An Outpatient Pilot: Expanding Chaplains’ Walk Toward Distant and New Clinical Partnerships

A Catholic healthcare ministry serving Ohio and Kentucky
Objectives

We have three core objectives for today’s conversation

1. Share the story of how an Outpatient Spiritual Care program was envisioned, launched, and sustained over the past three years

2. Focus on the major steps, stumbling blocks, and learnings encountered along the way

3. Spark ideas of how others might create their own Outpatient Spiritual Care program
What is Outpatient Spiritual Care?
A shared definition may be helpful to begin our conversation

Outpatient Spiritual Care seeks to offer chaplaincy services in every location that our organization provides medical care
Origins
There are three core areas that have shaped the spirit of our program

Theology
Philosophy
Institution
Origins

There are important building blocks for our program within these three areas

**Theology**
- Extending the compassionate ministry of Jesus
- ‘Missio’ meaning to go out or to send forth
- Religious heritage and tradition of our founders

**Philosophy**
- Integration of various disciplines, Clinical and Mission
- Spirit and service does not stop at the door
- Research and evidence-based chaplaincy

**Institution**
- Population Health patients and mandate
- Resources for funding, grants and acute budget
- Market landscape, cultural and economic factors
Key Challenges

We have learned to nimble pivot as challenges arise

1. **Logistics**
   - Equipment such as desks, laptops, phones
   - Physical office space within the hospital
   - Marketing materials to distribute to offices

2. **Buy-In**
   - PCP Offices to refer patients
   - ICD-10 codes for spiritual referrals
   - Charting / clinical standards
   - Tracking, assessing, preparing for research

3. **Technology**
   - Constructing the electronic build
   - Training the chaplaincy team
   - Determining our “go live” challenges

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1 ICD = International Classification of Diseases; full list of spiritual care referral codes listed in the appendix
Program Timeline

Our program has grown and expanded over the course of several years

Year 0
Launch
April 2016 – June 2017

“Go Live”

Year 1
Up and Running
July 2017 – June 2018

Year 2
Learnings
July 2018 - Today
Staffing
Our staffing has been minimal, yet has evolved over the past three years

Year 0
1 PRN Chaplain
1 Part-Time Chaplain
1 Full-Time Volunteer
5-10% of Acute Chaplains’ Time

Year 1
“Go Live”
1 Full-Time Chaplain
1 Full-Time Volunteer
10-20% of Acute Chaplains’ Time

Year 2
Funding

Our program has also operated on a shoe-string budget

Year 0
$5,000 Budget

Year 1
$60,000 Budget

Year 2
$100,000 Budget

$5,000 Budget

$30,000 Foundation grants

$30,000 Acute budget

$50,000 Foundation grants

$50,000 Acute budget

“Go Live”
Day-to-Day Management
On a daily basis, our staff focuses on a number of key activities

- Education of patients and staff
- Advance Directives
- Phone calls, acute visits, letters
- Social Services support
- Engaging referral base
- Funding and expansion
- Program Development
  - Patient Care
    - Education of patients and staff
    - Advance Directives
    - Phone calls, acute visits, letters
    - Social Services support
    - Engaging referral base
    - Funding and expansion
Total Referrals by Month

Our monthly referral numbers have varied, but show steady overall growth.
Total Referrals by Source (1/17 – 3/19)

Our referrals have come from a variety of different sources

- Primary Care Physicians: 32%
- Congestive Heart Failure: 32%
- Chaplains: 22%
- Wound Care: 8%
- Other¹: 6%

¹This category includes referrals from Ambulatory Surgery / Ambulatory Care, Acute Care / Home Health Case Managers, Physical Therapist, Pharmacy, Psychologist, Self, and Transition Care Nurse
Total Referrals by Source

The percentage of provider referrals has risen significantly over time.
Learnings
We continue to learn and adjust our program to meet patient needs

- Anonymity effect
- Importance of communicating
- Standardizing charting
- Physical presence in offices
- All-care model
- Seasonality of referrals
Objectives
We have now covered the three core objectives for today’s conversation

1. Share the story of how an Outpatient Spiritual Care program was envisioned, launched, and sustained over the past three years

2. Focus on the major steps, stumbling blocks, and learnings encountered along the way

3. Spark ideas of how others might create their own Outpatient Spiritual Care program
Thank you!

Any questions?
Contact Information

Feel free to reach out to our team members with any additional questions

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Appendix
ICD-10 Codes
These codes are used to refer patients to Outpatient Spiritual Care

<table>
<thead>
<tr>
<th>Problem search terms</th>
<th>ICD 10 code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem with religious or spiritual beliefs regarding medical care</td>
<td>V62.6, Z53.1</td>
</tr>
<tr>
<td>Spiritual Distress</td>
<td>V62, Z65.8</td>
</tr>
<tr>
<td>Religious or spiritual problem</td>
<td>V62, Z65.8</td>
</tr>
<tr>
<td>At Risk for Spiritual Distress</td>
<td>V49, Z91</td>
</tr>
<tr>
<td>Advance Directives/ counseling discussion</td>
<td>V65, Z71</td>
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<tr>
<td>Counseling regarding advance directives and goals of care</td>
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</tr>
<tr>
<td>No Advance Directives</td>
<td>V49, Z78.9</td>
</tr>
<tr>
<td>Grief</td>
<td>309.0, F43</td>
</tr>
<tr>
<td>Bereavement (uncomplicated…..)</td>
<td>V62</td>
</tr>
<tr>
<td>Recent Bereavement</td>
<td>V49</td>
</tr>
<tr>
<td>Adjustment to Life threatening illness</td>
<td></td>
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</tbody>
</table>
“In times of stress, the best thing we can do for each other is to listen with our ears and our hearts and to be assured that our questions are just as important as our answers.”

— Fred Rogers
East Market Geographical Coverage