27

Outcome Oriented Chaplaincy

Intentional Caring

Rev. Brent Peery, DMin, BCC

The term "outcome oriented chaplaincy" seems to have been introduced by Larry VandeCreek and Art Lucas in their book *The Discipline for Pastoral Care Giving: Foundations for Outcome Oriented Chaplaincy*,[1] though, as they acknowledge, there were certainly those writing about and doing research on the subject for at least two decades before their book was released in 2001.[2] Their work has been so formative in the movement that some professional chaplains use "The Discipline" as a label for this approach to chaplaincy care; however, "outcome oriented chaplaincy" generally communicates the concept more clearly. Also, the specific model of outcome oriented chaplaincy articulated by Lucas and his colleagues is not the only approach available. It may not even be the best approach for every context.

My interest in the subject began as a group of chaplains employed by our large health care system were brainstorming ways we could more meaningfully engage the company's mandated quality improvement program. This eventually led to the discovery of VandeCreek and Lucas's work. A few months later we invited Art Lucas and Sue Wintz, who had been trained by Art and his staff, to come spend a full day training us. For over five years outcome oriented chaplaincy has been a strong and fruitful emphasis among the chaplains within the Memorial Hermann Healthcare System.

How does one define outcome oriented chaplaincy (OOC)? It is a method of chaplaincy care that emphasizes achieving, describing, measuring, and improving outcomes that result from a chaplain's work. Its primary components include chaplaincy assessment, chaplaincy interventions, and chaplaincy outcomes.

Many chaplains initially recoil at the notion of associating terms like "achieving, describing, measuring, and improving outcomes" with their care. These are objective concepts. They protest, "How can one quantify the sacred?" "Who can compute what occurs between a professional chaplain and another when spirit touches spirit?" "Can one measure meaning?"[3]

The reality is that there *are* aspects of chaplaincy care that will remain subjective. They cannot be adequately observed, described, or measured. They remain part of the complex beautiful art and mystery of the profession. However, this truth does not negate the fact that much of chaplaincy care is objective. OOC intentionally concerns itself with these aspects. It does so for a variety of reasons discussed later in this chapter. Above all, its aim is to improve the care chaplains give to others. It is about intentional caring.

In this chapter we will first discuss how OOC came to be. Then we will examine the foundational ideas of OOC and its components.

How Did OOC Come to Be?

Very often when chaplains discuss OOC or one of its component parts, they make the error of focusing on one impetus for its evolution to the exclusion of all others. The most frequent of these is health care reform.[4] However, OOC has its origins in a variety of sources. At this time in the history of professional chaplaincy, there are numerous influences—personal, contextual, and historical—coming together to contribute to its emergence. These are like streams flowing together from a variety of directions but headed toward the same end. It is a confluence. A confluence is "a flowing or meeting together; a joining."[5]

Personal Influences

Chaplaincy is intensely personal work. The chaplain's primary instrument of care is his or her self. So certainly among the strong influences affecting OOC is the individual person working as a chaplain. His or

her personal spirituality and sense of vocation impact practice. Other aspects of the chaplain's individuality, including character, temperament, personality, culture, ethnicity, gender, and sexual orientation, could be potential personal influences on his or her care. The chaplain's competency is another personal factor. In 2004 the Spiritual Care Collaborative defined minimum competencies needed to be a professional chaplain.[6] Nonetheless, there remains great variety of education, training, skills, and experiences among professional chaplains beyond the minimum needed to be board certified. These also affect practice.

Although the relative neglect of OOC in the training of professional chaplains needs to be addressed in the future, it certainly should not be at the expense of focus on traditional issues of clinical pastoral education (CPE) like self-awareness and pastoral authority. Again, OOC's emphasis on the objective aspects of chaplaincy care does not negate the influences of the personal and subjective. It seeks to understand these and their potential impact—for good or for ill—on the care provided to others.

In sum, who we *are* as chaplains is as essential to our efficacy as what we *do* and the *context* in which we do it.[7] There may be health care disciplines in which there is little correlation between the type of person doing the work and the outcomes achieved by that work. Chaplaincy is not one of them.

Contextual Influences

That said, context has a powerful and justifiable influence on how any professional does his or her work. Chaplaincy is no exception. Most professional chaplains work in the context of health care organizations, a complex and dynamic milieu in which to serve. Let's examine a few of the many cultural influences that shape both the context of health care and the work of chaplains.

Professional chaplains are generally clergy. As such we are influenced by the ministry culture of our particular faith tradition. We are also influenced by the broader cultural expectations—from within and without—of how a clergyperson should carry out his or her work. In an earlier, more homogeneous, era of chaplaincy, there was greater consensus regarding these expectations. Today chaplains work in an environment of cultural and spiritual diversity. However, there remains relatively broad agreement that clergy should be persons of integrity

and faith who care about others. These values shape OOC. For almost all chaplains who engage in it, OOC will never be primarily about data. That is not what motivates us. It will be about caring for people.

