SPIRITUAL CARE PILOT STUDY
Alice Peck Day Extended Care Facility

October 16, 2006 — April 12, 2007

FINAL REPORT

JEANNE CHILDS, Spiritual Care Provider
8 Bacchus Circle, Hanover, New Hampshire 03755
(603) 643-4440
PILOT STUDY — FINAL REPORT  
Alice Peck Day Extended Care Facility, Lebanon, New Hampshire  
October 16, 2006 — April 12, 2007  

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The SPIRIT Program™
EMERGING NEED

In long-term care facilities today, there is new recognition of the need for consistent Spiritual Care. Clergy visits and services are the primary point of delivery. Staff is encouraged to support residents, and family/friend visits are vital to the morale of the elderly person. Yet all of the above can and do fall very short in meeting true needs. The all-too-frequent reality is that clergy visits can be quite random and benefit only a few as some residents do not define themselves as religious and/or do not identify with a denomination. The demand on staff time is often stretched too thin to provide attentive, skilled listening. Busy families and friends, even if they visit frequently, are often too personally involved to meet the spiritual needs of their elder relative.

“The need for spiritual care is crucial at the twilight of life. Issues arise for the elderly that focus on life and death, meaning and purpose, and loneliness and loss, which are often magnified in institutional settings ... removed from familiar surroundings and the supporting social environment where their individuality was confirmed and reinforced daily as a husband, wife, mother, father, sister, brother, or grandparent.” The spiritual care provider “…can be particularly effective in helping the resident adjust to their new surroundings and status, relating to each resident as an individual, allowing him or her to express hopes, aspirations, anxieties, guilt, disappointments.” Spiritual care “… needs to affirm all persons’ spirituality, even those who profess no particular religious faith ... who may nonetheless have a deep sense of spirituality. (AARP Guidelines from the Interreligious Liaison Office, 1989.)

“With inclusion of definitions and standards for chaplaincy in Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) procedures has come pressure for chaplains in long-term care facilities to assess, plan, treat, and document spiritual care. (Chaplaincy Today “Spiritual Care Treatment Trees Designed to Meet JCAHO Standards for Long-term Care Facilities” by Hall and Bates)

SPIRITUAL CARE

Spiritual Care is actually care for the spirit of the individual. Spiritual Care as recommended for long term care facilities differs markedly from psychological treatment, medical/physical care, random clergy visits, and family/friend visits.

A Spiritual Care Provider offers committed, one-on-one, unhurried time to residents. It is characterized by undivided, non-judgmental, skilled listening. A person trained in providing Spiritual Care will draw out a person gently in a friendly, open, calm way by “showing-up” routinely and building a supportive relationship. She will engage and listen deeply to what the resident says, the meanings, tone and pattern, facial expression, the feeling beneath the words, what may be implied, and what may be left unsaid. Skilled response to what is heard at this depth can and usually does tap the resident’s spiritual resources to help the body, mind and spirit resolve unrest and come to terms with whatever issues are present, bringing hope and a sense of well-being. Life is enhanced through concern for the total person.

The content of the visits is based solely on what the person leads the provider to in themselves, from joking, to reminiscing, to raw grief. I have been taught to follow the lead of the person I am visiting, reflecting back what is heard, sometimes helping them reframe, and, hopefully, come to peace with the difficult adjustments so rampant at their stage of life. There is no religious agenda, proselytizing, or instruction; any belief content is that which is brought by the resident as having meaning for her/him. I am entirely focused on helping them touch and draw strength from their own sources of empowerment.
Among the challenges faced by residents and addressed by spiritual care are the following:

**LOSS** - of a beloved home, pet, community, friends, way of life, freedom (drivers license).

**GRIEF** - the death of a partner or friends/family members. Or grief associated with declining health, sight, mobility.

**DIMINISHED CONTROL** - the agony of no longer feeling in charge of oneself, one’s body, one’s daily schedule, one’s possessions, one’s privacy, and the resulting diminishing sense of self.

**WORRY/ANXIETY** - With all of the above can come a pervasive sense of worry. Little things take on immense importance because of the vulnerability of the person. Even small disappointments or misunderstandings can feel cataclysmic to the resident.

**LONELINESS** - New surroundings, shyness, lack of friends or the ability to make friends, family faraway … any of a wide variety of situations can produce feelings of isolation.

**MISERY and DESPAIR** - Any of the above can cause misery and despair when the person fails to find anything to give him or her hope.

**RESENTMENT or ALIENATION** - These conditions are not uncommon when people move into a facility and meet change and relationship challenges. Jealousies, power and control issues, and inevitable disappointments can lead to toxic discontent, lack of cooperation, and other difficult behaviors.

**END OF LIFE ISSUES** - Feelings about meaning, legacy, regrets, forgiveness, faith, suffering and death itself may need to be explored and resolved.

**BENEFITS OF SPIRITUAL CARE TO THE INDIVIDUAL**

It has been estimated that 80% of what upsets people can be profoundly alleviated by the skilled listening methods I have been taught. Giving undivided attention, drawing out interests, providing non-judgmental reflection and empathy, can be enormously powerful in validating and reinforcing a person’s sense of self. But even more importantly, when the person is in distress such as produced by grief, loneliness, isolation, confusion, ill health or fear, skilled reflective therapeutic listening can be crucial in helping that person work through his/her process successfully and emerge to enjoy life more. Not emerging from such periods can lead to emotional and physical decline, clinical depression, and other serious conditions.

