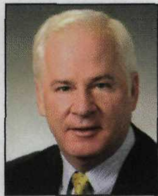
Plotting the Future: The Case at Catholic Health East

Long-Range Plan for Comprehensive Care Management Requires New Priorities for Spiritual Care



BY PHILIP BOYLE, Ph.D.
Dr. Boyle is vice president, mission and ethics, Catholic Health East, Newtown Square, Pa.

What would you do if half of your workforce was on target to reach retirement age in less than five years and the workplace setting was expected to dramatically change during that same time?

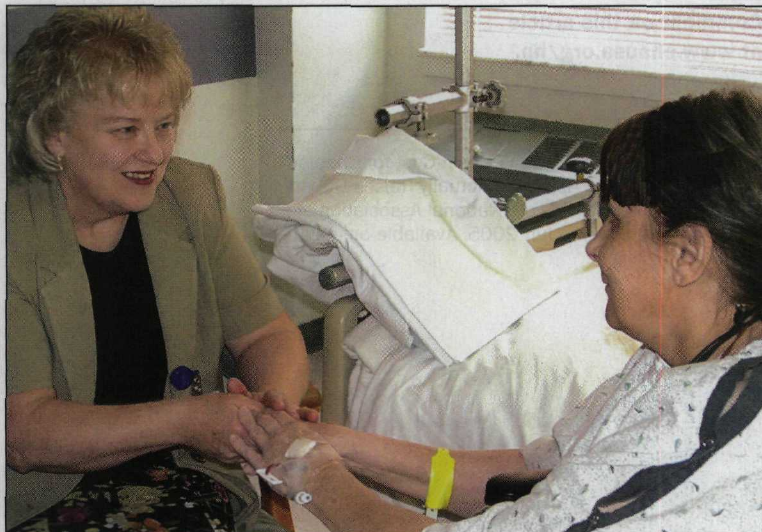
Chaplaincy within Catholic Health East and across the nation is facing just such a challenge. Given this serious situation, one that calls for aggressive and creative measures, Catholic Health East's mission integration division commenced a system-wide visioning process for spiritual care that is now in its third year.

In a broader context, Catholic Health East, like most Catholic health care systems nationwide, is in the midst of unprecedented economic, social and industry trends. No area, spiritual care included, is immune from the substantial impact of these trends. For example, the system's Vision 2017, its 10-year outlook for health care delivery for facilities across 11 eastern states, projects that *patient services will move away from predominately acute care to a more comprehensive care model based on providing a continuum of care.*[1] This means that, increasingly, a substantial portion of care will be offered in homes, long-term care facilities and outpatient centers.[2]

As a result of this expansion of care sites, and a limited number of chaplains, pastoral care leaders will need to set care priorities about which patients and what settings other than acute care will need coverage. Although many of these changes are expected to occur during the next decade, some are already in place. For example, chaplains tend to the spiritual needs of patients at outpatient centers, such as dialysis units and cancer care centers. Assuming, though, chaplains will be unavailable to meet all needs across the continuum of care, serious thought needs to be given to how best meet holistic spiritual needs.

The challenges, though, are related to more than just a change in the place of delivery. The system's long-range outlook projects that care in the near future will be provided according to a comprehensive model that is persons-centric, not institution-centric. Comprehensive care management embraces holistic patient care that attends to needs of body, mind and spirit.

A snapshot of the system's chaplains suggests this is only part of the challenge. Currently, the average age of a chaplain within Catholic Health East is 63, and of the 158 system-wide chaplains, more than 40 percent are vowed religious, both women and men. With declining numbers of religious, systems will increasingly look to qualified



Chaplain Eileen Aguiar (left) talks with a patient at Marian Community Hospital, Carbondale, Pa.

lay persons to serve as chaplains. Yet the median chaplain's salary is between $38,000 and $42,000 (according to research by Catholic Health East), an amount unlikely to attract and retain lay persons, particularly those with families. Add to this the costly fact that for certification, national professional associations require chaplains to complete a master's degree in theology or a related discipline and four units of Clinical Pastoral Education, including at least 1,600 hours of supervised training, among other requirements. This goal poses a workforce challenge. At present, only 50 percent of Catholic Health East's chaplains are certified. Another 25 percent have some Clinical Pastoral Education combined with a master's degree in a field other than theology.

