Original Article

How Do Healthcare Executives Understand and Make Decisions about Spiritual Care Provision?

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Objectives: This pilot study explores how healthcare leaders understand spiritual care and how that understanding informs staffing and resource decisions.

Methods: This study is based on interviews with 11 healthcare leaders, representing 18 hospitals in 9 systems, conducted between August 2019 and February 2020.

Results: Leaders see the value of chaplains in terms of their work supporting staff in tragic situations and during organizational change. They aim to continue to maintain chaplaincy efforts in the midst of challenging economic realities.

Conclusions: Chaplains' interactions with staff alongside patient outcomes are a contributing factor in how resources decisions are made about spiritual care.

Key Words: chaplaincy, decision making, executives, health care, spiritual care

Healthcare systems' responses to coronavirus disease 2019 (COVID-19) have drawn attention to the importance of addressing patients' spiritual and religious needs. Even before the pandemic, there was growing evidence that spiritual care was a critical component of health and well-being. In 1969, The Joint Commission required all hospitals to address the religious and spiritual needs of patients,[1] and recent guidelines stipulated that hospitals are to respect "the patient's cultural and personal values, beliefs, and preferences" and to accommodate "the patient's right to religious and other spiritual services."[2] The Centers for Medicare & Medicaid Services states, "Spiritual needs related to palliative care patients are to be addressed in order to promote the resident's well-being, comfort, and dignity throughout the dying process."[3] The National Comprehensive Cancer Network emphasizes the need to screen patients for emotional and spiritual distress.[4]

This article is the first to our knowledge to ask how hospital leaders understand and make decisions about providing chaplaincy and spiritual care in their hospitals. It is based on a growing body of research that suggests that patients who are visited by chaplains are more satisfied with their hospital stays,[5–10] and that spiritual care is associated with higher satisfaction among families whose loved ones died while in the intensive care unit.[11] Small studies suggest that visits from chaplains may affect anxiety and other measures of patient and family coping.[12,13] Such findings are not surprising given that religion and spirituality are among the most important resources people turn to when they or their loved ones are facing serious health problems.[14–16]

Chaplains, the professionals most responsible for offering spiritual care in hospitals, emerged in the United States in the mid-20th century.[17] Spurred by changes in Protestant theological education, they joined local clergy who visited their constituents and eventually became a distinct professional group.[1,18–20] Data from the American Hospital Association suggest that between

Key Points

- Chaplaincy and spiritual care departments are integrated into their healthcare systems in a variety of ways.
- Executives recognize the importance of chaplains in terms of their ability to manage the personal and social effects of death and dying in the hospital as well as during times of crisis and tragedy.
- Executives see themselves continuing to direct economic resources to chaplaincy departments in the midst of the challenging economic realities of healthcare organizations.

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half and two-thirds of hospitals had a chaplaincy service between 1954 and the present.[21,22] Over time, chaplains became more religiously diverse and increasingly identified as interfaith or multifaith chaplains who care for all of the patients in a particular unit rather than only those with whom they share a religious background.

Recent evidence suggests that at least half of patients want to discuss religious and spiritual beliefs or concerns with their physicians or other healthcare providers.[23,24] Although between 54% and 65% of hospitals currently have chaplains, the number of patients who are actually visited by one is estimated at between 10% and 30%.[9,15] These numbers are much lower than the 30% to 70% of patients, according to other studies, that would welcome or expect a visit from a chaplain.[8,25,26]

There are no national standards about the provision of spiritual care in health care and no corresponding metrics or best practices about chaplain-to-patient ratios that guide healthcare leaders when making decisions about staffing chaplains.[27] Evidence suggests that larger hospitals, with an average daily census of ≥200, those in urban areas, and those that are religiously affiliated are more likely to have chaplains than others.[15] Healthcare leaders make ongoing decisions to create and/or to maintain a spiritual care department, which often is difficult as chaplaincy is a non-revenue-producing service.[28–30] With the exception of Medicare pass-through funds, which can support chaplains-in-training, the work of chaplains is paid from the bottom line of healthcare organizations.[31,32]

This pilot study examined how healthcare leaders understand spiritual care and make decisions about whether to hire chaplains. We find that leaders perceive the value of chaplains in terms of their work supporting staff in tragic situations and during organizational change. They aim to maintain chaplaincy efforts in the midst of challenging economic realities and generally do not articulate concerns about costs.

