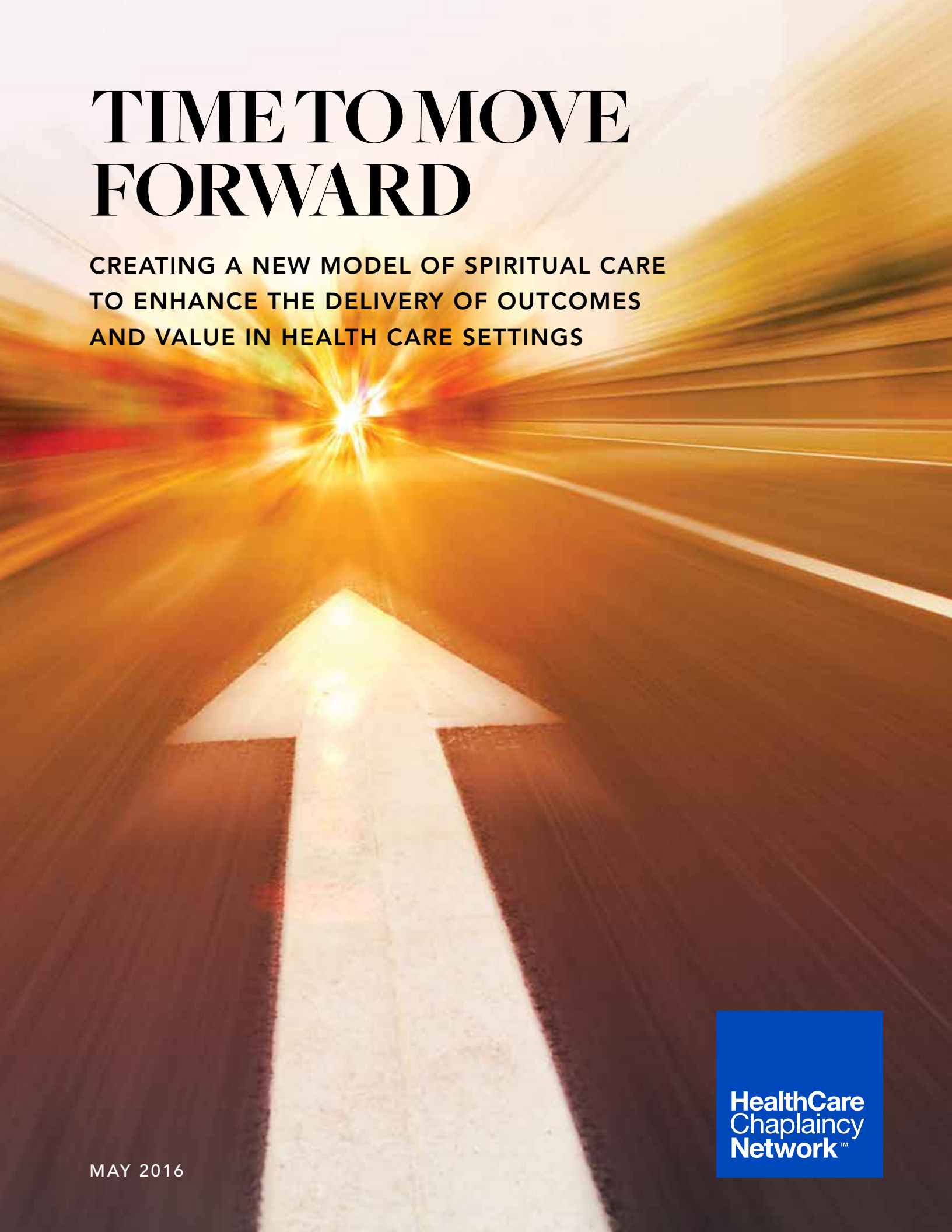

TIME TO MOVE FORWARD

CREATING A NEW MODEL OF SPIRITUAL CARE TO ENHANCE THE DELIVERY OF OUTCOMES AND VALUE IN HEALTH CARE SETTINGS

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HealthCare Chaplaincy Network™ (HCCN), founded in 1961, is a global health care nonprofit organization that offers spiritual care-related information and resources, and professional chaplaincy services in hospitals, other health care settings, and online. Its mission is to advance the integration of spiritual care in health care through clinical practice, research and education in order to improve patient experience and satisfaction and to help people faced with illness and grief find comfort and meaning——*whoever they are, whatever they believe, wherever they are.*

EXECUTIVE SUMMARY

Professional health care chaplains, while caring for the emotional and spiritual needs of individuals regardless of religion or beliefs, are laser-focused on upholding the humanity of the patient. Now more than ever, they must also look beyond the bedside. In today's health care environment, they must consider the expectations of health care settings—most of all, mounting pressure on all disciplines to contribute to metrics such as patient satisfaction, patient experience, medical outcomes, and cost savings. Value derived from quality outcomes is paramount. These facts of contemporary medicine place professional chaplaincy at a critical crossroads.

Concerns raised by thought leaders for decades about gaps in the field of spiritual care are taking on increased urgency. Without evidence-based tools as a framework for care—specifically, measurable quality indicators and set of competencies, the field is hard pressed to validate the contribution spiritual care makes to quality health care. Without consistent training and certification based on demonstration of clinical competencies, it is difficult to identify chaplains who can provide the most effective care.

Now is the time for professional health care chaplaincy to demonstrate its true value. As stated in "The Critical Role of Spirituality in Patient Experience," a white paper released in 2015 by The Beryl Institute and HealthCare Chaplaincy Network, "We have an opportunity to ensure alignment on both purpose and role and expand and reinforce the dialogue of the outcomes a focus on spiritual care can drive."

The solution: a new model that for the first time defines, delivers, trains and tests for the provision of high-quality spiritual care. The model builds upon established guidelines and existing research. It subjects chaplains to the same rigors placed on other providers. At its core are the development of evidence-based Quality Indicators; evidence-based Scope of Practice; standardized training built upon these tools; objective testing for demonstrated clinical competencies; and certification founded in evidence-based requirements and objective testing to demonstrate clinical competencies, knowledge, and best practices.

Before us is the opportunity as never before to transform the field—to show that professional health care chaplains have the knowledge and competencies to provide spiritual care that contributes to enhanced outcomes and value.

