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Integrating Spiritual Care in Population Health and Care Management

Two Case Examples

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ABSTRACT

Purpose/Objectives: The purpose of this case study is to describe the movement of spiritual care into outpatient, managed care and population health settings, as it has evolved in a major not-for-profit health care system in the United States. The objective is to begin to establish the effectiveness of integrating spiritual care as a part of the interdisciplinary team (IDT) in these contexts.

Primary Practice Setting(s): The case study presents two practice settings: a remote patient monitoring program for patients with complex medical conditions, and integration into population health as a part of a Medicare Advantage Insurance program that is a cooperative venture between the health care system (Ascension) and an established insurance program (Centene).

Findings/Conclusions: The cases presented suggest that the integration of spiritual care into the outpatient, managed care and population health contexts has a threefold benefit: enhancing patient care, increasing the effectiveness of the IDT, and providing for the care and support of the members of the IDTs themselves.

Implications for Case Management Practice: The cases presented suggest inclusion of spiritual care in the care management/population health approach to patient care is viable and valuable both for the benefit of the patient and the functioning of the care team.

Key words: *chaplain, managed care, outpatient, population health, spiritual care, virtual care*

Historically, spiritual care within the context of the health care system has found its focus in providing care for patients in acute care settings. As health care has evolved in the past 40 years, however, length of patient stays, and even the need for hospitalization, has had a significant impact on the chaplain's ability to address emerging spiritual needs. Health care systems increasingly look at their care of patients from a population health perspective. Utilizing care management and similar modalities, patient well-being has been increased in ways that prevent hospitalizations, providing preventive and palliative care, which does not require either the expense or the dislocation associated with inpatient stays. Within the care management realm, LeDoux et al. (2019) have suggested the importance of attending to spiritual and religious concerns as a part of this care. Handzo et al. (2020) have presented a clear summary of this emerging trend from the perspective of spiritual care.

In this article, we explore the ways in which chaplains in one major health care system have begun to explore modalities of care that reach beyond the inpatient setting. Two cases have been presented, which illustrate different iterations of the evolution of spiritual care in response to the changing needs of the patient and the changing understandings of the role of health care in their lives.

The first case involves the embedding of spiritual care into the care team for remote patient monitoring, which currently serves patients in five states in the South and Midwest United States. This program represents an innovative move of spiritual care from facility-based to patient-focused population health care, and the close integration of the chaplain into the care management team, which is composed of medical, social work, and care management professionals to meet the needs of patients with complex medical needs outside of the acute care setting.

In the second case, we explore a groundbreaking program developed to integrate spiritual care into the care management stream of a Medicare Advantage (MA) program serving patients with complex

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medical needs. This is the first-of-its-kind program and has been operational since January, 2021. It is open to patients in eight states in the South, Southeast, and Midwest United States. As a supplemental benefit for the MA program, it is unique in its specific connection to the patient and the patient's needs and concerns beyond any health care facility or practice.

By sharing these cases, we intend to demonstrate that the inclusion of spiritual care in the population health/care management setting is viable and valuable, both in terms of the patient's overall well-being and as a valuable contributor to the larger care team.

Background

The role of spiritual care in acute inpatient settings is well recognized and long established (Cadge, 2013). Attention to a patient's spiritual and religious needs is seen as a significant aspect of institutional health care, and frequently referenced in common standards of care (Ehman, 2018; Handzo et al., 2008). What chaplains do, and their salutary effect on the patient's (and caregivers') overall health in the acute care setting was less clearly defined as the professional identity of chaplains evolved in the last quarter of the 20th century. Since the late 20th century, and increasingly in the 21st century, health care chaplaincy has sought to become a research-informed profession (Fitchett & Grossoehme, 2012). This has included employing research to describe their work and its benefits (Damen et al., 2020; Fitchett, 2017; Labuschagne et al., 2020).

Meanwhile, medical care and management for patients with complex needs has increasingly shifted to outpatient and ambulatory settings (Abrams et al., 2018). Population health approaches to patient care have sought to address emergent patient needs before acute care is required, and to provide outpatient supports to patients with complex medical conditions to minimize the disruptions involved in inpatient hospitalization. In response, there has been an interest in better understanding how spiritual care might follow patient needs into these new adapted patient settings, indicating patients overwhelmingly indicate their comfort in discussing their own and caregivers' spiritual health in the context of their outpatient care (Calton et al., 2020).

