OPPORTUNITY FOR CATHOLIC HEALTH CARE

The Evidence-Based Spiritual Care Paradigm

A Guide for Group or Personal Reflection

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Catholic Health Association of the United States

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CHA's May-June edition of *Health Progress* magazine has a special focus on pastoral care. It features an article by George Fitchett and Allison DeLaney, titled, "Opportunity: The Evidence-Based Spiritual Care Paradigm." The authors contend that Catholic health care is well-equipped to lead the development of evidence-based spiritual care beyond the inpatient setting to the outpatient clinics and homes where those suffering from chronic illnesses reside. Citing the heightened awareness that, in addition to quality medical services, social determinants of health such as education, income, housing and social support play a very large role in health, they advance the case that religion and spirituality are among those social determinants, albeit frequently unrecognized.

In the pages that follow a reflection process is offered to engage leaders around the central questions the article poses. The process is designed to be used flexibly by individuals or groups as a reflection, as part of personal formation and as an exercise between in-person sessions for participants in senior leader formation programs. We hope that it will be useful to executives, managers, clinical and non-clinical associates, board members, sponsors, ethics committee members and others.

Suggested Reflection Process

1. Begin your reflection with prayer – one is provided.
2. Read the Executive Summary of the article.
3. Review the Questions for Reflection, noting their concepts, but not answering them yet.
4. Read the full article.
5. Return to the Questions for Reflection:
    A. Review the questions after reading the entire article.
    B. Take time to consider each question, jotting down any responses, considerations or questions that come to you.
    C. If you are completing this as an individual, you might consider taking time to discuss your responses with a colleague – get her or his thoughts on the questions; see if the person agrees with your thoughts or has different viewpoints to offer. If you are discussing as part of a group, take your written notes with you to the meeting. For group use, it could be helpful to assign the reading and then convene either by phone or in person for group discussion.
6. Close with prayer – a concluding reflection is provided.

As you use this guide, please let CHA know if it is useful in your ongoing formation, as well as any changes, suggestions or insights about it that you would like to share. It is a resource for

the ministry, and we want it to best suit your needs. To share comments, please contact Mary Ann Steiner, editor, *Health Progress*, at masteiner@chausa.org.

Opening Prayer

Creator and Source of All Being,
We give you thanks for the beauty of this day,
For the gift of this world,
And for the gift of each other.

We especially give you thanks for the gift of our vocation to Catholic health care.
We thank you for the ways in which you become present to us in our service of the sick and the suffering, the poor, and the outcast.

As we gather here at this meeting, we ask you to be with us as we continue to reflect on this unique vocation and seek to live it more fully in the world.

Open our eyes — that we may see what you wish us to see.

Open our ears — that in our dialogue we may hear what you want us to hear.

And, open our hearts—that we may feel as you feel toward those in greatest need of our services.

Bless all that we do here in our gathering; may it be a holy work done in your name.
We ask this in the name of Jesus and in the power of the Spirit. Amen.

Executive Summary

Now that we are well into the 21st century, it appears that an evidence-based approach to chaplaincy is the emerging paradigm. An indication is the number of standards and competencies about research that professional chaplaincy organizations are adopting.

Chaplains should embrace a research-informed or evidence-based approach to their work because research and evidence provide a way to evaluate and improve the quality of care that chaplains can provide. A research- or evidence-based approach also makes it possible to communicate what professional chaplains do and the benefits associated with their care.

A comprehensive analysis of health care in the United States highlights a shift from inpatient care to outpatient settings and an increase in chronic disease management with a concurrent increase in informal caregiving that usually is unpaid. There is a heightened awareness that, in addition to quality medical services, social determinants of health such as education, income, housing and social support play a very large role in health. A case has been made that religion and spirituality are among those social determinants, albeit frequently unrecognized.

Now there is an opportunity to continue the healing ministry of Jesus in the context of population health to those living with chronic illnesses, which often are disproportionately burdensome to the poor. Catholic health care is well-equipped to lead the development of evidence-based spiritual care beyond the inpatient setting to the outpatient clinics and homes where those suffering from chronic illnesses reside.