Health care is shaped by the culture of science. Science can be defined as "the observation, identification, description, experimental investigation, and theoretical explanation of phenomena."[8] These are also the endeavors of OOC. The specific phenomena of interest to chaplains is the struggling and coping of persons—patients / residents, their families, and the professionals who care for them—in a health care setting. Since the mid-1970s there has been a growing emphasis on the practice of evidence-based medicine within health care. OOC is in part chaplaincy's response to this focus on choosing health care interventions based on their demonstrable potential for producing desirable outcomes. Some erroneously contend medicine is a purely scientific enterprise. Medicine, like chaplaincy, is both art and science. Both commingle the subjective and mysterious and soft with the objective and known and hard.

Health care is shaped by business culture. More specifically, health care organizations are concerned with generating at least enough income to keep the organization operating. While most chaplains do not bill for their services, there are aspects of OOC that have in the past and can in the future demonstrate the value of chaplaincy care to the business of health care.[9] Another feature of business culture is quality improvement programs. The principles of OOC have enabled the chaplains with whom I work to participate in these in meaningful ways. It has been rewarding to both meet an organizational obligation and improve our chaplaincy care.

Health care is shaped by academic culture. This is true even when the institution is not an academic medical center. Those who work in health care are frequently well educated. This includes professional chaplains, who must complete an accredited graduate theological degree to be board certified. Most have spent at least nineteen years in school before obtaining their first chaplain position. Academic culture places a high value on publishing articles and books that advance thinking and practice. OOC includes values that facilitate research and publishing.

OOC reflects many influences from the complex context of health care. It is a contextually appropriate method for chaplaincy in that setting. It also remains true to the personal influences that have formed the chaplains who serve in that context. All of these features make

OOC a timely emphasis for professional chaplains. That has never been truer than now.

Historical Chaplaincy Paradigms

To appreciate the timeliness of OOC, it is helpful to broadly and briefly examine the past century of professional chaplaincy. John Gleason has been a chaplaincy educator, researcher, and author for several decades. Borrowing from the concepts of the late philosopher of science Thomas Kuhn, he contended there have been three succeeding prominent paradigms under which chaplains have approached their work in the past hundred years.[10] As professional chaplaincy emerged in the early twentieth century, it operated primarily from a paradigm of "a response to individual sin." Chaplains helped persons heal from the effects of their sin within the mutually agreed upon theological constructs of a shared faith tradition. The three dominant American faith traditions of this era were Judaism and Catholic and Protestant Christianity.

In the 1960s, as societal norms and institutions enjoyed far less consensus, there arose a new paradigm for professional chaplaincy. It was based upon the client-centered therapy of Humanist psychologist Carl Rogers. Chaplains embraced a method of caregiving built primarily on the three principles of congruence / genuineness by the helper paired with empathic understanding of and unconditional positive regard for the client. Prominent among chaplains during this era has been a strong emphasis on the "ministry of presence." It stressed the healing sufficiency of a calm and caring chaplain. Gleason called this the "Rogerian paradigm," which he explained dominated through the later part of the twentieth century.

As Gleason wrote in 1998 he observed a new paradigm for chaplaincy care was on the ascent. "The emerging paradigm appears to have as its defining aim and coherent principle *a response to individual need.* It is arising—uneasily, conflictually, but irresistibly—within the increasing inadequacy and breakdown of the current paradigm."[11] Among the signs of paradigm shift he cited are new models of chaplaincy assessment, interventions, and outcomes accompanied by increasing attention to research in chaplaincy care.[12] Though Gleason reflected on chaplaincy primarily in the United Sates, Meg Orton noted similar changes in the United Kingdom and Australia.[13] In other words, OOC is the operant paradigm for professional chaplaincy for the twenty-first century.

