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# What organizational and business models underlie the provision of spiritual care in healthcare organizations? An initial description and analysis

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## ABSTRACT

Two-thirds of American hospitals have chaplains. This article explores the organizational and business models that underlie how chaplains are integrated into hospitals. Based on interviews with 14 chaplain managers and the 11 healthcare executives to whom they report at 18 hospitals in 9 systems, we identify three central findings. First, there is significant variation in how spiritual care programs are staffed and integrated into their hospitals. Second, executives and chaplain managers see the value of chaplains in terms of their quality of care, reliability and responsiveness to emergent patient and staff needs, and clinical training and experience working within a complex environment. Third, few departments rely on empirical data when making decisions about staffing, tending instead to default to the budgetary status quo. These findings provide the basis for a larger more systematic study.

## KEYWORDS

Business models; chaplains; executives; healthcare organizations; spiritual care

## Introduction

Two-thirds of American hospitals employ chaplains (Cadge, Freese, & Christakis, 2008). A growing body of research explores what chaplains do and what effects their work has on patients, family members and staff (Fitchett, White, & Lyndes, 2018). Less attention has been given to how chaplains are integrated into healthcare organizations and what effects the organizational structure has on their work. While some hospitals employ large numbers of chaplains, who are well integrated in inpatient care teams and attend multi-disciplinary rounds, others report limited staff who only respond to crises or emergencies.

This article explores the organizational and business models that underlie chaplains' integration in hospitals. We also ask how executives gather information about chaplains' organizational effectiveness and use it for organizational improvement and growth.

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The Joint Commission requires hospitals to address the religious and spiritual needs of patients but does not require that chaplains be the staff members who do so (The Joint Commission, 2018). Chaplains are not required in hospitals and institutions, therefore there are many different organizational approaches to integrating them. While the main professional chaplaincy organizations have clear standards for educating and credentialing chaplains as “Board Certified,” the credential is not a gatekeeper to practice in the way licensing process for nurses and physicians is (Association of Professional Chaplains, 2015). This leaves hospitals greater hiring freedom for chaplaincy. While several articles have reported staffing ratios (VandeCreek, Siegel, Gorey, Brown, & Toperzer, 2001), there are no national chaplain-to-bed or chaplain-to-patient standards for healthcare organizations (Wintz & Handzo, 2005). Chaplains are also non-revenue producing further leading individual hospitals and systems to make local, at times idiosyncratic, decisions about how to staff and deploy them.

Few studies have asked how chaplains are integrated into and aligned with the institutions in which they work. For example, research describes the care chaplains provide in general (Handzo, Flannelly, Kudler, et al., 2008; Handzo, Flannelly, Murphy, et al., 2008) and in specific clinical contexts such as palliative care and the ICU (Jeuland, Fitchett, Schulman-Green, & Kapo, 2017; Labuschagne et al., 2020). Research has also begun to describe the impact of that care on outcomes for patients and families. Patients who are seen by chaplains report higher levels of satisfaction with their hospital stays (Marin et al., 2015; Williams, Meltzer, Arora, Chung, & Curlin, 2011). Chaplaincy care is also associated with greater satisfaction among families whose loved ones died in an ICU (Johnson et al., 2014). Chaplain care has also been found to contribute to lower levels of anxiety and improved coping for patients (Bay, Beckman, Trippi, Gunderman, & Terry, 2008; Berning et al., 2016; Iler, Obenshain, & Camac, 2001).

