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Effective patient selection is a perennial concern for chaplains. Various methods have been proposed, including case finding, third-party referral and standard response. As a form of standard response, protocol-based referrals provide a rational plan for selecting patients. Protocol-based referrals include end-of-life, crisis, transition-in-care and procedure-specific situations. A patient selection system utilizing protocol-based referrals capitalizes on electronic medical records and provides a solid clinical backbone for hospital-based chaplaincy.

IN 1939, RUSSELL DICKS, a chaplain at Presbyterian Hospital in Chicago, Illinois, delivered a seminal speech at the annual meeting of the American Protestant Hospital Association. Dicks outlined four requirements, which in a later work were expanded to eight, that he considered essential for effective work of the chaplain. Of these four, the second requirement is of interest to this paper: the chaplain “shall have a plan whereby he [sic] selects the patients he is to call upon.” He later modified this requirement with the adjectival addition of “rational.”

According to Dicks, “the chaplain can no longer wander from bed to bed, chatting agreeably, relieving distress occasionally as he discovers it, while down the hall behind a door ....” In other words, without a rational plan for selecting patients, chaplains are left guessing among door number 1, door number 2 and door number 3. This need for a rational and effective selection plan remains a perennial concern as echoed some sixty years later in the work of Fitchett, Meyer and Burton: “How do hospital chaplains and managers of hospital spiritual care departments decide which patients should receive a visit from a chaplain?”

Though the heart and soul of chaplaincy remains rooted in relationship, the “net” that chaplains cast to capture spiritual needs must fit well with the modern clinical environment. Door-to-door or unit-to-unit relational chaplaincy may once have been the best net to capture need. However, the current reality of ever-decreasing length of stay in acute care settings, ever-increasing demands on a chaplain’s time and dictates of quality, calls for a more effective and rational net for identifying patients. This rational net should not replace relational chaplaincy; rather, it should complement it.

This paper presents a protocol-based referral model for patient selection, which combines and reinterprets previous models as found in the literature. Critical to the implementation of this model are the new electronic medical records that are becoming standard in most hospitals today. Following a short review of literature in which the various patient selection models are discussed and new terms introduced, the author will explore the strengths and limitations of a patient selection model that uses protocol-based referral as its backbone.

Literature review

Over the years since Dicks challenged chaplains to develop a rational plan for selecting patients various models have been put forth. Gregory Stoddard distilled these into three categories:
1. Case finding – chaplain-initiated rounds, e.g., visits to all new admissions or rounding at nursing stations to inquire after people in need.

2. Referral – chaplain involvement through the referral of third parties.

3. Standard response – chaplain involvement in predetermined situations by administrative mandate which usually is defined by department or hospital policy, e.g., cardiac arrest calls, emergency room traumas.⁶

Case finding
Also called chaplain-initiated rounds, this method is a time-honored model supported by such pastoral care luminaries as Ernest Bruder and Lawrence Holst.⁷ Examples may include seeing all new admits and/or making chaplaincy rounds to nursing stations in order to identify patients in need of spiritual care. Holst describes this form of pastoral care intervention in the following manner: “The right of geographical initiative is a valuable vestige of pastoral care’s rich heritage. It is ‘a custom of the discipline.’ It is essentially the chaplain’s freedom to create and control the time, place, setting in which, and person to whom, pastoral care is offered.”⁸

This model certainly speaks to chaplains who see a combination of freedom and control as an essential part of their particular practice; however, as Stoddard claims, a case-findings model alone is difficult to justify and to defend in the current cost-conscious environment.⁹ Also, since it depends on luck and timing or on nurses’ abilities to recognize spiritual needs and to provide appropriate referrals, this model falls victim to Dicks’s critique of potentially missing those with significant spiritual needs. Patient selection may incorporate some case-finding referrals, but this should not comprise the whole of the model.