Contemporary Evidence of the OOC Paradigm

In the fall of 2004, six major North American professional pastoral care organizations developed and affirmed *Common Standards for Professional Chaplaincy*.[14] This document defined the minimum required competencies for someone to be board certified as a professional chaplain. Among these are several that support the practice of OOC:

- Formulate and utilize spiritual assessments in order to contribute to plans of care.
- Provide effective pastoral support that contributes to well-being of patients, their families, and staff.
- Document one's contribution of care effectively in the appropriate records.
- Establish and maintain professional and interdisciplinary relationships.[15]

In the spring of 2010, the Association of Professional Chaplains (APC) completed *Standards of Practice for Professional Chaplains in Acute Care Settings*.[16] "Standards of practice are authoritative statements that describe broad responsibilities for which practitioners are accountable."[17] This document articulated expectations regarding the ongoing work of a professional chaplain in an acute care hospital setting. Of the thirteen standards, six strongly and specifically reiterate principles of OOC:

> Standard 1, Assessment: The chaplain gathers and evaluates relevant data pertinent to the patient's situation and / or bio-psycho-social-spiritual / religious health.
>
> Standard 2, Delivery of Care: The chaplain develops and implements a plan of care to promote patient well-being and continuity of care.
>
> Standard 3, Documentation of Care: The chaplain enters information into the patient's medical record that is relevant to the patient's medical, psycho-social, and spiritual / religious goals of care.
>
> Standard 4, Teamwork and Collaboration: The chaplain collaborates with the organization's interdisciplinary care team....
>
> Standard 11, Continuous Quality Improvement: The chaplain seeks and creates opportunities to enhance the quality of chaplaincy care practice.

> Standard 12, Research: The chaplain practices evidence-based care including ongoing evaluation of new practices and, when appropriate, contributes to or conducts research.[18]

Together these two relatively recent documents represented important landmarks in the advancement of chaplaincy as a profession. The priority they placed on the principles of OOC illustrates the growing value within the profession for chaplains to be knowledgeable and skilled in the application of OOC in their daily practice. Let us now examine more thoroughly the substance of OOC.

The Substance of OOC

Having examined the confluence of factors that have given rise to OOC, we turn our attention to the matter of understanding the substance of OOC in more detail. As a reminder, our definition of OOC is *a method of chaplaincy care that emphasizes achieving, describing, measuring, and improving outcomes that result from a chaplain's work*. Below you will find the commitments upon which OOC is built and a discussion of its component parts.

Foundational Commitments

OOC is built upon three foundational commitments. These can be called the ABCs of OOC. The first is the commitment to *accountability*. It is a commitment we make to our employers. Health care institutions that employ chaplains have a right to evidence that the chaplain's work is making a positive difference in the lives of the patients / residents and their families the organization serves and the health care professionals it employs. As administrators make difficult budgetary decisions about staffing, they should do so with information about the unique and valuable contributions professional chaplains can make to quality health care. Through the practice of OOC, chaplains demonstrate accountability for their work.

The second foundational commitment of OOC is *best practice*. It is a commitment we make to those we serve. "Best practice refers to a technique, method, or process that is more effective at delivering a particular outcome or a better outcome than another technique, method, or process. Best practices are demonstrated by becoming more efficient or more effective. They reflect a means of exceeding the minimal standard of practice."[19] OOC reflects the commitment of a chaplain to discover

and practice the most helpful chaplaincy interventions known to the profession. The motive for such a pursuit is for others to benefit from the best possible chaplaincy care.

The third foundational commitment of OOC is *collaboration*. It is a commitment we make to our fellow health care professionals. Patients / residents and families in a health care setting receive optimal care when they are able to access all the needed resources of a well-functioning interdisciplinary care team. In part, OOC is an attempt to demystify chaplaincy as much as possible. It is rooted in the idea that the better other members of the health care team understand our work, the better equipped they will be to partner with us in caring for others. We are committed to that partnership.

Primary Components

The primary components of OOC are *assessment*, *interventions*, and *outcomes*. The whole infrastructure of OOC is built on just these three. This is an important realization for those who find the notions of OOC foreign or confusing. It all comes together around assessment, interventions, and outcomes.

According to the *Standards of Practice for Professional Chaplains in Acute Care Settings*, "Assessment is a fundamental process of chaplaincy practice. Provision of effective care requires that chaplains assess and reassess patient needs and modify plans of care accordingly."[20] Note that chaplaincy assessment is a dynamic and ongoing process. It occurs before, during, and after intervention. An assessment is more involved than a screening or a history. (See chapter 4 for a more extensive treatment of these subjects.)

There are numerous models for chaplaincy assessment available for use. OOC can appropriately utilize a variety of those plans. George Fitchett, a contributor to this book, is one of the most widely-known and respected chaplaincy researchers in the profession. He provides thoughtful and helpful guidelines for evaluating the alternatives.[21] For the purposes of this chapter, I will offer some broad reflections on chaplaincy assessment.