While professional chaplaincy organizations have Standards of Practice for the care provided by their members (Association of Professional Chaplains, 2015) there are few standards or guidelines about spiritual care from healthcare or medical organizations (Davidson, 2017; Ferrell, Twaddle, Melnick, & Meier, 2018) and none include specific details about chaplain training or staffing levels. There is some evidence about which hospitals have chaplaincy programs and the geographic and institutional factors (e.g., size of city where located, size of hospital) associated with having one (Flannelly et al., 2012). Existing research comes from two older studies. One reported data from 370 spiritual care department managers (74% response rate) who were surveyed in 1997–98 (VandeCreek et al., 2001). The other reported data from a survey of 494 healthcare executives (15% response rate) (Flannelly, Handzo, & Weaver, 2004). Both reported the number of chaplains per inpatient beds. VandeCreek et al. (2001) reported a mean of 1.85 chaplains per 100 patients across all the programs with a range of 0–12. Religiously affiliated community hospitals had a higher mean (2.90) compared to the non-religiously affiliated hospital (1.22). The findings in the Flannelly et al. study (2012) were similar. Religiously affiliated hospitals had 2.6 chaplains per 100 patients compared to 1.3 for non-religiously affiliated hospitals. Flannelly and colleagues also reported the percent of chaplains who were certified which ranged from 50% to 79% depending on institutional characteristics. Both studies also recorded information about care provided by volunteers or local clergy. VandeCreek et al. (2001) reported the average percent of

care provided by volunteers was 19% (range 0%–100%). Flannelly et al. (2012) reported the percent of departments that relied solely on local clergy or volunteers varied by location; in rural hospitals it was 58%, suburban hospitals 31%, and urban hospitals 14%.

Of interest for the present project, VandeCreek et al. (2001) asked department managers about the hospital executives to whom they reported. More than half (56%) said they reported to someone at the vice president or associate CEO level; an additional 21% said they reported to the hospital president or CEO. More than half the department managers (54%) said the executive to whom they reported changed every five years or more. One-third of the department managers reported more frequent turnover on those relationships.

Chaplaincy departments are integrated into hospitals in varied ways. Cadge (2012) separates chaplaincy departments at large academic medical centers into groups she calls professional, transitional and traditional. While chaplains in professional departments are integrated into healthcare teams, are regularly called as parts of protocols, and always called for specific situations, those in traditional departments are not. Hospitals with traditional departments do not have any situations in which chaplains are always called and tend to work more at the periphery of their institutions. While the chaplains in professional, traditional or transitional departments—which are those transitioning from being traditional to professional—may have the exact same skills and competencies, their ability to do their work is supported or constrained by their organizational setting.

At more and more hospitals, chaplains are engaging in quality improvement efforts around their work which also tends to focus more individually than organizationally (Berlinger, 2008). Some studies focus on how many patients individual chaplains see or how to prepare chaplains to serve certain patient populations. None appear to include efforts to change the organizational structures required for chaplains to have the best chance of being successful (Berlinger, 2008). Underlying these efforts is an important national shift to make the work of chaplains' evidence-based and thus asking unaddressed questions. Evidence-based chaplaincy efforts aim to focus on not just how this evidence informs chaplains' care, but their supervisors and the institutions they serve (Fitchett, 2017). Many of these studies also focus on individuals rather than trying to build generalizable insights about organizations that can help to strengthen the profession (Fitchett, 2017). While some branches of the military think about chaplains as force multipliers, that enable front line members of the military to perform better, that is not the way healthcare organizations have thought about chaplains (Stahl, 2017). Spiritual care for staff has also been a longstanding focus in professional chaplaincy, but it is less clear what proportion of chaplains' time should be spent in this work, what shape it should take, and how it connects to chaplains' broader institutional goals (Keogh, Sharma, Myerson, & Marin, 2017).

## Methods

We focused on 24 hospitals in three similarly sized cities in three different regions of the country. Since religious demographics might shape how hospitals staff chaplains, we selected cities in the Midwest, South, and Pacific Northwest expecting that those in the

