The Volunteer Advisory Council In a Healthcare Setting

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INTRODUCTION

In the summer of 1987, the Director of Volunteers and Patient Services at Roanoke Memorial Hospitals, Roanoke, Virginia, was asked by hospital administration to prepare a long range plan for the volunteer services component of the department. The request and subsequent plan were part of an ongoing institutional-wide evaluation which resulted from an organizational restructuring begun in June of that year.

The goal of the operational plan was "to restructure the organization of the Volunteer Services Program so that overall program operations can be managed more effectively and efficiently to meet the current and future supplementary staff needs of the hospitals." To achieve that goal, the first objective listed was "to institute an Adult Volunteer Advisory Council."

The Advisory Council became a reality in January 1988, after having been successfully piloted as an Adult Volunteer Task Force during the preceding three months. After two-and-a-half years of existence, including its tenure as a "task force," the Advisory Council has significantly contributed to the viability of the hospitals' volunteer services program. The following will address the reasons and process for, and outcome of the Advisory Council's implementation.

THE SETTING

Roanoke Memorial Hospitals is a 677 bed acute care facility and tertiary care center for Southwest Virginia. The Volunteer Program and the Patient Representative Program comprise the responsibilities of the Department of Volunteers and Patient Services. The Director has department head status and reports to a hospitals' administrator. She, along with designated department staff, assumes total responsibility for all program operations. The volunteer services component of the department is comprised of two categories of volunteers: 1) Inservice volunteers who are recruited, oriented, and trained by hospital volunteer program staff and 2) support group volunteers from community based volunteer programs, *i.e.*, Mended Hearts, Cancer Society, Foster Grandparents Program. The inservice volunteer program provides services in both the clinical and nonclinical areas of the hospitals. Fund raising activities by these volunteers are minimal.

In July 1986, the hospitals experienced an organizational restructuring during which time the name of the existing holding company, Roanoke Hospital Association, was changed to Carilion Health System. This change more adequately reflects the mission of the system as a regional provider of healthcare services. While Carilion oversees the operation of other diversified health related subsidiaries, Roanoke Memorial "Hospitals," is the flagship hospital of the system and includes: Roanoke Memorial Hospital, the 527 bed acute care facility; Roanoke Memorial Rehabilitation Center (150 beds); and the Cancer Center of Southwest Virginia, an outpatient radiation therapy treatment center. Volunteer services are predominantly concentrated in these three facilities.

Concurrent with the restructuring of the healthcare system were changes in the hospitals' leadership team. With new leadership came new management philosophies. Like other hospitals which have undergone the process of reorganization, Roanoke Memorial quickly faced many internal challenges.

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Some had a significant impact on the volunteer services program.

First, there was a switch in marketing focus from "hospitals" to "system." As such, the previously experienced high public visibility of the hospitals and its volunteer program tended to be somewhat obscured within the system. Recruitment of new volunteers, therefore, became a more difficult task. The program could no longer just rely on the excellent reputation of the hospitals and volunteer program for attracting new adult volunteer workers. Second, rising costs in general required the hospitals be cost effective and highly efficient in the use of resources, especially personnel. Fiscal restraints greatly reduced the possibility of obtaining any additional volunteer management staff for the next two years. The program would continue to be managed by the equivalent of two (2) full-time employees.* Yet, it was almost a guarantee that increasing personnel needs in the hospital setting would place additional pressure on the volunteer program to produce more volunteers.

The external systems changes and the hospitals' internal new challenges were not the only pressures on the volunteer program. Prior to the restructuring, the volunteer program staff had been concerned about a downward trend in the previous year's retention rate of volunteers as well as the increasing number of volunteers who chose to go on inactive status. At the time of the reorganization, the adult volunteer program consisted of one-hundred and twenty-seven (127) active inservice volunteers who, for fiscal year 1986-87, contributed 20,000 hours of service in fifteen (15) different clinical areas and hospital departments. However, the volunteer retention rate for the same fiscal year had demonstrated a remarkable decline.** The number of volunteer resignations was considerably greater than the number of new adult volunteers recruited. A net gain of only two (2) volunteers was realized for the entire year. In addition, there was another concern regarding volunteer commitment and dependability. Monthly report statistics exhibited a wider and wider margin between the total number of volunteers enrolled and the total number of volunteers active at the end of the month. In other words, the rate of volunteer absenteeism per month was increasing.

