



# United Methodist Endorsing Agency

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## Capturing Spiritual Care Services in Value Added Terminology:

### Showing the Relevance of Clinical Chaplaincy in Dollars and Cents

*By Michael T. Curd, D. Min.*

To be relevant in corporate healthcare is to show, in addition to the traditional chaplain functions, positive impact on the bottom line. This is as true in non-taxed entities (not for profit) as it is for taxed entities (for profit) regardless if they are faith based institutions or not. Some of what follows is relevant in military and Veterans Administration healthcare as well. "That which cannot be quantified is not valued" said David White, CEO of a cluster of taxed healthcare facilities (Pastoral Care Steering Committee, Nashville, Tennessee, May, 1997). One of the age old struggles for Clinical Chaplaincy (chaplaincy) is to quantify ministry. It can be a challenge and is a process which must be constantly reviewed and modified, because what is valued in healthcare changes, frequently. The Spiritual Care Services (CSC) which are most vulnerable to reduction or elimination are those which have not quantified their ministry in ways which are meaningful to management and/or reevaluated the paradigms service. This paper identifies strategies and provides examples to significantly increase the relevance of Spiritual Care Services in the healthcare setting.

For purposes of understanding, "healthcare setting" is meant to include all services/institutions which are in the continuum of care (e.g., wellness, diagnostic, inpatient, outpatient, hospice, and grief). All healthcare institutions experience an economic ebb and flow of resources for many reasons. When system-wide funding reductions occur, chaplaincy must be the leader in "having skin in the game" by setting the example of reducing their budgets. Leaders in chaplaincy harm their credibility and programs when they ask for entitlement and exceptions to policy when reduction in strength is required. Pastoral Care Services must have plans in place, at all times, for spaces to be eliminated, programs to discontinue and how to continue offering vital services. Whining and martyrdom are the antithesis of relevance! When there is no money, services must be cut, regardless.

A number of strategies are frequently overlooked by chaplaincy. In some cases, it doesn't mean doing more, it means capturing and identifying the data in new ways. If what is listed below is not being done, consider adding one or more to the departmental game plan. Be ready to share chaplaincy's fiscal impact, particularly at budget approval time. Strategies to consider:

- BE AN INTEGRAL PART OF CONSTANTLY IMPROVING THE PROCESS OF SAVING LIVES!
- When lifesaving is not possible, work with all for a "good death."

- Spend at least as much time ministering to staff, especially senior staff, as one does with patients.
- Educate nursing staff to call the chaplain EVERY time a patient or family threatens to sue.
- Encourage nurse managers to inform chaplains when staff is considering resignation.
- Initiate a protocol for chaplains to be at the patient's head and actively involved with a trauma/medical resuscitation.
- If a hospital has a Sexual Assault Response Team program, insure specially trained chaplains are a part of the team.
- Constantly collect data on formal counseling, informal counseling, debriefings, defusing, deaths, resuscitations involving chaplains, referrals from staff for chaplain services and membership/participation in System committees/boards.
- Have a strategic plan, with measurable outcomes, that is consistent with that of the institution, and follow it.
- Reevaluate and re-imagine the relevant functions of the Spiritual Care Service no less than every three years.
- Develop strategies with outpatient services and case management to reduce hospitalizations and manage the anxiety of all.
- Intentionally work to increase staff/patient/family satisfaction.
- Document cost avoidance.
- Document and actively practice revenue generation.
- Consider actively recruiting former/retired military chaplains for clinicians/directors.
- Provide Continuing Education Units to the staff and community.

Perhaps, a word or two of explanation is appropriate. These strategies are supported with hard data and phenomenological research. All have been implemented and tested in military and/or civilian healthcare institutions over a period of thirty years. Change rarely comes easily. Throughout my forty-five years of ordained ministry, the single greatest resistance to change has come from other clergy. Approaching these strategies with an open mind and a spirit of "how can we make some of this work for us?" may save Full Time Equivalencies during the next budget reduction and increases the value of chaplaincy.

In the United Methodist Endorsing Agency paper, "The Challenge Confronting Chaplaincy Today: Relevance" (April 2014), a citation is noted from the President and CEO of Kalispell Regional Healthcare as saying "...that the impact of continuing cuts to Medicare would lead to cuts of the chaplaincy department because it is not absolutely essential to saving a person's life." (*Daily Interlake News*, Kalispell, Montana, "Health-care Execs Question Impact of Affordable Care Act," April, 2012). Whether or not that is true is hardly the issue. It is a clarion call to directors of Spiritual Care Services to make their programs a sustaining part of the lifesaving process **in the long run** (i.e., if chaplaincy goes away staff turnover increases, outsourcing creates additional costs, staff burnout increases, and **all** satisfaction surveys plummet). No CEO or leadership team in healthcare wants that outcome. It is incumbent on every chaplain and Spiritual Care Services to address their validity in healthcare given the definition that the system puts on chaplaincy services, not how SCS defines it.

