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.” 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.” Surveys of chaplains both in the U.S. and around the world suggest strong support for this new evidence-based paradigm.

**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.”

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.”

The second reason for adopting a research-informed approach to practice is that it helps us...
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 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 struggle25 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-
association’s commitment to “promote and defend human dignity; attend to the whole person; and care for poor and vulnerable persons” 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 — 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.

GEORGE FITCHETT is a professor and director of research in the Department of Religion, Health and Human Values at Rush University Medical Center in Chicago. He also co-directs the Transforming Chaplaincy project (www.transformchaplaincy.org).

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
17. Dariush Mozaffarian et al., “Heart Disease and Stroke Statistics — 2016 Update.”
20. Kenneth I. Pargament et al., “Patterns of Positive

**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?

- 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.