From left, chaplain Blair Holtey blesses the hands of Donya Anders, Tonya Parks, Nick Sofarelli, RN, and Hollie-Anne Rhynard, RN, as part of Nurses Week celebrations at Morton Plant Mease Health Care in Dunedin, Fla.

Creating a Charter on Spiritual Care

The entry point for developing our long-range plan for pastoral care was defining the identity and role of chaplains. Perceptions and misperceptions of spiritual care were formidable barriers. Chaplains who were interviewed generally expressed feelings of being underappreciated because the value and services their ministry brings to health care is often underrated. On the other hand, mission executives, CEOs and other executives were not always certain of what they could legitimately expect from chaplaincy, in part because no agreed-upon accountability measures are available. To rectify this confusion, system leaders initiated a dialogue to create a shared understanding among chaplains, mission executives, boards and sponsors about the role and identity of chaplains and spiritual care providers in our ministries. The dialogue resulted in a charter on spiritual care, which addressed several significant issues, including a need to define standards of excellence in the profession and establish processes for accountability and quality improvement.

As the ink was drying on the charter, directors of spiritual care began to ponder: What would a model for our future require? What steps would be needed to effect change? What would be the time frame? The group determined it needed tools to identify, assess and address the spiritual needs of patients, family and staff. Spiritual care leaders are currently engaged in strategic planning on these first steps, while simultaneously working on long-term elements that need to be examined and, to some extent implemented, in the short run. Take for example the need to have a spiritual screening tool that is professionally developed, yet is understandable to non-chaplains. Assuming that chaplains will no longer be present across the continuum of care, such a tool would enable social workers, nurses and other health care professionals to do a simplified screening and referral for spiritual care.

It will be up to spiritual care departments to determine priorities, such as what spiritual care resources will be needed to meet a variety of situations and levels of need. For example, it will be important to determine whether a pastoral volunteer who offers a listening presence would provide a sufficient level of care in some situations, or whether in some circumstances the greater spiritual acuity of a certified chaplain would be required. Clear priorities will also assist in establishing the rationale and justification for spiritual care staffing patterns according to a fluctuating patient census. Finally, the need to meet established priorities might encourage spiritual care departments to think creatively about engaging faith groups and religious resources in local communities.

Another defined planning need is to identify and develop metrics. It has been notoriously difficult to agree upon what counts as a good outcome in spiritual care. A national collaboration between the Catholic Health Association and the National Association of Catholic Chaplains (see survey analysis on pg. 22), which is currently exploring potential metrics, will be a helpful guide; but in the meantime, our executives

continue to ask for measurable accountabilities for pastoral care, as they do for every other area within the ministry. In a multi-faith health care setting, the measures of yesterday, such as the number of sacraments provided, are inadequate. With one eye to the national dialogue, spiritual care directors are actively examining productivity measures such as units of services and adjusted patient days, as well as such outcome measures as patient satisfaction and the value of a chaplain's presence at the end of life.

Understanding the Four Elements of Change

Knowing what has to change and grow is a different issue from effecting the change, which typically requires all involved to have a clear understanding of the elements of change management. Consequently, spiritual care directors are keeping in mind four of these elements, recognizing that if each is not fully understood and addressed, reaching the system's goals identified in the aforementioned Vision 2017 may not happen.