Lucas noted the importance of identifying a person's needs, hopes, and resources in his model of assessment:

> The traditional approach starts with patient needs. The caregiver finds out the patient's needs based on their diagnosis and various

> assessments, and then, as a caring professional, takes care of those needs. That traditional approach casts the patient as a big bag of needs, and each caregiver, including the chaplain, as big bags of resources involved in a one-way repair and reclamation process. Starting with Needs, Hopes *and* Resources acknowledges that the patient has needs. It also acknowledges they have *hopes* that provide energy, direction, impetus, and motivation for the future. Hopes draw the individual forward. The illness is part of that life. This means that the question becomes, "How can the chaplain help this patient cope with, integrate, or overcome this illness in a way that taps the extant energy present in the hopefulness?" Additionally, starting with Needs / Hopes / Resources acknowledges that patients have *resources* available. Patients typically possess a wide variety of spiritual resources that were helpful to them up to the present moment. Ignoring those resources demeans the person, makes ministry more difficult (and our lives poorer), and lessens the availability of healing for patients and families.[22]

This approach is important because it respects the strength and dignity of the person being helped along with the expertise of the chaplain as a helper.[23] The two work together to seek the well-being of the chaplaincy care recipient.

Fundamentally, chaplains provide spiritual, emotional, and relational support to patients / residents, their families, and the health care team. Consequently, chaplaincy assessments are primarily concerned with these areas. It should be noted that these spheres of concern are not completely distinct from one another. They are deeply intertwined with each other and with the biomedical status of the person. A chaplain must keep all of these in mind during the process of assessment. So, as a chaplain approaches a chaplaincy care situation, he or she seeks answers to the following questions:

- What are the spiritual needs, hopes, and resources?
- What are the emotional needs, hopes, and resources?
- What are the relational needs, hopes, and resources?
- What are the biomedical needs, hopes, and resources?

Some answers to those questions will come from recipients of chaplaincy care. Others will derive from the experience and observations of the chaplain or other members of the health care team. All of the answers—

or lack thereof—will inform the desired chaplaincy outcomes and the chaplaincy interventions employed to achieve those goals of care.

Lucas writes:

> The things we intentionally do in the name of movement toward ... outcomes constitute interventions. Interventions include being with the patient in ways we believe will be helpful. Interventions include doing what we planned, in the way we assessed would be helpful and with an eye toward the contributions to care we intended to make.... They are, at base, relational, intentional and something for which we own responsibility.[24]

Interventions are the means through which those for whom we care benefit from all of our knowledge, skill, and experience. Interventions are paired with the resources of the others to address their needs and / or move toward their hopes. My observation in teaching and consulting with chaplains on the subject of OOC is that frequently their skill at offering chaplaincy interventions exceeds their ability to articulate them. See Figure 27.1 for an alphabetical sampling of potential chaplaincy interventions. On a related note, Gleason has worked on research called the "Ideal Intervention Project." Through it he is gathering data from chaplains and CPE students about the efficacy of various chaplaincy interventions in addressing needs.[25]

Outcomes are simply the observable results of our care. There are no doubt important non-observable subjective results of our care. However, OOC is concerned with the objective. Lucas stressed that outcomes should be sensory based. They can be recognized through what we see, hear, or feel. He additionally emphasized that they should be communicable. Chaplaincy outcomes can be clearly and briefly described in a manner other members of the health care team can comprehend. Clarity and brevity are related. Lucas suggested outcomes requiring more than one sentence to describe are not yet clear. The language of outcomes can initially feel too clinical or manipulative to chaplains. He reframed them thusly: "After we have gotten to know the patient, what are we hoping for? What is our prayer for the patient?"[26] Examples of chaplaincy outcomes are:

- Patient / resident is able to express gratitude
- Patient / resident is able to articulate a hopeful story about the future that incorporates the sequela of his or her injury

CHAPLAINCY INTERVENTIONS

- Advocated for patient / family
- Arranged, upon death, expedited death notice and body release so funeral can take place within 24 hours to meet family's religious needs
- Celebrated with patient / family
- Clarified, confirmed, or reviewed information
- Consulted with interdisciplinary team
- Encouraged focus on present
- Encouraged self-care
- Explored issues of faith & belief
- Facilitated decision making
- Facilitated exploration of ethical considerations
- Facilitated exploration of meaning
- Facilitated identification of emotions
- Facilitated religious needs / rituals after death
- Facilitated respect for religious practice during hospitalization
- Facilitated story telling
- Heard confession
- Helped alert staff to upcoming religious fasting
- Helped with advance directive
- Helped with waiting
- Identified & evaluated alternatives
- Identified & evaluated coping strategies
- Identified & evaluated spiritual resources
- Identified & evaluated support system
- Initiated a relationship of care and support
- Listened empathically
- Mediated conflict
- Normalized patient's / family's experience
- Provided anxiety containment
- Provided baptism
- Provided chaplaincy education
- Provided grief counseling
- Provided guilt counseling
- Provided hospitality
- Provided information
- Provided prayer
- Provided relationship counseling
- Provided religious material needed for prayer such as Sabbath candles, rosary, etc.
- Provided religious reading matter
- Provided religious resources
- Provided ritual
- Provided silent and supportive presence
- Read sacred text
- Reinforced appropriate coping strategies