**Table 1.** Demographics of study participants.

	Healthcare Executives ( <i>N</i> = 11) <i>N</i> (percent)	Chaplain Managers ( <i>N</i> = 14) <i>N</i> (percent)
Gender		
Female	8 (72)	6 (43)
Male	3 (27)	8 (57)
Ethnicity		
African American or Black	0 (0)	1 (7)
Asian American/Pacific Islander	0 (0)	0 (0)
Caucasian	10 (91)	13 (93)
Latino/a	0 (0)	0 (0)
Mixed Ethnicity	1 (9)	0 (0)
Age (average)	57 years	57 years
Highest Degree Earned		
Bachelors	2 (18)	0 (0)
Masters	8 (72)	13 (93)
Doctorate	1 (10)	1 (7)
Has significant spiritual care experience		
Yes	3 (27)	14 (100)
No	8 (73)	0 (0)
Time in Hospital administration (average)	28 years	22 years
Time at hospital (average)	17 years	13 years
Full Time	11 (100)	12 (86)
Part Time	0 (0)	2 (14)
Religious Affiliation		
Christian	9 (82)	14 (100)
Protestant	6 (67)	9 (64)
Catholic	3 (33)	5 (36)
Non-Christian	2 (18)	0 (0)

more religious southern cities might better integrate their spiritual care programs into the work of the hospital. We identified all of the hospitals in each city and focused on non-governmental facilities which included those that were for-profit, non-profit, and/or religiously based. We thought hospitals that were founded within religious traditions and/or were recently affiliated with religious organizations might also more fully integrate chaplains in ways different from their colleagues in secular hospitals.

We invited executives from each hospital to participate and conducted 11 interviews with them and with 14 chaplain managers at the 18 hospitals in three regions of the United States that fit the criteria, a 46% and 58% response rate, respectively. Because the names of the executives to whom chaplaincy and spiritual care departments report are not typically in the public domain, we first interviewed the manager of chaplaincy or spiritual care (*N* = 14, a 58% response rate) and then asked the managers to introduce us to their supervisor at the executive level. We attempted to contact 13 executives at least 3 times by email. One chaplaincy director was not comfortable asking their supervisors to participate. Of the 12 supervisors invited to participate, 11 responded affirmatively for a 91% response rate. The demographics of those we interviewed are in [Table 1](#). Interviews were conducted between August 2019 and February 2020, prior to the COVID-19 crisis.

Semi-structured interviews (*N* = 25) were recorded and transcribed. They were conducted by Zoom and lasted between 20 and 45 minutes. Transcripts were loaded into Atlas.Ti, a qualitative software program (Version 8), and analyzed inductively following the principles of Grounded Theory (Chun Tie, Birks, & Francis, 2019). Two researchers developed the initial codes; they were then refined through subsequent processes of

writing and analysis. The data analyzed in this paper emerged from the following interview questions: *Has the hospital ever considered having local clergy provide spiritual care rather than chaplains? Are there times in the hospital when chaplains are always called? How do you think about cost and revenue in relation to the work of chaplains? What type of data, if any, does the spiritual care department keep about chaplain's activities?*

We divided the hospitals into four groups: for-profit (1), academic (4), community (4) and faith based (9). We consulted the American Medical College directory to determine which hospitals were affiliated with medical schools (Medical Colleges, 2020). Distinguishing between faith-based and community hospitals complicated the process since we found that many had historical ties to faith institutions that have evolved legally and culturally into the present. In addition to checking hospital mission statements and asking chaplain managers and their supervisors during interviews, we also followed up with local Catholic dioceses to confirm faith-based affiliations. Details on the hospitals and healthcare systems that employed our interviewees are included as Table 2.

## Results

### *How are Chaplains staffed and integrated across hospitals?*

Chaplaincy and Spiritual Care Departments are staffed and integrated into the 18 hospitals (representing 9 health systems) we studied in several ways. The titles of the chaplain managers we interviewed included Director of Spiritual Care and Chaplaincy, Director of Pastoral Care, and Manager of Spiritual Care and Wellbeing. The titles of the executives 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. These departments primarily rely on professional chaplains to deliver spiritual care. In addition, to providing 24/7 coverage they also utilize per diem staff, Clinical Pastoral Education (CPE) residents and interns, local clergy, and volunteers. In all cases except two, professional chaplains who are board certified provided the majority of coverage. In only one case, the only for-profit hospital in our sample, was there only one full-time professional chaplain who managed over a dozen volunteers.