Questions for Reflection

Authors George Fitchett and Allison DeLaney endorse an evidence-based approach to pastoral care. They argue that research is one of the best ways to describe the spiritual needs of patients, the care chaplains provide to address those needs and the outcomes related to that care.

- Research, charting and assessment are necessary elements of an evidence-based approach. How willing and how able is your ministry to invest the time and resources in pursuing an evidence-based approach? How is this related to patient and employee satisfaction?

- Improving the quality of pastoral care in the context of population health is particularly important to Fitchett and DeLaney. How does their example of congestive heart failure as a major chronic disease make the case for how evidence-based pastoral care could contribute to improved outcomes?

- The authors suggest that religion/spirituality could be considered a social determinant of health. Do you agree? Discuss how spiritual care focused on reducing religious/spiritual struggles and developing inner peace in patients fits into a population health framework.

OPPORTUNITY FOR CATHOLIC HEALTH CARE

The Evidence-Based Spiritual Care Paradigm

GEORGE FITCHETT, DMin, PhD and ALLISON DELANEY, MA, BCC, PT

Around the world, a new evidence-based paradigm is informing the work of health care chaplains. This is a change from the dominant paradigm for spiritual care in the mid-20th century, shaped by the client-centered model of the psychologist Carl Rogers, which focused on empathic presence and active listening.[1] John Gleason, BCC, in 1998 described an emerging paradigm shift at the beginning of the 21st century to spiritual care as a response to individual need. He pointed to the developing models of spiritual assessment as an indicator of the shift. Gleason's observations were astute.

Now that we are well into the 21st century, however, it appears to us that the emerging paradigm for this period is an evidence-based approach to chaplaincy. Indicators of this are the inclusion of standards and competencies about research by the professional chaplaincy organizations. For example, the National Association of Catholic Chaplains requires chaplains to have the competency to "articulate how primary research and research literature inform the profession of chaplaincy and one's spiritual care practice."[2] The Salzburg Statement of the European Network of Health Care Chaplaincy also reflects this paradigm, saying, "The European health care chaplaincy community actively promotes research as an integral part of chaplaincy activity ... All chaplains must develop their ongoing practice in the light of current research."[3] Surveys of chaplains both in the U.S. and around the world suggest strong support for this new evidence-based paradigm.[4,5]

EVIDENCE-BASED CHAPLAINCY

There are two central reasons why chaplains should embrace a research-informed or evidence-based approach to our work. The first is that research provides a way to evaluate and improve the quality of our care. It helps us to answer the question, "How do we know the care we are providing is the best care that can be offered?"

In the first journal article to use the term "evidence-based pastoral care," Canadian chaplain-researchers Thomas St. James O'Connor and Elizabeth Meakes made the case for evidence-based chaplaincy, writing, "Evidence from research needs to inform our pastoral care. To remove the evidence from pastoral care can create a ministry that is ineffective or possibly even harmful."[6]

Some chaplains are uncomfortable with the idea of evidence-based practice because they believe it requires a simple-minded application of standardized interventions. This is a misconception. Standard definitions of evidence-based practice, such as that of the American Psychological Association, note that it consists of three things: "The integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences."[7]

The second reason for adopting a research-informed approach to practice is that it helps us

communicate what we do and the benefits associated with our care. This is reflected in the part of the European Network of Health Care Chaplaincy statement that says, "Sharing research findings will also inform healthcare providers and faith communities of the role and importance of chaplaincy and thus promote chaplaincy services."

Chaplains and the services we provide are not widely understood by the public, by the health care colleagues with whom we work, or by the managers who make decisions about health care resources. Research is an important way to describe the spiritual needs of the patients we serve, the care we provide to address those needs, and the outcomes associated with that care. Using research to communicate these things is especially important when we are addressing health care colleagues and decision-makers.