The clearest example of this adaptation of spiritual care is the rise of hospice chaplaincy. Chaplains worked in collaboration with the care team, as medical care at the end of life has developed means of meeting patient needs and goals by providing palliative care in home, or more home-like settings (Siebold, 1992). The importance of such spiritual care as an integral part of hospice and palliative care has become well recognized, and is in fact a named standard of care for hospice and palliative care certification (e.g., National Coalition for Hospice and Palliative Care, 2018; Puchalski et al., 2014).

Another setting in which spiritual care has found footing in the outpatient world is in the treatment of cancer, where a growing number of outpatient cancer centers are providing spiritual care and support to patients receiving chemotherapy and radiation treatment (Sprik et al., 2020). The National Comprehensive Cancer Network (2020) has developed standards for spiritual care, and a growing body of literature suggests that patient quality of life is enhanced as spiritual needs and distress are attended to (Astrow et al., 2018).

Behavioral and mental health professionals have followed this movement even further "upstream," embedding social workers, licensed clinical social workers, and psychologists directly in primary care and community clinics, providing for a seamless attention to a patient's emotional and mental health needs alongside the medical care received in their primary care visits (McGough et al., 2016). This transition has been aided by the fact that such professions have been increasingly recognized as care providers by third-party payers, and so have been able to bill for their services in a manner similar to the standard business model of a primary care clinic. "Pay as you go" billing provides an income stream for clinics that makes provision of such services financially viable (Grazier et al., 2016).

Embedding spiritual care in the primary care setting has presented a greater challenge. The value of attending to patients' spiritual needs is generally acknowledged (Ehman et al., 1999, Galek et al., 2007, Grossoehme et al., 2020). How and where to situate chaplains in the flow of patient care, however, has been a limiting factor in the development of such care. The sheer size of the patient panel in primary care practice makes the ability to screen or identify patients needing spiritual care more critical. In addition, the pace and cadence of the primary care clinic does not easily accommodate the more casual and conversational style of a spiritual care visit, and patient expectations of the time spent at the doctor's office do not easily accommodate the exploration of spiritual stressors. A model needs to be developed by which patient needs can be assessed, and chaplains can respond in ways that are effective, timely, and efficient.

In addition to this change of the *location* of patient care from inpatient to outpatient contexts, an evolution in the modality of such care has occurred as virtual tools for patient encounters have gained increasing acceptance for providers of all types of patient care, from well care visits to triage, and from case management to behavioral assessment and treatment (Bashshur et al., 2016). One of the most significant

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impacts of the COVID pandemic has been the implementation and acceptance of virtual care both in inpatient and outpatient contexts (Monaghesh & Hajizadeh, 2020; Temesgen et al., 2020).

The advent of virtual care modalities has had a significant influence on the increased viability of the expansion of the role of spiritual care into population health and managed care settings. In all of the settings discussed earlier, such technologies have been employed to meet emergent patient needs with positive effect. Spiritual care has participated in the evolution of such virtual care modalities, both in the inpatient world (providing vital connections between patients and their families, especially at the end of life) but in the outpatient and ambulatory contexts as well (Sprik et al., 2020).

It has become increasingly apparent that patients are responsive to receiving care in such remote ways, and anecdotally it seems to be effective in the delivery of care to those who would otherwise be underserved. This suggests that a supple model for spiritual care in the managed care and population health context will include significant attention to the use and efficacy of such interventions. There is similar anecdotal evidence that the inclusion of spiritual care in case management and interdisciplinary care benefits not only the patient, but provides significant support to the other members of the care team. For example, a report from the Sandwell and West Birmingham CCG of the National Health System of Great Britain noted the significance of "chaplains for well-being" on both patient care and the effective working of the care team (Boughey & Kevern, n.d.; Kevern & Hill, 2015). For the benefit of both patients and other members of the care team, it would seem that the inclusion of spiritual care into the managed care and population health context would be of value.

A first step in developing a model for spiritual care in the context of managed care and population health would be to identify particular cases in these contexts, which demonstrate the potential, and feasibility of such interventions. This article provides two case studies of care provided alongside care management within a population health model. These cases, set within a large, non-profit, religiously affiliated health care system, provide some initial insights into the promise and barriers to such care.

Each case is based on the report of the attending chaplain, interviews with the care managers involved in the case, and review of the patient record. Patient consent was obtained to share the details of their encounters, assuring them that any identifying markers would be modified to assure their anonymity. As structured, these case studies are understood to be exempt from institutional review board review.