It is time to move forward.

INTRODUCTION: WHERE WE WERE, WHERE WE ARE, WHERE WE NEED TO BE

"For some their spiritual needs are met by religious care, the visits, prayers, worship, rites and sacraments often provided by a faith leader, or representative of the faith community or belief group. Spiritual care can be provided by all healthcare staff, by carers, families and other patients. When a person is treated with respect, when they are listened to in a meaningful way, when they are seen and treated as a whole person within the context of their life, values and beliefs, then they are receiving spiritual care. Chaplains are the specialist spiritual care providers [on the interdisciplinary health care team]."

Source: Spiritual and Religious Care Capabilities and Competencies for Healthcare Chaplains, National Health Service Education for Scotland

For hundreds of years, hospitals have been meeting the religious needs of patients and family members by making available clergy to meet with them; this continues today. Recognition that this pastoral care served a clinical purpose led in 1925 to the development of the first unit of Clinical Pastoral Education (CPE), and in mid-century to the establishment, by a chaplaincy organization, of the first requirements to become a Board Certified Chaplain. Professional chaplaincy was originally provided by Christian clergy for Christians; today, health care chaplains come from many faith traditions or none, are trained to serve all people regardless of religion, beliefs, or cultural identity, and commit to a code of ethics that prohibits proselytizing for a specific faith. This broader role has coincided with trends in America—the growing diversity in religious and ethnic groups, and the growing number of people who say they are "spiritual and not religious."

Over the past two decades, we have witnessed evolving—and more demanding--expectations for health care chaplains and for spiritual care in general. There is greater recognition that spiritual care is a vital component of whole-person care. These providers, as they meet patients' and families' emotional needs, embody the patient-centered care of humanistic medicine. Moreover, the shift mirrors the overall movement in health care toward outcome-driven solutions, and best practices, research, training and qualifications that hold all disciplines to higher standards. In 2004, under the initiative and financial support of HealthCare Chaplaincy Network (HCCN), the Common Standards for Professional Chaplaincy were developed and adopted by six chaplaincy and pastoral counseling membership associations in North America.

Health care chaplains are increasingly being integrated into interdisciplinary teams, particularly on palliative care teams—a change that has begun to raise their visibility and bring the value of spiritual care to the attention of other disciplines. Prestigious bodies, including the National Consensus Project for Quality Palliative Care, and The Joint Commission, recognize spirituality as an essential element of palliative care. National Quality Forum Preferred Practices for Hospice and Palliative Care call for a plan based on assessment of religious, spiritual and existential concerns; and the inclusion on palliative care and hospice care teams of a chaplain or other spiritual care professional certified in palliative care.

In addition, research studies and anecdotal evidence have begun to show the positive impact of spiritual/chaplaincy care.

- Chaplain visits result in increased scores on patient satisfaction surveys (HCAHPS, Press Ganey), overall patient satisfaction, and patients' willingness to recommend the hospital.

Source: Marin DB, Sharma V, Sosunov E, Egorova N, Goldstein R, Handzo G. 2015. The relationship between chaplain visits and patient satisfaction. Journal of Health Care Chaplaincy. 21 (1):14-24.

- A strong association exists between satisfaction with spiritual care and satisfaction with total ICU experience.

Source: Wall, Richard J., Ruth A. Engelberg, Cynthia J. Gries, Bradford Glavan, and J. Randall Curtis. "Spiritual Care of Families in the Intensive Care Unit." Critical Care Medicine 35.4 (2007): 1084-090.

- Professional chaplains facilitate end-of-life care discussions for advanced cancer patients that can influence patient satisfaction, hospice enrollment, and better quality of life near death.

Source: Balboni, T. A., L. C. Vanderwerker, S. D. Block, M. E. Paulk, C. S. Lathan, J. R. Peteet, and H. G. Prigerson. "Religiousness and Spiritual Support Among Advanced Cancer Patients and Associations With End-of-Life Treatment Preferences and Quality of Life." Journal of Clinical Oncology 25.5 (2007): 555-60. Balboni, Tracy A., Mary E. Paulk, Michael J. Balboni, Andrea C. Phelps, Elizabeth T. Loggers, Alexi A. Wright, Susan D. Block, Eldrin F. Lewis, John R. Peteet, and Holly G. Prigerson. "Provision of Spiritual Care to Patients with Advanced Cancer: Associations with Medical Care and Quality of Life Near Death." The Journal of Clinical Oncology 28.3 (2009): 445-52.[1] Balboni, Tracy, Michael Balboni, M. Elizabeth Paulk, Andrea Phelps, Alexi Wright, John Peteet, Susan Block, Chris Lathan, Tyler VanderWeele, and Holly Prigerson. "Support of Cancer Patients' Spiritual Needs and Associations with Medical Care Costs At the End of Life (419-C)." Journal of Pain and Symptom Management 41.1 (2011): 243-44.

- Chaplains help patients cope with their illness, align care plans with values—promoting a culture of respect and dignity, and tap into inner strengths and resources.

Source: Kevin Massey, Marilyn JD Barnes, Dana Villines, Julie D Goldstein, Anna Lee Hisey Pierson, Cheryl Scherer, Betty Vander Laan and Wm Thomas Summerfelt. What do I do? Developing a taxonomy of chaplaincy activities and interventions for spiritual care in intensive care unit palliative care. BMC Palliative Care 2015, 14:10 doi:10.1186/\s12904-015-0008-0.

There is no doubt that significant advances in the field have taken place. Professional chaplains have claimed their place in the health care system. Yet, with pressure on all health care settings to provide, and rightly so, the highest quality of care and to show outcomes, chaplaincy continues to be questioned. What is its value? How does it contribute to outcomes? What should a health care chaplain's qualifications be? Even, will chaplaincy survive? A field under a microscope—even at a time when patients and their families increasingly say they want spiritual and emotional support.

The field has come far. But ongoing questioning like this demands a disruption. Modernizing and standardizing spiritual care can further enable and empower chaplains to demonstrate and reliably deliver value, effectively contribute to quality care, and improve the patient experience in health care settings. We face a critical juncture that offers the opportunity as never before to show that professional health care chaplains can demonstrate clinical competencies, and to work with the medical and clergy communities to ensure that high-quality spiritual support—providing comfort and meaning to those in health crisis, regardless of background or beliefs—is available for all who desire and need it.

