

Surveying Hospital CEOs Regarding Spiritual Components of Palliative Care: Summary of Responses



*Prepared for the Archstone Foundation
by National Health Foundation*

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INTRODUCTION

In the coming months, the Archstone Foundation anticipates launching its *Spiritual Care Demonstration Projects*, the goal of which is to improve the quality of screening and assessing spiritual needs by palliative care teams in Southern California Hospitals, resulting in enhanced spiritual care services to patients and their families. In order to better understand hospital CEOs' readiness and interest in engaging in these demonstration projects and sustaining project components and outcomes indefinitely, the Archstone Foundation provided a grant to National Health Foundation (NHF) to collect baseline data of hospital CEO perceptions and opinions. NHF and the Archstone Foundation worked together to develop a survey that would address:

- Hospital CEOs' interest in adopting/strengthening a spiritual care component of their hospital-based palliative care program;
- Hospital CEOs' willingness to support this type of culture change in their hospital; and
- What outcomes or information would persuade hospital CEOs to sustain culture change and program developments resulting from a demonstration project.

It is anticipated that having this information will allow the Archstone Foundation to design the components of the *Spiritual Care Demonstration Projects* in order to maximize adoption and sustainability.

To obtain this baseline data, NHF conducted a small scale telephone survey of Southern California hospital CEOs and palliative care directors. Using a broad network of connections, including a strong partnership with the Hospital Association of Southern California, NHF reached out to hospital leadership to conduct the survey. Initially, an introductory E-mail was sent to selected hospital CEOs informing them of the survey. This E-mail was sent under the signatures of Jim Barber, President/CEO of the Hospital Association of Southern California (HASC) and David Kessler of HASC's Palliative Care Committee. After this E-mail was sent, NHF contacted the hospital CEOs and their assistants to set up survey times. After approaching hospital CEOs for participation, NHF conducted similar outreach and follow-up with hospital palliative care directors. When surveys were conducted, NHF used a survey tool with both quantitative and qualitative measures to capture the data. Copious notes were taken during the telephone interview and then transferred into an Excel document for analysis.

Statistics on the demographics of Southern California hospitals with palliative care programs (N=63) has been provided for comparison to demonstrate the representativeness of the survey sample. This data is based on National Health Foundation's 2008 statewide survey of hospitals regarding their palliative care programs, funded by the California HealthCare Foundation.

While the Archstone Foundation was hoping to obtain data for 20 hospital CEOs, NHF found it difficult to obtain their participation. A discussion with Jim Barber, President/CEO of the HASC indicated that CEOs may not respond to this survey because they are not entirely familiar with the palliative care program and are often not the decision makers when it comes to sustaining programmatic changes to a service such as palliative care (unless there are significant financial implications that are not dealt with on a department level). With that said, 30 hospital CEOs were approached to complete the survey;

- A total of 22 individuals completed the survey. Of those;
 - 8 CEOs completed the survey.
 - 12 Director-level staff completed the survey and declined to obtain input from the CEO.
 - 2 Director-level staff completed the survey and obtained input from the CEO.

DEMOGRAPHICS

- All hospitals interviewed (N=22) have palliative care programs.
- Regional Distribution

	Survey Respondents	Southern California Hospitals with Palliative Care Programs (N=63)
Los Angeles	45.5%	53%
San Diego	18.2%	14%
Orange	13.6%	12%
San Bernardino	9.1%	11%
Santa Barbara	9.1%	3%
Ventura	4.5%	3%
Riverside	0%	2%

- Hospitals' Type of Business Operation

	Survey Respondents	Southern California Hospitals with Palliative Care Programs (N=63)
Nonprofit	77.3%	89%
Investor	13.6%	6%
District	4.5%	3%
City/County	4.5%	2%

- Bed Size of the Hospitals

	Survey Respondents	Southern California Hospitals with Palliative Care Programs (N=63)
0-99	4.5%	3.2%
100 – 249	31.8%	25.4%
250 – 399	40.9%	39.7%
400 – 549	18.2%	27.0%
550 +	4.5%	4.8%

- Special Characteristics of Hospitals

	Survey Respondents	Southern California Hospitals with Palliative Care Programs (N=63)
Teaching Hospital	9.1%	11.0%
Small or Rural Hospital	4.5%	3.0%
Neither of the Above	86.4%	84.0%

- Number of responding hospitals with palliative care programs that serve adults, pediatrics or both.*
 - Adults: 72.7% (16)
 - Pediatrics: 9.1% (2)
 - Both: 18.2% (4)
 - While the Archstone Foundation focuses on senior and aging issues, two of the hospitals included in this survey were pediatric hospitals. Despite the fact that they serve a different

population, NHF felt that their input was still valuable and would reflect similar opinions and perceptions of those hospitals serving both adults and children.