Spiritual care can go a long way in preventing such sad and needless outcomes. Concerned, focused, attention to a resident’s spirit has produced results such as the following:

- positive adjustment to the facility, - relief from depression,
- resolution of old and ongoing grief, hurt, and loss, - reduction in medications,
- visible evidence of thriving - less sickness,
- interest and participation in group activities, - less isolation,
- inner well being, happiness, - pursuit of interests,
- the ability to achieve satisfaction
BENEFITS TO THE FACILITY (Bottom Line)

Happier, more well-adjusted residents can benefit the facility’s bottom line in many ways:
- fewer “problem” residents (energy drains on staff; bad community morale)
- fewer “calls” on nursing staff (time drains on staff)
- potentially less turnover of nursing staff (reduction in burnout factors such as the two above. If elected, the option of spiritual care for staff can help diffuse stress and reduce burnout)
- less dissatisfaction contagion (drain on community spirit)

Having a Spiritual Care Provider available affords the facility a unique marketing position. What other facility do you know that provides spiritual care?
- the program can be used in marketing and further distinguishing your facilities;
- family members as well as residents can be assisted in their processes;
- grief support can be provided in cases of terminal prognosis or death;
- presentations to local community groups can be made, which generate interest and reflect positively on the facility;
- articles for related professional journals can be written and presentations at professional conventions made, putting the facility’s “ground-breaking” services on the map and generating press release and promotional opportunities.

Additionally, the Spiritual Care Provider could be helpful to the activities department by
- providing suggestions for activities that emerge from in-depth resident contact;
- providing suggestions and/or actually leading activities that have a self-empowering, spirit enhancing focus for residents. Note: the group activities would have varying themes and grow out of the interests of the participants. Further, they could be conducted in such a way that all members felt valued, could easily participate, and could build relationships with each other.
- providing nondenominational services should clergy not be available (I have both training and experience in doing this.)
- providing small group classes/discussion for residents, staff and/or families on such topics as skilled listening.

Finally, the opportunity to capture compensation for more staff hours to pay for the spiritual care program exists.

PILOT PROGRAM PROPOSAL

Pilot Study Plan:
The facility director would meet with Jeanne to determine what questions are we looking to answer with this Pilot? Possibilities include effects on residents, effects on staff, effects on family members, needs discovered, delivery issues, marketing potential, continuing costs and cost defrayment options, program expansion potential (other facilities, staff, family), community involvement potential.

Duration:
A Pilot Program of three or four months in duration depending on the population to be served. It is suggested that one-two days a week be chosen for Jeanne to come to the facility during the best hours recommended by the director and nursing staff there. That day would primarily involve spontaneous interaction with residents, meaningful group activities (such as services) as determined with the facility director, and one-on-one visits by Jeanne.
NOTE: Included in her “day” would be necessary visits outside the allotted time, such as serious illness, impending death, transfer to the hospital or CCF, or special community events, and presentations to outside or inside groups.

**Introduction and Participation:**
The best way to introduce the program to the residents would be determined. A soft approach is recommended and would involve personal introductions by a trusted contact person, perhaps a flyer to residents and staff describing the services, presentations to staff and possibly residents.

**Integration:**
An integral part of the program would be that Jeanne be part of the community and very visible to facilitate familiarity. She could attend a meal on her appointed days, affording the opportunity to interact and build relationships with residents. She could join the nursing staff on some occasions to build relationship/community with them also.

**One-on-One Visits:**
Jeanne will conduct these visits during each scheduled day’s service. This could happen on a sign-up, referral, spontaneous and/or availability basis. Jeanne has been well trained and is experience in initiating contact, building trust and cultivating relationship.

**Spiritual Assessment and Care Plans:**
Jeanne would prepare a spiritual assessment and care plan for each participant. She would take notes and confer (as determined in the pilot program plan) with the administration/nursing staff.

**Privacy:**
All privacy and confidentiality regulations would be strictly observed.

**Feedback:**
A way to gather feedback from administration and staff should be identified and such feedback collected.

**Final Summary of Findings:**
At the end of the pilot program, Jeanne and administration will produce a summarization of findings. It will include all detail determined to be included in the pilot program plan. This data can then provide the basis for evaluation, continuation and modification of the spiritual care program.

**Cost:**
A one-day per week, six-month pilot program costs $2280.

**Supervision:**
Jeanne will secure and pay for all her costs during the Pilot Program, including the cost of her supervision as a spiritual care provider.
APD PILOT STUDY PLAN — AS ACTUALIZED

PURPOSE STATEMENT:
This pilot is a Qualitative Study
  (1) to discover if providing dedicated, regular, consistent compassionate
      spiritual care to residents will impact their inner well being positively
      and enhance their quality of life.
  (2) to discover if the above will impact positively the well being of the
      ECF unit as a whole: overall program, staff, resident’s families.

DURATION:
The Study commenced on October 16, 2006 and concluded on April 16, 2007.

TERMINOLOGY:
Spiritual care, pastoral care, chaplaincy are all terms used to refer to that particular type of care
which attends the inner spirit of a person. In this pilot study, it is offered to people of all faiths or
of no religious affiliation, and no church interests are involved.

METHODOLOGY:

  (1) Provider/Duration: The Spiritual Care Provider (SCP), Jeanne Childs, provided
      spiritual care to residents of the unit 12 hours per week for six months.
  (2) Method of Delivery: Service was delivered primarily one-to-one. On Dec. 7, 2006, a
      once-a-week group spiritual care intervention was implemented in response to perceived
      resident spiritual needs.
  (3) Documentation: Documentation of resident visits was provided in a privacy-
      secured NOTEBOOK which was made available to persons designated by the
      Administrator.
  (4) Stages: The study consisted of two stages as follows:

Stage One: Preliminary discovery (2 months)
  a. THE ECF UNIT
     - SCP attended APD Orientation.
     - SCP discovered the “culture” of the unit.
     - SCP met and interacted with staff persons; learned about their roles.
     - SCP became aware of and complied with special regulations, systems,
       procedures, practices and processes of the ECF, as directed by the
       Administrator and as observed in interactions.
     - SCP discovered how to interact effectively within the ECF team.
     - SCP discovered a reporting strategy which met service team’s needs.
- SCP discovered a reporting strategy which met service team’s needs.
- SCP participated in bi-weekly service team meetings.
- SCP explored with the team her role expectations and processes.
- SCP prepared a draft of the study plan to the Administrator. They refined and formalized it, and prepared evaluation surveys.

b. RESIDENTS
- SCP did not have access to patient records. Her relationships with residents was developed by discovery.
- The Administrator provided specific information and direction to the SCP at her discretion regarding residents, and the regulation/policies of the unit.
- SCP solicited specific visit referrals from the Administrator, Director of Nursing, Social Workers, and the Activities Director. She asked for case consults with all of the above as needed.
- SCP followed-up on referrals and initiated contact with other residents at random, building familiarity, relationship, and trust. This included introducing herself and her role, engaging and listening deeply to what each resident disclosed about his/her state of mind, adjustment, concerns. She formulated preliminary spiritual assessments and explored/provided appropriate spiritual care interventions.
- SCP wrote brief narrative summaries of these visits in the NOTEBOOK specifically kept for this Pilot Study at the nurses station. As she was not privy to medical records, all observations were offered to the team, trusting their judgment to determine merit and relevancy to residents’ overall plans of care.
- SCP explored opportunity for group spiritual care.