Referral
This category also has received support from various quarters within the pastoral care tradition, including Stoddard himself.¹⁰ These referrals often are independent of chaplain-initiated rounds and generally originate from a third party, such as a member of the hospital staff or a patient/family member. Stoddard contends that a referral-based model is critical to departmental plans and that “experiencing a growing number of documented referrals serves as hard evidence of the demand for chaplaincy.”¹¹ A study conducted by the Catholic Health Association of the United States supports this statement, concluding that “because of time constraints and greater acuity, fewer and fewer departments are seeing every patient. Pastoral care will increasingly rely on others to refer those who find themselves in spiritual distress.”¹² In other words, there is a movement away from case finding to third-party referral.

Such referrals are near the heart of relational chaplaincy. Through making daily rounds, attending interdisciplinary rounds, and providing in-services, chaplains develop relationships with the staff and provide education on spiritual care. All of this hopefully results in appropriate referrals. Referrals that come via these relationships and education will remain key to a chaplain’s overall selection plan. However, maintaining this level of staff support and education requires considerable time, which some chaplains may not be able to provide on a consistent basis. This time constraint, coupled with the availability of electronic medical records as a triage tool for identifying potential spiritual needs indicates that a rational plan for patient selection should not depend on referrals alone.

Standard response
Chaplaincy departments that respond to codes, deaths and traumas as directed by administrative policy use a standard response model. This model may include an acuity-based algorithm through which chaplains triage their responses to these standard situations based on acuity, again as defined by administrative policy.
Though the term “standard response” rarely appears in pastoral care literature, the idea of chaplains responding to predetermined situations does appear in various forms.

- **Diagnosis:** As one example, Dicks speaks of “watching the admission slips ... [that] carry an admission diagnosis. That information is useful to the chaplain to this extent: he is able to select those who on the basis of their illness are facing serious stress.” In other words, as Dicks continues, ulcerative colitis generally produces a level and kind of stress that differs from an appendectomy. Based on diagnosis, i.e., a predetermined situation, a chaplain could triage care, which is a form of standard response.

- **Clinical pathway:** A second example qualifying as a form of standard response appears in discussions of clinical and spiritual pathways. George Handzo, in his introduction to a symposium on clinical pathways published in *Chaplaincy Today*, notes that two of the articles “seek to link spiritual issues and pastoral care tasks to distinct points in the treatment continuum.” (emphasis added) Jason Cusick notes that “clinical pathways provide a map for the general care as well as a place for each service to play a part in the multidisciplinary treatment of the patient.” (emphasis added) This results in making “pastoral care an official part of the clinical team.” Cusick further argues that clinical pathways result in “the development of pastoral ministry to patients with specific illnesses.” Clinical pathways are sets of illness-specific protocols designed to meet certain outcomes, which include “distinct points” where pastoral interventions may be more efficacious than at other points. Including referrals to chaplains at these distinct points is an example of standard response.

- **Protocol-based:** A third example of a standard response referral system, protocol-based referral, “is found in George Handzo’s list of twelve practice areas that “are increasingly accepted as representing the highest quality in professional pastoral care.” Along with traditional protocols, such as “codes, deaths, organ donation, radical change in prognosis, execution of advance directives, and disasters,” Handzo adds another category. He connects this additional category with transitions in levels of care for the patient within the health care system, such as changes “from hospital to hospice, assisted living to long term care facility, regular medical care to intensive care, or from curative treatment to palliative care.” Handzo recommends a chaplain referral be made at each of these distinct transitional points in a patient’s clinical experience.

### Defining protocols

Three major categories may be isolated from Handzo’s lists of protocols:

2. Crisis protocols – codes, disasters, radical change in prognosis.
3. Transition-in-care protocols – hospital to hospice, curative to palliative, acute care to intensive care, one facility to a second.

This author suggests a fourth, procedure-specific protocols. This might include all pre-op patients or those in a specific category, e.g., open heart, valve replacement, amputation. It might also include procedures such as certain chemotherapies, pacemaker insertion, percutaneous coronary interventions, e.g., stents, and/or specific treatments related to a clinical area.

