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Effect of Chaplaincy Visits in an Elder Care Setting: A Pilot Analysis of Existing Data

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Religion is a consistent, positive predictor of health in older adults. Studies focused on religion and spirituality as a coping mechanism find significant positive effects on the lives of older adults. This study investigated how an older person's living situation influences his or her access to spiritual and religious resources and, consequently, his or her health. Utilizing existing data, this pilot project examined the relationship between visits from a chaplain and the mood, pain level, functional ability, and/or discharge status of elders residing in the rehabilitation unit of one long-term care facility. Samples of patients who did

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and did not have chaplaincy visits were matched based on their level of frailty. Analytic comparisons revealed no significantly different outcomes in terms of mood, pain level, functional ability, or discharge status for patients visited by a chaplain. The outcomes suggest future hypotheses and offer a model for outcomes-based chaplaincy research.

KEYWORDS *Chaplain, elders, rehabilitation, outcomes-based research*

INTRODUCTION

Religion is a consistent, positive predictor of health in older adults. Older adults demonstrate the highest levels of religious participation among any age group (Branco, 2001; Cohen & Koenig, 2003; Idler, McLaughlin, & Kasl, 2009; Koenig, George, Titus, & Meador, 2004; Koenig et al., 1999; Koenig, Weiner, Peterson, Meador, & Keefe, 1997; McFadden, 1995). Multiple studies suggest that older adults who have strong religious beliefs and/or are religiously affiliated have enhanced physical and psychological well-being (Branco, 2001; Branco & Crane, 2014; Fry, 2000; Koenig et al., 1997, 2004; Krause, 2003; Pargament, Koenig, Tarakeshwar, & Hahn, 2004; Patterson, King, Ball, Whittington, & Perkins, 2003; Scandrett & Mitchell, 2009; Vitorino et al., 2016). In a study of 3,000 elderly persons over a 6-year period, Koenig et al. (1999) found a strong link between religious attendance and health for individuals aged 64–101 years. Attending religious services has been associated with higher well-being, less depression, less anxiety, less substance abuse, fewer suicides, lower blood pressure, fewer strokes, and longer survival (Armstrong, Van Merwyk, & Coates, 1977; Colantonio, Kasl, & Ostfeld, 1992; Ellison, 1991; Koenig, Ford, George, Blazer, & Meador, 1993; Koenig, George, Meador, Blazer, & Ford, 1994; Koenig et al., 1997, 1999; Kendler, Gardner, & Prescott, 1997; Timio et al., 1988).

Studies focus on religion and spirituality as a coping mechanism find it has significant positive effects on the lives of elders, including overall life satisfaction (Ellison, 1991), feelings of happiness (Poloma & Pendleton, 1990), and greater levels of self-esteem (Krause, 2003). Several studies report older adults citing religion as the primary coping mechanism to help them deal with stressors such as living in a new environment or deteriorating health (Branco & Crane, 2014; McFadden, 1995; Nichols, 2013; Patterson et al., 2003; Vitorino et al., 2016; Wallace & O'Shea, 2007). Older

persons who attend religious services at least once a week are generally physically and mentally healthier, have larger social support networks, and overall live healthier lifestyles than others (Armstrong et al., 1977; Colantonio et al., 1992; Ellison, 1991; Kendler et al., 1997; Koenig et al., 1993, 1994, 1997, 1999; Timio et al., 1988).

Missing from studies of religion and health among older adults, however, is the question of how an older person's living situation influences his or her access to spiritual and religious resources and, consequently, their health. While much of the existing research is based on samples of community-dwelling elders, growing numbers of older adults live in retirement facilities, long-term care facilities, nursing homes, or other institutionalized contexts (Vitorino et al., 2016; Wallace & O'Shea, 2007). According to the U.S. Census Bureau (2014), more than 20% of U.S. residents are projected to be aged 65 or older by 2030, and as of 2012, 1.3 million Americans were living in nursing homes (Institute on Aging, 2018). A minimal amount is known regarding how long-term care facilities provide spiritual and religious support to residents and what effects such provision has on the health of residents.

A few prior projects suggest that religion is a coping mechanism for people in long-term care settings. When older adults enter such settings, religion helps them cope with challenges and adapt to the new environment (Patterson et al., 2003; Vitorino et al., 2016). Pargament et al. (2004) found that 86% of the long-term care patient sample used religious activities to cope with health-related problems. Patterson et al. (2003) found that individuals in assisted living facilities used religious practices to cope with the challenges of life such as losing their past lives, adjusting to a community living environment, dealing with declines in their physical and mental health, experiencing emotional distress, and feeling uncertainty about the future. Religion helped residents maintain continuity with their lives, manage pain, and prepare for death. Branco and Crane (2014) also explored the relationship between optimism and ways of coping among older adults living in assisted living facilities. He found that older adults who turned to religion to cope with problems, such as serious illness and threat of death, were less pessimistic about regaining some of the abilities that they had prior to entering the facility, such as walking, feeding, and bathing themselves, and having control over bodily functions.