Figure 27.1

- Patient / resident achieved calm as evidenced by the reduction of visible signs of distress and verbal report
- Patient / resident is engaging effective coping strategies
- Patient / resident is able to identify and effectively utilize their support system

Secondary Components

The secondary components of OOC are no less important than the primary components of assessment, interventions, and outcomes. They are secondary because they are derivative of or consequential to chaplaincy care focused on the primary components. We will discuss six: documentation, chaplaincy care pathways, chaplaincy education, quality improvement, research, and publication.

I taught an eight-hour professional development intensive at the annual APC conference in 2010. At the beginning of our day together, I asked the participants to tell me why they came. By far the most frequently cited reason was related to chaplaincy documentation. These chaplains wanted to improve their ability to document their care in the patient's medical record. This interest in charting seems to be linked to the increasing number of health care organizations converting from paper to electronic medical records. However, OOC documentation can be implemented through either medium.

For an expanded treatment of the subject of documentation, I refer the reader to chapter 6 of this work. For the purpose of illustration I share here the chaplaincy charting model developed by the chaplains of the Memorial Hermann Healthcare System.[27] I helped develop it, and it is the one I use in my daily practice. The Memorial Hermann model consists of five parts:

- **Reason:** Why is the chaplain making the visit?
- **Interventions:** What did the chaplain do to help the person?
- **Outcomes:** What difference did the chaplain's interventions make?
- **Assessment:** How would the chaplain summarize this person's current spiritual / emotional / relational state to the rest of the interdisciplinary health care team?
- **Plan:** What does the chaplain intend to do further or recommend to the interdisciplinary health care team?

Some chaplains using this model have found the mnemonic phrase "run in on a prayer" to be helpful. See Figure 27.2 for a sample chart note using this model.

One of the benefits to OOC experienced by the chaplains at Barnes-Jewish Hospital was they began to notice patterns of struggling and coping among different patient populations.[28] This has led some chaplains to develop chaplaincy care pathways as a tool for describing these patterns. A chaplaincy care pathway has been defined as "a descriptive series of indicators of what may be happening to a person spiritually in the midst of a particular life predicament and some suggested ways of optimally assisting that person."[29] See Figure 27.3 for a sample of a chaplaincy care pathway.

Chaplaincy care pathways have informed and improved the care chaplains provide to specific groups. They use the collective past experiences of others in similar circumstances to guide the care of a person in the present. This knowledge should be balanced with the recognition of the uniqueness of any one person's needs, hopes, and resources. We are cautioned not to assume all the characteristics of the general population are true for every individual.

Chaplaincy care pathways have also been a valuable tool for educating the interdisciplinary team. Sharing them with other members of the health care team has increased their knowledge of the spiritual, emotional, and relational needs of patients and families. It has additionally increased their knowledge of how chaplains can partner with them to address those needs.

Chaplaincy education involves both training professional chaplains and helping others understand the capabilities of chaplains. The principles of OOC have been beneficially used as a part of some CPE programs.[30] Expanding this would increase the readiness of CPE graduates for work as professional chaplains.

As for the latter part of chaplaincy education, very few health care professionals finish their training with a thorough understanding of professional chaplaincy. Most, however, have a good understanding of patient care based upon assessment, interventions, and outcomes. OOC provides an easily understood conceptual framework for describing our work to them. Their awareness of our work benefits patient and family care because it leads to more appropriate partnership with chaplains toward that end. It also benefits chaplains because our fellow

SAMPLE CHART NOTE USING MNEMONIC "RUN IN ON A PRAYER"

Reason for Visit:

- Visit per referral from RN because of spiritual and emotional distress

Interventions:

- Consulted with RN regarding observations of patient's needs / hopes / resources
- Initiated a relationship of care and support with patient
- Provided chaplaincy education
- Facilitated story telling
- Listened empathically
- Explored issues of faith & belief
- Facilitated identification of emotions
- Identified & evaluated coping strategies
- Reinforced appropriate coping strategies
- Identified & evaluated spiritual resources
- Identified & evaluated support system
- Encouraged focus on present
- Provided prayer

Outcomes:

- Patient shared his medical narrative
- Patient verbally and tearfully processed anxiety regarding prognosis
- Patient articulated questions of theodicy
- Patient identified both intermediate and ultimate hopes
- Patient distinguished between matters within and beyond his control
- Patient expressed gratitude for life experiences and important relationships
- Patient and chaplain identified ways to utilize support system
- Patient appeared less agitated and more calm as visit progressed

