Spiritual Care in the Midst of Health Care Reform

Creating a Framework for Effective Staffing

By BRIAN P. SMITH, MS, MA, MDiv

Health care in the United States today is marked by extraordinary change. The Affordable Care Act has highlighted the significance of meeting not only our mission-related goals, but our operating margins as well. As health and hospital systems adjust to ongoing financial pressures, meeting the spiritual and emotional needs of patients in cost-effective and efficient ways takes on renewed focus.

Spiritual care departments across the spectrum of health delivery systems are attempting to define the value proposition they bring to the healing process. The early research, however, is not always easy to translate into dollars saved and outcomes data.

Part of the challenge is that the language of spiritual care is very different from that of operations and finance. We often point to the beginnings of Christianity, when care of the sick and care of the spirit were part of the same healing process. We turn to the *Ethical and Religious Directives for Catholic Health Care Services*, which call Catholic health to be: "... a community of healing and compassion while providing care not limited to the treatment of a disease or bodily ailment but embracing the physical, psychological, social, and spiritual dimensions of the human person."

In recent years, spiritual care departments have used patient satisfaction scores to show that patients and families desire a holistic approach to healing. The advancement of "person-centered care," as well as new standards by the Joint Commission to accommodate the spiritual preferences of patients, further support the thesis that spiritual care provides value for the patient and results in higher patient satisfaction and better health outcomes.

The Catholic Health Association's mission department often is asked for a benchmark patient-to-chaplain ratio to determine if a facility or region is appropriately staffed. While patient census is one factor to consider in staffing a spiritual care department, it should never be the sole factor. Effective core staffing takes an array of factors into account.

For example, chaplains minister not just to patients and their loved ones, but to the staff as well. That is why some systems count the number of encounters, or interactions, a chaplain has with patients, spouse/significant others, children, staff, etc.

Also, as health care delivery continues to change, new locations and styles of giving spiritual care are emerging. Many Catholic systems are seeing more patients in their non-acute settings — clinics, outpatient ambulatory centers, rehab centers, long-term care facilities, adult day

As health care delivery continues to change, new locations and styles of giving spiritual care are emerging.

care, hospice, and patients' homes — than in their acute care facilities. Spiritual care departments are beginning to include these settings in their staffing models.

Just as health systems have redirected clinical resources from acute to non-acute settings, so, too, are spiritual care resources being shifted. This development presents exciting possibilities for engaging the full skill set of a professional chaplain, but it complicates the process of setting effective staffing benchmarks. One thing is clear however: Catholic health care's commitment to holistic healing requires that spiritual care be considered wherever patient care is delivered. The *Directives* do not limit the provision of spiritual care to acute or long-term care settings. Directive 10 states, "A Catholic health organization should provide pastoral care to minister to the religious and spiritual needs of all those it serves."

Catholic health care's commitment to holistic healing requires that spiritual care be considered wherever patient care is delivered.

As recently as 10 years ago, chaplains moved from room to room, visiting all patients in a hospital or facility, regardless of their level of critical illness. Because medical care is moving to different settings, patient acuity becomes an important component for determining staffing models for spiritual care in these new surroundings.

Based on time studies from several Catholic health systems, basic assessments and interventions require an average of 18 minutes of a chaplain's time, including documentation and care planning. As acuity rises and interventions become more complex and nuanced, assessments and interventions require increased time allotments. In the ICU, a spiritual assessment and care plan needs 39 minutes, end-of-life care requires 44 minutes, and assisting a patient in palliative care to identify his or her values and hopes for treatment takes an average of 34 minutes. Determining adequate staffing involves matching the number of these kinds of services within a setting to the time needed to offer the care.

For spiritual care staffing, systems also must consider factors such as broad differences in the way chaplains function across the country, cultural differences in chaplain roles and varied philosophies about the function of spiritual care professionals within health care systems. In some settings, chaplains are expected to provide presence and ritual; in others, chaplains offer administrative expertise to the broader goals of healing and the patient experience. Spiritual care providers help shape and nurture workplace spirituality and culture, in ways overt and operational as well as subtle and invisible. Some chaplains teach by example and listening; others by lecture and webinar; and many by both.

In general, there are three categories of core competencies for chaplains: spiritual assessment and care; education; and ritual ministry.