All departments in this study had clear guidelines for the hiring of chaplains and nearly all sought to hire board certified chaplains. The certification process is monitored by professional organizations of healthcare chaplains and requires a chaplain to have completed a master's degree with graduate theological education, four units of clinical pastoral education, endorsement from a recognized faith organization, and demonstrated competency in functioning as a chaplain. For per diem staff, one unit of CPE (at least) was required. Other qualifications included ordination or faith group endorsement and a Master of Divinity, Theology or Religious Studies. Two institutions accepted years of experience in place of a degree. Professional experience as a chaplain was often preferred. The spiritual care departments had between 1 and 15 chaplains and between 1 and 13 Full Time Equivalent staff. Ten or 56% of the hospitals had a CPE program.

To better understand what chaplains contribute to local hospitals and how they are integrated, we asked respondents to tell us why they use chaplains rather than relying

Table 2. Description of respondents and organizations.

Region	Type	Historically Faith Based? Y/N	Part of Health System? Y/N	# of hospitals	# of chaplain managers interviewed	# of 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
Northwest	Faith Based	Y						
	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			
Midwest	Faith Based	Y	Y	2	1	1	System	3
	Faith Based	Y			1			
	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
Totals	Faith Based	Y						
	4-Academic		9 systems	18	14	11		25
	4 -Comm.	12 Historically Faith based						
	9-Faith Based 1-For Profit	6 Secular						

on local clergy. Much of what makes chaplains unique is their integration within a hospital setting. However, there is variance across hospitals as to how well integrated chaplains are within organizations. Overall, executives and chaplaincy managers favored chaplains over clergy for three reasons: (1) chaplains provide quality care, (2) they are reliable and responsive to emergent patient and staff needs and, (3) have clinical training and experience working within a complex environment.

Chaplain managers and executives also expressed concerns about the quality of care being compromised when patients, family, and staff work with non-clinically trained chaplain volunteers. For managers, CPE is the chief differentiator because, as one chaplaincy manager stated, “you go to CPE to learn how to work with people. Clinically trained chaplains are more effective in their interpersonal skills, in their own self-awareness, such things as transference and other kinds of dynamics that happen in the helping professions. The residency just helps people understand boundaries, professional boundaries.” As one executive at a hospital with the region’s number 1 trauma center noted, “it is beneficial to have chaplains rather than clergy provide spiritual care because they are part of an intact team that hands off to each other. There are very few exceptions, particularly during emergencies.”

Faith-based hospitals have long histories of providing spiritual care through professional chaplains and local clergy in facilities. Executives within faith-based, mainly Catholic, healthcare systems have mandates for sacramental coverage within their hospitals provided by local clergy. At the same time, the executives in faith-based systems emphasized the strong commitment to ensure that those who are providing clinical care are professionally trained, board certified or eligible chaplains.

## **Two examples**

To determine how integrated a chaplaincy department is within its hospital we gathered information from each department about times when chaplains are called, whether there are policies for chaplain presence at the time of death and their level of visibility within the hospital. The majority of hospitals studied (89%, 16 out of 18) had times when chaplains were always called which clustered around themes: interpersonal acuties within the hospital, and patient, family or staff events. Thirty-nine percent (7 out of 18) of hospitals had a policy that required chaplains to be called to all deaths, especially when families are present. This varies across organizations, although it was acknowledged in nearly all responses.

To further illustrate a spectrum of how chaplaincy departments are integrated into hospitals, below are two descriptions: one a professional department that is highly integrated and a second transitional department that is far less integrated (Cadge, 2012). Both departments are based in the flagship hospital (with over 500 beds) of two large health care systems in the Pacific Northwest. The manager of each reports to a senior level hospital executive and the work of chaplains is primarily oriented toward patients and families.

Department A is in a faith-based hospital and has 15 staff chaplains, 13 FTE including a director and administrative support and around 40 volunteers. (FTEs may be lower than the number of staff chaplains when some chaplains are part-time.)