These four categories certainly overlap, and some chaplaincy departments already may have predetermined responses to some of these situations. The issue, according to Handzo, is whether these predetermined responses have been formalized through departmental policies that have administrative approval. Such policies would require chaplain referrals for each of these predetermined situations and would outline a method for triage. Formalizing this step provides an
opportunity to educate administrators about the spiritual needs of patients and the role of chaplaincy in a health care setting. It also elicits their explicit buy-in and continued support. Further, it shows that chaplaincy services are “based on a plan with outcomes,” which is another practice area Handzo outlines as critical for achieving the highest quality in professional chaplaincy.\textsuperscript{22} Justifying such protocols, especially those focused on end of life, may be easier due to administrators’ expectations that chaplains should have a role in such situations.\textsuperscript{23} Handzo does not address the question of how these referrals are made or entered into the system. Who or what generates the chaplain referral? If it remains up to the chaplain to identify situations to which the protocols apply then protocol-based referrals become a form of case finding and/or third-party referrals. As noted earlier, referrals mediated in this fashion are subject either to the chaplain’s detective skills or to the judgment, memory and/or good will of a third party. An automatic, system-wide, nonsubjective process is needed that both formalizes referrals and assures that they are made by integrating protocols into the clinical plan of care as true standard responses. Procedure-specific protocols illustrate this process.

**Procedure-specific protocols**

Procedure-specific protocols capitalize on electronic medical records by embedding chaplain referrals within the electronic medical record itself. These protocols connect automatic chaplain referrals to specific medical orders for predetermined medical procedures. For example, surgeries are predetermined medical procedures. Some chaplaincy departments see all pre-op patients via the following, or a similar, method:

- Acquire a daily list of surgical patients.
- Visit all or some of them.
- Document the visits.

Though this appears to be an example of a procedure-specific protocol, as defined in this article, it is not. These referrals are indirect, added on as it were, to the list of surgical patients. The chaplain does not receive a list of referrals; instead, the chaplain receives a list of patients to which referrals are added. In essence, this is no different than Dicks watching the admission slips.

A chaplain referral that is added on after the fact is not an integral part of the clinical pathway. Instead of the clinical system itself recognizing the need for a chaplain referral through direct and explicit inclusion, the chaplain “jumps on the band wagon” after the fact. This philosophical or systemic problem is addressed within traditional clinical pathways wherein referrals to chaplains are integral; however, this method often requires action by a third party—nurse, chaplain or other clinician—and thus effectively reverts to the referral mode.

The goal of procedure-specific protocols, and by extension all protocol-based referrals, is to integrate the chaplain referral into the medical procedure in such a way that it does not require the mediation of a third party. Electronic medical records make the automatic generation of all protocol-based referrals possible.

Although this means of obtaining referrals moves chaplaincy away from relying exclusively on its traditional relationship-based form, the chaplain continues in partnership with staff while at the same time partnering with the system to meet the spiritual needs of patients. Just as each third-party referral may or may not be appropriate, so each automatically generated protocol-based referral may or may not be appropriate. Every referral, regardless of origin, requires a chaplain’s spiritual assessment to determine a plan of care. The major difference is that third-party referrals are subject to the quality of staff education to identify spiritual distress whereas protocol-based referrals are subject to the quality of the research, which predicts the statistical likelihood of
spiritual distress for a given clinical situation. Thus, protocol-based chaplaincy is intended to complement relational third-party and case-finding chaplaincy rather than to replace it.

**Using electronic medical records**

Electronic medical records are here to stay. Chaplaincy practice may capitalize on these new systems to enhance as well as to integrate patient selection methods. In electronic medical records, medical orders are entered individually or as part of an “order set” to which any number of referrals may be attached automatically. For example, when a surgical order is placed that also requires orders for various lab tests, nursing preparations, postoperative technical supports and/or discharge needs, these concomitant orders form the order set attached to the single surgical order. Entering that single surgical order now generates automatic referrals to the appropriate clinical disciplines. With proper administrative approval, chaplaincy referrals may be added to any order set as well.