Methods

We focused on 24 hospitals in three similarly sized cites in three different regions of the United States. We selected cities in the Midwest, South, and Pacific Northwest, hypothesizing that those in the more religious southern cities may be more likely to understand and want to support spiritual care programs. We identified all of the hospitals in each city and focused on nongovernmental facilities, which included those that were for-profit, non-profit, and/or religiously based. We hypothesized that hospitals founded within religious traditions and/or recently affiliated with religious organizations would also have leaders who understood spiritual care in ways that are different from their colleagues in secular hospitals.

We invited senior leaders from each hospital to participate and conducted interviews with leaders at 11 of the 24 hospitals that fit the criteria, a 46% response rate. We first interviewed the manager of chaplaincy or spiritual care (N = 14, a 64% response rate) and then asked the managers to introduce us to their supervisor at the senior leadership level. We attempted to contact 13 executives at least three times by e-mail. One chaplaincy director was not comfortable asking supervisors to participate. Of the 12 supervisors invited to participate, 11 responded affirmatively, for a 91% response rate. Details about the hospitals and healthcare systems that our interviewees worked for are included in Table 1. The demographics of those we interviewed are in Table 2. Interviews were conducted between August 2019 and February 2020, before the announcement by the World Health Organization of the COVID-19 pandemic (March 2020).

Interviews were conducted by Zoom, recorded and transcribed, and lasted between 20 and 45 minutes. Interview questions included how decisions about spiritual care staffing and budget are made, whether there had been proposals for additional spiritual care staffing or staff reductions, and how, if at all, the work of chaplains connected to the mission of the hospital. Transcripts were loaded into Atlas.Ti (version 8; ATLAS.ti Scientific Software Development GmbH, Berlin, Germany) and analyzed inductively following the principles of grounded theory.[33] Initial codes were developed by two researchers and then refined through subsequent processes of writing and analysis.

Results

The titles of the 11 senior leaders interviewed included Director of Patient and Family Engagement, Director of Patient Relations, System Vice President of Mission and Spiritual Care, Chief Nursing Officer, Chief Executive Officer, and President. Each one directly supervised the manager of the chaplaincy or spiritual care department in their institution. The leaders had oversight of 18 hospitals within 9 healthcare systems. The 18 hospitals included 4 community hospitals, 9 faith-based hospitals, 4 academic medical centers, and 1 for-profit hospital, as described in Table 1. Among the senior leaders, 27% were ordained or had significant spiritual care experience, as described in Table 2.

Although historically, spiritual care managers report to an executive in the hospital, this has changed in some institutions. Four of the hospitals included here have directors of chaplaincy who report to a regional spiritual care executive, who is responsible for spiritual care services at several sites. In most of the academic and community hospitals, the reporting line was through patient services or chief nursing officers. There was one exception at a community hospital where the budget and staffing of the spiritual care department was decided by the diocese of one of the founding religious groups of the hospital. In this case, the religious group had a formal agreement with the hospital that ensured staff stability in terms of full-time equivalent lines in the department. We found wide diversity in how budget, staffing, and resources decisions about spiritual care were made across hospitals.

Value of Chaplains: Support for Staff

When asked about the value and contributions of chaplains, leaders spoke about the support they provide staff during tragedies and death. Certain staff, mainly nurses, were more aware of and likely to advocate to executive leadership for chaplains' work. As one chief nursing officer at a community hospital noted, "Maybe bedside nurses know what chaplains do but

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Table 1. Description of respondents and organizations

Region	Type	Historically faith based? Y/N	Part of health system? Y/N	No. hospitals	No. chaplain managers interviewed	No. executives interviewed	Does the executive have oversight at the hospital or system level?	Total interviews
South	Academic	Y	Y	1	1	1	Hospital	2
	Community	N	N	1	1	1	Hospital	2
	For-profit	N	Y	1	1	0	Hospital	1
	Faith based	Y	Y	2	1	0	System	1
	Faith based	Y						
Pacific Northwest	Academic	N	Y	1	0	1	Hospital	1
	Academic	N	Y	1	1	2	Hospital	3
	Community	Y	Y	3	1	1	Hospital	4
	Community	Y			1			
	Community	N			1			
	Faith based	Y	Y	2	1	1	System	3
	Faith based	Y			1			
Midwest	Academic	N	Y	1	1	1	Hospital	2
	Faith based	Y	Y	2	1	2	System	4
	Faith based	Y			1			
	Faith based	Y	Y	3	1	1	System	2
	Faith based	Y						
	Faith based	Y						
Totals	4 academic 4 community 9 faith based 1 for-profit	12 historically faith based 6 secular	9 systems	18	14	11	7 hospital 4 system	25