In summary, the negative trends in the program's recruitment and retention statistics, along with the reorganization of the hospital and its current and anticipated impact on program operations, set the stage for evaluating and changing management philosophy within the volunteer program itself. The Director of Volunteers and Patient Services was prompted to seek a mechanism which would assist and enhance both the effectiveness and efficiency of program operations. The primary purpose of such a tool was to promote and facilitate communication to, from, and concerning volunteers in what rapidly had become a large complex organization. Costs to the hospitals needed to be minimal. The target date of implementation was October 1, 1987, the beginning of the hospitals' new fiscal year.

SOLICITING STAFF SUPPORT

The need to provide a channel of communication for volunteers was a novel idea for the volunteer program at Roanoke Memorial Hospitals. It differed considerably from the former, more traditional methods: volunteers provided little to no input into program operations. As stated previously, this function was left to volunteer program staff. Therefore, in spite of the fact that volunteer-employee relationships were very positive throughout the hospitals, some staff were reluctant to encourage volunteer involvement in operational matters. They were concerned that the type and amount of input could be inappropriate and cause unnecessary problems for volunteer management staff as well as for managers where volunteers were assigned.

To help alleviate this concern and potential risk, the Director of Volunteers and Patient Services set up meetings with

*Some Volunteer Program Management Staff are responsible for the Patient Representative Program including the provision of both supervisory and direct patient services functions.

**Retention rate = ratio of # volunteers recruited/# volunteers resigned.

department managers/supervisors in those departments and clinical areas where volunteers provided services. The purpose was to introduce the concept of an Adult Volunteer "Advisory" Council, a structure successfully used in many government sponsored and other community-based volunteer programs. Having been a former director of the Retired Senior Volunteer Program (RSVP) in Florida, the Director of Volunteers and Patient Services had experienced a positive working relationship with committee members who served in an advisory capacity only. It was believed that a similar type of forum could be successful in a hospital.

After meetings with the Director, department supervisors and managers received the concept favorably. First, the Director outlined the problems the programs had experienced, especially those relating to volunteer retention rates. Since several departments had lost volunteers during the year, their staff could personally identify with the problem. Second, the committee's role was discussed with emphasis placed on "advisory" versus "policy-making" functions. Along this line, staff were assured that the volunteer committee members would not become involved with or "meddle" in the very positive work relationships between volunteers and staff. Rather, should problems arise, intervention and resolution would remain the function of volunteer program staff. Finally, it was explained that the Advisory Council would be initiated on a three month trial basis.

TASK FORCE IMPLEMENTED

The committee was called a "Task Force" during the trial period. This proved to be very beneficial as it provided an opportunity for volunteer management staff to assess the "workability" of the advisory council concept before committing to the idea and implementing it on a permanent basis. It was also decided to experiment with the adult sector of the program before including or expanding to the youth volunteer component.

The Adult Volunteer Task Force was comprised of six adult volunteers who were appointed by the Director of Volunteers and Patient Services after discussion with volunteer management staff. Five members represented the large acute care facility, and one represented the Rehabilitation Center/Cancer Center complex. Criteria used in the selection process included: length of volunteer service, dependability, demonstrated commitment to the department and hospitals, relationships with other volunteers and staff, personal integrity, and professionalism.

The Task Force members ranged in age from 55 to 80; two were men; five were retired and one was employed as a real estate agent. Previous occupations among the retirees included businessman, human resources specialist, teacher, homemaker, and executive secretary. In addition to these diverse backgrounds, the members represented a variety of volunteer placement areas within the hospitals. They included the admitting office, medical education department, volunteer office, and surgery department at Roanoke Memorial Hospitals, and the Information Desk and Admitting Office at the Rehabilitation Center.