- Number of responding hospitals with spiritual care providers on the adult palliative care team.*
 - Have spiritual care providers: 70% (14/20)

- Number of responding hospitals with spiritual care providers on the pediatric palliative care team.*
 - Have spiritual care providers: 83.3% (5/6)

- Number of responding hospitals with an ethics committee available to the palliative care team for end of life issues.*
 - Have an ethics committee: 86.4% (19/22)

* This data is based on National Health Foundation's 2008 statewide survey of hospitals regarding their palliative care programs, funded by the California HealthCare Foundation.

INTERVIEW QUESTIONS

QUESTION 1. DOES YOUR HOSPITAL'S PALLIATIVE CARE PROGRAM HAVE A SPIRITUAL CARE COMPONENT?

- 21/22 Hospitals reported having a spiritual care component.

QUESTION 1A. IF YES, HOW WOULD YOU RATE ITS PERFORMANCE TO DATE, ON A SCALE OF 1 – 5, ONE BEING POOR, FIVE BEING EXCELLENT?

- Range of answers: 1 - 5
- Mean: 3.78
- Median: 4
- Mode: 5
- Frequency of Rating:
 - 1-1.99: 1
 - 2-2.99: 2
 - 3-3.99: 6
 - 4-4.99: 6
 - 5: 6

QUESTION 1AA. DOES THE HOSPITAL HAVE ANY INTEREST IN STRENGTHENING THE SPIRITUAL CARE COMPONENT OF THE PALLIATIVE PROGRAM?

- For hospitals with a spiritual component, 100% (20/21) are interested in strengthening it. Some of their comments included:
 - To build and develop the resources to help answer the end-of-life questions.
 - To educate staff in spiritual care.
 - To do a better job at documenting what works best for each specific palliative care case.
 - To better work with the families.
- One hospital felt that their spiritual care component was very strong and was not sure what strengthening it could/would entail.

QUESTIONS 1B. IF NO, DOES THE HOSPITAL HAVE ANY INTEREST IN ADOPTING A SPIRITUAL CARE COMPONENT TO THE PALLIATIVE CARE PROGRAM?

- There was one responding hospital without a spiritual component that expressed interested in adopting one. This hospital is licensed for between 100 and 250 beds.

QUESTION 2. WHAT DO YOU THINK ARE THE BENEFITS OF HAVING A SPIRITUAL CARE COMPONENT TO A PALLIATIVE CARE PROGRAM?

Three hospitals indicated that a spiritual component is essential to overall palliative care:

- Key to everything in palliative care
- It is very necessary and often times the most important piece.
- We feel you cannot have a holistic palliative care program unless it has a strong spiritual care dimension.

Of 22 responding hospitals, 12 noted the support it provides for families:

- Provides support to deal with end of life issues
- Palliative care helps address the family's crisis
- Improves the bereavement support services

Of 22 responding hospitals, 20 specifically mentioned the positive impact that spiritual care can have on patients.

Of those 20, half discussed how a spiritual care component addresses or helps meet patients' spiritual needs.

- Patient's spiritual needs, whether they may be related to God or dying, are addressed in a way in which patients' values and beliefs are recognized and respected.
- Palliative care actually opens a window to the patients spiritual needs.
- The care we provide is strong faith-based so patients can have clarity on their religion/spirituality.

Six respondents talked about how spiritual care can help patients make decisions and transition through the hospital.

- Helps patients answer questions such as why, how can I feel comfortable with this diagnosis, what do I do.
- Helps to involve the patients in their own care
- Help them make decisions that are influenced by religious beliefs

Seven respondents discussed how spiritual care can actually impact a patients' symptoms and diagnosis.