Along with procedure-specific protocols, those addressing end of life, crisis, transitions in care and other situations of spiritual risk also may generate automatic referrals via the electronic medical record, *provided an appropriate order is identified to which the referral may be attached*. Examples of such orders are do no resuscitate (DNR), allow natural death (AND), palliative care, hospice/nursing home placement, certain critical diagnostic tests and advance directives. The key is to find an appropriate order and to obtain administrative approval to attach a chaplaincy referral as part of the concomitant order set. Once this is accomplished, the chaplain’s patient selection practice capitalizes on the advantages of the electronic era.

Using the electronic medical record has distinct advantages. The first is the ease with which clinical staff may place an order for the chaplain in the electronic system and the ease with which the chaplain may check for new orders throughout the day. Stat orders still may be placed via pagers.

A second advantage is that the electronic medical record tracks all referrals. As Stoddard noted, “experiencing a growing number of documented referrals serves as hard evidence of the demand for chaplaincy.” The electronic medical record facilitates both tracking and retrieval of data.

The third advantage may first present as a disadvantage. Whether it is busy or slow, whether the chaplain is in-house or on vacation, referrals continue to be generated per protocols, which may result in referrals that are not followed up. This apparent weakness, however, may prove to be a strength as it establishes unmet need. Few chaplains are able to meet all the pastoral or spiritual needs of their patient population. Protocol-based, computer-generated, chaplaincy referrals, which remain unmet after discharge in an electronic medical record, provide documentation of unmet needs, which may be helpful in justifying requests to administrators for an expanded chaplaincy presence.

Many hospitals currently are transitioning to electronic medical records. Some systems come prepackaged with protocols already hardwired into them, including some chaplain referrals. Others may provide for customization prior to installation. Chaplaincy departments need to be involved proactively during the planning stages in order to insure that the system provides for appropriate chaplain referrals. As the institution’s spiritual care specialist, the chaplain continues to provide education on meeting the spiritual needs of the patients, but the bulk of this education moves to the beginning of the process instead of being in the day-to-day operations.

**Designing a selection plan: getting the right mix**

A rational, efficient and effective plan for selecting patients—the right net as it were—is critical to a chaplain’s professional practice. Designing an intentional selection plan involves identifying the right mix of case-findings, third-party referral and standard response protocol-based/procedure-specific referrals for one’s particular setting. Though basing chaplaincy involvement on the level of
staffing rather than on the spiritual needs of the patients may not be considered best practice, designing a workable selection plan may need to consider the chaplain’s setting within his/her respective institution.\(^{25}\)

For example, a one-person chaplaincy department may find that adding one or two hospital-wide protocol-based referrals is sufficient given its limited resources. In such a situation, an end-of-life protocol, e.g., new DNR/AND orders and/or palliative care orders, may be most appropriate. On the other hand, a multitask department may have sufficient resources to add a number of hospital-wide protocol-based referrals as well as some that are specific to particular service lines.

Regardless of the size of the department and the number of protocol-based referrals, the more significant part of a selection plan centers on two factors:

1. The strategic value to the institution.
2. The demonstrated impact of chaplaincy care on the targeted population.\(^{26}\)

If an institution’s mission revolves around or highlights a particular service or patient population, then the chaplaincy department might design appropriate protocol-based referrals that specifically target these. For example, a pediatric hospital’s chaplaincy department, or a pediatric service line chaplain, would design protocols for this population. A chaplaincy department connected to a cancer or heart clinic, or a service-line chaplain in oncology or cardiology, would design protocols for these populations. A regional medical center which heavily markets its stroke or bariatric program may use protocol-based chaplaincy referrals to target one of these groups. Such a selection model strategically aligns the outcomes of chaplaincy with the mission of the institution.