It is time to move forward: to create a new model of spiritual care to enhance the delivery of outcomes and value in all health care settings.

THOUGHT LEADERS IN THE FIELD HAVE SAID FOR DECADES THAT THE EXISTING PROFESSIONAL CHAPLAINCY MODEL HAS BECOME FROZEN IN TIME AND HAVE CALLED FOR MAJOR CHANGES

- "Chaplains (must) address questions regarding the basic concepts of outcome and evidence: Why are these concepts so important to healthcare? How can we demonstrate the value of the professional chaplain in a language that both physicians and administrators can understand and appreciate? Can the chaplain truly measure the care provided in such a way that it maintains the integrity of the care while measuring its impact on health and the bottom line?"

Source: Harold G. Koenig, M.D. & Kevin Adams, M.Div., BCC, "Religion and Health," Association of Professional Chaplains publication, Healing Spirit (Fall 2008)

- "Chaplains are inclined to argue among themselves over best practices, once again dividing the occupational group and slowing efforts to professionalize. If members of the occupation cannot agree on how to define and measure their own work, then why should society grant them professional status?"

Source: Raymond de Vries, Nancy Berlinger, Wendy Cadge, "Lost in Translation: The Chaplain's Role in Health Care," Hastings Center Report (November-December 2008)

- "I don't think tweaking or revising the standards will work this time, and I want to encourage you to think about how you would design an educational program for chaplains if you were doing so from scratch. I'll be surprised if you come up with the model you have now."

Source: Wendy Cadge, Ph.D., "Chaplaincy After Pluralism: Engaging the Big Professional Picture," Association of Professional Chaplains annual conference, June 24, 2012

- "While chaplaincy leaders and educators in each of these areas could work together to imagine new, more interdisciplinary, and more integrated training models, change is not likely to be easy. Change is important, however, if chaplains are to become more than 'tinkering tradespersons' fulfilling needs seen as peripheral to their organization's main missions."

Source: Wendy Cadge, Ph.D., "Paging God: Religion in the Halls of Medicine," Chicago: University of Chicago Press, 2012

- "A question for the chaplaincy profession is whether designing CPE residency curricula around the certification competencies is an effective way to educate people for professional chaplaincy or whether it is time for a fresh look at education for professional chaplaincy … The merit in investigating licensure for chaplaincy is that standards of professional competency, propositional knowledge, and objective outcome-oriented clinical practice could be identified and tested through methods currently employed by other professional licensures and the question of who may train chaplains and how they may train chaplains becomes tangential."

Source: George Fitchett, D.Min., Ph.D., Alexander Tartaglia, D.Min., Kevin Massey, BCC, Beth Jackson-Jordon, Ed.D. & Paul E. Derrickson, BCC (2015) Education for Professional Chaplains: Should Certification Competencies Shape Curriculum?, Journal of Health Care Chaplaincy, 21:4, 151-164, DOI: 10.1080/08854726.2015.1075343

- "Even with increasing awareness, a lack of consistency exists in how spiritual care programs are operated or implemented in health care organizations today. We have an opportunity to ensure alignment on both purpose and role and expand and reinforce the dialogue of the outcomes a focus on spiritual care can drive."

Source: "The Critical Role of Spirituality in Patient Experience," The Beryl Institute and HealthCare Chaplaincy Network, 2015

LONG-TIME GAPS AND BUILDING BLOCKS

As we look to create a new model of spiritual care, it is critical to identify long-time gaps in professional chaplaincy and analyze the current health care landscape. While chaplaincy always strives to uphold the humanity of the patient, we also must consider expectations of health care settings—alignment with mission, and contributions to metrics such as patient experience, patient satisfaction, medical outcomes, and cost savings. At the same time, it is essential to build upon the strengths of the field's existing guidelines and research. Lastly, it is important to understand that various components of the new model of spiritual care that is presented in this report may require adjustments as additional evidence-based findings emerge.

- Chaplaincy care had not been able to demonstrate value because defined, evidence-based quality indicators and competencies did not exist. Yet, health care providers and payers are increasingly focused on value derived from quality outcomes.

- Training must be founded in research. A knowledge base tied to evidence-based quality indicators and evidence-based scope of practice can establish what chaplains need to be doing to provide evidence-based quality care and impact outcomes.

- Board certification of chaplains based merely on a required number of hours, faith endorsement, and a subjective process does not ensure the delivery of effective care. Common Standards are not a statement of what makes a chaplain competent; they are simply standards that were common among associations at their adoption in 2004. Not all of these signers continue to use them as originally written. It is time to put professional chaplains to the test—to demonstrate clinical competences as defined by very specific evidence-based indicators and deliverables. An objective process that includes such a demonstration would conform with best practices in other health professions.

CREATING A NEW MODEL TO ENHANCE SPIRITUAL CARE AND PROFESSIONAL CHAPLAINCY

STEP 1: DEFINE THE FIRST EVIDENCE-BASED QUALITY INDICATORS

Other health care disciplines utilize evidence-based tools as a framework for care. Increasingly, all services are being judged—and funded—by the value of what they add to the system with value defined as Quality/Cost. In the U.S., the major quality goals are known as the "triple aims": improved medical outcomes, reduced cost, and patient satisfaction.

The inability to agree on outcomes has been especially problematic in spiritual care where the normal medical metrics of cure rates and readmissions seemingly do not apply. Further, the normal bar for proposing a quality measure or indicator is that it is "evidence-based." Until recently, this evidence was lacking for any indicator that would support spiritual care.

To move the field forward, it is necessary to develop measurable indicators that demonstrate the contribution spiritual care makes to quality health care and outcomes. It is vital for spiritual care to join the other domains of care in defining what quality means in the provision of spiritual care by chaplains. Determining quality of care rests on having an agreed set of quality indicators, the metrics that indicate the degree of quality present, and evidence-based tools that reliably measure that quality.

In late 2015, in a direct response to calls within the health care field for such indicators, HCCN convened a distinguished, international panel chosen for their demonstrated expertise in medicine, nursing, chaplaincy, palliative care, or research to provide guidance.

