessed unit must be determined, and to insure objectivity, it is best to secure census data from the institution's finance department or the unit's nursing leadership.

Inpatient units are assessed according to the three criteria—visibility, ability, urgency—using a scale of one to four, with one being the highest level. The sum of these three area scores is used to classify the unit by acuity level (A-high acuity to D-low acuity) and to assign a specific chaplain-to-patient ratio. (See GRASP for detail, including the unit assessment form.)

For example, the intensive care unit (ICU) has a visibility score of one, an ability score of two and an urgency score of one. Adding these three numbers gives this ICU a total acuity score of four, which classifies this ICU as A-level/high acuity. This particular ICU has an average daily census of eighteen patients, and the GRASP model specifies a ratio of one chaplain to forty-five patients on A-level units. Thus, according to the GRASP model, 18/45 or .4 of a full-time chaplain's time should be allocated to daytime pastoral care for this unit. This leaves .6 of this particular chaplain's time for ministry to other areas.

When determining the available staffing for a given department, the contract approach comes into play. For example, a hypothetical pastoral care department has 3.5 staff members: a full-time department director, a half-time departmental secretary and two full-time staff chaplains. After conducting a staffing analysis using the GRASP model, it was determined that 3.5 chaplains would be required to provide adequate inpatient pastoral care. Though this department has 3.5 staff, the secretary provides no direct pastoral care. Further, the director's "contract" with the hospital calls for her to spend approximately half of her time on administrative tasks and other duties, e.g., ethics committee chair, leaving .5 available for direct patient care. Thus, the department's actual pastoral care allocation is 2.5, and an additional full-time chaplain is needed to meet GRASP criteria.

In a similar fashion, based on the contract with their institutions, pastoral care departments must determine how to count the contributions of clinical pastoral education (CPE) students and/or volunteer clergy. For example, some hospitals take the educational demands of CPE programs into consideration and count CPE residents/students as full-time staff.

Conclusion

The GRASP model has proven to be very helpful to the pastoral care department at Grant Medical Center and Riverside Methodist Hospital, both to support requests for additional staff and as a guide for allocating pastoral care resources. To date, a handful of other pastoral care departments have used the GRASP model, and their experience supports the validity of this assessment process.

It should be noted that the GRASP ratios were arrived at through the professional judgment of the developers, which is a definite limitation especially if this model is to be used to justify additional staff. The model's credibility would be enhanced greatly if the assessment process and ratios were supported by wide usage and consensus within the pastoral care community.

Hospital administrators place a strong emphasis on quantitative data for decision making in general. They often utilize consultants who draw upon national benchmark data to assess staffing levels in a variety of disciplines. Though there may be national consulting groups that have developed benchmarks for pastoral care staffing, these benchmarks do not reflect the consensus of the larger pastoral care community. Chaplains who seek benchmarking data often contact a group of comparable hospitals to support their requests. Savvy hospital administrators, however, understand all too well that this provides little in the way of credible data.

Requests for maintaining or expanding pastoral care staffing certainly need to include a contractual dimension as described in this article. These requests will be strengthened by the incorporation of a well-established assessment process and nationally benchmarked chaplain-to-patient data. In the very competitive health care environment, the ability to point out that a hospital's competitors meet such criteria for pastoral care staffing will make a persuasive argument to maintain or expand staffing levels.

The establishment of a credible model for assessing and establishing pastoral care staffing levels using a ratio approach should be a priority for the pastoral care community. Organizations such as the Association of Professional Chaplains conduct national surveys of salary levels for pastoral care professionals, but there is no similar resource for pastoral care staffing.

The GRASP model is offered to the larger pastoral care community as the beginning of an enhanced process for establishing and supporting pastoral care staffing levels though a ratio approach. The author hopes that it will serve as the basis for a model that may one day become the standard within the pastoral care community. As a credible, internationally based organization, the Spiritual Care Collaborative is well positioned to lead in such an initiative.

Author's note

My thanks to the following team of chaplains from the pastoral care department at Grant Medical Center and Riverside Methodist Hospital, Columbus, Ohio, for their fine, creative work in collaborating with me to develop the GRASP instrument: Anne Money, Donna Morley, Mike Oskin, Corey Perry and Mary Whetstone. The team thanks Stan Mullin, former director of pastoral care at Clarian Health Partners, who contributed the concepts of visibility, ability and urgency around which the model was built.

---

[1] Susan K. Wintz and George Handzo, *Chaplaincy Today* 21, no.1 (Spring/Summer 2005), 1-10.

[2] Ibid.

[3] American Association of Pastoral Counselors (AAPC), Association for Clinical Pastoral Education (ACPE), Association of Professional Chaplains (APA), Canadian Association for Pastoral Practice and Education (CAPPE), National Association of Catholic Chaplains (NACC), National Association of Jewish Chaplains (NAJC).