*Cost avoidance* is a frequently over looked part of the budget of a Spiritual Care Service. The single largest item in this column is to document when chaplains have been involved with patients and/or families threatening law suits. Experience teaches that very few suits are caused by malpractice. Litigation is most frequently initiated by poor customer service, lack of communication and/or misplaced control issues of the plaintiff(s). Given that chaplains have extended training and (hopefully) skills in communication, they can help to defuse the anger, helplessness and reactions of potential plaintiffs. They are not summoned to, "Talk people out of suing." Rather their primary responsibility is to listen and then facilitate resolution to miscommunications and oversights on the part of a harried staff. The

cost avoidance of one major law suit not happening because of a chaplain's intervention can underwrite the SCS's operating expenses for a year or more.

Most chaplains have discovered that extending spiritual care to their staff is the best way to establish credibility and to receive timely referrals to other staff, patients and/or families, thereby empowering more effective use of time. Patients come and go. Staff remains. Good spiritual care reduces burnout and turnover. It also improves the quality of patient care. Ministry to senior staff has far reaching results. If the CEO has a headache, the system has a headache. Chaplains are the de facto work place pastors of staff. The chaplain, who knows their staff by name, is able to assess the occasional bad day, signs of depression/ Post Traumatic Stress/PTSD and other work inhibiting problems that can be addressed with the assurance of confidentiality. At a minimum, the cost of recruiting one Registered Nurse is in excess of \$10,000. When a chaplain's intervention can be documented, the impact on the bottom line and relevance quotient is increased.

Chaplains who are actively involved in resuscitations reduce the time it takes to "run" one, improve the quality of the event for staff, patients and family, reduces stress for staff and subsequently saves the hospital money. With the chaplain standing next to the patient during the resuscitation, the other team members are freed from the task of trying to keep the patient calm. Explanation of procedures are better understood by the patient when they are given by the chaplain in a calm, reassuring voice and with whom eye contact is being maintained, rather than hearing from a disembodied voice, "You're going to feel a stick in your groin." When the chaplain is present, anxiety is reduced for the medical team and the patient.

Chaplains will courier messages from the physician and patient to the family, which significantly reduces their anxiety and that, reduces their being an interruption to the staff. They are also relieved when the chaplain returns to the trauma room because she/he has become a representative of them to the patient. If the situation is dire, the chaplain can begin to prepare the family for a negative outcome as well as courier messages to the patient. If the patient is unconscious the chaplain can gather medical history and known allergies to the physician. Family members are also consoled by reports of religious resources, consistent with their faith tradition, being provided to the patient when that is appropriate. The use of scripture and/or prayers for the patient, when said loudly enough for the staff to hear, also reduces anxiety for the them, thereby improving the quality of care they provide. This ministry of liaison gives patient and family a closer bond in the crisis than is had sans chaplain.

In 1993, this protocol for "The Chaplain's Role in Trauma/Medical Resuscitations" was developed at Brooke Army Medical Center, San Antonio, Texas. It continues to be used there and has been taught to a number of Army and Air Force ministry teams. It is the premier protocol for military chaplains in combat. It is particularly useful in Level I and Level II trauma centers with direct impact on healthcare costs and staff support. It is also used in a few civilian hospitals with very positive results.

Each time a chaplain provides formal or informal counseling with staff, that is cost avoidance because it would otherwise be billed to the Employee Assistance Program or be an out-of-pocket expense for the staff member. Likewise, debriefings and/or defusings, (i.e., Critical Incident Stress Management (CISM) or the National Organization for Victim Assistance (NOVA) performed by chaplains is cost avoidance. It reduces stress for staff and serves as prophylaxis for PTSD and burn out. Many chaplains have this training and can provide it on very short notice. Rarely, is a chaplain attending a death or being present for patients and families who have "just received bad news" considered cost avoidance, yet it is. The chaplain's presence and spiritual care frees other staff from attending to these situations. To not attend to them leads to longer lengths of stay, more frequent hospitalizations and/or quality of life issues.

A conservative estimate of the cost avoidance gained by using two CPE residents providing twenty plus hours per week each vs. one FTE of clinician is more than \$15,000 per year. Where a CPE program exists, those cost avoidance figures must be reflected in the budget. Residents are not a substitute for long term clinicians and the impact they have on staff. Residents and interns provide more cost effective ways to staff the on call duty roster and patient units which have a lower acuity. CPE also trains the next generation of clinicians and provides a yearlong opportunity to evaluate their potential for subsequent employment (i.e., only the best are hired if there is an opening). Too frequently, a resume and interview does not provide adequate input for a good hire. What is the cost avoidance of not making a bad hire?