Stage Two: Plan Refinement & Continuation (4 months)

a. PLAN ADJUSTMENTS
- The Administrator prioritized a list of residents for visits by the SCP, thus making the study list of participants more manageable.
- Designated Service Team members conducted the first resident survey to determine study effectiveness thus far.
- The Service Team members each completed a survey of their observations and evaluations of the pilot study thus far.
- SCP authored and distributed to Service Team members at bi-weekly meetings one-page handouts on various aspects of spiritual care and the pilot study. This was offered at the suggestion of the Administrator as inservice education and clarification around the subject of spiritual care and the role of the SCP.
- SCP designed and conducted a weekly group spiritual care intervention, Spirit Hour™.
- SCP conducted Spiritual Needs Self Assessments with residents.

b. PLAN CONTINUATION (as in Stage One)
PILOT STUDY CONCLUSION

(1) Service Team members conducted the final resident survey of pilot study effectiveness. Surveys were delivered to Administrator.

(2) Surveys were distributed ECF staff to obtain staff observances and evaluations of pilot study. Surveys were turned in to Administrator.

(3) The Administrator created spreadsheets to display results of all surveys.

(4) SCP prepared draft of final pilot study report and delivered to Administrator. Contents included the Proposal, the Study Plan (as actualized), a Statistical Report, SCP’s Final Report, Conclusions and Recommendations; Staff Education Handouts; Other Relevant Information.

(5) Administrator added spreadsheets of all survey results and her final report and recommendations.

(6) The complete report in individual notebooks was presented by Pilot Study Investigator/SCP Jeanne Childs and ECF Administrator Liz Pomeroy to APD President/CEO Harry Dorman, and Trustees Closey and Whit Dickey (pilot study funders) and Roney Hoffman.

COST/FUNDING:
The study was funded for one day per week for six months ($2,280) at eight hours a day.

ADDITION OF DHMC CPE RELATIONSHIP:
Unexpectedly, the Chaplaincy Department of Dartmouth Hitchcock Medical Center offered SCP Jeanne Childs an unsolicited scholarship to participate in an advanced unit of Clinical Pastoral Education (CPE). Since this included clinical supervision for Jeanne (one hour every two weeks), the opportunity for additional study of spiritual care to the elderly, and the mentoring of an established chaplaincy department, it was deemed to be an exceedingly positive enhancement to this study at the ECF. It was determined that the dates of the Pilot Study would coincide with the dates of the CPE Unit. DHMC executed a site agreement with APD and provided “internship” liability insurance. DHMC also provided the required immunizations for the SCP. Another advantage in accepting this partnership was that the CPE internship required 12 hours of clinical practice per week (300 total). Therefore, at no extra charge, ECF residents received four more hours per week than were funded, creating a very generous amount of time to explore the purposes of this study. This contribution by the DHMC Chaplaincy Department is most gratefully acknowledged. This extra investment of time and effort by the ECF Administrator is also most gratefully acknowledged.

Finally, the study was morally and financially supported by Whit and Closey Dickey, whose passionate involvement with Alice Peck Day Health Care System is legendary. Their vision and commitment coupled with Harry Dorman’s leadership in spearheading this study is profoundly acknowledged with gratitude.
RECORDED ONE-ON-ONE VISITS

- Total number of one-on-one visits 297
- Number of individual residents visited overall 52
- Normal length of visit 50 min
- Range of time spent with each resident per visit 15 min - 1.5 hours
- Range of visits per resident 1 - 25
  1-5 : 34  6-10 : 10  11-15 : 4  16-20 : 3  21-25 : 1

UNRECORDED VISITS

- “Hallway” visits ... average per week 12
  Time range/topics ... 5-10 min. check-ins/pleasantries
- “Small Group” visits ... in activities room and resident rooms 5
  Time range/topics ... 10-30 minutes; residents introduced to each other; engaged in group conversation; various topics.

GROUP ACTIVITIES

- Spirit Hour ... number held 18
  Attendance range 12 - 20
  Number of individual residents winning bouquet centerpiece 27
- Activity Room Design Group ... number held 5
  Attendance range 2 - 8

OTHER ECF ACTIVITIES ATTENDED

- Rosary 1
- Communion 1
- Memorial Service 1
- Christmas Party 1
- Band/Ice Cream Social 1
- Pancake Breakfast 1

OTHER SERVICES PROVIDED

- Christmas ... special Spirit Hour 1
- Easter ... ecumenical service 1

SACRAMENT OF THE SICK REQUESTS FACILITATED 3

DEATH’S ATTENDED (immediately after) 1
Typical Content of One-on-One Visits

- The content of the visits is based solely on what the person leads me to in themselves from joking, to reminiscing, to raw grief. I follow the lead of the person I am visiting, joining them, reflecting back what is heard, sometimes offering a reframe, or summary, or clarifying question. This is a process of affirmation, companionship, and integration.

- I support whatever belief content is brought by the older person as having meaning for her/him. This may be religious or not religious. It may be Christian and it may be something else. My training includes supporting the diversity of faiths among people, as well as persons who do not identify with religion.

- I am entirely focused on helping them touch and draw strength from their own sources of empowerment.

- Through this respectful, attentive process, life is enhanced for the total person.