Assessment:

- Patient expressed moderately elevated anxiety normal to circumstance, which visibly decreased after chaplaincy interventions
- Patient cites his Roman Catholic faith as a significant source of support
- Patient reports no one from his faith community is aware of his hospitalization
- Patient reports supportive relationships with wife and three adult children, but geographic distance and employment responsibilities limit their availability
- Patient could benefit from follow-up chaplaincy support

Plan:

- Per patient's request, will contact his faith community (St. Mary's) and request sacramental visit by priest
- Chaplain will follow for spiritual, emotional, and relational support
- Chaplain recommends bedside caregivers page chaplain on duty if patient shows signs of acute spiritual or emotional distress

Figure 27.2

CHAPLAINCY CARE PATHWAY

Pediatric Traumatic Brain Injury

Division of Spiritual Care—Memorial Hermann Healthcare System

Possible Spiritual, Emotional, and / or Relational Issues	Possible Chaplain Actions / Interventions	Desired Outcomes
• Shock / denial • Helplessness; powerlessness • Loss of control • Impatience regarding uncertain prognosis • Grief • Guilt • Anxiety • Fear • Anger • Gratitude • Family conflict • Disrupted cultural & spiritual beliefs / practices • Theodicy questions • Providence questions • Ethical concerns • Hopelessness • Emotional or physical fatigue	• Establish and maintain relationship of empathy, trust, and caring • Elicit and listen carefully to story of patient's injury • Discover family cultural and spiritual beliefs / practices • Access relational support system • Identify desired outcomes of chaplaincy support • Help family process experience and reactions through questions, listening, clarifying, and summarizing • Facilitate ritual, scripture, or prayer needs • Normalize family's spiritual, emotional, & relational issues • Provide education or referral resources available from chaplaincy and interdisciplinary team • Encourage self-care • Document assessment, goals, interventions, and outcomes • Participate professionally with interdisciplinary team	• Family talks openly about experience of injury, hospitalization, and rehabilitation, including thoughts, emotions, and beliefs • Family identifies and accesses spiritual, emotional & relational resources • Family demonstrates increasingly healthy spiritual, emotional & relational coping with injury, hospitalization, and rehabilitation Family is able to: • participate appropriately in their child's care • remain focused on concerns of present, rather than past or future • understand the difference between functional and dysfunctional guilt and able to respond accordingly • articulate losses and begin grief process • envision a hopeful future that incorporates effects of patient's injury

Figure 27.3

CHAPLAINCY CARE PATHWAY (continued)	
Pathway Triggers for Chaplain Referral	**General Triggers for Chaplain Referral to Patients and / or Families**
1. Admission to PICU 2. Sustained intracranial pressure (ICP) above 20	1. Anxiety / fear / ineffective coping 2. Spiritual / emotional distress 3. Significant change in diagnosis / prognosis / condition 4. Spiritual / religious needs (Communion, prayer, etc.) 5. Diverse spiritual / cultural needs 6. End-of-life concerns 7. Ethical issues

Developed by Chaplain Brent Peery, DMin, BCC, Memorial Hermann Healthcare System—Division Approval / Revision 12/10/2007. (Editor's note: Research articles cited in the development of this pathway omitted because of space limitations.)

Figure 27.3 (continued)

health care professionals are able to have a deeper appreciation for the value of our contributions.

Another of the benefits to OOC noted by the chaplains at Barnes-Jewish Hospital was evaluating and improving their care.[31] This relates to the quality improvement component of OOC. Providing spiritual, emotional, and relational support to persons in the midst of illness and injury is important work. Most chaplains want to do that work well. OOC provides us with some tools to evaluate and advance the quality of our work. Those we serve deserve our commitment to do all we can to provide them with the best possible care. As alluded to earlier, the business culture of health care is increasingly interested in improving the quality of patient-centered care and customer satisfaction. Chaplains bring valuable expertise to those organizational quality improvement efforts.[32] Memorial Hermann chaplains have built quality improvement initiatives around researching and writing chaplaincy care pathways, improving customer and employee satisfaction, and improving chaplaincy

documentation through chart audits. (See chapter 29 for a more extensive examination of the subject.)

Research and publication are the last components of OOC to be addressed in this chapter. I have paired them together because they so readily complement each other. OOC provides a vocabulary and framework for chaplaincy research design. As the findings from these research studies are published, they serve to improve chaplaincy care across the profession.