1. Making the Case: To spiritual care providers, the need for holistic care is a given. However, if others within the ministry are less convinced about the need for spiritual care as part of comprehensive care management, then the change is unlikely to occur. Imagine, for example, if everyone involved with building a comprehensive care management model, from clinicians to information system personnel, lacked appreciation for the critical role of spiritual care as a component of holistic care. In such a case, spiritual care concerns might be left behind. Consequently spiritual care directors are putting pen to paper to ensure clear articulation of who they are and what they do in spiritual care. They do this to secure the rightful place of spiritual care in a comprehensive care management system.

2. Understanding Barriers: Imaging the change that needs to occur to get to Catholic Health East's Vision 2017 means being clear about everything that could go wrong and that stands in the way of accomplishing goals. Because a modern health care system is extraordinarily complex, with numerous shifting parts, it will be critical to determine who is responsible for effecting change. In the past, a powerful personality, for instance a strong mission executive, might have been all that was required. Today, however, a vision cannot become reality without the input, passion and commitment of every player in spiritual care. Trust, continual communication and transparent dialogue have become staples in managing change. Take for example the goal to develop

Chaplains at St. Mary Medical Center in Langhorne, Pa., lead the blessing of a new catheterization lab at the facility.

agreed-upon metrics. Even if there is broad agreement on which metrics to use, they may never be implemented without candid dialogue, which necessarily includes an assessment and understanding obstacles in the way.

3. Identifying Politics: Political dynamics are neither morally good nor morally bad; they are human realities. In any environment involving change, the political impact of the change on those who stand to gain or lose must be acknowledged and taken into account. As with all professions, change will require rethinking, identifying and assessing spiritual needs – a process that, if extended to non-chaplains on the care team, could be seen as an infringement on professional authority. Therefore, chaplains will need to balance tradeoffs involved with a vision of the ways in which they and their profession will be enhanced.

4. Training for Change: Chaplains will need the ability, motivation and opportunity to adapt to the new situations. The need to have a workforce ready to meet the challenges cuts across training, retention and recruitment. Training with an eye to the future must be the first step.

Exhortation or communication alone will not help people if they don't know how to act, if action is perceived to be contrary to their self-interest, or if they are not given the opportunity to act. A pragmatic recognition that not all current or future chaplains will have obtained sufficient Clinical Pastoral Education or other educational requirements must be acknowledged, given that geographical and financial limitations of our ministries make completion of graduate programs in chaplaincy difficult. To address this gap, Catholic Health East, along with 10 Catholic health systems, have developed the Spiritual Care Champions Program, which offers webinars on themes in pastoral and Catholic systematic theology. Several directors of spiritual care have set expectations that chaplains who are not certified, as well as volunteers, should attend these sessions. Additionally, Catholic Health East has developed a three-tiered career ladder within chaplaincy and is starting to adjust salaries to help attract lay persons into the profession.

To address recruitment and retention issues, Catholic Health East officials have initiated discussions with university programs that specialize in pastoral training. System leaders are also exploring new models of pastoral training, which include coordinating the existing six Clinical Pastoral Education programs across the system. For example, itinerant education supervisors could visit local ministries to offer needed education and pastoral mentoring. But these alone may not be enough, so Catholic Health East leaders have taken first steps in designing education programs for clinical staff so that all colleagues will be able to recognize and address the signs of a patient's spiritual distress. Realizing that demand for spiritual care will outstrip resources, several sites have begun to train and supervise pastoral volunteers.

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Conclusion

Working collaboratively across our own system and with other health care systems, Catholic Health East officials are charting and pursuing a future course for spiritual care that they feel will best meet the needs of our health care ministry for years to come. What creates a burning platform for change across a system is the recognition that 10 years from now, the sustainability of the ministry as one committed to holistic care will require more than charismatic leaders. Rather, new systems will need to be put in place, a critical effort that will rely on full support for its success. ■

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NOTES

1. Kathleen Popko, "Developing an Aging Strategy for the Future," *Health Progress* 89, no. 1 (January-February 2008): 31-36.
2. It is estimated that acute care services in Catholic Health East's member facilities will drop to 60 percent from the present 85 percent of overall services provided.