The goal is to establish that evidence-based quality indicators for spiritual care are possible and measurable; stimulate discussion, testing and publication of these indicators and others in various care settings; and encourage development of more evidence for quality indicators, as well as test usability and applicability of metrics and measures. In addition, the quality indicators could improve understanding of the chaplain's role and how it intersects with other members of the interdisciplinary team.

HCCN released the resulting Quality Indicators document in early 2016 (see appendix). It is meant to be a fluid document—one that will evolve as new research related to spiritual care unfolds.

STEP 2: DEFINE THE FIRST EVIDENCE-BASED SCOPE OF PRACTICE

Throughout the last decade, since the publication in 2004 of the Common Standards for Professional Chaplaincy, there has been a significant amount of new evidence in the area of spiritual care and the profession of chaplaincy, as well as significant changes in the delivery of health care. These developments warrant review of necessary competencies for chaplains.

Having identified the quality indicators for spiritual care as the reference point for all that is to follow, the next step is to establish what chaplains must be doing to meet those indicators and provide evidence-based quality care. HCCN again gathered a second international panel of experts to review the competencies for professional health care chaplaincy, taking into consideration new evidence that would impact these competencies.

The resulting Scope of Practice document was released in early 2016 (see appendix). It is the first evidence-based scope of practice for professional chaplaincy that defines the set of competencies chaplains need to effectively and reliably produce quality spiritual care. This new Scope of Practice incorporates standards from the 2004 Common Standards and from other models worldwide. It now defines The New Generation of Common Standards for Professional Chaplaincy. It gives spiritual care specialists, other providers, and administrators the second framework (in addition to Quality Indicators) in which to provide quality spiritual care in health care settings.

The panel's chair expects the Quality Indicators and Scope of Practice to "catalyze a wave of improvement initiatives progressively resulting in spiritual care that reliably identifies and meets the needs of clients and improves their ability to achieve health and healing."

HCCN has encouraged and requested ongoing comment for possible incorporation to ensure that these documents continue to reflect the best perspective for our profession and our field.

STEP 3: ESTABLISH THE FIRST COMPREHENSIVE CURRICULUM INCORPORATING THE EVIDENCE-BASED STANDARDS

Currently, there is no consistent, standardized curriculum to educate chaplains. Clinical Pastoral Education (CPE) can vary widely from one CPE supervisor to another. This can create a large variation of knowledge among chaplains.

With the emergence of the Quality Indicators and Scope of Practice, it becomes possible to inform changes around chaplaincy education and training, and develop curriculum that teaches to the evidence-based standards. Not only does this new knowledge base bring standardization to the field, it ultimately should provide care recipients with demonstrably reliable, high-quality spiritual care.

Here is one example of how each of these efforts build on each other, resulting in curriculum based on the evidence-based standards:

Quality Indicator 2.A.	"Specialist spiritual care is made available within a time frame appropriate to the nature of the referral."
The Aligned Competency	"The chaplain integrates effective and responsive spiritual care into the organization through policies and procedures, use of evidence-based assessment and documentation processes, and education of the interdisciplinary team about spiritual care."
The Aligned Curriculum	1. Building and Maintaining a Chaplaincy Department 2. What We Hear and Say: Spiritual Assessment and Documentation 3. When Care Is Tough: Supporting the Interdisciplinary Team 4. What We Do Matters: Continuous Quality Improvement and Research Within Chaplaincy and Health Care

STEP 4: INSTITUTE AN OBJECTIVE ASSESSMENT OF COMPETENCY

The current certification process in professional chaplaincy relies on self-report of clinical encounters (verbatims) and an interview with chaplain volunteers; the process is so subjective that it can be influenced by personal bias. This subjective and inconsistent assessment does not ensure that the chaplain who is deemed competent actually is.

A new model that assesses both the chaplain's knowledge and demonstrated competency of practice would for the first time provide evidence of a chaplain's competency. An objective evaluation would include testing knowledge and understanding of evidence-based scope of practice and demonstrated clinical competencies by verbatim/case notes or standardized patient exam/simulated patient encounter. This process would align with the competency testing rigors of other health care disciplines.

STEP 5: LINK CERTIFICATION TO EVIDENCE-BASED REQUIREMENTS

Status quo requirements for board certification among chaplaincy organizations fall short of having chaplains demonstrate clinical competencies to deliver high-quality spiritual care. Rather, they include criteria that are not evidence-based and are unrelated to being a competent chaplain. The objective testing to demonstrate clinical competencies, knowledge, and best practices would be the major component of a new model for certifying and credentialing professional chaplains. Requirements linked to competencies are essential, both to ensure that chaplains deliver high-quality spiritual care and to elevate chaplaincy to the level expected of other health care disciplines. In addition, a new model would:

- Replace the requirement for a graduate theological degree with a requirement for Master's degree from a Council for Higher Education-accredited (or international equivalent) institution in a content area relevant to chaplaincy. Concentrations could include but not be limited to theology, study of sacred texts, medical or professional ethics, psychology, sociology, family systems, counseling, social work, nursing, world religions and belief systems, organizational development, gerontology, communication, and the relationship of spirituality and health.

  These concentrations are identified because the work of competent chaplains, as noted in the Quality Indicators and Scope of Practice, includes demonstrated skills that stem from the study of these disciplines. It is essential that chaplains have a firm foundational knowledge in religious, spiritual, or existential belief systems. However, the work of the professional chaplain goes far beyond traditional theological education that focuses on the history, texts and policies of only one religious group—that of the chaplain. Traditional theological education only minimally—if at all—touches on issues of the care for persons of other faith traditions (or no faith tradition). To function inclusively and effectively, chaplains must have knowledge in these other areas of concentration. Accepting these degrees and augmenting them with additional chaplain-specific education requirements that meet the Scope of Practice will increase a chaplain's competence to provide evidence-based professional chaplaincy care.

- Reduce the minimum number of required Clinical Pastoral Education units for Board Certification from four to two. As noted previously, there currently exists no consistent, standardized curriculum to educate chaplains because Clinical Pastoral Education can vary widely among CPE supervisors. To the best of our knowledge, the only research conducted on the value of the current CPE model, including the number of CPE units, was a 2008 analysis conducted by an HCCN research team. That study was inconclusive, and HCCN is undertaking additional research.