The department has grown in terms of staffing in the last 5 years and has established a CPE program. Hospital policy requires paging a chaplain when a patient dies, when there is a trauma, and when patients, family or staff are in distress. Aside from direct bedside care, chaplains serve on committees for ethics, palliative care, and patient and family engagement. They lead and co-facilitate initiatives and including large-scale hospital-wide Schwartz Rounds for staff to Passage Quilt programs for patients.

Department B is in a community hospital and has 5 staff chaplains and 6 FTEs including a director and administrative support and a dozen volunteers. This department has been stable in terms of staffing for the last 5 years although the director has to convince administrators of the value of spiritual care during cost cutting times. There is no CPE program. Chaplains are called to all traumas and when patients or visitors are in distress, but hospital policy does not mandate that a chaplain is called at the time of death. Aside from direct bedside care, chaplains' visibility is low. According to the Chief Nursing Officer who oversees spiritual care as a part of their portfolio, "maybe bedside nurses know what chaplains do but executives do not." Chaplains serve on few hospital committees.

### ***How do Chaplains engage in the institutions they serve?***

Chaplain managers and their executives situate the work of chaplains in the context of the broader priorities of the institutions in terms of patient care, staff needs, and staff care. They think about the value of chaplains in terms of their emotional and moral benefit to patients, family and staff weighed alongside the financial cost of running the department.

Across many of our interviews the prevailing theme related to chaplains' work with patients and families was that chaplains will be the first person they page when "...the teardrop falls, when a family's upset, when a patient's depressed. When they don't know who else to call and somebody's dying, when they're trying to get decisions made when they've got yelling and screaming and physical altercations in the hallway." Almost all of the spiritual care departments studied listed different initiatives related to patients who are actively dying or at the end of life such as companion programs, passage quilt programs, prayer or remembrance services and music-thanatology.

In addition to working at the bedside with patients, chaplain managers outlined a variety of ways they contribute to the hospital with initiatives and programming for staff. We heard about peer-to-peer programs that match clinicians who are experiencing personal or professional challenges, large scale events like Schwartz rounds, emergency response through Critical Incident Stress Management debriefings with staff, and long-term programming for patients, families and staff.

Reflecting on the work of chaplains, managers used a variety of terms to discuss cost and revenue including "cost savings, cost avoidant and an investment in the institution." and often said they don't think about the work of chaplains in terms of revenue. Chaplains are non-revenue producing. Some chaplain managers see their work as increasing the bottom line of the healthcare organization in indirect ways including staff retention, patient satisfaction, and shortening length of stay. When asked how they

think chaplains could increase revenue, these managers spoke of advanced directives, and creative ways for chaplains to harness growing outpatient needs for spiritual care.

Executives, in comparison, either talk about chaplaincy in terms of its cost like any other non-revenue generating department or employ a variety of terms to frame the work chaplains do as ‘cost avoidant.’ Some describe it as ‘cost effective,’ ‘risk mitigation,’ having ‘revenue potential,’ ‘support[ing] revenue generating departments,’ and ‘caus[ing] a positive indirect fiscal impact on the organization.’ One executive summed up the dominant perspective by stating chaplains are “not a lot of money for a lot of value.” Mirroring some of the response from the chaplain managers, executives also spoke about the value of chaplaincy in relation to the potential to generate revenue or mitigate costs to the hospital in terms of crisis management, readmission rates, advanced directives, staff retention, and the revenue from Medicare pass through which only relates to CPE students and their educators.

### ***Approaches to organizational effectiveness, improvement, and quality***

In thinking about chaplaincy departments as parts of their healthcare organization, we asked how managers and executives understood their effectiveness and undertook efforts to improve it. Formally, chaplain managers reported to their supervisors in different ways which had implications for the organizational level at which quality improvement could take place. Reporting structures varied due to consolidation within healthcare markets. While spiritual care managers historically reported to an executive in the hospital, this has changed in some institutions. Four of the hospitals included here have directors of chaplaincy that 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. These structures create different possibilities in terms of chaplaincy department staffing, tracking systems, and quality improvement measures.