Representative Spiritual Issues of Residents

- **Family relationships:** gratitude for family support, concern of being a burden, dislike of certain family members, sadness at not having company, sadness at death of family members, missing someone dead, worry about family members.

- **Inner concerns:** difficulty with self-forgiveness, not wanting to be here, not wanting present physical condition, confusion about current circumstances, just coping day-to-day, boredom, loneliness, desire for company, insecurity about status (guardianship, medicare)

- **Fears:** of staff, of other residents, of becoming like certain other residents, of what else might happen to them physically or mentally, of what the end would be like

- Desire for death

- Pain/discomfort

- Need to pay for sins

- Being buried in the ground

- Not having any religious beliefs, hence, inner questioning about meaning

Examples of Spiritual Assessments Used With Residents

- Life histories (including spiritual)

- Open-ended questions

- Using pictures and room decorations to invite comment

- Listening in conversational dialogue for indication of spiritual needs/strengths
• Continuum scales
• Sentence completion techniques
• Several assessment tools learned in Chaplaincy training
• Personal Values Card Sort
• Observations: behavior, reactions, emotions in halls and activities room, and one-on-one.
• Observations offered by family members and facility staff
• Small group conversations
• Spiritual Needs Self Assessment (which I designed; results in Section 3)

Examples of Interventions with Residents

• **Reminiscence:** Resident recounts past life events; I integrate, affirm, celebrate.
• **Reframing:** Finding alternative ways to look at circumstances.
• **Transcendence:** Rising above the present circumstances and altering the status quo even if limited to one’s own attitude toward the unavoidable; prayer.
• **Connection/Community** - Spirit Hour™: Important for getting beyond yourself, being validated, fun, being with others and learning about them, understanding a bigger picture, overcoming isolation, developing compassion, and other social/self esteem/hope benefits.
• **Non-verbal Pastoral Presence/Companionship:** Sitting empathically with someone while they cry, holding a hand, giving a hug, showing in expression and by sounds that you are fully with them and are responding with human caring.
• **Faithful Pastoral Presence/Companionship:** The act of showing up faithfully to give one-to-one, undivided, non-judgmental, attention to the spirit of another person.
• **Prayer and Blessing:** “One does not need to be religious to pray effectively or to benefit medically from prayer.” (Dossey, 1996)
• **Communicative Care:** Conversation to provide a sense of connection. I did this with residents who had dementias, residents with speech loss, and other residents, one-to-one, in small group “conversations”, and in introductions to each other.
• **Healthy Relationship:** Acknowledge the person by name, often, with respect.
• **Genuine Pleasure, Affection and Acceptance:** Connect with their capacity to feel.
• **Faith Support:** Recite together old familiar prayers.
• **Alert Response to Changes:** Notice / acknowledge sudden discomfort or cognitive change. Reading body language and non-verbal communication.
• **Activities for those with Speech Impairment:** Find ways to enable them to feel relationship and connection which does not involve speech, e.g. puzzles, special projects, games, listening to music. Through such experiences, isolation is bridged and a sense of meaning and hope can be engendered.
Representative Controls Used

- **Environmental Controls:** Seek a quiet place to visit. Turn off the TV. Make sure I am at eye level so my face can be seen.
- **Trust-building Controls:** Introduce myself by name and role. Call person by name. Convey respect, genuine interest; validate them no matter what state they are in.
- **Verbal Controls:** Use a calm, low-pitched voice and take my time speaking. Use short words and short simple sentences. Agree on and honor visual symbols for “Yes” or “No”. Ask one question at a time. Give plenty of time for response.

Representative Spiritual Issues with Families (came up a few times)

- Hate to see relative this way
- Dying/death of relative
- Devastation at family members room change. Never consulted.
- Peace of mind at having relative here

Representative Consults with Health Care Team

- Pain (paying for sins) belief of one resident
- Roommate issue of one resident
- Discussing sadness of family background with one resident
- Scale drawing project for one resident
- Advisability of Spirit Hour for one resident (attendance/spotlighting)
- Suggestions to honor independent spirit of one resident with off-site activities
- Safety of candy in room of one patient
- Appropriate people to spotlight in Spirit Hour
- Plus numerous questions at beginning of Pilot regarding appropriate touch, who to visit, role, feedback loop, etc.

Examples of Exchanges with Staff (at lunch, in passing)

- Answered questions about Spirit Program, spiritual care, pilot study.
- Gave moral support to tired and discouraged staff members.
- Gave support to staff member saddened with serious condition of resident.
- Thanked various staff members on numerous occasions for their support, care of residents, helpfulness.
- Listened and gave spiritual encouragement to one staff member with personal problems.
SPIRITUAL CARE PILOT STUDY
Alice Peck Day Extended Care Facility

Highlights: Spirit Hour
Community Intervention

Designed to meet the following spiritual needs:
- Dignity
- Recognition
- Personal validation
- Celebration with others
- Shared meaning
- Support
- Community (bridging isolation)
- Healthy relationship among residents
- Relaxation: with music, refreshments; “hanging out” together.

Typically included the following:
- Self introductions and a brief answer to “How is your spirit today?”
- Spotlighted 9 individuals; background/photos shared; 7 were assisted by a family member.
- Participant sharing: cards, photos, framed sayings, poetry, brief stories, jokes.
- Jokes (usually provided by Jeanne)
- Inspirational piece (usually provided by Jeanne)
- Floral centerpiece drawing (everyone eventually won because “all are winners.”)
- Non-denominational blessing (by Jeanne)
- Individual blessings (participants blessed each other going around the table).