  Due to the current level of evidence, it is reasonable to contend that two CPE units (800 hours) are sufficient to allow someone to take the new objective testing for board certification. Some candidates will need more clinical training to pass the competency tests. However, the bottom line—the test result, not the amount of training hours—is what proves whether the chaplain can demonstrate competency of knowledge and care. Over time, new evidence could dictate modification of the prerequisites. This proviso is consistent with a model that evolves over time based on learning and data.

- Eliminate the faith group endorsement requirement. It is not an evidence-based indicator of the person's competency as a chaplain, and can bar an otherwise highly qualified chaplain from becoming certified.

  Faith group endorsement is a relationship between a chaplain and his or her religious/spiritual/existential community. It is largely a Christian structure that is not practiced by most non-Christian groups. This reality has often meant that otherwise qualified and competent persons who are not from a tradition that endorses chaplains have either been denied the opportunity for certification or have had to compromise their own tradition in order to obtain an endorsement from another group for qualification purposes.

THE RESULT:
INTRODUCTION OF THE FIRST COMPREHENSIVE EVIDENCE-BASED MODEL TO DEFINE, DELIVER, TRAIN AND TEST FOR THE PROVISION OF HIGH-QUALITY SPIRITUAL/CHAPLAINCY CARE

- Brings to the profession of health care chaplaincy the same rigor in education, training and testing that is demanded by other health care professions, such as medicine, nursing, social work, to become certified and credentialed, and to practice
- Results from a foundation of well-established national guidelines, existing research, and tools that have already been developed and tested
- Establishes the framework for an ongoing process of implementation, research and quality improvement
- Ultimately calls for all chaplains to be tested for demonstrated clinical competency
- Provides the preparatory tools for testing
- Includes requirements for continuing education and training—i.e., 48 continuing education hours completed over two years
- Creates the first standardized curriculum and didactics for Clinical Pastoral Education
- Remains true to the essence of professional chaplaincy care as both an art and a science—to enable patients and their loved ones, and professional caregivers who are experiencing spiritual distress to identify and draw upon whatever is their source of spiritual strength to find comfort and meaning
- Recognizes that there are many chaplains who can demonstrate the competencies to perform normal chaplaincy tasks in non-complex settings or in complex settings under the supervision of a Board Certified Chaplain; these chaplains can merit the new title of Credentialed Chaplain that attests to their competency

18 evidence-based **Quality Indicators** define the various key aspects of successful spiritual care, including structural, process and outcomes.	The evidence-based **Scope of Practice**—with the Quality Indicators as a reference point—establish what chaplains need to be doing to meet those indicators and provide evidence-based quality care.	The **Knowledge Base** identifies the training and experience—what chaplains need to know and to demonstrate—so that they meet the Scope of Practice to deliver quality spiritual care.	**Objective Testing** assesses both the chaplain's knowledge and demonstrated competency of practice through two tools: • An online, multiple choice, on-demand test of knowledge/ understanding the evidence-based Scope of Practice • Demonstration of competency by standardized patient exam (simulated patient encounter).

CREATION OF THE MODEL HAS PROMPTED THE FORMATION OF THE SPIRITUAL CARE ASSOCIATION

With the imperative to raise the standard of professional health care chaplaincy, HCCN has embraced the model presented in this report through its establishment of the Spiritual Care Association (SCA).

SCA, introduced in April 2016, is the first multidisciplinary, international professional membership association for spiritual care providers that establishes evidence-based quality indicators, scope of practice, and a knowledge base for spiritual care in health care.

As health care providers emphasize the delivery of positive patient experience, SCA is leading the way to educate, certify, credential and advocate so that more people in need, regardless of religion, beliefs or cultural identification, receive effective spiritual care in all types of institutional and community settings in the U.S. and internationally. SCA is committed to serving its multidisciplinary membership—chaplains, other health care professionals, clergy, institutions and organizations—and growing the chaplaincy profession.

SCA has invited all chaplaincy associations and certifying bodies to participate in SCA and to aid the field through collaboration and application of the model's components for their own members. SCA is making the new model of spiritual care available to associations with no obligation of membership and with no requirement for members to switch their certification from their association to SCA.

A number of chaplaincy associations have enthusiastically accepted SCA's invitation to collaborate; the list is growing. Many individual chaplains have become members of SCA and have applied for Board Certification or Credentialing through SCA.

SCA's long-term desire is for all professional chaplains, both credentialed and board certified, to be tested and pass the objective competency exams—since that *and only that* is evidence that they have the knowledge, skills and experience to provide high-quality spiritual care that contributes to enhanced outcomes and value.

> The professional chaplaincy field must not be afraid to challenge its premises.
>
> The objective must be to obtain the best prepared chaplains and to provide the highest quality spiritual care.

CONCLUSION

A chaplain once described to an HCCN staff member what chaplains do, saying, "We walk into dark places to try to bring in light."

We all agree that professional chaplains have a vital role to play in today's health care system. Health care team members have a stake in their success. Health care systems have a stake in their success. And, most importantly, patients and their families have a stake in their success.

We believe this new model of spiritual care will allow the profession to achieve even greater accomplishments and acceptance. Its components—as designed and implemented through the Spiritual Care Association—reflect what thought leaders in the field have sought for many years in order to advance the field and give more people in spiritual pain the quality spiritual care they deserve.

It is time to move forward.

APPENDIX

Quality Indicators (Released February 17, 2016)

What Is Quality Spiritual Care in Health Care and How Do You Measure It?

Purpose: This statement provides guidance to advocacy groups, professional health care associations, health care administrators, clinical teams, researchers, government and other funders, faith communities, spiritual care professionals, and other stakeholders internationally on the indicators of quality spiritual care in health care, the metrics that indicate quality care is present, and suggested evidence-based tools to measure that quality.

Reason for Action: The value of any health care service is increasingly determined and reimbursed by the quality of that service rather than the volume of services that are produced. Determining quality of care rests on having an agreed set of quality indicators, the metrics that indicate the degree of quality present, and tools that reliably measure those metrics.

While there is widespread consensus that spiritual care is desired by patients and family caregivers and impacts important outcomes, there are currently no accepted indicators for determining the quality of spiritual care with the exception of the Quality of Spiritual Care (QSC) scale.[1] Validated and accepted health and health services indices such as symptom severity and cure rates do not apply to spiritual care. There is a need to address this gap by developing indicators that demonstrate the contribution spiritual care makes to quality health care and outcomes.