FIRST MEETING

The first Task Force meeting, held on October 9, 1987, was attended by the six volunteer representatives, the Director and Coordinator of Volunteers and Patient Services, and the Departmental Secretary. The Director began the meeting by discussing her concerns regarding the current volunteer program. Task Force members were asked to review a comparative statistical report of program operations for fiscal years 1985-86 and 1986-87. Special attention was given to the retention rate of volunteers and to the increase in volunteers placed on inactive status. A more recent concern about the lack of dependability among active status volunteers was also discussed. In essence, the Task Force members heard that the overall operation of the current volunteer program needed improvement, which the statistical reports confirmed.

The purpose of the Task Force as outlined by the Director was to:

1. Test the feasibility of an Adult Volunteer Advisory Council over a three month period.

2. Assist the Director and volunteer management staff with a comprehensive program assessment.

In addition, the Task Force would work

together in a collaborative effort. Members would have equal rank and there would be no officers. Since the Task Force was to operate in an advisory capacity and policy-making was not a function, a formal structure comprised of officers, defined job descriptions, etc. was not necessary. The Director would function as the Chair, and a volunteer Task Force member would record minutes of meetings. It was believed that an informal committee structure of this type would facilitate an effort of optimal teamwork. Communication would be unrestrained and opportunities to express honest opinions would be encouraged.

The Director stressed that members would be required to give volunteer time over and above their regularly scheduled volunteer activities at the hospital. In addition to scheduled monthly meetings, extra impromptu meetings might also be called. Attendance at all meetings was crucial. Volunteer hours from Task Force activities could be added to each member's cumulative record of hours earned.

The proposed two year operational plan for the volunteer program was then distributed. Included within the package was the first draft of the recommended guidelines for the Adult Volunteer Advisory Council which had been drafted by the Director. Task Force members were asked to review all materials before the next meeting. In summary, the Task Force had defined the most pressing issues during its first meeting: maintaining the existing volunteer force, thereby reducing the risk of losing additional volunteers to inactive status or resignations; and, enhancing the motivation of volunteers to be committed to performing their prescheduled tasks in a dependable fashion. Furthermore, it recommended concrete strategies for addressing those issues it had defined: a "Statement of Philosophy on Volunteer Dependability" would be drafted; also the formation of "attendance policies" which would set standards of volunteer attendance expectations was recommended. The attendance policies would specifically include the definition of "inactive" status as well as reasons for justified and non-justified causes of an absence.

TASK FORCE ACCOMPLISHMENTS

The Adult Volunteer Task Force met four more times between October, 1987 and January, 1988. During this period of time, all Task Force recommendations for addressing operational problems were achieved (see Appendices A and B). The harmonious "partnerships" which had developed between the volunteer management staff and Task Force members were responsible for such accomplishments. Work responsibilities became a shared experience. For example, one Task Force member assumed responsibility for drafting the Statement of Dependability while volunteer management staff formulated the first draft of attendance policies. All drafts were reviewed and revisions recommended at Task Force meetings. Final drafts were prepared by volunteer program staff and submitted to hospital administration for approval.

Another contribution of the Task Force during the trial period was the revision of all volunteer job descriptions and procedures. This was a major undertaking, but necessary, because it had been three years since the program's policy and procedures manual had been updated. As stated earlier, the Task Force members represented a wide variety of volunteer placements in the hospitals. Most of these involved assignments in departments or areas where volunteers were essential for enhancing the "smoothness" of daily operations. Because individuals who volunteered in these departments were required to be flexible and able to perform many different tasks, these job descriptions and accompanying procedures could be complex and subject to changes during the year. Thus, making any revisions could be a time-consuming endeavor.

Through the involvement of Task Force members, however, the revisions were expedited. Task Force members individually coordinated meetings with the volunteer program director, the managers or supervisors in volunteer placement areas, and other individuals assigned to the same department but who volunteered on different days. The results of the meetings were very positive. Not only were new job descriptions and procedures developed in a timely fashion, the meetings increased communications between volunteers and other department staff, as well as between volunteers and volunteers. One major finding was that in each department there were

several volunteers who did not fully understand their total job description; others felt unsure of the procedure for carrying out a particular job task. The meetings, therefore, served as a refresher training course for many volunteers and their respective staff members as well. Most importantly, through active participation in a quasi-volunteer management role, Task Force members gleaned and assimilated information from a different viewpoint. The experience enabled them to provide advice from a broader perspective of program operations.