Some observations:
- Attendee attention usually “riveted” on the longer bio presentations by family members about their resident.
- Lots of spontaneous applause for each other, e.g. after each self-introduction, for one person who spoke his name for the first time in the group, after sharings.
- Exchange of room number between a new resident and a old one after post Spirit Hour conversation between the two.
- Hand holding between residents at end of Spirit Hour (many instances).
- One resident going around to others to bid good-bye when she leaves.
- One resident going up to daughter of one resident after spotlight saying “It is a privilege to hear about your mother.”
- One resident stopping another in the hall to say how much she enjoyed hearing about him in Spirit Hour.
- One resident telling another to shut up during Spirit Hour.
- Family members being very happy to come and participate and meet other residents (I always introduced them around the room).
- One resident who has dementia and never participated before, becoming very animated after Spirit Hour in small conversation.
- One resident who has dementia and never evidenced awareness, opening her eyes and said “Oh!” in delight, and “Thank You! upon winning the flowers.
“SARAH”
Religiously devout person. Suffering much pain. Believes that she must suffer for her past sins even though she cannot remember them! “I just don’t know when I did all this sinning!” Red flag for me: was her medication PRN? Was she refusing it because she believed he HAD to continue suffering? Asked for consult with Nursing Director who felt that was valuable input and looked into the treatment plan.

“STANLEY”
Right side of body paralyzed by stroke; severe speech impairment. No religious beliefs. Mighty resistance to current physical situation and deep grief. Had been an action person. Aversion to philosophical discussion or transcendence talk. Aversion to most group activities. ECF was considering renovations. Received permission to work with this resident creating a scale drawing of the Activities Room and coming up with furniture layouts. This intervention was intended to engage the person by means of prior interests, validate the person in the here and now, generate opportunity for more creative involvement in the future. Although an activity, it was a spiritual intervention because it involved addressing the resident’s deep spiritual needs: helping the resident realize and draw on inner strengths, creating a new identity with the present, and helping thwart a possible decline into despair. Interestingly, several other residents joined us in the drawing sessions, becoming interested in the project and in “Stanley”. This resulted in small group discussions and visits to each other’s rooms to see photos on bulletin boards, therefore meeting a social need unexpectedly. Another nice result was personal validation for “Stanley” by the ECF Administrator and Activities Director, with interest in having him contribute to future projects. This resident also became willing to share his story in a Spirit Hour™ with his daughter’s help.

“AGNES”
End stage Parkinson’s resident who also suffered stroke. Could not speak but made unintelligible guttural sounds which family said was resident’s form of speech. Family also reported that resident was very conscious of what was going on. Pastoral care plan consisted of visits which included a lot of direct eye contact, with reports of what was happening outside (weather, events, etc.), affirmation of the resident, references to things family members had revealed about her life and interests. The primary intent was acknowledgement and validation of the person who was locked inside, bridging isolation, and offering companionship. Resident had explored many religions according to family members, but ultimately became an atheist. Therefore, an effort to connect with her philosophical background included a wide assortment of deep thinkers, as well as Robert Frost, who connected with her farming and nature background. I observed other residents avoiding contact with this resident in the common areas. In an effort to bridge this perceived isolation, I asked her daughter to share her story at Spirit Hour™. The result was a personalizing of this resident to the point that another resident reacted by saying to the daughter “It is a privilege to meet your mother.” I did observe that it was subsequently easier to have small group discussions include this resident’s presence, and a few people actually went up to speak to her.
“HAZEL”

This resident has cognitive impairment. She was one of several who vividly demonstrated to me that communicative connection is not dependent on the content of our exchange. Letting go of logic, one can hear amazing imagery coming from them, which may open into a world of new comprehension. “Hazel” referred a lot to the navy. She had not been in it and had no relatives in it. We talked more and I asked why she talked about the navy. She said “you don’t know where you are.” I asked her if she felt adrift ..... at sea ..... sometimes. She did! Her imagery brought me into her world, a world she was not familiar with and was trying to comprehend. We joined in that imagery. I have begun wondering about all that does come up in life reminiscence and how perhaps it too is imagery for something far deeper in the person. No story, no matter how many times I have heard it, is insignificant to me now. I am listening. I am looking in the teller’s eyes. I am wondering with them about what they are responding too in that imagery.” The point is to connect somehow with where that person is, so they can experience “communion” with another friendly soul.

“PENNY”

This resident has end stage Parkinson’s and stroke. Although her body was very rigid, it became apparent as she struggled to speak that her mind was very engaged and active. We enjoyed a great deal of communication by using a lot of guessing on my part and “yes”/“no” response on her part. However, I noted that her desire to say more would often produce great frustration. In an effort to be together in a less-exhaustive way, we stumbled on two extremely pleasurable activities. We sat for over 30 minutes one day in the hallway, intercepting slowly moving wheel chairs as they rounded the nursing station, and telling the occupants that they were “Cleared for take-off” down the west hall. The surprise and glee that this silliness provoked was very satisfying and all parties had a wonderful time! On another occasion we simply held hands and watched an Animal Planet program about orphaned baby grizzly bears being raised by a loving couple. There was a lovely sense of “communion” and enjoyment as she would make sounds of pleasure (or I would) at the adorable antics of these creatures. Spiritual companionship resulted.

“JENNIFER”

Estrangement and/or strained relations with family surfaced as a point of unrest in several resident’s souls. During nearly every visit, “Jennifer” brought up her relationships with two grandsons: one positive and one negative. This issue clearly was on her mind. To help her explore it, I asked questions which dealt with these relationships, and previous ones in the family, from several different angles. During our relationship, I did see “Jennifer” break through quite a few restrictive thoughts she had about other people. However, when we parted, this particular one remained unresolved and very much on her mind. I am left wondering at the toll it takes on one’s inner peace to have ongoing labor with inner grievances such as this.