There was variation in the types of data that spiritual care departments keep about their chaplains’ activity and productivity and how they are evaluated. When chaplain managers talked about data it was more about advocating for staffing and budget and less so about what to learn from data or how to use it to streamline processes. Surprisingly, although staff care was represented as a value of spiritual care to hospital executives, respondents report only informal, often intermittent, efforts to track the impact of staff care. Chaplain managers and executives alike acknowledge challenges and opportunities for quantifying the value and impact of chaplains.

The most common practice across chaplaincy departments was that chaplain managers use dashboard measures from the electronic medical record to track frequency of chaplains making patient visits, which units and staff are paging, and what kind of consults and deaths happen in the hospital. Many departments are complementing the use of medical records with data from patient satisfaction surveys or information they gather on their own through survey tools and spreadsheets. Many chaplain managers acknowledged that surveys and tracking patient interactions do not capture all that they do with staff and how they participate within the hospital more broadly. To address this, chaplain managers described creating shadow systems like Excel programs to track

what electronic medical records do not track for chaplains such as teaching, staff support, and how they serve the community, for example.

Departments most commonly reported relying on productivity data and impact to advocate or justify adding personnel to the chaplaincy department but not for streamlining processes or quality improvement. One manager recounts re-justifying an evening chaplain position, “I was using this HCAHPS survey I was able to pull all the information and say, ‘Outside of patient visits, these are all the other things that our evening chaplain is doing and this is why I think we need to have this position approved again.’ I want to do that for all of our chaplains just to have that data and have it available. And then see what does this look like? How much time is spent with patient care? How much time is spent with families? How much time is spent with staff? And then also with our students so then I can start presenting that information to the administration.”

There was one exception. Some executives related the value of spiritual care to their organization’s mission and strategy. The four 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 in the Midwest 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.”

Departments also reported not reviewing data on an ongoing basis with executives or using it to streamline processes. Managers explained that they do not collect any numbers or data because their executives are not requesting it. This perspective is best summed up, “We’ve talked about [using data for streamlining processes] but I don’t collect any numbers or data for this purpose. We’ve talked about that for the future, but no one wants to discuss it now. In some ways that’s sort of a freedom that [chaplains] have. They don’t have quotas.” When asked about using benchmarks to determine if chaplain productivity is satisfactory, one manager said, “I do not and because no one in higher administration is asking me that question and because I figure right now, we are just busy all the time.” Even in instances when managers are data-oriented, managers and executives do not consistently review data on chaplains in the context of quality improvement or streamlining processes. As one executive noted, “the chaplaincy

director doesn't produce reports for our bi-monthly meetings, I don't really need to know why the chaplain was called or how many times. But [the manager] has access to that, if we ever need it. [The chaplain manager] is more data-oriented than me when it comes to spiritual care."

## Discussion

Our findings add the organizational dimension to prior individually focused studies of chaplains. Chaplains' success depends on dynamics within their employing organizations, the people to whom they report, the ways they are integrated into the organization, and the culture in which they work. Absent staffing standards from health, medical or chaplaincy associations, individual hospitals and systems have developed their own approaches to staffing, integration and quality improvement as evident in the interviews described here. This study demonstrates the range of ways chaplains are staffed and integrated into their institutions and the frames and values executives put on them. Executives and chaplain managers see the value of the work of chaplains in terms of their quality of care, reliability and responsiveness to emergent patient and staff needs, and their clinical training and experience working within a complex environment. While concerns about payment and financial support for chaplains are frequently noted in professional chaplaincy circles, we heard little about this from executives who instead focused on the value chaplains bring. While several spoke about the ways chaplains might indirectly affect revenues, few were concerned about their status as non-revenue producing staff.

The findings from the study should be interpreted in light of its limitations. The most obvious limitation is the small sample which requires that this be seen as a preliminary investigation of factors associated with the integration of spiritual care in healthcare organizations. Additionally, while there was regional diversity in the healthcare organizations in the study it should be noted they were not a representative sample and included a large proportion of faith-based hospitals and hospitals with CPE programs.