One example of chaplaincy research comes from one of my colleagues. Chaplain Hazel Thomas developed an assessment tool to be used with new spinal cord injury patients at the rehabilitation hospital where she serves. She assessed patients upon admission and again as they neared discharge. Between the assessments she provided chaplaincy interventions. Her research demonstrated marked improvement in spiritual wellness among the patients in the study. She was able to present her findings at two different national spinal cord injury conferences.[33] (See chapter 30 for more on chaplaincy research.)

Final Words

I have subtitled this chapter "Intentional Caring." A simple definition of intention is "a determination to act in a certain way."[34] Intentional caring, therefore, is a determination to act in a caring manner. OOC is intentional caring. It is a timely method for chaplains within the context of health care to deliberately deliver the best care possible to patients, their families, and our fellow health care professionals.

Notes

1. L. VandeCreek and A. Lucas, eds., *The Discipline for Pastoral Care Giving: Foundations for Outcome Oriented Chaplaincy* (Binghamton, NY: Haworth Press, 2001).
2. Ibid., xiii–xx.
3. Gleason writes, "The majority of U.S. professional chaplains today say directly or act out silently the following: 'Our work is too holy, too special for us to submit to much analysis. The mystery out of which divine caring and healing comes refuses to be deconstructed into systematic spiritual assessment, predetermined pastoral care responses, or measurable outcomes. We will do the reports required to keep us on the payroll, but begrudgingly.'" See J. Gleason, "An Emerging Paradigm in Professional Chaplaincy," *Chaplaincy Today* 14, no. 2 (Autumn / Winter 1998): 10.

4. See, e.g., L. VandeCreek, *Professional Chaplaincy and Clinical Pastoral Education Should Become More Scientific: Yes and No* (Binghamton, NY: Haworth Press, 2001), xv–xviii. It should be noted that health care reform in the United States has been a matter of debate and action for at least three decades.
5. *Dictionary.com*, http://dictionary.reference.com/browse/confluence.
6. See Association of Professional Chaplains, *Common Standards for Professional Chaplaincy*, www.professionalchaplains.org/uploadedFiles/pdf/common-standards-professional-chaplaincy.pdf.
7. Mark LaRocca-Pitts contended professional chaplains choose their context because of who they are. See "The Chaplain's Motive," *PlainViews* 4, no. 7 (May 2, 2007), www.plainviews.org. This is no doubt true for some.
8. *Dictionary.com*, http://dictionary.reference.com/browse/science.
9. The coming changes that link Medicare reimbursement rates to patient satisfaction scores is one area among many where chaplaincy can be revenue enhancing, if not revenue producing.
10. Gleason, "Emerging Paradigm," 9–14.
11. Ibid., 10.
12. Ibid., 11.
13. M. Orton, "Emerging Best Practice Pastoral Care in the UK, USA and Australia," *Australian Journal of Pastoral Care and Health* 2, no. 2 (December 2008): 1–28.
14. The organizations were the Association of Professional Chaplains, the American Association of Pastoral Counselors, the Association for Clinical Pastoral Education, the Canadian Association for Pastoral Practice and Education, the National Association of Catholic Chaplains, and the National Association of Jewish Chaplains. See *Common Standards for Professional Chaplaincy*, www.spiritualcarecollaborative.org/docs/common-standards-professional-chaplaincy.pdf.
15. Association for Clinical Pastoral Education, "Objectives and Outcomes of ACPE Accredited Programs," *Standards & Manuals: 2010 Standards*, 29–30, www.acpe.edu/NewPDF/2010%20Manuals/2010%20Standards.pdf.
16. See Association of Professional Chaplains, *Standards of Practice for Professional Chaplains in Acute Care Settings*, www.professionalchaplains.org/uploadedFiles/pdf/Standards%20of%20Practice%20Draft%20Document%20021109.pdf#Project_Update. See also Association of Professional Chaplains, *Standards of Practice for Professional Chaplains in Long-Term Care Settings*, www.professionalchaplains.org/uploadedFiles/pdf/Standards_of_Practice_LTC_Document02162011.pdf.
17. *Standards of Practice for Professional Chaplains in Acute Care Settings*, 3.
18. Ibid., 1.
19. Ibid., 3.
20. Ibid., 5.
21. G. Fitchett, *Assessing Spiritual Needs: A Guide for Caregivers* (Lima, OH: Academic Renewal Press, 2002), 90–104.