“JAMES”

This resident was the soul of kindness to others. His life reminiscences always revealed a high sense of values and dedication to doing what was right, including defending the underdog. I pointed this theme to him; he paused and integrated it by remarking, “It is because I truly understand what it is to be bullied.” I also observed to him how unmerciful he punished himself for what he perceived as “bad” past acts. He was unable to budge from feeling terrible about them. Finally, I used his own humor on him, daring him not to even consider forgiving himself. As of our last meeting, I do not believe he reneged; but he did laugh about these events! Some shift had happened.
**SPIRITUAL CARE PILOT STUDY**  
Alice Peck Day Extended Care Facility

<table>
<thead>
<tr>
<th>Value:</th>
<th>Resident needs as expressed by <strong>them</strong>; valuable perspective for planning.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>How important is <strong>God</strong> in your life right now?</td>
<td>Don’t know/understand question</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Not important</td>
<td>0</td>
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<tr>
<td></td>
<td>Somewhat important</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very important</td>
<td>14</td>
</tr>
<tr>
<td>How important is <strong>religion</strong> in your life right now?</td>
<td>Don’t know/understand question</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Not important</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Somewhat important</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Very important</td>
<td>13</td>
</tr>
<tr>
<td>How important are <strong>your values</strong> in your life right now?</td>
<td>Don’t know/understand question</td>
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</tr>
<tr>
<td></td>
<td>Not important</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Somewhat important</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Very important</td>
<td>12</td>
</tr>
<tr>
<td>How much <strong>hope</strong> does your spirit have?</td>
<td>Don’t know/understand question</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>A little</td>
<td>5</td>
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<tr>
<td></td>
<td>A lot</td>
<td>9</td>
</tr>
<tr>
<td>How much <strong>meaning</strong> and <strong>purpose</strong> is in your life right now?</td>
<td>Don’t know/understand question</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>1</td>
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<tr>
<td></td>
<td>A little</td>
<td>4</td>
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<tr>
<td></td>
<td>A lot</td>
<td>10</td>
</tr>
<tr>
<td>How much <strong>peacefulness</strong> is in your spirit right now?</td>
<td>Don’t know/understand question</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>A little</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>A lot</td>
<td>9</td>
</tr>
<tr>
<td>How <strong>well-adjusted</strong> do you feel to this stage of life?</td>
<td>Don’t know/understand question</td>
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</tr>
<tr>
<td></td>
<td>Not at all</td>
<td>0</td>
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<tr>
<td></td>
<td>Somewhat</td>
<td>3</td>
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<tr>
<td></td>
<td>Very adjusted</td>
<td>12</td>
</tr>
<tr>
<td>How helpful are Jeanne’s <strong>visits</strong> to you at this time?</td>
<td>Don’t know/understand question</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Somewhat</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Very helpful</td>
<td>12</td>
</tr>
<tr>
<td>How helpful is <strong>Spirit Hour</strong> to you?</td>
<td>Don’t know/understand question</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Somewhat</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Very helpful</td>
<td>10</td>
</tr>
<tr>
<td>Do you feel <strong>connected with people</strong> here?</td>
<td>Don’t know/understand question</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Maybe a little</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>7</td>
</tr>
</tbody>
</table>

(Note: two residents had never attended and could not respond.)
Additional Resident comments, suggestions, observations:

- Attends communion: (5)
- Attends rosary: (5)
- Attends Sunday services: (4)
- Watches church on TV: (2)
- “A lot (of peace) was lost.”
- “(well adjusted) at this particular time; can change.”
- “(Jeanne’s visits) doesn’t hurt any”
- “Read as much as you can of my life.”
- “Want you to pray with me.” (4)
- “I can’t do very much” (values)
- “I want to go to heaven now.” (on hope)
- “It’s a real challenge just to live!” (on the issue of being adjusted)
- “I don’t like to make trouble”
- “Prayer helps me cope.”
- “(Religion) helps me be stronger.”
- “I can tell you things I can’t tell other people.” (on Jeanne’s visits)
- Considers recognizing all the other people “… all that counts. This is our home!”
- “It’s hard to live in a place like this … as peaceful as I can be here.”
- “(adjusted) because I have to be here. If you are dealt lemons you make lemonade.”
- “I am a very private person. Sometimes I do not feel like talking.” (on Jeanne’s visits)
- Enjoyed a clergy visit she had once.
- Feels connect to some of the staff.
- Had a relationship with a resident but “she’s changed.”
- “Would not be here without God.”
- Hard to feel connected here; people change a lot.
- Life is ok but he is not where he wants to be.
- Is Unitarian. “They don’t have that service here.”
- Children and family are her meaning.
- Loves to be with people and help.
- “No complaints whatsoever.”
- “When you come through that door I say ‘there is an angel’.” (on Jeanne’s visits)
- Would like a clergy visit
- “Prayer is very important to me.”
- “Your visits help me with adjusting.”
- Don’t know many (people), but few she does she is friendly with.
- “I don’t have a lot of ambition!”
- Spirit Hour good for companionship, mostly fun!
- My religion helps me cope.

NOTE:
For future planning purposes, a summary of gaps in spiritual care as provided at the time of the Pilot Study could be provided by Jeanne as a result of her many conversations with residents.
SPIRITUAL CARE PILOT STUDY
Alice Peck Day Extended Care Facility
Resident Evaluation
(Mid Point - 18 respondents)

What effect have Jeanne’s visits had on your spirit?

8 (don’t know) 1 (none) 5 (pretty good) 4 (really good) NA (0)

What effect on your spirit has “Spirit Hour” had?

6 (don’t know) 1 (none) 6 (pretty good) 5 (really good) NA (0)

Have you changed any attitude or behavior because of Jeanne’s visits or “Spirit Hour”?

2 (don’t know) 11 (none) 4 (a little) 1 (a lot) NA (0)

How much support does your spirit need right now in coping with your life?

3 (don’t know) 5 (none) 8 (a little) 2 (a lot) NA (0)

Comments, suggestions, observations --- or questions:
- She makes you think too much - I don’t like it.
- She’s doing a wonderful job.
- I get support from my family and staff here.
- It must be a lot of work to do what he does. I like her.
- She’s doing a wonderful job.
- It’s important to everyone. The longer she’s here, the more people come.
- She’s more important to me each week.
What effect have Jeanne’s visits had on your spirit?

6 (don’t know)  0 (none)  4 (pretty good)  7 (really good)  NA (3)

What effect on your spirit has “Spirit Hour” had?

9 (don’t know)  0 (not good)  2 (pretty good)  5 (really good)  NA (4)

Have you changed any attitude or behavior because of Jeanne’s visits or “Spirit Hour”?