- It's symptom management
- The anxiety the patient and family feel is relieved through palliative care
- Improves the healing process; there is evidence that spiritual care is needed to patient recovery
- Makes the care more hollistic; takes in account of the entire human being
- Spiritual issues can have a significant effect on the patient's mood, which affects the outcome of the medical treatment and the patient's quality of life

Six responding hospitals discussed the support that a spiritual care component can provide to the palliative care team, hospital staff and the overall hospital.

- Provides support for our individual staff members who care for patient with difficult situations.
- It results in interdisciplinary care
- It would also support the entire team specifically in moral distress: the staff has differing views on what is the right thing to do. Spiritual care would help reduce those conflicts amongst them.
- Helps by providing additional clinical assessments for patients

QUESTION 3. WHAT DO YOU SEE AS POTENTIAL BARRIERS TO STRENGTHENING SPIRITUAL CARE SERVICES WITHIN THE PALLIATIVE CARE PROGRAM?

Of the 22 responding hospitals, 20 could identify potential barriers to strengthening spiritual care services.

The majority of hospitals identified resources as a barrier. Nine of the 20 hospitals (50%) noted funding as a barrier:

- Any healthcare institution would say that funding is a barrier especially within palliative care. It's a risky environment because of the misconception that the program is fluff rather than "the icing of the cake"
- Funding, funding, funding
- It is also financially difficult to maintain a service that has not been established
- Lack of reimbursement for staff and the hospitals

Eight of the 20 hospitals indicated that personnel resources were a barrier.

- Administrative support for palliative care services
- Increase of personnel; it would allow more time to spend with patients but presently, it is difficult to develop a program with just one chaplain
- Spiritual care is a 24/7 need; however, volunteer chaplains are providing our spiritual care services on a part-time basis

Four hospitals also indicated that not only were personnel resources a challenge – but finding trained personnel can be a challenge.

- Finding professionals that are trained can be a challenge
- End-of-Life Nursing Education Consortium (ELNEC) courses must be broaden to include not just nurses but social workers, chaplains, etc.
- Certified chaplains are currently being stretched in the sense that don't necessarily have the skills for palliative care which could weaken the spiritual care

Two hospitals discussed the need for and challenge of ethnic and faith diversity within a spiritual care component.

- There is so much cultural diversity within the hospital... therefore differing the needed expertise for end-of-life care.

Responding hospitals also discussed the challenges in understanding and educating providers in spiritual care.

Whether because they believe this concept has not been well defined (as two hospitals report):

- Not understanding the spiritual competency definition

Or because of the culture within the hospital (as five hospitals report):

- There is some resistance in the medical world to include spiritual care into the process.
- Staff/clinicians are uncomfortable handling these types of situations. They are not trained or are not fully committed to spiritual care.

- More education needs to be done throughout the staff and with the physicians so that use the spiritual care services for advocacy and pain management skills. Chaplains are not just at the hospital to minister to those that are about to die, but to help families and patients through the comfort care process.

One hospital identified lack of spiritual assessment tools as a barrier and four other hospitals identified barriers specific to their hospital operations and environments:

- The hospital's chaplains are near retirement and visit patients briefly; they don't wrestle the issues that are important to them.
- The only barrier that we have is that because we have so many chaplains here, we have to be careful not to let them walk into patient rooms unannounced. It makes the patients feel like maybe something is wrong.
- After a hospital merger, new staff members are challenged with not knowing their role or having the same patient knowledge.
- The chapel is being relocated; so this could possibly affect patients and family in accessing the chapel.

QUESTION 4. IF PHILANTHROPIC SUPPORT WERE AVAILABLE TO THE HOSPITAL FOR STRENGTHENING THE PALLIATIVE CARE PROGRAM'S ABILITY TO ADDRESS SPIRITUAL CARE NEEDS, WHAT CHANGES WOULD THE HOSPITAL BE WILLING TO UNDERTAKE IN ORDER TO MAKE THE PROGRAM SUCCESSFUL?

Responding hospitals provided a wide range of answers to this question from: "I really don't think any [changes] to be honest; our program is pretty good right now" to "we would be open to almost anything."