Additionally, Nichols (2013) examined the implementation of a spiritual care program at two different retirement facilities to investigate the effects of spiritual and religious care. Results showed that overall life satisfaction gradually improved for residents as the program developed over time, providing evidence for the role that religious and spiritual engagement may play in the overall well-being and satisfaction level of

institutionalized aging populations. While some retirement and nursing facilities make it possible for residents to attend religious services outside of their facilities, others host weekly or monthly worship services in-house, regularly welcome volunteers from area religious organizations, and/or make ritual objects available for residents. Some facilities employ chaplains or host volunteer chaplains who also may play a role in the provision of spiritual or religious care.

This project continued to explore these questions by focusing on older adults in a rehabilitation unit of a long-term care facility. Individuals in such settings—and particularly older patients—often use religion and spirituality to cope (Anderson, Anderson, & Felsenthal, 1993; Easton & Andrews, 2000). Sailus (2017) outlined the roles chaplains play with rehabilitation patients as sources of support and listeners. With the help of chaplains, patients can experience increased motivation to participate more fully in their rehabilitation (Bauman, 2008). In this study, some participants were residents from the parent long-term care facility, placed in the rehabilitation unit for short periods of time while recovering from a surgery or illness. Others were elders in the community who came to the facility for a short-term stay to recover from a recent hospitalization or illness. As a Jewish affiliated organization, this center values the spiritual and religious experiences of patients and makes chaplains available throughout the facility including in the rehabilitation unit. Regular religious services are also held on-site though most of the rehabilitation unit residents are too ill to attend and cannot travel to services outside the hospital. Research about chaplaincy care in other healthcare settings demonstrates a strong relationship between chaplain visits and patient satisfaction, but a minimal amount is known about the effects of such visits in a long-term care setting (Balboni et al., 2007; Bay, Beckman, Trippi, Gunderman, & Terry, 2008; Iler, Obenshain, & Camac, 2001; Johnson et al., 2014; Marin et al., 2015; Snowden & Telfer, 2017; VandeCreek, 2004; Williams, Meltzer, Arora, Chung, & Curlin, 2011).

RESEARCH METHODS

A secondary analysis design was used to explore outcomes from a chaplaincy program implemented at Hebrew Rehabilitation Center, a long-term care facility within Hebrew SeniorLife, the parent organization serving elders, many from the Jewish tradition. Founded in 1903, the facility has long welcomed and supported full-time paid chaplains and more recently welcomed students from a range of backgrounds training for careers in chaplaincy.

For the purposes of this study we focused only on individuals receiving care in the rehabilitation units of Hebrew Rehabilitation Center located at two campuses, one in Boston and one in Dedham. Each unit has an average census of 40 patients and combined they serve approximately 2,000 patients annually. Some are residents of Hebrew Senior Life (HSL) who were hospitalized and returning to HSL after an illness or surgery. Others are community dwelling elders who also are recovering from an illness or hospitalization but are not residents of HSL. The Boston unit, combined with the medical acute care unit is staffed by one 0.6 full-time equivalency (FTE) chaplain and a clinical pastoral education student. The Dedham unit is staffed by the facility's full-time chaplain as well as one student. Most frequently, chaplain's visit with patients referred to them by staff members due to a perceived need.

The Minimum Data Set (MDS), a federally mandated comprehensive geriatric assessment completed every 90 days served as the source of data for the project. Residents of all HSL facilities received assessments of their health condition and experiences across a range of factors. Analyzed data came from completed assessments at baseline and subsequently at 3- and 6-month follow-ups. Chaplaincy visits, retrieved from documentation in the medical records, were matched with assessment results. To ensure that the health status of individuals did not influence results, we divided the sample into those who were and were not visited by a chaplain and then matched respondents in each subsample using a frailty scale developed by Howard and Morris (2018). The sample was matched using a 1:1 ratio because that is all that was possible given the available sample size. The use of a matched propensity sample based on frailty minimized the effects of health-factors on patient outcomes. Permission to gather and analyze the data presented in this article was received from the Institutional Review Board at Hebrew Senior Life. The IRB at HSL declared this study exempt under "45 CFR 46.101(b)(4) (also known as exemption category 4) of the pre-2018 rules." They wrote, "Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects."

