

## Handout

### **“Sharing Spiritual Care Knowledge for the Good of All”**

**Workshop S12**

**2:00 - 3:15 pm, May 22, 2011**

**NACC 2011 National Conference**

**Hilton Milwaukee City Center, Milwaukee Wisconsin**

**John (Jack) Gleason, BCC (retired), Presenter**

### **The Ideal Intervention Project Explained**

#### **Goals**

The goals of the Ideal Intervention Project (IIP) are five-fold:

- 1) To improve the overall quality of Spiritual Care (SC), thereby more effectively fulfilling the mission of those called to serve in the profession of clinical SC;
- 2) To help all SC practitioners, CPE students and seminarians consolidate learnings from both successful and problematic actual situations by brief, disciplined writing;
- 3) to forward writer-approved edited versions of this writing to an inductively organized, case-oriented, anonymized, on-line, free-access SC knowledge base of samples intended to assist all SC practitioners facing similar situations;
- 4) To ultimately validate effective replications of these samples as evidence based SC best practices' desired outcomes; and
- 5) In so doing, to insure a continuing place for SC professionals at the clinical table as a new paradigm emerges for health care delivery in which pay will be based upon achievement of those desired outcomes.

#### **Background**

The IIP was conceived by Henry G. Heffernan SJ, an NIH staff chaplain. He adapted the IIP paper for CPE students from a cognitive therapy template to consolidate learnings from verbatim presentations to peers and to allow improvement in the quality of spiritual care by amassing those learnings to apply to specific future situations. The IIP was introduced into the CPE curriculum and piloted with three intern groups and one resident group in the EC/ACPE Region in 2006 and 2007. Based on student and supervisory critiques, a revised protocol was tested. Further adjustments to the protocol have been made since that time. More recently, papers in a more concise format (see below) are also being solicited from clinical and military chaplains, parish clergy, seminarians, pastoral counselors, academics, and spirit-oriented members of other disciplines for editing and inclusion in the SC knowledge base.

#### **Project Design**

Steps Underway

- 1) The IIP consolidates SC practitioner and CPE student learnings by disciplined writing.
- 2) Certified SC clinicians edit the IIPs into potential best practices (PBPs).

3) An anonymized, on-line, free-access, international SC knowledge base inductively organized by central issue identifiers such as “preparing to die” is created.  
(Go to <http://www.ACPEResearch.net> to access the current SC knowledge base and back issues of the *Ideal Intervention Project e-Newsletter*.)

#### Steps Awaiting Action

- 4) A brief effectiveness questionnaire is created.
- 5) Institutional Review Boards (IRBs) approve the use of the effectiveness questionnaire.
- 6) SC practitioners whose IRBs have approved the use of the effectiveness questionnaire access the SC knowledge base by central issue identifiers and allow the appropriate PBPs to inform their interventions.
- 7) The recipients of that care rate effectiveness using the effectiveness questionnaire. Effective interventions are designated as tentative best practices (TBPs).
- 8) Other SC practitioners replicate TBPs. Effectiveness is again rated using the questionnaire. Effective TBP interventions are designated as evidence-based spiritual care best practices (SCBPs).
- 9) SCBPs are made widely available through professional SC associations via the SC knowledge base and the process of refinement and validation of effective interventions continues, thereby building the SCPB database over time.

#### **Current Situation**

The SC knowledge base currently contains 154 edited IIP samples grouped in 22 inductively-arrived-at central issue identifier categories. It is maintained at <http://www.ACPEResearch.net> by John Ehman, ACPE Research Network coordinator, and may be freely accessed by all SC practitioners and students to inform their interventions in similar situations. All IIP papers are initially routed to John Gleason BCC (ret), project coordinator, at [mariejohn50@att.net](mailto:mariejohn50@att.net) for editing into the SC knowledge base. Authors must okay revisions before entry into the knowledge base. The SC knowledge base to date has not reached the critical mass needed for wider application in further design phases.

#### **The Future**

The IIP awaits the growth of the SC knowledge base to a critical mass necessary for its wider applications in further design phases. Accordingly, the IIP also awaits an infusion of leadership, funding, and the individual and institutional commitment necessary to pursue IIP goals. Short-term IIP goals include engaging persons qualified to create the brief effectiveness questionnaire, oversee its applications, and interpret its results.

#### **Summary**

The IIP consolidates case oriented SC learning and inductively provides a means to make that learning appropriately available for the greater good. If properly supported and further developed, the IIP is poised to validate evidence based SC desired outcomes or SCBPs, improve the quality of SC, and ensure a continuing place for SC professionals at the clinical table as a new health care delivery paradigm emerges.