3 (don’t know)  8 (none)  1 (a little)  5 (a lot)  NA (3)

How much support does your spirit need right now in coping with your life?

3 (don’t know)  4 (none)  5 (a little)  5 (a lot)  NA (3)

Comments, suggestions, observations --- or questions:
- I think it’s great! Visits have made me happier. She’s a very cheerful lady.
- She’s a nice lady. I like her. (Resident had difficulty articulating anything else.)
- Resident wasn’t sure who Jeanne Childs is.
- I like her very well. My spirit is good. I don’t change.
- She is reassuring to all of us because she brings us a smile and good cheer to people who need it.
- Resident couldn’t remember who Jeanne Childs is.
- I enjoy her visits.
- I like her. She conducts a nice meeting. She gets people to talk. Face to face has been helpful.
- She does a very nice job. She visits people and some people really need it. I think it works out very good. She is considerate. She responds to people’s needs and I think that’s great.
- She does a good job. It helps.
- She makes me feel very peaceful.
SPIRITUAL CARE PILOT STUDY
Alice Peck Day Extended Care Facility

Staff Evaluation
(Mid Point - 5 respondents)

Rate the need, in your opinion, for Spiritual Care for the Residents at the ECF.

0 (don’t know)  0 (none)  3 (maybe a little)  2 (a lot)

Rate any impact on residents’ quality of life you may have observed from Jeanne’s Spiritual Care Visits to residents.

0 (don’t know)  0 (none)  2 (somewhat helpful)  3 (positive)

Rate any impact on resident quality of life you may have observed from “Spirit Hour”.

1 (don’t know)  0 (none)  1 (somewhat helpful)  3 (positive)

Rate any impact (direct or indirect) on you from the Spiritual Care Program?

0 (don’t know)  0 (none)  3 (somewhat helpful)  2 (positive)

Rate any impact Jeanne’s educational handouts have had for you?

0 (don’t know)  1 (negative)  2 (somewhat helpful)  3 (positive)

Comments, suggestions, observations --- or questions:
Rate the need, in your opinion, for Spiritual Care for the Residents at the ECF.

0 (don’t know)  0 (none)  0 (maybe a little)  10 (a lot)

Rate any impact on residents’ quality of life you may have observed from Jeanne’s Spiritual Care Visits to residents.

0 (don’t know)  0 (none)  1 (somewhat helpful)  8 (positive)

Rate any impact on resident quality of life you have observed from “Spirit Hour”.

0 (don’t know)  1 (none)  2 (somewhat helpful)  7 (positive)

Rate any impact (direct or indirect) on you from the Spiritual Care Program?

1 (don’t know)  1 (none)  1 (somewhat helpful)  7 (positive)

Rate any impact Jeanne’s educational handouts have had for you?

0 (don’t know)  1 (none)  4 (somewhat helpful)  5 (positive)

Comments, suggestions, observations --- or questions:

- I think what Jeanne is doing is wonderful, and she is good at it. I’ve heard many residents ask about, or for, her. She is a very positive influence on this unit. I can tell by how the residents react to her. She does what a lot of us wish we had time to do, which is spend more time visiting with residents. I’m glad she’s been a part of the ECF.

- Please make every effort to make sure that Jeanne can remain here as part of the staff of the ECF. My residents are impacted by Jeanne’s visits. They talk about how she spend time with them. There refer to her as “the woman who always wears the same dress.” After reading Jeanne’s booklet, I understood that comment and they look forward to Spirit Hour where they can share stories, jokes, pictures, etc. Having family participate in this group has also been special for our residents. Keep her please!

- I spoke with a resident recently about Spirit Hour. She had nothing but positive feedback to give. I could see how good it made her feel inside. She stated she wished everyone would “get it” and stop being so down and negative about life. These kinds of activities should be done more regularly.

- Spirit Hour is great interactions and allows the ability to express themselves. Spiritual Care program as a whole helped by providing more activities for residents. Handbook in the break room was good to read.
ON THE APD MISSION & SPIRITUAL CARE

“The mission of Alice Peck Day Health Systems, Inc. is to provide patient focused health care services that are responsible to community needs, to promote wellness, and to continually improve the quality of health care services in the community.”

Observations

- The essence of spiritual care is one-to-one relationship, that is, contact with and support of the inner person. In that sense, supporting the spiritual side of a person is consistent with the mission of APD. I applaud APD for being willing to explore providing spiritual care on its campus by a resident non-denominational chaplain integrated with the health care team. I feel the six month commitment, with 12 hour per week, afforded sufficient time to yield valuable data and observations.

- Sections 7 and 8 in this report includes many references to other medical studies and trends verifying the need for including spiritual care in patient-focused care.

- It is my observation that prior to the pilot study, the spiritual side of residents was provided for primarily in community worship services conducted by volunteer groups or individuals who are not members of the health care system. It seems that any personal visitation was targeted by pastors only to their church members. While this is definitely positive, it does not assure one-to-one spiritual care for all residents, nor is it integrated with total care provided by the health care team.

- I observe that APD is heavily committed to providing residential care for the elderly, with 50 beds on the ECF and 80 apartments at Harvest Hill.

Recommendations

- In the light of the APD commitment to 130 older persons already resident and part of the APD Health Care System, it seems critically essential to me that spiritual care for the elderly is not only called for, but that a committed, APD-driven, non-denominational spiritual care program be implemented as soon as possible. I believe that the Spiritual Care Pilot Study conducted on the ECF for six months supports this recommendation.

- Further, I recommend that a committee be established immediately to determine the goals of such a program, its scope, and its implementation.

- To assure that this program has the content and integrity of the highest standards of clinical pastoral care, it should be staffed by a properly trained and clinically supervised spiritual care provider. This professional should be a member of the institution’s health care team in order to integrate spiritual with physical/mental care. Further, this person should have the high degree of dedication and reliable commitment needed to establish this pioneering addition to APD’s health care.
ON THE EXTENDED CARE FACILITY: Site of Pilot Study

Observations

- The ECF population has unique characteristics: residents are very visible and accessible; residents have great need for personal contact and “spirit” support; personal contact is challenging due to varying levels of dementia and speech impairment.