The second factor, the demonstrated impact of chaplaincy care on the targeted population, raises the issue of quality for a protocol-based approach to chaplaincy mentioned above. Due to higher morbidity and mortality, some patient populations may experience higher levels of emotional, spiritual or existential distress. For some of these patient populations, research suggests the benefits of psychosocial and spiritual care interventions.\(^{27}\) Using this research to argue for the benefits of an automatic referral to a chaplain, who then conducts a spiritual assessment to determine actual need, is evidence based and makes for good practice. Thus, a chaplaincy department could design protocols that specifically target these patient populations.

Once in place, protocols automatically generate referrals on a daily basis. The chaplain also continues to educate staff, insuring the generation of third-party referrals as well. Responding to referrals, regardless of the source, also places the chaplain on the floors and thus in position to find emergent cases. Ultimately, the right mix reflects the particular institution, the needs of the patients and the “art” of chaplaincy as conceived by the individual chaplain.

**Future research**

Is a protocol-based referral system better than a third-party referral and/or a case-finding system? Is one particular combination of the three better than another? Further, does a protocol-based system lead to better third-party referrals on those units targeted by the protocols? How does one define “better” in such analyses? Does a patient selection plan that uses protocol-based referrals as its backbone capture more spiritual needs, or does it just make the chaplain busier? These are questions to be answered via research projects which might also examine which of the various protocols leads to better referrals and/or more consistently discovers spiritual needs.

One way to begin answering these questions would be to compare the quality of protocol-based referrals with the quality of case-finding and third-party referrals. Quality would be based on whether the chaplain’s subsequent spiritual assessment uncovered spiritual needs and whether resulting interventions produced measurable outcomes.
Conclusion
A patient selection plan for chaplaincy practice needs to be rational as well as relational. It also needs to fit current clinical practices. A selection plan that uses protocol-based referrals as its backbone meets the criteria Dicks set as rational. It strategically selects patients based on the institution’s mission and thus aligns chaplaincy with that mission. It selects patients that have been identified by research as having a statistically higher chance of experiencing spiritual distress. The chaplain’s spiritual assessment then determines specific needs and formulates appropriate plans of care.

Protocol-based referrals also are relational in that they foster ongoing involvement with clinical staff. This high visibility, responsiveness and accountability may lead to additional opportunities to educate staff and thus garner additional third-party referrals. The chaplain also is available to respond to emergent situations (case finding). A protocol-based selection plan does not replace third-party referral and case finding modes; it buttresses them.

A selection plan that uses protocol-based referrals as its backbone is well suited to the modern clinical environment. Twenty-first century chaplaincy care needs to be on the cutting edge of technology, and hard-wiring referrals into electronic medical records embeds it in the modern clinical environment and makes it more effective.

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2 Russell L. Dicks, “Standards for the work of the chaplain in the general hospital,” Hospitals (Nov 1940).
3 Ibid., 2.
4 Dicks, “Work of the chaplain,” 2.
8 Ibid., 68.
9 Stoddard, “Chaplaincy by referral,” 38.
12 The Catholic Health Association of the United States, Chaplaincy: Moving Toward the Next Millennium (St Louis, MO: The Catholic Health Association of the United States, 1997), 14.
13 Dicks, “The work of the chaplain,” 3.
15 Jason Cusick, “Paths they have not known: Ministry to leukemia patients using clinical pathways,” Chaplaincy Today 14, no. 2 (1998), 22.
Louis Nieuwenhuizen has developed a method for determining when pastoral interventions may be most effective. See Louis Nieuwenhuizen, "Spiritual care illustrated: Creating a shared language," *Journal of Pastoral Care & Counseling* 61, no. 4 (Winter 2007), 329-41.


Handzo, "Best practices," 663.

Handzo, "Best practices," 663.


Stoddard, "Chaplaincy by referral," 39.


Handzo, "Best practices," 663.