Whatever the setting — hospital, hospice, clinic, etc. — each patient who requests a visit or who is referred to the chaplain receives a spiritual assessment to identify spiritual needs as well as spiritual assets. In an acute setting, a chaplain may identify how unsettled grief is limiting a patient's ability to heal. Spiritual care interventions might include identifying resources in the community or encouraging the patient to express grief as a way to more effectively attend to her or his recovery.

A chaplain's spiritual care intervention could lead a patient to connect with a faith community or a wellness and prevention support group.

In a clinic setting, a chaplain's spiritual care intervention could lead patients to connect with a faith community or wellness and prevention sup-

port groups, thus helping patients improve their attitude and strengthen their resolve to manage a chronic disease. For patients in long-term post-acute care settings, chaplains can develop plans of care that address longer term issues while also responding to immediate spiritual concerns.

In hospital as well as non-acute settings, chaplains assist in orientation and formation of new staff, physicians, residents and medical and nursing students. They present the holistic care model and discuss the integration of spiritual care in the patient care plan. They also educate clinical care providers on how to conduct a spiritual screening interview. This includes how to identify spiritual distress, what conditions indicate the need for a referral to spiritual care and what a chaplain's formal spiritual care assessment and plan entail.

Some chaplains have created educational materials to help staff meet the religious/cultural expectations of patients and families. In providing ethics education to clinical staff, chaplains can work with them to help patients and loved ones come to clarify their values around medical ethics decisions and be able to complete their advanced directives.

Sometimes chaplains are asked to provide pastoral support in times of community crisis: Talking to high school students whose classmate committed suicide; being present to traumatized workers after an industrial accident; or ministering to a whole community that endured a natural disaster. Chaplains can be wonderful ambassadors to the broader community and create loyalty towards the health system that is reaching out to the community in crisis.

The third core competency of spiritual care is the skillful facilitation of meaningful ritual. Rituals serve a deeply human need to create meaning, honor important events and create sacred space for patients, families and communities.

Spiritual care providers offer ritual care for a variety of needs and occasions. In acute or long-term care settings, trained volunteers can provide Eucharistic ministry, while non-certified staff

NEXT STEPS

Based on the staffing subcommittee's research, here are key questions for various groups to consider as they review their spiritual care departments:

Sponsors and Senior Leaders

- Has there been a recent discussion between the sponsors and senior leaders (including mission and spiritual care leaders) on the integral nature of spiritual care in how Catholic health care approaches the healing ministry?
- As health systems look at new care delivery settings, is the provision of spiritual care being considered for those settings?

Mission and Spiritual Care Leaders

- Has the spiritual care department performed an inventory of the services it provides patients, families, staff and the community? With time studies? Has that information been shared with senior leaders? Has there been honest discussion about what services might be eliminated or added if the spiritual care department experienced reductions or additions in staff?
- Is there a spiritual care strategic plan that aligns with the health system's strategic plan for the provision of spiritual care in the various acute and non-acute care settings?

Spiritual Care Departments

- Has the spiritual care team looked at what it needs to let go or take on in order to provide pastoral care in new ways and new settings? What process is the team using to make those decisions?
- How might trained volunteers be used in areas of spiritual care that do not require the skills of a board-certified chaplain? What kind of training do those volunteers need and who will provide it to them?

Clinical Departments and Medical Staff

- Do other clinicians assist chaplains in spiritual care screening? Do they effectively identify those patients who would most benefit by seeing a professionally trained chaplain?
- Has clinical staff been introduced to spiritual screening tools as part of the initial patient assessment?

Quality Improvement Department

- Has the spiritual care department collaborated with the system's quality improvement team applying efficiency principles (for example, GE Lean, Six Sigma) to help determine greater efficiencies where professional chaplains are most needed?
- How can the quality department help the spiritual care department establish metrics that can be shared across the ministry? Can this research be used to develop benchmarks and quality standards?

priest chaplains can celebrate Mass and offer the Sacraments of Reconciliation and Anointing of the Sick. Board-certified chaplains may be best suited to conduct institutional rituals for bereavement services, prayer services for the loss of staff by death, retirement or reduction in workforce, or when facilities dedicate expansions or renovations.

In home or institutional hospice settings, board-certified chaplains offer end-of-life rituals for the dying process and provide prayer and memorial services for the bereaved.

Both creativity and flexibility are needed to determine the optimal match between the individual gifts and skills of particular chaplains with the needs for healing and the variables of location and health care modalities. Chaplains offer a broad mix of competencies that present the possibility of a unique cultural role and resource for the health care landscape of the future.