executives don't." A few respondents alluded to gaps in their own knowledge about chaplains' roles, particularly about how chaplains support staff during and after traumatizing events. The president of a faith-based hospital described a situation early on in his tenure when a medical error occurred, and the director of spiritual care held a critical incident stress management support session with the nursing staff involved: "I had no idea at the time that a chaplain could be a first responder in that way. Now I see. Because healthcare is tough business, people can be potentially traumatized by their job and giving them that immediate support after a potentially traumatic event is dollars and cents, if you're talking staff retention, for example." Another executive noted, "I think over time, people have seen the value in having spiritual care. I think also the fact that they're helping us with other things, like the staff distress, which could help us with turnover."

Some leaders also spoke about how chaplains help to address staff turnover by paying attention to moral distress and overall perceptions of scarcity in health care. As healthcare systems consolidate, leaders identified chaplains as "potential partners in helping employees." As one executive noted, they "understand that healthcare is changing but that change doesn't have to be negative. Chaplains can help to reframe and refocus people on the mission and the core components of the mission, and how we live it, I think, is one of the critical jobs that chaplains provide." In this way, chaplains are seen by some healthcare leaders as potential allies in maintaining productivity and addressing uncertainty from staff during periods of organizational change.

Most of the leaders also listed a range of events, programs, and initiatives that chaplains organize at their hospitals to proactively support staff as a key feature of their value in their hospital settings. Nearly every leader mentioned gatherings in which chaplains served staff (tea, coffee, desserts) and let them talk about their emotions in relation to the work. As one leader put it, "Those kinds of things are invaluable to making a staff and clinical teams feel like they are being cared about and it refills their bucket … when they feel someone being compassionate to them, they're able to extend compassion to their patients."

Maintaining Chaplaincy in the Midst of Limited Resources

We listened carefully to how leaders make resource decisions about spiritual care as they respond to the challenges they face in their work. These challenges include hospital capacity, high occupancy, readmission rates, staff retention, and low reimbursement rates. Respondents discussed expanding spiritual

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Table 2. Demographics of senior healthcare leaders (N = 11)

	N (%/average)
Sex	
Female	8 (72)
Male	3 (27)
Ethnicity	
African American or Black	0 (0)
Asian American/Pacific Islander	0 (0)
White	10 (91)
Latino/a	0 (0)
Mixed ethnicity	1 (9)
Age, y	11 (57)
Highest degree earned	
Bachelor's	2 (18)
Master's	8 (72)
Doctorate	1 (10)
Has significant spiritual care experience	
Yes	3 (27)
No	8 (73)
Time in hospital administration, y	11 (28)
Time at hospital, y	11 (17)
Full time	11 (100)
Part time	0 (0)
Religious affiliation	
Christian	9 (82)
Protestant	6 (67)
Catholic	3 (33)
Non-Christian	2 (18)

care into outpatient settings through technology, continuing to meet the emotional and spiritual needs of patients and staff, and lowering readmissions rates by addressing gaps in community support[34] as ways chaplains could help address these challenges.

When asked about how they make resource decisions about chaplains, most leaders described a standard financial discernment process made during regular annual budget cycles in which the status quo was the norm. Leaders tended to speak about patient volume and acuity as the factors that shape their staffing decisions more frequently than industry standards or benchmarking. One-third of respondents mentioned chaplaincy research broadly and two-thirds of respondents did not mention any research being done about the effects of chaplains on patients, families, and staff.

Spiritual care is vulnerable to budget cuts because it is nonrevenue generating, although most of the departments we learned about had been stable in terms of full-time equivalents during the past 5 years. We asked about layoffs, wondering whether chaplaincy positions had been cut in recent years. Most of the hospitals were coping with fiscal shortfalls, and nonrevenue-generating departments are more often subject to budget cuts. In several hospitals there were hospital-wide cuts, in which chaplain positions were reduced by attrition. Where spiritual care staff was reduced, there were several months of restructuring in which small, often nonrevenue-generating departments merged, combining managers and administrative support.