Despite overwhelming attention to evidence and data in healthcare organizations, there is also little evidence that the executives interviewed here draw on data about chaplains to make budgetary and other decisions. Few rely on empirical data when making decisions about staffing, tending instead to default to the budgetary status quo. Most chaplaincy managers do not regularly bring recent studies or data about their own departments to their supervisors who are not asking for or seeking to analyze it. Taken together, it seems that if healthcare organizations want to know more about the efficacy of spiritual care, they have to ask. Clear measures tied to organizational goals, strategic plans or vision statements would appear to be the most robust choice for value propositions for chaplaincy.

These findings suggest that growing attention to research and evidence among chaplains is not filtering up to the executives to whom they report and who make budgetary and other decisions. None of the executives mentioned studies that connect the work of chaplains to outcomes for patients and families, suggesting that this research is not yet influential for staffing decisions. In addition to expanding training for chaplains who seek director and other leadership positions in their organizations, this study suggests

the importance of helping chaplains learn how to translate research to their colleagues and supervisors. Empirically based organizational and business cases for chaplaincy and spiritual care remain to be written.

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## References

- Association of Professional Chaplains. (2015). Standards of practice for professional chaplains. Retrieved from <http://www.professionalchaplains.org/content.asp?pl=198&contentid=198>.
- Bay, P. S., Beckman, D., Trippi, J., Gunderman, R., & Terry, C. (2008). The effect of pastoral care services on anxiety, depression, hope, religious coping, and religious problem solving styles: A randomized controlled study. *Journal of Religion and Health*, 47(1), 57–69. doi:10.1007/s10943-007-9131-4
- Berlinger, N. (2008). The nature of chaplaincy and the goals of QI: Patient-centered care as professional responsibility. *The Hastings Center Report*, 38(6), 30–33. doi:10.1353/hcr.0.0083
- Berning, J. N., Poor, A. D., Buckley, S. M., Patel, K. R., Lederer, D. J., Goldstein, N. E., & Baldwin, M. R. (2016). A novel picture guide to improve spiritual care and reduce anxiety in mechanically ventilated adults in the intensive care unit. *Annals of the American Thoracic Society*, 13(8), 9.
- Cadge, W. (2012). *Paging god: Religion in the halls of medicine*. Chicago: University of Chicago Press.
- Cadge, W., Freese, J., & Christakis, N. (2008). The provision of hospital chaplaincy in the United States: A national overview. *Southern Medical Journal*, 101(6), 626–630. doi:10.1097/SMJ.0b013e3181706856
- Chun Tie, Y., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. *SAGE Open Medicine*, 7, 2050312118822927. doi:10.1177/2050312118822927
- Davidson, J. E. A., Rebecca, A., Long, A. C., Puntillo, K. A., Kross, E. K., Hart, J., Cox, C. E. ... Randall, (2017). Guidelines for family-centered care in the neonatal, pediatric, and adult ICU. *Critical Care Medicine*, 45(1), 26. doi: 10.1097/CCM.0000000000002169.
- Ferrell, B., Twaddle, M., Melnick, A., & Meier, D. (2018). National consensus project clinical practice guidelines for quality palliative care guidelines, 4th Edition. *Journal of Palliative Medicine*, 21(12), 1684–1689. doi:10.1089/jpm.2018.0431
- Fitchett, G. (2017). Recent progress in chaplaincy-related research. *The Journal of Pastoral Care & Counseling: JPCC*, 71(3), 163–175. doi:10.1177/1542305017724811
- Fitchett, G., White, K. B., & Lyndes, K. (2018). *Evidence-based healthcare chaplaincy: A research reader*. Philadelphia: Jessica Kingsley Publishers.
- Flannelly, K. J., Emanuel, L. L., Handzo, G. F., Galek, K., Sifton, N. R., & Carlson, M. (2012). A national study of chaplaincy services and end-of-life outcomes. *BMC Palliative Care*, 11(1), 6. doi:10.1186/1472-684X-11-10
- Flannelly, K. J., Handzo, G. F., & Weaver, A. J. (2004). Factors affecting healthcare chaplaincy and the provision of pastoral care in the United States. *The Journal of Pastoral Care & Counseling: JPCC*, 58(1–2), 127–130. Retrieved from files doi:10.1177/154230500405800119
- Handzo, G. F., Flannelly, K. J., Kudler, T., Fogg, S. L., Harding, S. R., Hasan, Y. H., ... Taylor, B. E. (2008). What do chaplains really do? II. interventions in the New York Chaplaincy study. *Journal of Health Care Chaplaincy*, 14(1), 39–56. doi:10.1080/08854720802053853