This statement developed by an international, multidisciplinary panel of experts in the field seeks to provide guidance to providers of spiritual care and those who advocate for that care on the indicators of high-quality spiritual care, the metrics that can measure those indicators, and suggested evidence-based tools that can reliably quantify those metrics. The panel began with well-established indicators from national guidelines or research and used tools that have already been developed and tested. The hope is to jump-start a process of testing and validating that will further the integration of demonstrably high-quality spiritual care in health care. We see this document as a first step in a continuing process of defining and promoting quality indicators in spiritual care.

Recommendations

Quality Indicator	Metric	Suggested Tools
1. STRUCTURAL INDICATORS		
1.A: Certified or credentialed spiritual care professional(s) are provided proportionate to the size and complexity of the unit served and officially recognized as integrated/embedded members of the clinical staff.[2,3]	Institutional policy recognizes chaplains as official members of the clinical team.	Policy Review
1.B: Dedicated sacred space is available for meditation, reflection and ritual.[4]	Yes/No	
1.C: Information is provided about the availability of spiritual care services.[5]	Percentage of patients who say they were informed that spiritual care was available	Client Satisfaction Survey
1.D: Professional education and development programs in spiritual care are provided for all disciplines on the team to improve their provision of generalist spiritual care.[6]	All clinical staff receive regular spiritual care training appropriate to their scope of practice and to improve their practice.	Lists of programs, number of attendees, and feedback forms
1.E Spiritual care quality measures are reported regularly as part of the organization's overall quality program and are used to improve practice.[7]	List of spiritual care quality measures reported	Audit of organizational quality data and improvement initiatives

Quality Indicator	Metric	Suggested Tools
2. PROCESS INDICATORS		
2.A: Specialist spiritual care is made available within a time frame appropriate to the nature of the referral.[6]	Percentage of staff who made referrals to spiritual care and report the referral was responded to in a timely manner. Percentage of referrals responded to within Chaplaincy Service guidelines	Survey of staff Chaplaincy data reports
2.B: All clients are offered the opportunity to have a discussion of religious/spiritual concerns.[8]	Percentage of clients who say they were offered a discussion of religious/spiritual concerns	Client Survey
2.C: An assessment of religious, spiritual and existential concerns using a structured instrument is developed and documented, and the information obtained from the assessment is integrated into the overall care plan.[4,6]	Percentage of clients assessed using established tools such as FICA,[9] Hope[10], 7X7[11] or Outcome Oriented[12] models with a spiritual care plan as part of the overall plan of care	Chart Review
2.D: Spiritual, religious and cultural practices are facilitated for clients, the people important to them, and staff.[4]	Referrals for spiritual practices	Referral Logs, including disposition of referrals
2.E: Families are offered the opportunity to discuss spiritual issues during goals of care conferences.[13]	Percentage of meeting reports in which it is noted that families are given the opportunity to discuss spiritual issues	Chart Audit
2.F: Spiritual care is provided in a culturally and linguistically appropriate manner.[4] Clients' values and beliefs are integrated into plans of care.[14]	Percentage of clients who say that they were provided care in a culturally and linguistically appropriate manner. Percentage of documented plans of care that mention client beliefs and values	Client Survey Chart Audit
2.G: End of Life and Bereavement Care is provided as appropriate to the population served.[15,4]	Care plans for clients approaching end of life include document attention to end-of-life care. A documented plan for bereavement care after all deaths	Chart Audit

Quality Indicator	Metric	Suggested Tools
3. OUTCOMES		
3.A: Clients' spiritual needs are met.[16]	Client-reported spiritual needs documented before and after spiritual care	• Spiritual Needs Assessment Inventory for Patients (SNAP)[17] • Spiritual Needs Questionnaire (SpNQ)[18]
3.B: Spiritual care increases client satisfaction.[19]	Client-reported spiritual needs documented before and after spiritual care	• HCAHPS #21[20] • QSC1
3.C: Spiritual care reduces spiritual distress.[22]	Client-reported spiritual distress documented before and after spiritual care	"Are you experiencing spiritual pain right now?"[21]
3.D: Spiritual interventions increase clients' sense of peace.[22]	Client-reported peace measure documented before and after spiritual care	• Facit-SP-Peace Subscale[23] • "Are you at peace?"[24]
3.E: Spiritual care facilitates meaning-making for clients and family members.[25]	Client-reported measure of meaning documented before and after spiritual care	• Facit-SP- Meaning subscale • RCOPE[26]
3.F: Spiritual care increases spiritual well-being.[27]	Client-reported spiritual well-being documented before and after spiritual care	Facit-SP

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Scope of Practice (Released March 16, 2016)

This document seeks to articulate the scope of practice that chaplains need to effectively and reliably produce quality spiritual care. It follows on the work of an international, multidisciplinary consensus panel that identified a list of evidence-based quality indicators for spiritual care and suggested metrics and measures for each.

Having identified the quality indicators for spiritual care to create the reference point for all that is to follow, this next step seeks to establish what chaplains need to be doing to meet those indicators and provide evidence-based quality care.

This scope of practice represents the first step in the development of an internationally recognized list of competencies for chaplains. The process started with reviewing and cross walking existing published lists (see appendix). Redundant competencies were combined; those that did not seem to map to an indicator were eliminated; and competencies that seemed necessary for a given indicator but which did not appear on a prior list were added. This process yielded a list of competencies judged too long for this stage of the process. Thus, the list was cut down to those judged most essential.

As the list of quality indicators expands, the scope of practice will need to expand. These competencies will need to be tested to determine whether indeed mastery of them raises the likelihood that the indicator will be achieved. Several contexts have developed competency frameworks that recognize a range of levels for chaplaincy capability. This document is intended to describe a level of competence that all professional health care chaplains should attain. However, investigation should continue on the utility of competencies for different levels of practice and different specialty settings.

It is intended that this scope of practice will invite and inform the conversations around changes to chaplaincy education and training and become the basis for certification and credentialing processes with the ultimate goal of providing care recipients internationally with demonstrably reliable, high quality care to help meet their spiritual needs and support their spiritual strengths. Further, while this scope of practice is necessary to that end, the need to ensure integration of a practitioner's personal history, beliefs and values as a fundamental aspect of their education and practice-based training remains.