- There is much evidence on the unit of respect toward residents, e.g. personal grooming and dressing, cleanliness of the facility, caring from staff, activity programming and group worship. Clearly, the personal dignity of residents is being supported.

- Having said that, I also noted that because of the work of keeping such an intense operation going 24/7, staff does not appear to have the luxury of spending much one-on-one conversational time with residents. By necessity, staff time spent with residents seems functionally driven. It has been a privilege to work along side this obviously dedicated, caring professional team. I am sure social workers and a few others are trained and could meet resident needs in some of the ways I do. The key question is time and frequency. There is no doubt in my mind that the amount of time and modes of intervention I provide for residents in an unhurried way on a regular basis would be difficult for others to achieve.

- And, I observed a deep need for the spirit-focused visitation I offered. Residents were warm, welcoming and very accessible. They were also very open about their needs. I feel the one-to-one visits became highly important for many. As my relationships with them deepened, I saw residents trust me more; they knew their spirits were safe and were heard by me. My observation, which was actually expressed by one resident, was that there is something wonderfully nurturing to the soul about having your inner reality observed respectfully by another, and to have that other show up routinely, non-judgmentally, and unhurriedly, to sit with you in supportive understanding. I supplied personal faith support for many in a way not supplied in group religious services. And the quality of my attention to them was skilled and in depth.

- I also observed that our group intervention “Spirit Hour” sm was very popular. I think it is because it addressed inner spiritual needs: personal validation and dignity; celebration in community of self and of personal triumph over loss; sharing meaning with others; support, sometimes in coping with loss; bridging isolation; developing relationships among residents; relaxing in an accepting way with each other; winning (flowers); finding out about each other (they really seemed very interested!); and being uplifted with inspiration and blessing.

- A further observation was that with 12 hours per week on the unit, I barely had time to visit an average of 10 people, have a few group discussions and hall-way visits, attend meetings, run “Spirit Hour” sm, and make entries in the record book.

- A final observation was that although I contributed my observations to the health care team via a special notebook, information sharing was not reciprocal. I felt handicapped by lack of knowledge medical records or team sharing provides. However, I did work within those limitations, responding to what the residents presented, and seeking consults with various team members as needed.
Recommendations

- I recommend that the ECF have its own dedicated chaplain. I believe all the observations, surveys and findings of this study support this conclusion.

- I recommend a complete spiritual care program for residents consisting of the following: one-on-one visitation with residents; group intervention “Spirit Hour™,” and intergenerational good works projects “Spirit Works™.”

  The later component was not explored in the Pilot Study. It would complete the other two aspects of a well-rounded spiritual care program for older adults: resolution and integration; connection; and service beyond self.

  I see the intergenerational projects bringing young people together with ECF residents around service and outreach work. An example: making things such as wooden puzzles for new residents, hospital patients, families, and the gift shop. This could involve an Eagle Scout candidate (perhaps one interested in medicine) who, with his troop, would come and figure out how to work with our residents various handicaps and actually help them make the three-dimensional puzzles. Another example: partnering with an English class in exchanging letters about what life is like for the students and for the residents. This would include periodic visits so that residents and students would meet each other face-to-face. I anticipate that both of these examples would build relationships, understanding, and broaden the participants view of the world, effectively getting people out of themselves and into community (communion) with one another, hopefully building support and understanding across the generations. This is one of the main tasks of aging cited by Erik Erickson.

- I observed some staff members experiencing grief and loss around resident’s deaths. I recommend offering staff spiritual support.

- I recommend continuing staff education around spiritual care in a more formal way for participant credit.

NOTE:

For future planning purposes, Jeanne has many ideas for planning and implementing a Chaplaincy presence at APD. These include ECF-only delivery to system wide delivery featuring a slow entry into the system which would be both cost effective and administratively easy. Jeanne also has many ideas on how to make this happen fairly effortlessly and cost efficiently.
SPIRITUAL CARE PILOT STUDY  
Alice Peck Day Extended Care Facility

Observations & Recommendations

Administrator’s Final Thoughts and Recommendations

Observations
- Jeanne’s work supported increased unit activities and one-one activities with residents.
- The Spirit Hour was a well-attended activity and brought together residents and families in celebration of our residents’ lives and those pieces of history that residents hold dear in memory of their lives.
- It continued to be difficult to discern “Spiritual Care” vs. Social Work and friendly visits. The vital piece of discernment is in identifying boundaries and expectations. It became clearer that Spiritual Care is done by all of the above at times, but Pastoral Care is intrinsically different. Jeanne provided unique forums, such as the Spirit Hour and more time in one-one visits than we currently provide by our staff. Jeanne also was able to focus on prayer and pastoral support.
- Our staff are not trained in Pastoral Care, and our staff also have the critical pull of full caseloads and regulatory accountability with documentation, assessments, etc., that take time from one-one visits.

Recommendations
- Based on survey data, and solicited feedback from residents, family members and staff, there is support for ongoing Spiritual Care programming.
- I recommend that the Leadership Teams discuss the role of Spiritual Care across the health system. Considerations for patient/resident involvement:
  - Palliative Care
  - Relocation Stress
  - Grief Support
  - Creation of a “sanctuary” at APD
  - Religious support
  - Religious liaison
  - Spiritual programming (Spirit Hours held at the ECF and Harvest Hill)

Jeanne and I have spoken at length, and there is tremendous value in “The Spirit Program”. My efforts on ECF are focused at this time on development, enhancement and strengthening of regulatory programs, and programs with increased revenue probabilities. I do not see the development of a position of this kind in FY 07 or FY 08, but have incorporated this into the long range goals and will incorporate this into the ECF Strategic Plan. I think a discussion must occur around organizational philosophy and operational functions. The creation of this program will be one of expense — there are no billable services. This is reality, not opposition. Improvement in the areas of quality of life and potentially, improved patient care (resulting from one-one visits and enhanced emotional support) is invaluable.