- Handzo, R. G. F., Flannelly, K. J., Murphy, K. M., Bauman, R. J. P., Oettinger, S. M., Goodell, S. E., ... Jacobs, R. M. R. (2008). What do chaplains really do? I. visitation in the New York Chaplaincy study. *Journal of Health Care Chaplaincy*, 14(1), 20–38. doi:10.1080/08854720802053838
- Iler, W. L., Obenshain, D., & Camac, M. (2001). The impact of daily visits from Chaplains on patients with Chronic Obstructive Pulmonary Disease (COPD): A pilot study. *Chaplaincy Today*, 17(1), 5–11. doi:10.1080/10999183.2001.10767153
- Jeuland, J., Fitchett, G., Schulman-Green, D., & Kapo, J. (2017). Chaplains working in palliative care: Who they are and what they do. *Journal of Palliative Medicine*, 20(5), 502–508. doi:10.1089/jpm.2016.0308
- Johnson, J. R., Engelberg, R. A., Nielsen, E., Kross, E., Smith, N. L., Hanada, J. C., ... Curtis, J. R. (2014). The association of spiritual care providers' activities with family members' satisfaction with care after a death in the ICU. *Critical Care Medicine*, 42(9), 1991–2000.
- Keogh, M., Sharma, V., Myerson, S., & Marin, D. (2017). The Chi Cart Ministry. *Nursing Management*, 48(8), 32–38.
- Labuschagne, D., Torke, A., Grosseohme, D., Rimer, K., Rucker, M., Schenk, K., ... Fitchett, G. (2020). Chaplaincy care in the MICU: Describing the spiritual care provided to micu patients and families at the end of life. *American Journal of Hospice and Palliative Medicine*, 1, 8.
- Marin, D., Sharma, V., Sosunov, E., Egorova, N., Goldstein, R., & Handzo, G. F. (2015). Relationship between chaplain visits and patient satisfaction. *Journal of Health Care Chaplaincy*, 21(1), 14–24. doi:10.1080/08854726.2014.981417
- Medical Colleges, A. o. A. M. (2020). AAMC Medical School Members. Retrieved from <https://members.aamc.org/eweb/DynamicPage.aspx?site=AAMC&webcode=AAMCOrgSearchResult&orgtype=Medical%20School>.
- Stahl, R. (2017). *Enlisting faith: How the military chaplaincy shaped religion and State in Modern America*. Cambridge: Harvard University Press.
- Joint Commission on Accreditation of Healthcare Organizations. (2018). Comprehensive Accreditation Manual: CAMH for hospitals effective January 1, 2018. Joint Commission.
- VandeCreek, L., Siegel, K., Gorey, E., Brown, S., & Toperzer, R. (2001). How Many Chaplains Per 100 Inpatients? Benchmarks of Health Care Chaplaincy Departments. *Journal of Pastoral Care*, 55(3), 289–301. doi:10.1177/002234090105500307
- Williams, J. A., Meltzer, D., Arora, V., Chung, G., & Curlin, F. A. (2011). Attention to inpatients' religious and spiritual concerns: Predictors and association with patient satisfaction. *Journal of General Internal Medicine*, 26(11), 1265–1271. doi:10.1007/s11606-011-1781-y
- Wintz, S. K., & Handzo, G. F. (2005). Pastoral care staffing and productivity: More than ratios. *Chaplaincy Today*, 21(1), 3–10. doi:10.1080/10999183.2005.10767268