MEASURES

For the purposes of this project, we examined four outcome measures: mood, activities of daily living, pain, and discharge status. Mood was measured using the Depression Rating Scale (DRS), a clinical screen for

depression, ranging from 0 (no mood impairment) to 8 (severe depression). Activities of daily living (ADL) was a measure of seven performance items, including personal hygiene standards, locomotion, eating, dressing, toileting, transferring, and movement in bed, ranging from 0 (no impairment) to 28 (total dependence). Pain was measured using two items to create a score ranging from 0 (no pain) to 3 (pain). Discharge status was measured as the site to which the patient was discharged. Aware that visits from chaplains improved patient satisfaction in other settings, we hypothesized that patients who were visited by a chaplain might have improved mood, less pain, more ability to complete activities of daily living, and/or shorter stays in the rehabilitation unit. Given the limited research in the field, however, these hypotheses were necessarily exploratory.

Covariates—as evident in [Table 1](#)—included age, gender, race/ethnicity, marital status, whether the respondent spoke English, whether the respondent had cancer, the number of special treatments received and the facility type. The number of special treatments refers to treatments, procedures and programs respondents received in the 14 days before the survey including chemotherapy, dialysis, IV medications, oxygen therapy, radiation, suctioning, tracheostomy, transfusions, ventilator/respirator, BIAP/CPAP, hospice care, respite care-in facility, and isolation for active infectious disease. Data from 2011 through 2016 were pooled across the two rehabilitation units to complete the analyses.

Statistical Analysis

Descriptive statistics were utilized to show patients' demographic characteristics. For the outcomes mood, pain, and ADL, repeated measures analysis of variance (ANOVA) were used to understand the effects of chaplaincy visits, revealed by the interaction of survey wave (baseline, 3-month and 6-month follow-ups) and treatment status. To understand discharge status, a multivariate logistic regression model was performed for each survey wave, controlling for seven covariates (i.e., age, gender, race/ethnicity, marital status, whether the respondent spoke English, whether the respondent had cancer, and the number of special treatments received). Significant results related to discharge status are listed in the next section. Statistical analysis was performed using Stata, version 15.1.

RESULTS

Data generated from 3,846 individuals were included in the analyses. All were patients in Hebrew Rehabilitation Center Rehabilitative Services

TABLE 1. Descriptive Statistics for Baseline Assessment ($N=3,846$)

Variable	No Pastoral Visits	One or More Pastoral Visits
	Mean or Percent (<i>SD</i>)	Mean or Percent (<i>SD</i>)
<u>Independent Variable</u>		
Number of Pastoral Visits	0 (0)	1.504 (1.141)
Frailty Score	4.059 (2.866)	4.059 (2.866)
<u>Covariates</u>		
<u>Age</u>		
Under 60	3%	4%
60–69	13%	11%
70–79	26%	22%
80–89	40%	40%
90+	18%	22%
Gender (Female)	64%	68%
Race/Ethnicity (White)	92%	92%
<u>Marital Status</u>		
Never married	12%	13%
Married	42%	38%
Widowed	37%	41%
Separated	0%	0%
Divorced	8%	7%
Cancer (Yes)	6%	8%
Language (English)	95%	96%
Number of special treatments received	1.078 (1.155)	0.894 (1.120)
<u>Facility Type</u>		
HSLRSU (48.75%)	43%	55%
NBOCRSU (51.25%)	57%	45%
<u>Outcome Variables</u>		
Mood Scale [0,8]	1.087 (1.358)	1.222 (1.540)
ADL Long Scale [0,28]	16.274 (4.000)	16.438 (4.317)
Pain Scale [0,3]	1.078 (1.005)	1.041 (0.958)
<u>Discharge Status</u>		
Community	44%	42%
Another nursing home or swing bed	7%	19%
Acute hospital	32%	23%
Psychiatric hospital	0%	0%
Inpatient rehabilitation facility	0%	0%
Deceased	1%	1%
Long-term care hospital (LTCH)	–	6%
Other	16%	10%

Notes. HSLRSU, HebrewSenior Life Rehabilitative Services Units; NBOCRSU, NewBridge on the Charles Rehabilitative Services Units.

Units. A little more than half (51%) were in the facility in Dedham and the rest were in the facility in Boston. By design, half received no chaplaincy visits and half received at least one visit. The average number of visits received during their stay was 1.5. Descriptive statistics are included as [Table 1](#). More than half of respondents were age 80 or above, two-thirds

TABLE 2. The Effects of Chaplaincy Visits on Mood, Pain, and ADL

Source	Partial SS	<i>df</i>	MS	<i>F</i>
Mood				
Model	13996.45	3,582	3.91	10.82***
Treatment	26.80	1	26.80	6.88**
id Treatment	13934.05	3,577	3.90	
Wave	46.22	2	23.11	64.00***
Treatment # Wave	0.48	2	0.24	0.66
Residual	1484.69	4,112	0.36	
Total	15481.14	7,694	2.01	
Pain				
Model	5600.76	3,619	1.55	7.53***
Treatment	0.28	1	0.28	0.18
id Treatment	5572.01	3,614	1.54	
Wave	26.61	2	13.30	64.75***
Treatment # Wave	0.33	2	0.17	0.81
Residual	678.79	3,304	0.21	
Total	6279.55	6,923	0.91	
ADL				
Model	165,395.00	3,753	44.07	5.09***
Treatment	200.99	1	200.99	4.87*
id Treatment	154,669.77	3,748	41.27	
Wave	18,310.55	2	9,155.27	1,057.87***
Treatment # Wave	94.06	2	47.03	5.43**
Residual	38,849.77	4,489	8.65	
Total	204,244.77	8,242	24.78	

Note. * $p < 0.5$.