It is accurate to say that some of the examples above are a normal part of a chaplain's job description. That is precisely the point. If a clinically trained chaplain is not present, these functions will be provided by other staff, frequently not trained to do it, or it must be out sourced. If directors of SCS educate senior leadership and others to the reality that the functions chaplains perform will spontaneously be done by others, or negative consequences will result, the value of chaplaincy is reframed in more economically positive ways. All cost avoidance functions should be given the fair market value (FMV) that it would cost to outsource them with equally competent personnel, e.g., an in service should be recorded as \$125 or the FMV, and be reflected in the SCS budget as such. Most are surprised that as much as twenty percent of an SCS's operating expenses are offset by cost avoidance.

*Revenue generation* is probably the least frequently used means of positive impact on operating expenses for Spiritual Care Services. If there are not enough FTEs of chaplains to see everyone in house, how can revenue be generated? The tradeoff to be considered is how one's time is best spent, seeing a few more patients or earning hard dollars for the System. Chaplains naturally and with intent provide services outside the System. Preaching, teaching, CISM, mentoring, are but a few examples. Likewise, all ordained clergy in judicatories must pay a "temple tax" of time and service to the extended mosque, synagogue, temple or church. However, clinically trained chaplains, by definition, have additional skills and expertise to their counterparts in the local worship setting. Those can be marketed for hard dollars and increase the sphere of influence of the system.

Chaplains who are also credentialed as pastoral counselors, psychologists or psychotherapists can be part of a counseling center which receives referrals from the inpatient psych services of the System as well as from the community. Satellite offices for counseling and wellness can be placed in faith based worship facilities. Chaplains have the greatest connection to denominations and places of worship as anyone in the System. Conflict resolution, marriage enrichment, contemporary social issues, ethics, medical ethics, lay pastoral care and spiritual direction, to name a few, are areas of expertise for chaplains which can be actively marketed to generate revenue.

Spiritual Care Services can offer classes to local clergy, and charge, with a number of topics. Who better to offer Spiritual Care in a medical setting to local clergy? On rare occasion, physicians' practices, staffs, churches and judicatories experience conflict. A clinical chaplain with expertise in conflict resolution is an outside resource who understands these venues and who can help bring resolution while extending the privilege of confidentiality. The expertise shared and income generated is limited only by one's imagination.

Administrators in rural hospitals are often hesitant to hire chaplains because: a) they don't know how to supervise them and b) they are afraid to fire God, or at least God's representative, if expectations are not being met. A multiple FTE chaplaincy program can offer rural settings part or full time chaplains who are hired, trained and supervised by the SCS which then reduces the resistance of rural administrators. Standard business practices allows a management fee (usually ten to fifteen percent), for the supervising chaplaincy program.

Offering spiritual needs assessment can frequently result in additional income for an SCS while extending their sphere of influence and increase outmigration for the System. In cases where the urban Healthcare System offers management contracts to rural hospitals, having the chief of the SCS on the presentation team with the promise of a spiritual care needs assessment can have a very positive impact on the probability of a contract being agreed to. This generates revenue for the System. For revenue production or cost avoidance, the SCS can also train local clergy for volunteer chaplaincy in the rural hospitals. As in all things, accurate data collection aimed at evidence-based outcomes is a must. These arrangements produce significant revenue and add trained chaplains to the duty roster of the System.

Hiring military chaplains can also be more cost effective because of the vast experiences and amount of continuing education they receive while on active duty. Many are dual or even triple credentialed in allied fields which can be applied in revenue generation and cost avoidance. They are well versed in extremely diverse settings with appreciation for multiple cultures and faith groups. They also have a competent understanding of leadership and multiple task management. Usually, the “train up” time for them is short and they are accustomed to engaging in ministry quickly.

An SCS that offers Continuing Education Units inexpensively to the allied professions can generate revenue and build good will in the community. “Brown bag” lunches with guest speakers that result in CEUs garner appreciation and familiarization with professionals. Tours of the facility, interaction with System leaders/SCS personnel is also useful. Free meals are always a winner, especially with clergy, and can show off dietary services, simultaneously giving chaplains the opportunity to interact with food service personnel – frequently a forgotten group of employees.

The cultural emphasis on spirituality, “How one relates to their universe” (Anonymous), the reorganization of the healthcare industry, the onset of the Affordable Care Act, and the increasing advancement in medical technology have converged to provide unprecedented opportunities for clinical chaplaincy and spiritual care. Professional chaplains and their organizations must be creative, intentional and bold in asserting their contributions to the fabric of corporate healthcare and the process of saving lives. The reward will be a new era of expansion and credibility for clinical chaplaincy. The primary impediment to this growth is our own reluctance to change. The necessary choices will be made intentionally or unintentionally, but they will be made. How then shall the history of spiritual care be written in your setting?

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