One hospital indicated that it would be open to change but didn't identify any specific changes it would be willing to make. Another hospital responded that they would be open to making changes if changes were related to the service's current objectives, if the changes added value to the hospital, and depending on the hospital's required financial commitment.

The remaining hospitals indicated a number of different changes they would be willing to make. Generally speaking, six hospitals reported that they would be willing to provide more support for the palliative care program and/or increase the volume of services provided.

- Provide more support for hospice care
- Provide more support and services for the patients

A few hospitals (2) responded with ideas to strengthen or improve their current palliative care program:

- Develop/strengthen the existing tools to better assess the spiritual needs of patients/families
- Expand/add music therapy

Ten responding hospitals were open to hiring new staff and expanding size of their team, particularly with chaplains and spiritual care providers:

- Have a dedicated chaplain that can assist patients on a more needed basis. If this were the case, these benefits could be extended to all patients.

Three hospitals indicated a willingness and/or desire to train and educate spiritual care staff:

- Complete ELNEC training
- Have chaplains continue with chaplaincy education or go through certification to further enhance the program

Five hospitals responded with changes to train, educate and support other hospital staff:

- "Care for the care providers"
- Most importantly, getting the staff involved and keeping them up to date on the subject
- Implementing significant educational programs including nurse and physician training

Four hospitals reported changes that indicated a willingness to reach out to and work with the community:

- Market the program so that it is more visible to all patients
- We could easily bring in come interns to do training and fellowship here at the hospital
- Opportunities to reach out to the spiritual community to see how they can them or learn as a group to help families cope at home with patients' illness(es).
- Seek out donor support in order to create continual support for the program once there is data supporting change

QUESTION 5. WHAT INFORMATION WOULD YOU NEED TO HAVE TO ENCOURAGE YOU TO SUSTAIN ANY CULTURE, PROGRAMMATIC OR STAFF CHANGES RESULTING FROM A NEW PROJECT?

Almost half of the responding hospitals (10/21) indicated that general programmatic outcomes would help encourage sustainability of any changes resulting from a new project. Just as one hospital said, "I mean did we did something different or better? If we did, then I think we would want to sustain it." Other hospitals put it differently:

- Measure its outcomes and determine whether there is evidence that the program is addressing their well-being
- I would want to know whether or not it was successful. Did we have more families reached? How helpful were the changes to all involved- families, staff and patients.
- Better metrics for measurement of the productivity, quality and value of spiritual services to our patients, their families, our staff and the hospital
- Outcomes of project. Build in some parameter and outcome measurements.
- Outcomes experienced by the child and family
- Development of a pediatric specific spiritual assessment tool: separate from the family assessments
- Identifying best practices

Six hospitals reported that measurements of patient and family satisfaction would help the case for sustainability:

- Get feedback on family satisfaction.
- Narrative and descriptive analysis on behalf of families would be needed to sustain changes.

Three hospitals pinpointed the need for financial outcomes in order to achieve sustainability:

- A financial benefit would be helpful.
- See the return of the investment; financial resources wouldn't be wasted and see the positive and tangible investments/results.

Three hospitals talked about the changes within the staff that would promote sustainability:

- Improvement in the advanced care planning process
- Intensify the presence of staff
- Measuring the satisfaction of employees
- Decrease the moral support on staff
- Main issues would be the culture of the hospital; culture of medicine
- make sure that nurses become certified; train the chaplains to palliative care

Four hospitals provided additional recommendations that were more specific and varied:

- Survey data to determine what it needs to change (hospital uses Avatar as a tool to measure their care)
- Educational/information papers on topics such as: What is spiritual care? How do you access spiritual care? How do you incorporate spiritual care? Practical bedside information that could be understood across the board.
- Measurements that track number of referrals to hospice
- Measurements that track utilization and retention of overall palliative care

QUESTION 6. DO YOU HAVE ANY OTHER THOUGHTS THAT COULD INFORM NEXT STEPS AND/OR THOUGHTS YOU WOULD WANT SHARE WITH THE FOUNDATION?