As in other efforts of this kind, one discovery has been that the terminology commonly used is not as universally understood as one might assume. Thus the panel chose to name this a "Scope of Practice" with the understanding that it could easily be understood as a set of competencies. We recognize that in some contexts Scope of Practice is a vehicle for describing the responsibilities of a specific practitioner. In this document, we use it to describe the practice of an entire discipline. Likewise, there is much discussion about the name to be given to those receiving spiritual care in documents like this. Clearly not all those served by chaplains are "patients". We chose "clients" realizing that this identifier also has limitations in what it implies for the relationship with the spiritual care provider. Finally, we use the term "chaplain" to describe the person giving care although in some contexts this same person might be called a "spiritual care professional".

STRUCTURAL INDICATORS

Indicator 1.A. Chaplains as certified or credentialed spiritual care professional(s) are provided proportionate to the size and complexity of the unit served and officially recognized as integrated/ embedded members of the clinical staff.

Competencies

PROVISION OF CARE

The chaplain supports and advocates for the growth and integration of spiritual care within the organization to make spiritual care more accessible to clients, families and staff.

The chaplain performs an audit of spiritual care needs in the organization and produces a strategic plan to support the inclusion of spiritual care professionals.

The chaplain is aware of and has a working knowledge of relevant healthcare policies (national and local), delivery plans, key drivers and levers for change, and understands why this is important for chaplaincy.

The chaplain is aware of the difference between management and leadership and why cultivating leadership is significant.

INTEGRATION WITH CARE

The chaplain articulates his or her unique professional role as the spiritual care leader to other members of the team.

The chaplain articulates an understanding of the goals of spiritual care, current models to achieve them, and how they integrate with the treatment plans of the interdisciplinary team.

The chaplain demonstrates an understanding of the competencies required of his or her role and the discipline's scope of practice.

The chaplain utilizes common medical, social, and chaplaincy terminology in order to communicate with other members of the team.

The chaplain utilizes a working knowledge of the key physical, psychological and social issues/principles in spiritual care sufficient to effectively communicate with other team members in a particular clinical setting.

Indicator 1.B. Dedicated sacred space is available for meditation, reflection and ritual.

Competencies

The chaplain advocates effectively for the allocation and equipping of dedicated space for meditation, reflection and ritual taking into account the particular cultural, ethnic and religious needs of the community.

Indicator 1.C. Information is provided about the availability of spiritual care services.

Competencies

The chaplain makes information on the range of spiritual care services in the organization available to staff, clients and families and educates them on how to access those services.

The chaplain maintains links to local faith communities and belief groups and makes this information available to staff, clients and families as requested.

The chaplain identifies and makes available information and resources explaining spiritual needs and services to clients new to the organization.

The chaplain is able to provide information to clients and families about resources for communicating their care preferences to the medical team and assists in their completion as appropriate.

The chaplain develops and makes available client and family care resources and information to assist with the integration of the client's identified spiritual care goals.

Indicator 1.D. Professional education and development programs in spiritual care are provided for all disciplines on the team to improve their provision of generalist spiritual care.

Competencies

The chaplain, in collaboration with educators from other professions, provides education in the practices and processes involved in spiritual care as provided by each member of the interprofessional team (e.g., for healthcare: physician, nurse, social worker, physical therapist, pharmacist, quality improvement) and introduces spiritual care practices/processes into training for the other team professionals.

The chaplain participates with the interprofessional members of the healthcare team to modify, innovate, and implement practices and processes for the provision, collaboration, communication, education, and quality improvement of spiritual care.

Indicator 1.E. Spiritual care quality measures are reported regularly as part of the organization's overall quality program and are used to improve practice.

Competencies

QUALITY IMPROVEMENT

The chaplain integrates with any organizational quality team and supports the inclusion of relevant spiritual care outcome measures in organizational quality reports.

The chaplain identifies quality improvement processes, objectives and outcomes in spiritual care.

The chaplain uses quality improvement data to refine spiritual care programs and services.

RESEARCH

The chaplain is familiar with research processes and practice within spiritual care.

The chaplain accesses spiritual care journals and other expert sources of research data and best practices to apply to his or her work.

The chaplain engages in the discussion of research findings with other chaplaincy colleagues and the interdisciplinary team.

PROCESS INDICATORS

Indicator 2.A. Specialist spiritual care is made available within a time frame appropriate to the nature of the referral.

Competencies

The chaplain integrates effective and responsive spiritual care into the organization through policies and procedures, use of evidence-based assessment and documentation processes, and education of the interdisciplinary team about spiritual care.

Indicator 2.B. All clients are offered the opportunity to have a discussion of religious/spiritual concerns.

Competencies

The chaplain supports and advocates for the establishment of timely and documented spiritual screening to discover and refer clients for discussion of religious/spiritual concerns.

The chaplain provides timely response to all referrals and facilitates discussions of religious/spiritual concerns.

Indicator 2.C. An assessment of religious, spiritual and existential concerns using a structured instrument is developed and documented, and the information obtained from the assessment is integrated into the overall care plan.

Competencies

The chaplain implements a process to define and give structure to goals of care, interventions, and care plans that can be articulated clearly according to the situation and applied appropriately and is able to modify them based on changes in the status of the client or situation.

ASSESSMENT

The chaplain demonstrates a working knowledge of the methodologies of spiritual screening, spiritual history, and spiritual assessment that takes into account the diversity of the population served.

The chaplain uses several published models for spiritual assessment appropriately choosing and applying the model suitable for each specific situation, client and family.

The chaplain evaluates and executes new models of spiritual assessment that have been tested for effectiveness.

PLAN

The chaplain respects and advocates for the development of plans of care that accurately incorporate the client's or surrogate's stated beliefs, values, culture and preferences without inserting the chaplain's own beliefs.

The chaplain develops clear, concise and personalized spiritual care plans for clients and families based upon the assessment of spiritual, religious, existential, and cultural beliefs, values, needs and practices, and integrates them into the client's overall care plan.

The chaplain collaborates effectively with clinicians from other disciplines to create and implement an interdisciplinary treatment plan.

The chaplain makes follow-up visits to clients as indicated and informs the team of his or her findings.