## The Emerging Paradigm for Health Care Delivery

### Health Care Costs

Health care expenditures in the United States exceed \$2 trillion a year. (Source: *Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group*;) In comparison, the federal budget is \$3 trillion a year. The amount people pay for health insurance increased 30 percent from 2001 to 2005, while income for the same period of time only increased 3 percent. (Source: *Robert Wood Johnson Foundation*) Health care expenditures in the United States are the highest of any developed country, at 15.3% of GDP. The country with the next highest spending is Switzerland, at 11.6% of GDP. (Source: *Organisation for Economic Co-operation and Development*)

### Pay for Performance (P4P) Systems

Pay for performance (P4P) systems link compensation to measures of work quality or goals. As of 2005, 75% of all U.S. companies connect at least part of an employee's pay to measures of performance, and in health care, over 100 private and federal pilot programs are underway. Current methods of healthcare payment may actually reward less-safe care, since some insurance companies will not pay for new practices to reduce errors, while physicians and hospitals can bill for additional services that are needed when patients are injured by mistakes. (Source: *The Commonwealth Fund*) Education is among other disciplines caught up in this trend. For example, several states have now committed to using value-added analysis in teacher evaluation in order to secure financing from the Obama administration's *Race to the Top* program. (Source: *David Leonhardt, "Stand and Deliver," The New York Times Magazine, September 5, 2010*)

### The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act will: in 2011 create the Independent Payment Advisory Board which will recommend ways to improve health outcomes for patients; in 2012 implement programs and controls that improve quality outcomes for patients and encourage more accountability among healthcare professionals; and in 2015 begin rewarding quality of care rather than amount of services in Medicare. (Source: <http://www.healthcare.gov/law/about/order/byyear.html>) US Centers for Medicare and Medicaid Services Director Donald Berwick, in redefining patient centered care, recognizes that this "will involve some radical, unfamiliar and disruptive shifts in control and power, out of the hands of those who give care and into the hands of those who receive it." (Source: *Donald M. Berwick, "What 'Patient-Centered' Should Mean: Confessions of an Extremist," Health Affairs, 28:4, 2009*)

Note: Should the Affordable Care Act or parts thereof be found unconstitutional, the ever-rising costs of providing US health care will continue to drive the emergence of the new paradigm.

## **UK Chaplaincy Findings**

A United Kingdom report points chaplaincy toward evidence based care. Commissioned by the National Health Service, it concludes that “treatment should be evidence based... if a practice is not supported by evidence it is unlikely to be resourced... hospital chaplaincy finds itself in a political setting... value for money is part and parcel of how chaplains are judged... healthcare chaplains are being asked to show that what they do results in desired outcomes for those they work with... this requirement is linked to resource allocation... healthcare chaplaincy currently needs to identify its core tasks and skills and its place within a modern healthcare system... the distinction between religion and spirituality requires that health care chaplains are more robust in their approach to their evidence base... the secure future and positive potential for chaplaincy is linked to creating a better knowledge base about practice.” (Source: Harriet Mowat, “*The Potential for Efficacy of Healthcare Chaplaincy and Spiritual Care Provision in the NHS (UK)*” 1:08, 11, 16-17, 21, 49) The US government is examining other countries’ models. The implications are clear.

## **Summary**

Remuneration in health care delivery is increasingly being based on the demonstrated achievement of evidence based desired outcomes. Inductive, case oriented knowledge bases (vis-à-vis the traditional deductive, *common factors* approach) are foundational in this emerging paradigm. All of the professional disciplines, including professional SC and education, are now-- or soon will be--affected. The IIP is inductive and case-oriented. One of the goals of the Ideal Intervention Project (IIP)--to validate effective SC interventions by use of the SC knowledge base, and to thereby assure continued remuneration for SC professionals in the emerging health care reimbursement paradigm in which pay will be based upon achievement of effective desired outcomes. The Ideal Intervention Project is chaplaincy’s singular entrée into the emerging paradigm.

## **Ideal Intervention Form**

(For Use by All Spiritual Care Practitioners and CPE Students)

**1. Statement of the Spiritual Care Central Issue** (e.g., Feeling Angry and Abandoned by God; Hope in Terminal Illness, etc.)

**2. Narrative Summary of the Actual Spiritual Care Intervention** (No more than two paragraphs of narrative description. Take confidentiality precautions.)

**3. Narrative Summary of the Ideal Spiritual Care Intervention** (No more than two paragraphs of narrative description of how you would do the intervention differently if given another opportunity. Write so that another practitioner with a similar situation could benefit from your insights.)

**4. Resources that You Would Recommend to Other Spiritual Care Givers Regarding This Topic** (Books, journal articles, pamphlets, etc.)

**5. Forward a copy of this completed form to Knowledge Base Editor John Gleason at [mariejohn50@att.net](mailto:mariejohn50@att.net)** as a Microsoft Word attachment for inclusion with similar data toward validating evidence based spiritual care best practices. Confidentiality precautions will be taken. You will be asked to approve the edited version before entry in the SC knowledge base. Thanks for your contribution!

(Please go to <http://www.acperesearch.net> and click on “Special Section: Ideal Intervention Paper (IIP) Project” to view the free-access national spiritual care knowledge base and for further information on the Project.)