Up until now, the focus of spiritual care research has been the inpatient setting. For example, observing the distress of intubated patients in the ICU led Chaplain Joel Berning and his colleagues at New York-Presbyterian Hospital to develop and test a communication board to facilitate spiritual care.[8] Deborah Marin, MD, and her colleagues at Mount Sinai in New York tracked the satisfaction of 8,978 inpatients using items from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and Press Ganey surveys and found that those patients visited by chaplains were more satisfied with their hospital stay compared with those who were not visited by chaplains.[9] The "Hear My Voice" study led by Chaplain Katherine Piderman and her colleagues at the Mayo Clinic in Minnesota has evaluated a promising chaplain-led intervention for patients with neurologic illnesses.[10, 11] In addition to these studies, a robust body of chaplaincy case study research is developing.[12]

CHANGING FOCUS

Although spiritual care and spiritual care research focused on the inpatient context is and will remain important, the focus of health care is changing, and spiritual care must change with it. A comprehensive analysis of the U.S. health care system highlights the shift from inpatient care to the outpatient setting and an increase in chronic disease management with a concurrent increase in unpaid informal caregiving.[13] There is a heightened awareness that, in addition to quality medical services, social determinants of health such as education, income, housing and social support play a very large role in health.[14] A case also has been made that religion and spirituality are among those social determinants, albeit frequently unrecognized.[15]

In the past decade, population health — with its Triple Aim of improving the health of a population, improving the quality of care and outcomes for individuals, and reducing the cost of care — has become the framework for shaping efforts to address the challenges of health care cost, delivery and accessibility. It has given birth to accountable care organizations, risk stratification methods, patient registries, patient-centered medical homes and other models of team-based care. The focus is on helping people to stay well and live to their fullest in the context of chronic illness. This is the new context in which spiritual care must find its place.

While it is clear that population health will be central for the future of health care, it is unclear what spiritual care should look like in the context of population health. Although there is no model for spiritual care in this context, one important element to consider is addressing the spiritual needs of people living with chronic illness. For illustrative purposes, we will focus on people living with congestive heart failure, a good example, in part, because it is widely prevalent, with approximately 5.7 million adults in the United States living with that condition.[16]

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Congestive heart failure is a major contributor to adult mortality, with 1 in 9 deaths in 2009 including heart failure as a contributing cause,[17] and it costs the nation an estimated $33.7 billion each year, including the cost of health care ser-

vices, medications to treat heart failure, missed days of work and informal caregiving.[18,19]

A modest body of research has examined religious and spiritual issues associated with living with congestive heart failure. Two findings from that research are important: The first is about religious/spiritual struggle, which often is measured with a scale whose items include, "Wondered whether God had abandoned me" and "Wondered what I did for God to punish me."[20]

RELIGIOUS AND SPIRITUAL STRUGGLE

Three studies have examined religious/spiritual struggle in people with congestive heart failure, and they find a consistent pattern of greater emotional distress, poorer physical functioning, poorer adherence to important health behavior (not smoking, for example) and more hospital days among those with higher scores for religious/spiritual struggle.[21,22,23] The second finding focused on feelings of inner peace. In a sample of nearly 200 patients with moderate to severe congestive heart failure, investigators examined the association between responses to an item about inner peace ("I feel deep inner peace or harmony") and five-year survival. In models that adjusted for other factors associated with survival (age, severity of heart failure, depression, health behavior), compared to patients who reported feeling inner peace never, almost never, or on some days, those who reported feeling inner peace on most days or many times a day had a 20 percent increased likelihood of survival.[24]

Further research, including qualitative and case study research, is needed to better understand religious/spiritual struggle and lack of inner peace in patients with congestive heart failure. Meanwhile, we would argue that the existing studies point to several directions for spiritual care for these patients. Specifically, we suggest that protocols developed to screen for patients with potential religious/spiritual struggle[25] be employed in congestive heart failure clinics and that screening also include the measure of inner peace used by Crystal L. Park, PhD, and colleagues.[26] Patients whose responses suggest religious/spiritual struggle or low levels of inner peace could then be referred to a chaplain for more in-depth spiritual assessment and spiritual care as indicated.

The spiritual care offered to these patients should address religious/spiritual struggle and help patients develop inner peace. While one study has shown that chaplaincy care lowered religious/spiritual struggle for cardiac surgery patients,[27] additional research should be used to inform the development and testing of best practices in chaplains' care for these concerns.

In addition to individual spiritual care, group interventions and telechaplaincy should be developed and tested. In light of the existing research, reducing religious/spiritual struggle and increasing inner peace for patients living with congestive heart failure may have the potential to increase their adherence to recommended health behavior, increase their emotional well-being and quality of life, reduce their hospitalizations and increase the likelihood of their survival.