- The hospital has taken a step involving the spirituality in its palliative care program but would like to see the direction that it is heading.
- Philanthropic support in this area of end-of-life care is crucial. Especially in our setting where physicians are only knowledgeable in what they know and emphasis on the patient's needs outside of treatment/illness is lacking.
- This is very exciting that the foundation is doing this and being supportive of the spiritual care component of our programs.
- There has been an amazing response from patients/families. Expand each component of spiritual care with a social worker or have documentation of the success is highly important.
- The hospital currently has a robust program. They have been approached by neighboring hospitals and have asked for their assistance in developing palliative care programs within their own hospitals. It's important to create collaborations within hospice programs and share experiences with the community to develop palliative care resources within their county.
- Hospital hasn't built their program because of their budget.
- Looking forward to the opportunity.
- I think this is an excellent idea. I think we under-utilize this (spirituality component) as a part of the program. Palliative care is a whole team and I think the chaplain and the spiritual piece is just as important as the nurse and doctor- maybe even moreso.
- There needs to be formal health services outcomes research for spiritual services.

- This discipline needs to be subjected to rigorous outcomes research to understand the added value of these services to health outcomes and thus defining their value. Also, basic professional standards need to be defined for spiritual counselors, along with benchmarks for professional performance, productivity and labor standards. These issues would help advance the profession within hospitals, hospice, nursing homes and other medical settings.
- [We are] excited about the opportunity. Palliative care patient will have a better experience. Hopefully literature will be published that discusses the outcomes.
- It is terrific that funding could become available for strengthening palliative care with a focus in spiritual care. Palliative care requires a blend with the community, not just the patient but the family and other resources.
- Programs need more support within the community; have post-education.
- Currently, the program has grown within the last 2 yrs., however it still needs a long way to go. The spiritual care is very weak presently therefore limiting its full growth potential.
- Glad to know that Archstone Foundation has recognized the spiritual care need; the end of life support is a critical element in palliative care. This area is not well developed is very happy to know that the Foundation is willing to expand this aspect of care.
- CPE programs should be part of the hospitals (currently they have a CPE training program at their facility) and this care should reach all people not just the patient. There needs to be a connection/coordination between ethic consults and palliative care.
- The way that the hospital delivers palliative care is unique; the hospital wants to implement the ELNEC and measure the patient satisfaction.
- Our chaplains are committed to our patients and to the interdisciplinary approach to palliative care; however... the demand of spiritual care services is vast. Our interfaith ACPE Certified chaplains provide services to several units in the hospital.
- Foundation should look into funding of additional staff and education of staff.
- We are very interested in strengthening and committing to having a model palliative care program in the San Fernando Valley, where there are few model programs within hospitals.
- We have received grants on behalf of the Archstone Foundation and we would like to continue to work with them as we have experience for a number of years.

CONCLUSION

This survey was conducted as a precursor to the Archstone Foundation's launch of *Spiritual Care Demonstration Projects*, the goal of which will be to improve the quality of screening and assessing spiritual needs by palliative care teams in Southern California Hospitals, resulting in enhanced spiritual care services to patients and their families.

The survey enabled NHF to collect robust data on the opinions and perceptions of hospital CEOs and palliative care directors regarding the spiritual care component of their palliative care program. In general, the respondents of the survey seemed very familiar and comfortable with the concept of spiritual care and found it very valuable. In general, hospitals rated highly their current spiritual care efforts, but at the same time, expressed interest in the opportunity to strengthen what they have. In particular, respondents were committed to the idea of sustaining demonstration project changes and identified a variety of measurable outcomes, including programmatic, administrative and financial, that could help sustain these changes.

It is anticipated that having the outcomes presented in this report will allow the Archstone Foundation to better understand hospital CEOs' readiness and interest in engaging in *Spiritual Care Demonstration Projects*, and design the components of the projects in order to maximize adoption and sustainability.

If this type of survey is conducted again, NHF has identified one significant lesson learned. From the outset of this project, NHF tried to directly engage CEOs in this survey. In the future, it might be advantageous to engage the palliative care director as the primary contact. Because these directors are, generally speaking, very passionate and committed individuals, they could help provide access to the CEO.

Based on the survey responses, the Archstone Foundation's proposed activities seem timely and of merit given the interest expressed in spiritual care.