Chaplains offer a broad mix of competencies that present the possibility of a unique cultural role and resource for the health care landscape of the future.

LETTING GO IN ORDER TO EMBRACE

Amid all the changes unfolding in health care, it is time to reevaluate chaplains' priorities and activities. Like other clinical disciplines, chaplains need to make best use of their training, expertise and competencies. Chaplains working at the top of their certification complete formal spiritual assessments and design care plans; educate patients, families, staff and the community on advance directives with attention to cultural and religious needs; and provide ritual ministry, especially in crisis situations. They focus on patients in critical areas and train volunteers to help with those in less critical areas.

Some systems are beginning to ask if it is possible to provide in-house spiritual care 24/7. No one is proposing that sacramental coverage not be available at all times, however the chaplain population is aging, and there are not enough board-certified chaplains in the pipeline to replace them. Systems that require a 24/7 in-house spiritual care presence in their Standards of Spiritual Care need to grapple with some important issues — very soon.

One system changed their chaplains' role in helping patients with advance directives. In the past, chaplains had been engaged in the whole process: delivering forms; answering questions and helping patients understand the form; witnessing the signatures; making copies and getting them to medical records. With better system effort around advance directives, it became clear that the best use of the chaplain's expertise was the values conversation about the specifics of advance directives. The clerical work was then handed over to others.

Other systems are turning to technology to extend spiritual care in non-acute settings. While some provide spiritual care over the phone, others use the technology of telemedicine to offer a face-to-face encounter between the chaplain and the patient in a rural or remote setting. The ability of chaplains to adapt to these new ways of delivering spiritual care will be critical.

Also, new models of spiritual care staffing use a team approach, recognizing the varying degrees of training, competencies, personal skills and expertise among the members of the spiritual care department and other staff collaborating in this holistic ministry.

Volunteers introduce spiritual care services to patients in non-critical areas, provide compassionate presence and listening, offer prayer when possible, and keep attuned for spiritual needs that require greater skill.

Members of the clinical care team carry out spiritual care screenings and refer to chaplains those patients or residents who need a spiritual care assessment and care plan.

Change is rarely easy. Professionally trained chaplains may resist letting go of practices they prefer in order to undertake new models that ask them to be with patients and families in spiritual crisis. If the system is considering reducing staff or eliminating spiritual care practices, such decisions should be based on a local review of the spiritual care team's current activities — meetings, patient care, education services, ritual ministry, administrative tasks, reports, committee work.

We need to experiment with new ways of using chaplains as health care delivery moves into the non-acute setting.

One director of spiritual care reported that when he showed the CEO what services would be lost at their facility if their department were to eliminate two chaplains, the CEO maintained that those services were "core" to being a Catholic hospital and changed his mind.

It is only logical that leaders in Catholic health systems are asking spiritual care departments to demonstrate their value and justify the staffing levels they request. The question itself does not imply loss of Catholic identity or an undervaluing of the holistic approach to healing. The question simply suggests that with limited resources, we need to ensure everything we do adds measured value.

Two years ago, when CHA's Pastoral Care Advisory Committee established the staffing subcommittee, we hoped to develop an algorithm to help standardize the way Catholic health care facilities determine spiritual care staffing. That proved impossible because of the wide variation in practice patterns across the ministry. There was no such thing as a standard unit of service for spiritual care, therefore, no national benchmark for staffing.

The research did, however, discover an emerging framework to consider when planning for effective and appropriate spiritual care staffing in a variety of Catholic health care settings. Among the factors to take into account: the number of encounters (patient, family and staff); the range of acuity encountered; the unique types of services a setting expects or desires; the levels of integration of spiritual care services within the multidisciplinary care team; and the cultural expectations within a facility, system or community.

The complexity of health care reform and the effect it will have on the delivery of care, including spiritual care, is just beginning. It is in Catholic health care's best interest to enter this new phase as a time of research and development.

We need to experiment with new ways of using chaplains as health care delivery moves into the non-acute setting, while still providing the necessary care to patients who are extremely sick or dying in our acute facilities.

We need to continue to refine what a professional chaplain should be doing and what can be done by others.

Finally, we need to share our questions, struggles, ideas and attempts at effective chaplaincy staffing models with each other.

This article was written with the help of the CHA Pastoral Care Committee's staffing subcommittee. For more resources, please visit www.chausa.org/pastoralcare.

BRIAN P. SMITH is senior director of mission integration and leadership formation, the Catholic Health Association, St. Louis.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, September - October 2014