NEED FOR RESOURCES AND LEADERSHIP

This research and associated clinical initiatives will require both leadership and resources. Catholic health care historically has been a strong advocate for spiritual care as a central component of health care. A pastoral letter of the American Catholic bishops published in 1981 by the United States Catholic Conference stated, "Without health of the spirit, high technology focused strictly on the body offers limited hope for healing the whole person."[28]

However, despite its impressive commitment to spiritual care, Catholic health care has not been at the forefront of developing an evidence-based approach to spiritual care. Now there is an opportunity to continue the healing ministry of Jesus in the context of population health to those living with congestive heart failure and other chronic illnesses, which often are disproportionately burdensome to the poor. The Catholic Health Asso-

Catholic health care historically has been a strong advocate for spiritual care as a central component of health care.

ciation's commitment to "promote and defend human dignity; attend to the whole person; and care for poor and vulnerable persons"[29] can be fulfilled, in part, by learning from patients, caregivers and communities through research how to better steward our resources to support them. As the largest nonprofit health care provider in the United States — caring for 1 out of every 6 patients each day and with 109 million outpatient visits per year,[30] — Catholic health care is well equipped to lead the development of evidence-based spiritual care beyond the inpatient setting to the outpatient clinics and homes where those suffering from chronic illnesses reside. In our changing health care landscape, now is the time for advancing an evidence-based approach to spiritual care.

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ALLISON DELANEY is a board-certified chaplain and Transforming Chaplaincy Research Fellow. As part of her fellowship, she is completing a master of public health degree at Virginia Commonwealth University, Richmond, Virginia.

NOTES

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QUESTIONS FOR DISCUSSION

Authors George Fitchett and Allison DeLaney endorse an evidence-based approach to pastoral care. They argue that research is one of the best ways to describe the spiritual needs of patients, the care chaplains provide to address those needs and the outcomes related to that care.

- Research, charting and assessment are necessary elements of an evidence-based approach. How willing and how able is your ministry to invest the time and resources in pursuing an evidence-based approach? How is this related to patient and employee satisfaction?
- Improving the quality of pastoral care in the context of population health is particularly important to Fitchett and DeLaney. How does their example of congestive heart failure as a major chronic disease make the case for how evidence-based pastoral care could contribute to improved outcomes?
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Closing Prayer

Leader
Our time together here has been marked by rich and deep conversation around an issue about which each of us feels very passionately. As we close this discussion, let us pause to reflect on one moment in which we experienced a new insight, a new understanding.
(Pause for reflection)
Leader
Lord, we thank you for opening our minds and hearts to new learning. Like the disciples after the miracle of the loaves and fishes, we gather all of the fragments of our time together that not one blessing from our common conversation should be lost. As we go forth from this place, we ask that you help us to hold onto the wisdom that has been shared in this room and move the ideas expressed here forward, continuing to grow and develop them in our individual, on-going work in this field.

All
Lord hear us. Hear our prayer.

Leader
Let us also pause to call to mind a moment in which we did not feel at harmony with one another — a moment perhaps when an idea was expressed that concerned us deeply; that troubled us. Perhaps a moment in which we felt that we were misunderstood. And let us hold that moment in prayer, too.
(Pause for reflection)
Leader
Lord, we thank you for the words of challenge that have been part of this gathering. We know that the conversations that we have had with one another have been graced, but they have also been difficult. Though we now prepare to part one another's company, we ask nevertheless that you weave us ever closer together as a community of leaders, marked by growing understanding, charity, patience and commitment to dialogue.

All
Lord hear us. Hear our prayer.

Leader

As we close our time together, let us lastly call to mind one patient or patient's family from our own organization that we know is currently facing painful decisions. Let us place these persons into God's shepherding hands.

(Pause for reflection)

Leader

Lord, *we* know that *you* know each and every one of your sheep by name. In the Psalms you tell us that you provide us with all we need, even as you walk with us through the darkest of valleys. Be with the patients whom we have entrusted to your care. Be with their families and their caretakers. May our work always serve their greatest good.

All

Lord hear us. Hear our prayer.

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