Leaders reported making several different arguments about the value of chaplaincy. Many related the value of spiritual care to mission and strategy. The two faith-based healthcare systems appeared to have an easier time connecting the work of chaplains to the mission of the hospital. In one of the few examples of an executive using benchmarking for staffing decisions, a system-level executive who oversees spiritual care at the regional level for a Catholic health system stated, "If spiritually centered care is our mission, then we need to be able to deliver and the only way to do that is to have a robust chaplaincy program." After significant budget issues at the end of the fiscal year, national leaders at this executive's hospital system recommended cutting the spiritual care budget after benchmarking their system against the market in a different region within the same system, one that staffs at the lowest level of chaplains within the entire national organization. When the budget was under review that year, the system spiritual care manager presented findings to the national leader from an audit of the level of chaplaincy at the large secular hospital competitors in his market. The findings showed that if the budget cuts were implemented in the faith-based system, then the hospital would be staffing their chaplains at a lower level than their secular competitors. This argument to maintain the chaplaincy budget was successful according to this executive because, "In order to be an organization that is authentic and works with integrity, we have to walk the walk. Otherwise, I can't stand up and honestly say what differentiates us is this spiritually centered holistic care because actually my secular competitors are providing it better than I am."

At non-faith-based hospitals, arguments clustered around strategy and connecting the work of chaplains to broader hospital goals. Several leaders referred to their institutions' goals and vision statements in making arguments about spiritual care staffing and resources. When the only staff chaplain at a children's hospital in a predominantly African American community was at risk of not being replaced due to retirement, an executive used the healthcare system's recent national initiative around maternal-fetal health disparities for African Americans to successfully argue to fill the position. Her argument was that the decision to cut the position in the children's hospital was, "shortsighted and a lack of utilizing our resources to the best opportunity to achieve our strategic goals." Other strategic arguments were present as decision makers tied chaplain positions to meeting hospital goals around staff retention, particularly with nurses. These executives understood the logic that chaplains contribute to decreasing staff turnover by meeting the emotional needs of staff. Another point raised several times was the frequency of death in trauma units and the benefit of having chaplains to lead staff debriefings.

A few topics were noticeably absent from the arguments that executives made about the value of chaplaincy. The role of chaplains around palliative care was rarely mentioned nor were research studies about the effects of chaplaincy and spiritual

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care. Spiritual care managers and executives also rarely mentioned using data about their own institutions when making decisions about spiritual care budgets and staffing.

Discussion

Limited research empirically assesses the extent to which chaplains' interactions with staff affect retention or workplace satisfaction.[35–37] The leaders in this study tended to see the value of chaplains in terms of their work supporting staff in tragic situations and during organizational change and described ways to maintain chaplaincy efforts in the midst of challenging economic realities. These findings elevate chaplains' interactions with staff to those often mentioned as related to patient outcomes as a contributing factor in how hospital leaders make resources decisions about spiritual care.

Leaders are not making decisions about spiritual care based on studies of its efficacy, however. Rather, leaders emphasize the alignment between chaplains and the mission and values of the hospital and the value that they see chaplains bringing staff in their organizations.

Although most of the leaders were aware that chaplains are representative and symbolic of the mission of their hospitals, their knowledge of chaplains' day-to-day work varied. The number of chaplains were stable overall, according to these leaders, with exceptions for institutions with system-wide cuts. Perhaps because of the small sample and pilot nature of this work, we did not find support for our hypothesis about regional or cultural differences in administrative support for spiritual care.

Conclusions

This is the first study to gather information about how healthcare leaders across regions, religious demographics, types of hospitals, and association with health systems understand the work of chaplaincy and spiritual care and make related resource decisions. It is hoped that this pilot study will lead to larger studies focused on whether healthcare leaders in more religious regions of the country think and make decisions around spiritual care differently from those in less religious regions. Future researchers may also consider how decision making about spiritual care varies across types of hospitals. We hope that future work considers ways to educate nonchaplain supervisors about the role, value, and significance of chaplaincy. There needs to be a more consistent message transmitted to healthcare leaders about what their spiritual care resources are and how to benefit most from them.

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