22. Arthur Lucas, "Introduction to *The Discipline* for Pastoral Care Giving," in *The Discipline for Pastoral Care Giving: Foundations for Outcome Oriented Chaplaincy*, ed. Larry VandeCreek and Arthur Lucas (Binghamton, NY: Haworth Press, 2001), 8.
23. Fitchett wrote of balance on this topic: "The question is whether it is possible for caregivers to locate themselves and their power and authority somewhere between the coercive extreme of authoritarian, moralistic pastoral care and the vagueness and indistinct perspective of modern value-neutral pastoral care. Can curious or troubled souls find counselors who will neither burn them at the stake nor leave them at a loss for guidance?" (*Assessing Spiritual Needs*, 96).
24. Lucas, "Introduction to *The Discipline*," 23–24.
25. John Gleason, www.acperesearch.net/IIP.html.
26. Lucas, "Introduction to *The Discipline*," 19–20.
27. B. Peery, "Chaplaincy Charting: One Healthcare System's Model," *PlainViews* 5, no. 8 (May 21, 2008), www.plainviews.org.
28. Lucas, "Introduction to *The Discipline*," 3.
29. G. Hillsman, "A Spiritual Pathway for Prior Grief," *Chaplaincy Today* 14, no. 2 (Autumn / Winter 1998): 38. This issue of *Chaplaincy Today* contains several other articles on chaplaincy pathways.
30. VandeCreek and Lucas, *Discipline for Pastoral Care Giving*, 133–41, 149–58. See also S. Nance, K. Ramsey, and J. Leachman, "Chaplaincy Care Pathways and Clinical Pastoral Education," *Journal of Pastoral Care and Counseling* 63, nos. 1–2 (Spring–Summer 2009): 12.1–4; and A. Van Hise and P. Derrickson, "Curriculum for a Spiritual Pathway Project: Integrating Research Methodology into Pastoral Care Training," *Journal of Health Care Chaplaincy* 16, nos. 1–2 (January–June 2010): 3–12.
31. Lucas, "Introduction to *The Discipline*," 2.
32. N. Berlinger, "The Nature of Chaplaincy and the Goals of QI: Patient-Centered Care as Professional Responsibility," *Hastings Center Report* 38, no. 6 (2008): 30–33.
33. H. Thomas, "Creating and Using a Spiritual Wellness Assessment at a Rehabilitation Facility," *PlainViews* 7, no. 16 (September 15, 2010), www.plainviews.org.
34. *Dictionary.com*, http://dictionary.reference.com/browse/intention.

Further Reading

Berlinger, Nancy. "The Nature of Chaplaincy and the Goals of QI: Patient-Centered Care as Professional Responsibility." *Hastings Center Report* 38, no. 6 (2008): 30–33.

Fitchett, George. *Assessing Spiritual Needs: A Guide for Caregivers*. Rev ed. Lima, OH: Academic Renewal Press, 2002.

Gleason, John. "An Emerging Paradigm in Professional Chaplaincy." *Chaplaincy Today* 14, no. 2 (Autumn / Winter 1998): 9–14.

Hillsman, Gordon. "A Spiritual Pathway for Prior Grief." *Chaplaincy Today* 14, no. 2 (Autumn / Winter 1998): 38–41.

LaRocca-Pitts, Mark. "The Chaplain's Motive." *PlainViews* 4, no. 7 (May 2, 2007).

Nance, Susan, Kenneth Ramsey, and Joseph Leachman. "Chaplaincy Care Pathways and Clinical Pastoral Education." *Journal of Pastoral Care and Counseling* 63, nos. 1–2 (Spring–Summer 2009): 12.1–4.

Orton, Meg. "Emerging Best Practice Pastoral Care in the UK, USA and Australia." *Australian Journal of Pastoral Care and Health* 2, no. 2 (December 2008): 1–28.

Peery, Brent. "Chaplaincy Charting: One Healthcare System's Model." *PlainViews* 5, no. 8 (May 21, 2008).

Thomas, Hazel. "Creating and Using a Spiritual Wellness Assessment at a Rehabilitation Facility." *PlainViews* 7, no. 16 (September 15, 2010).

VandeCreek, Larry, ed. *Professional Chaplaincy and Clinical Pastoral Education Should Become More Scientific: Yes and No*. Binghamton, NY: Haworth Press, 2002.

VandeCreek, Larry, and Arthur Lucas, eds. *The Discipline for Pastoral Care Giving: Foundations for Outcome Oriented Chaplaincy*. Binghamton, NY: Haworth Press, 2001.

Van Hise, Angelina, and Paul Derrickson. "Curriculum for a Spiritual Pathway Project: Integrating Research Methodology into Pastoral Care Training." *Journal of Health Care Chaplaincy* 16, nos. 1–2 (January–June 2010): 3–12.

About the Contributor

Rev. Brent Peery, DMin, BCC, is director of the Chaplaincy Services Department for Memorial Hermann–Texas Medical Center in Houston, Texas. He previously served as a congregational clergyperson and as a pediatric chaplain. In addition to serving as chair of the OOC task force for Memorial Hermann Healthcare System, he has taught, consulted, and written on the subject for several years.