** $p < 0.1$.

*** $p < 0.001$.

were women, and the vast majority were white. Most spoke English and had received one or fewer special treatments. More than one third were widowed and more than one third were married. Few (less than 8%) had cancer. Individuals on average had slight depression problems, some pain issues, and were somewhat dependent for assistance in completing activities of daily living. About half of the individuals were discharged to the community, and the remainder were discharged to acute hospitals, other nursing homes, or swing beds.

Mood

Respondents who received chaplaincy visits had significantly worse mood conditions than those who did not at the baseline assessment. At the two follow-up assessments, the mood conditions of both groups improved significantly. There was no significant result for mood at the $p = 0.05$ significance level. Respondents who received chaplaincy visits had higher mood scores than those who did not at the two follow-ups but the difference between the two groups were not statistically significant. Results of repeated measures ANOVA are shown in Table 2. Please note the

interaction terms of treatment status and survey wave are the coefficients of interest.

Activities of Daily Living

There is no significant result for ADL at the $p=0.05$ significance level. Respondents who received chaplaincy visits and those who did not had similar ADL conditions at the baseline and two follow-up assessments. As time went by, both groups significantly improved ADL scores, suggesting they could do more activities of daily living than at the baseline assessment.

Pain

There is no significant result for pain at the $p=0.05$ significance level. Respondents who received chaplaincy visits had similar pain conditions to those who did not at the baseline and two follow-up assessments. As time went by, pain decreased for members of both groups, indicating they felt less pain at the follow ups than at the baseline assessment.

Discharge Status

The majority of respondents were discharged to the community or to other facilities. To understand the effect of chaplaincy visits on discharge status, multinomial logistic regression analysis was performed (not shown). Respondents who received chaplaincy visits were more likely than those who did not to be discharged to another nursing home or to a swing bed. These results were consistent through the baseline and the two follow-up assessments. We suspect these results are indicative of inverse causality. Respondents who received chaplaincy visits were more likely to be discharged to another nursing home or to a swing bed than those who were not, probably because staff members were more concerned about them so referred them to chaplains for visits.

DISCUSSION AND CONCLUSION

This article represents a first attempt to examine the relationship between chaplaincy visits and the experiences of elders in a long-term care facility. Some of the patients were residents of the facility and others were community-dwelling elders who were cared for in the rehabilitation unit and then discharged back to the community. More than half were over 80 and

all were recovering from an illness or surgery and in need of in-patient, restorative care.

We utilized data from existing surveys, not designed to assess the effects of chaplaincy interventions, and linked that data to information about whether or not a patient was visited by a chaplain as reported in the medical record. This approach—based on existing data—is premised on chaplains' reporting their visits in the medical record. Standard ways of charting visits and conceiving of the interventions chaplains' offer—as being explored by Kevin Massey, Deb Marin, and others—will improve efforts to understand the effects of chaplaincy visits (Massey et al., 2015; Sharma et al., 2016). One of the most important take home messages from this study is that chaplains who work in elder-care settings need to consistently and effectively chart their visits to make studies about the effects of those visits possible.

These analyses show, first, that many patients in the rehabilitation unit received chaplaincy visits. They also speak to the importance of matching those who did and did not receive chaplaincy visits on measures of health—in this case a frailty index—to minimize the effects health status may have on outcomes. The results, specifically on the relationship between chaplaincy visits and discharge status, suggest that those most in need of visits likely received them. For instance, at the two follow-up assessments, respondents who received chaplaincy visits were more likely to be deceased than those who did not, suggesting patients in need of end-of-life care received chaplain services. While we were not able to statistically establish relationships between chaplaincy visits and the mood of patients, their ability to complete activities of daily living, or their pain, it is possible that there were effects on other outcomes—like patient satisfaction—we were not able to assess with existing assessment data.

We hope that these analyses will encourage chaplains and researchers to continue to partner with one another and to consider where there may be existing data that will enable them to begin to assess the effects of chaplaincy visits in patient outcomes. As the U.S. population continues to age, we particularly hope these analyses will spur further questions about the provision of chaplaincy services to elders in a range of institutionalized settings, the effect of that provision, and the skills chaplains most need to deliver (and record) effective care.

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