ADVISORY COUNCIL IMPLEMENTATION

The many achievements of the Task Force during the three month period facilitated the implementation of the Adult Volunteer Advisory Council. Prior to its first meeting on January 6, 1988, volunteer program staff had concurred that existing Task Force members should be invited to continue their participation in volunteer program operations as Advisory Council members. Having been involved in the development of the council's Guidelines for Operation, each member was already aware of his/her role and responsibilities. All Task Force members consented to becoming members of the Advisory Council. The commitment required active participation for another two years.

During the first Advisory Council meeting, the "Guidelines for Operation" were revised for the last time. One change recommended was to increase the representation in the Rehabilitation Center/Cancer Center complex from one to two members. The Council believed that the addition of one member would more fairly represent the interests of the volunteers in those areas. Two other important items of business were also discussed: 1) a review of program operation statistics for the last quarter; and, 2) plans for the first group meeting of all adult volunteers.

The next Advisory Council gathering was an unscheduled meeting called at the last minute by the program director. It was held the day before the all-inclusive volunteer meeting, and the purpose was to review and refine the agenda for the next day. Both volunteer program staff and Advisory Council members realized that planning a successful meeting was of utmost importance to successfully communicating the variety of changes in operations of the volunteer program; also, the meeting served as a recruitment tactic—hospital volunteers were encouraged to bring friends who were prospective volunteers.

The Advisory Council recommended the following agenda for the occasion: 1) an administrative welcome by the Vice President over the department; 2) a historical overview of the volunteer program including an account of past, present, and future operations by the Director; 3) an explanation of the Advisory Council concept, its purpose and functions, and an introduction of Advisory Council members; 4) reports by other volunteers about activities in those departments/areas where volunteers provide services; and, 5) reports of Advisory Council activities by council members.

Relative to the last agenda item, Advisory Council members felt there was a need to distribute and review the new statement of Philosophy on Volunteer Dependability as well as the policies on volunteer absenteeism. At the conclusion of the meeting, council members recommended that a written survey on volunteer program operations be given to each volunteer for his/her input. The survey's results would be published in the Spring edition of the volunteer program's newsletter.

The assistance of the Advisory Council with planning and formulating written surveys as part of the volunteer program's evaluation process has been very helpful to program staff. Information gathered from the first survey enabled other surveys to be developed which targeted areas of concern about specific program components such as recognition, job satisfaction, and training. The results of these surveys not only revealed general attitudes about the components in question, but also provided new group recommendations. For example, the survey about recognition led to a suggestion involving a change in format of the annual volunteer recognition ceremony; another proposed that the Hospitals' Board of Directors' Christmas gift to employees during the Christmas season (a frozen turkey) be extended to volunteers who met certain criteria; specifically, volunteers would be eligible to receive the Board's gift if they had contributed a cumulative total of

1,000 hours and earned a minimum of two hundred and fifty (250) hours each year thereafter.

CONCLUSION

During the first year and a half of existence, the Adult Volunteer Advisory Council has made many contributions to the reorganization process of the volunteer program at Roanoke Memorial Hospitals. In addition to its role of formulating recommendations for improvements in operation, the Advisory Council members have also provided valuable advice to the Program Director and volunteer management staff when confronting new, sensitive issues. Such issues have included changing the name of the volunteer program newsletter and initiating a no-smoking policy in the volunteer program's headquarters, including the volunteers' lounge area. These and many other operational matters have been successfully addressed and resolved without jeopardizing volunteer morale or decreasing the size of the Adult Volunteer ranks. In fact, statistics of operation for fiscal year 1987-88 showed a 100% increase in number of new volunteers recruited, from 40 in 1986-87 to 80 in 1987-88. More importantly, some improvement in the Adult Volunteer retention rate for fiscal year 1987-88 was noted with a net gain of twelve (12) additional volunteers. Relative to the rate of volunteer absenteeism per week, a system requiring manual tabulation of each volunteer's presence made record keeping very difficult. The dependability factor, while appearing to have improved, could not be factually substantiated.