The chaplain incorporates spiritual assessment and documentation into the discharge planning/continuity of care plan.

The chaplain integrates knowledge of specific community-based resources such as hospice, home health, long-term care, counseling, and grief and bereavement services into discharge and continuity of care plans.

DOCUMENTATION

The chaplain understands the importance of documentation and the requirements of organizational and regulatory guidelines.

The chaplain implements best practices for chaplaincy documentation including documenting the spiritual, religious, cultural, existential, emotional and social needs, resources, and risk factors of clients and any needed referrals.

Indicator 2.D. Spiritual, religious, cultural practices are facilitated for clients, the people important to them, and staff.

Competencies

The chaplain understands the concepts of cultural competency and inclusion.

The chaplain can articulate his or her own cultural values, beliefs, assumptions and biases, and has the self-awareness to set those aside in order to provide spiritual care to clients and families from diverse backgrounds.

The chaplain facilitates, provides and accommodates religious, spiritual and cultural events, rituals, celebrations and opportunities appropriate to the population served.

The chaplain provides client-centered, family-focused spiritual care that understands and respects diversity in all its dimensions and takes into account cultural and linguistic needs.

The chaplain integrates into his or her provision of care a basic knowledge of different religious and cultural groups including common beliefs and practices related to health care.

The chaplain acquires knowledge of unfamiliar cultures, religious/spiritual beliefs, or existential norms as needed to provide appropriate care.

The chaplain assesses, documents and includes in care plans appropriate spiritual/religious interventions for cross-cultural situations.

The chaplain identifies and integrates in care the unique spiritual/religious/cultural beliefs within vulnerable client populations.

The chaplain creates partnerships with community religious and cultural leaders to enhance the cultural understanding of the care team and ensure effective support to the client/family.

The chaplain works collaboratively with the care team as a culture broker in identifying, recommending and integrating appropriate diversity concepts, needs and interventions into client/family care plans and organizational programs and policies.

Indicator 2.E. Families are offered the opportunity to discuss spiritual issues during goals of care conferences.

Competencies

Within the discipline's scope of practice, the chaplain leads, guides or participates in goal clarification with clients, families and teams.

The chaplain supports and advocates for clients and families in goal clarification and family meetings.

The chaplain provides and models a leadership role within the spiritual care team when talking with families who identify significant religious, spiritual, existential and/or cultural issues in regard to care decisions.

The chaplain has a working knowledge of the ethical and moral challenges that may occur in relation to spiritual care, as well as the ethical principles of respect, justice, non-maleficence and beneficence.

Within the discipline's scope of practice, the chaplain participates effectively in the process of ethical decision-making, including with the ethics committee as appropriate to the setting, in such a way that theological, spiritual, and cultural values are supported.

The chaplain secures and disseminates to the team information on faith tradition directives regarding the provision, withholding or withdrawing of medical treatments.

The chaplain understands the benefits and burdens of specific medical interventions in clients with advanced illness including nutrition and hydration, and the issues involved in physician assisted death and terminal sedation.

The chaplain understands the process to determine client decision making capacity and government regulations regarding those designated to make decisions for the client.

Indicator 2.F. Spiritual care is provided in a culturally and linguistically appropriate manner. Clients' values and beliefs are integrated into plans of care.

Competencies

The competencies for this Indicator are the same as the competencies for Indicator 2.D.

Indicator 2.G. End of Life and Bereavement Care is provided as appropriate to the population served.

Competencies

The chaplain identifies and integrates into care appropriate grief interventions for those at end-of-life and those who are grieving.

The chaplain effectively uses culturally appropriate, evidence-based strategies for communicating with clients and families regarding pain and suffering, loss, complicated and anticipatory grief, and life review.

OUTCOMES

Indicator 3.A. Clients' spiritual needs are met

Indicator 3.B. Spiritual care increases client satisfaction

Indicator 3.C. Spiritual care reduces spiritual distress

Indicator 3.D. Spiritual interventions increase clients' sense of peace

Indicator 3.E. Spiritual care facilitates meaning making for clients and family members

Indicator 3.F. Spiritual care increases spiritual well being

The competencies listed below were determined to apply to all of the outcomes for Indicators 3.A through 3.F, so are listed as a group rather than repeating the same list for each competency.

GENERAL COMPETENCIES

The chaplain integrates theories from the behavioral sciences into spiritual care practice.

The chaplain integrates spiritual, existential and emotional concepts for clients and families in spiritual care, including faith, hope, forgiveness, meaning and remorse.

The chaplain integrates a thorough knowledge of chaplaincy practice into interventions to support the client's identified religious, spiritual, existential or cultural beliefs and values.

The chaplain utilizes evidence-based practices in spiritual care and chaplaincy to improve spiritual care services.

The chaplain understands and abides by the ethical standards of care giving in general and chaplaincy in particular.

The chaplain effectively uses best practice in communication, including listening habits and techniques.

The chaplain effectively and appropriately uses supportive responses with clients who experience traumatic events so that they can manage the situation and respond appropriately.

The chaplain utilizes evidence-based practices to help clients and families address their fears, as well as distress (spiritual and otherwise) related to chronic, serious, life-limiting illness, and/or end-of-life care.

GLOSSARY

From- *Spiritual and Religious Care Capabilities and Competencies for Healthcare Chaplains.* National Health Service Education for Scotland.

Competence describes what individuals know or are able to do in terms of knowledge, skills and attitudes at a particular point in time.

Capability describes the extent to which an individual can apply, adapt and synthesise new knowledge from experience and continue to improve his or her performance.

Spiritual care is often used as the overall term and is relevant for all. For some their spiritual needs are met by religious care, the visits, prayers, worship, rites and sacraments often provided by a faith leader, or representative of the faith community or belief group. Spiritual care can be provided by all healthcare staff, by carers, families and other patients. When a person is treated with respect, when they are listened to in a meaningful way, when they are seen and treated as a whole person within the context of their life, values and beliefs, then they are receiving spiritual care. Chaplains are the specialist spiritual care providers. For them, spiritual care is the reason for their employment, and they are expected to be knowledgeable, capable and competent in the areas of spiritual and religious care. They are expected to take their place as members of the multi-professional healthcare team and to fulfill a meaningful role within the healthcare community.

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