Grant/Riverside acuity staffing process (GRASP)

Unit assessment

You are asked to assess the pastoral care needs of your respective units. This assessment will measure three basic areas: visibility, ability, and urgency. Each of these three areas and the criteria for defining them are given below. Each unit will receive a score of 1 to 4 in *each* of the three areas. Further, you are asked to report the average daily census/volume of each unit. This information should be available from the nurse manager of each unit.

Visibility – This is a measure of how routinely visible a chaplain needs to be on the unit.

1. Daily presence: Chaplain has daily, routine presence. Knows patients, families, and staff well. Aware of issues arising daily. Participates in regular meetings, improvement teams, and the like.
2. Frequent presence: Chaplain knows staff well. Rounds through unit 2/3 times per week. Aware of issues, changes, needs on regular basis.
3. Periodic presence: Chaplain visits unit approximately 1 time per week. Checks with RN manager to see if there are outstanding needs or issues.
4. Infrequent presence: Chaplain only responds to unit when crises arise or chaplain is called.

Ability – This is a measure of how competent the chaplain who is assigned to the unit needs to be and how complex the needs for that unit are.

1. Board certified staff chaplain/advanced or second-year CPE resident: Person exhibiting high competency, capable of managing complex, stressful cases requiring strong interpersonal skills, knows staff and unit dynamics well.
2. Less experienced or noncertified chaplain/first-year CPE resident: Some sophistication and experience needed, number of complex cases is fewer, not necessarily life-or-death issues, though deaths may still be relatively frequent.
3. CPE intern: Fewer deaths, acuity of patients is much lower, no ventilator supported patients, very few crises, and level of complexity is markedly low.
4. Trained pastoral care volunteer: Virtually no deaths. Most patients are ambulatory, and complexity of care is minimal.

Urgency – This is a measure of how urgent the requests/needs of this unit are.

It includes any death/crisis calls, which *always* require immediate attention. It also assesses the relative triage level and is a measure of how *frequently* the unit requests pastoral care services.

Answer the following question using the criteria below: *How frequently do I, or the on-call chaplain, receive urgent requests/pages from this unit?*

1. Virtually *daily*.
2. 3 – 5 requests per *week*.
3. 1 – 3 requests per *week*.
4. 1 – 3 requests per *month* or fewer.

Unit assessment form

Unit Name: _____ Average Daily Census/Volume: _____

Unit Description/Types of Patients: _____

_____

Unit Rating: Visibility _____ Ability _____ Urgency_____

Total Acuity Score: _____

Acuity scale

This is a measure of the acuity of the unit and a corresponding level of coverage. It is assumed that any unit that require less intensive focus may be covered by staff with greater competencies, i.e., a unit that is suitable for an CPE intern to cover may be covered by a CPE resident or staff chaplain.

A Unit score: 3/4 – High Acuity – These units face constant life-and-death issues with very intense and complex family/social/spiritual dynamics. Length-of-stay is frequently high, with very intense medical treatment requirements. The needs of these units are extremely high requiring frequent, highly competent, pastoral presence.

Staffing requirement: Board certified chaplain or highly competent/experienced CPE resident.
Staffing ratio maximum: 1 chaplain to no greater than 45 patients.

B Unit score: 5/6 – Medium-high Acuity – These units do not face regular life-and-death issues, though deaths may still be relatively frequent. The complexity of medical care is lower, though some patients may be ventilated and require significant care. Family/social/spiritual dynamics may be significant, but these do not impact the daily care and treatment of the patient as significantly as high acuity units. Average length-of-stay is usually less than seven days. The needs of these units are still quite demanding and require regular pastoral care presence.

Staffing requirement: Noncertified chaplain or less experienced first-year CPE resident.
Staffing ratio maximum: 1 chaplain to no greater than 70 patients.

C Unit score: 7/8/9 – Medium-low Acuity – These units experience very infrequent deaths/crises. The complexity of medical care is relatively low, with no ventilated patients and most patients able to ambulate. Family/social/spiritual issues do not pose significant impact on treatment and length-of-stay is usually one to three days. The needs of these units are significantly less demanding and require only periodic pastoral presence.

Staffing requirement: CPE intern/basic student or trained pastoral care volunteer.
Staffing ratio maximum: 1 chaplain to no greater than 100 patients.

D Unit score: 10/11/12 – Low Acuity – These units experience virtually no deaths/crises. The complexity of medical care is low, and almost all patients are able to ambulate. Length-of-stay can be measured in hours or a few days. The needs of these units are low, requiring pastoral presence only on referral, usually for such needs as completion of advance directives or the occasional emotionally distraught patient/family/staff member.

Staffing requirement: On-call chaplain coverage for stated needs only or trained pastoral care volunteer.
Staffing ratio maximum: No ratio required.

back to article