Given its existence of just two and a half years, it may be too premature to deem the Advisory Council concept successful. New representatives were recently selected as four original members rotated off the Council. While it is difficult to predict how well the new group will work together, the structure of the Council appears to have fostered a communication system in which potential conflict among members has been diminished. First, all volunteer Advisory Council members share equal authority; the only member who has been given a specific function is the recording secretary. This role is nonthreatening to the other members. The end result is a group in which collaborative efforts are promoted and Council recommendations to the Director reflect collective advice in a concrete form. Second, only volunteer members have a vote on recommendations. This procedure allows only the volunteers' perspective to be represented. Third, the size of the Council, while small, has been effective. A group bonding and commitment to the single purpose of improving the volunteer program has occurred.

The achievements of the Advisory Council suggest the fulfillment of its purpose and responsibilities as set forth in the Council's Guidelines. The Council has served as a communications mechanism through which adult volunteers can give input and receive feedback concerning program operations. Whether it is through organized gatherings or informal meetings and phone conversations with Advisory Council members, volunteers feel more involved in and part of the program and hospitals. The result of this may be reflected in the upward trend in number of volunteers recruited and the retention rate the past fiscal year. Furthermore, the Council has served as a cathartic ear to volunteer management staff who confront the daily challenges of motivating and managing nonpaid people to the maximum and mutual benefit of both the organization and the volunteers. The Council has therefore functioned as a support system for other volunteers and volunteer program staff as well. Finally, the advent of the Advisory Council reintroduced a purpose, sense of direction, and enthusiasm for the volunteer program from all personnel including administration, hospital employees, and volunteers. Any previous skepticism about shared control from hospital personnel has been dissipated.

Hospitals, institutions, or other organizations which utilize volunteers and are seeking to revamp existing communications channels or construct new ones may wish to consider the Advisory Council concept. The following fundamental guidelines for successful implementation are suggested:

1. Obtain administrative and staff support of the concept.
2. Clearly define the purpose of the Council to all volunteers.
3. Ensure that Council members adequately represent quantity and quality

of the volunteer force.
4. Test concept during a trial period.
5. Provide a mechanism for monitoring and evaluating the Council's impact on program operations.
6. Provide a means of communicating the Council's activities to the volunteer force on an ongoing basis.

In summary, the implementation of the Adult Volunteer Advisory Council at Roanoke Memorial Hospitals has been an avenue through which reorganizing and improving the volunteer program has been achieved. Operational components like recruitment, staff education, and recognition are fundamental to the viability of any volunteer program; however, in a rapidly changing healthcare environment, they can no longer be maintained by volunteer program staff alone. Operational effectiveness and efficiency can be maximized when volunteer program staff ensure that operations are a shared experience between staff and volunteers. The Adult Volunteer Advisory Council at Roanoke Memorial Hospitals appears to have become a successful mechanism for that shared experience. In addition to the improvement noted in the recruitment and retention rates, a need to provide an avenue for monitoring the volunteer dependability factor was also defined. As a result, a volunteer services software program has been purchased to assist with managing volunteer absenteeism information in addition to recruitment and retention data.

Future plans include developing a separate Council for the Youth Volunteer Program* and expanding the current Adult Council membership to incorporate representation of volunteers from community-based volunteer programs and other Carilion Healthcare System subsidiaries.

*The Youth Volunteer Program is operated predominantly during the summer months.

APPENDIX A

ROANOKE MEMORIAL HOSPITALS
ADULT VOLUNTEER SERVICES PROGRAM

Advisory Council
Guidelines for Operation

I. *Purpose*

The Advisory Council shall function to advise and assist the Director of Volunteer Services and Volunteer Services Program staff.

II. *Responsibilities*

The Adult Volunteer Advisory Council shall:

a. Provide advice and support to the Director of Volunteers and designated departmental staff in the planning, development and execution of operational policies and procedures for volunteers.

b. Provide advice to the Director regarding components of program operation including effective utilization of volunteers, recruitment strategies, recognition events, and staff/volunteer relationships.

c. Assist the Director of Volunteers with the planning and implementation of special events; i.e. Winter Volunteer Meeting, Annual Recognition Event.

III. *Structure and Composition*

a. The Advisory Council will consist of seven (7) members of the Adult Advisory Program with five (5) representatives from the Main Hospital, and two (2) from the Rehabilitation Center/Cancer Center complexes. Staff representation will include the Director of Volunteers, Coordinator, Rehabilitation/Cancer Center, and one (1) designated staff member.

b. The Director of Volunteers will serve as Chairman of the Advisory Council; minutes of Council meetings will be documented by a Council Member who serves as the Council Secretary.

IV. *Term of Service*

Volunteer Advisory Council members will serve a two year term beginning October 1 through September 30. A volunteer council member may serve only a one year term upon written request to the Director of Volunteers by August 1st. After the first term of two years, four members will rotate off to be replaced by four new members.

V. *Selection/Orientation of Members*

a. By July 1, the Director of Volunteers will appoint an *ad hoc* committee from the Advisory Committee to submit recommendations for new Advisory Council volunteer members. Such recommendations must be received by August 1. The Director of Volunteers has the authority to approve or disapprove any recommendations.

b. New members will be oriented by the Director and returning Advisory Council members to the role and function of the Advisory Council, as well as to the goals and objectives of the next fiscal year's plan of operation.

VI. *Committees*

The Director of Volunteers may establish *ad hoc* committees for special purposes and will be responsible for appointing the chairman of each such committee. The chairman will report for the committee at Advisory Council meetings.

VII. *Voting*

Each Volunteer Advisory Council member will have one vote for issues discussed at a meeting. The Director of Volunteers and department staff will have no vote. Motions are carried by a majority of those present. A quorum of five members is required for action on issues/recommendations made. The Director will have the authority to approve or disapprove, accept, or reject all recommendations made by the Advisory Council.

VIII. *Meetings*

The Volunteer Advisory Council will meet quarterly during the year. Meetings will be held in October, January, April, and July of each year. Additional meetings may be called by the Director of Volunteers.

APPENDIX B

ATTENDANCE POLICIES

(from Program Policies)

A. Philosophy
   1. Roanoke Memorial Hospitals Volunteers are vital to the successful operation of Roanoke Memorial Hospitals. In addition to providing supplementary staff functions, volunteers offer an added dimension of care to patients and family through their emotional support and empathy.
   2. Even though volunteers are not paid employees, hospital departments and areas are dependent on volunteer support to effectively and efficiently meet the normal routine of their day-to-day operations. As such, volunteers who demonstrate dependability and commitment to their chosen place of volunteer service are greatly appreciated and highly valued by the Hospitals' administration for their quality and quantity of service provided.
   3. Volunteers, like employees, perform their duties with varying amounts and degrees of commitment and enthusiasm. However, standards of dependability for volunteers must be established to ensure a fair and equitable reward mechanism for those who have demonstrated exceptional quality of work and dependability on an on-going basis.

B. Definition of "In-Active Status"
   1. A Roanoke Memorial Hospital volunteer will be placed on "inactive" status for the following reasons:
      a. Does not volunteer for a period of 3 consecutive times without **justified cause* during the year.
      b. Does not attend the required hospital/department orientation for new volunteers within a 3 month period from the date of acceptance and participation in the program.
      c. Does not call Volunteer Services department staff and/or staff in the department where the volunteer is placed in advance of/or on the day of absence from their day of scheduled volunteer activity.
   2. A volunteer who is placed on "in-active" status anytime during the year for a *non-justified* cause will automatically lose the following volunteer benefits:
      a. Opportunity to continue volunteering on the volunteer's preferred day of assignment and in the volunteer's preferred department; i.e., day and department, when returning to active status.
      b. Loss of 20% discount of medicines purchased at the Roanoke Memorial Hospitals' pharmacies.
      c. Opportunity to attend the annual Volunteer Recognition Reception and Awards ceremony.
   3. A volunteer who is placed on "in-active" status for a justified cause* cannot always be guaranteed that his/her preferred day and department of volunteer service will be available when returning to "active" status.
   4. Any exception to the above #1-3, will be at the discretion of the Department Director.

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*Justified causes of volunteer absence are: personal illness, hazardous weather conditions, travel, family illness of immediate family member (child, parent, spouse) or serious, critical illness of family member requiring your support and presence.