Following a brief description of the patient, the chaplains will look at the particular issues and concerns the patient presented, and the ways in which the spiritual needs or concerns might have played a role in the patient's larger well-being. The chaplains will then seek to articulate the nature of the chaplain's intervention, and how that intervention was received both by the patient and other members of the care team. Finally, it will be explored how, in the chaplain's, patient's, or care team's assessment, the intervention was effective. In each case the patient's larger medical record was reviewed to ascertain whether the chaplain's work, alongside the rest of the team, had a salutary impact on the patient's overall health. Each of these emerging settings for spiritual

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care is situated within Ascension, a large, not-for-profit health care delivery system in the United States. Ascension is a Catholic health care system, but its spiritual care is specifically committed to serving the needs of patients without regard to their religious or spiritual background.

Remote Patient Monitoring—Spiritual Care in the Context of Care Management

Spiritual care as a component of complex care management was introduced in segments of the Indiana, Tennessee, Florida, and Kansas markets of Ascension to augment their remote patient monitoring program (RPM) for patients diagnosed with congestive heart failure, chronic obstructive pulmonary disease, and diabetes and at high risk for readmission (Hagland, 2019). Beginning in 2020, a Spiritual Distress Screen was integrated into the regular screening process of the patients at the 2-week point of their engagement. The three-question screen, adapted from the research of Steven King and colleagues (King et al., 2017), yields a numeric scoring of the three questions on a 4-point scale (0–3) for a total possible score of 9 (see Table 1). Scores greater than 2 prompted an automatic referral for a chaplain who followed standard case management protocols to follow up within 72 hours, with three documented attempts to reach the patient before completing care.

In initial interviews, patients were assessed for spiritual care needs and strengths, and chaplain activities were tracked using a modification of the Advocate Taxonomy developed by Massey et al. (2015). Chaplain encounters were documented within the patient chart, and care was provided until the patient successfully completed their care management program, opted out of care, concluded spiritual care by agreement with the chaplain, or was lost to follow-up.

From April 2020 to March 2021, the center in Indiana (mostly serving Indiana, Florida and Tennessee) reported 1,453 new patient referrals for RPM: 500 of those patients screened positive for spiritual distress (35%) and were referred for spiritual care. The Texas center (serving patients in Kansas and Texas) referred 220 of 2,354 patients for spiritual care during the same period (9%). The Indiana center elicits patient satisfaction ratings on the completion of care for all patients. A total of 267 patients completed patient satisfaction ratings of the spiritual care offered, and 96% responded favorably to "How well time with chaplain(s) meet your spiritual/emotional needs," whereas 97% provided a positive rating to "Please rate the care provided by your Ascension chaplain(s)."

Case Study

Background—Angela, an African American woman in her early 70s, was admitted to Remote Care Management (RCM) in the spring of 2021 to monitor for hypertension. Her husband died several years ago and she lives alone. She has one daughter, who checks in on her occasionally but is not actively involved in her care. She identified as Christian, and spoke of connection to a congregation from a Pentecostal tradition, noting she had been a Christian since she was 19. Her Spiritual Concerns Screen indicated "a great deal" related to spiritual or religious issues and "somewhat" regarding concerns related to end-of-life issues (a score of 4). The chaplain was a female in her 50s with 3 years post-residency experience, and in the process of applying for board certification with the Board of Chaplaincy Certification, Inc. (BCCI). A specific competency of board-certified chaplains is demonstrated ability to work with patients from any or no religious tradition or background without prejudice, and taking care not to proselytize.

Chaplain care was initiated in mid-spring of 2021, and continued for approximately 10 weeks. The chaplain support included 10 telephone visits. Early in the encounters the patient appeared guarded, expressing feelings of loneliness and isolation, but saying "A Christian should never feel alone." She spoke of a deep reliance on scripture and prayer,

TABLE 1
Spiritual Distress Screen

At Ascension Health, we're committed to caring for the whole person: body, mind, and spirit. Because of this commitment to holistic care, I'd like to ask you a few questions to determine any level of concern you might have in a few areas. Please respond regarding your level of concern regarding each area using the following scale: "not at all, somewhat, quite a bit, and a great deal."
Level of concern related to loss of meaning and/or joy in life
___ Not at all (0) ___ Somewhat (1) ___ Quite a bit (2) ___ A great deal (3)
Level of concern related to spiritual or religious issues
___ Not at all (0) ___ Somewhat (1) ___ Quite a bit (2) ___ A great deal (3)
Level of concern related to end-of-life issues
___ Not at all (0) ___ Somewhat (1) ___ Quite a bit (2) ___ A great deal (3)
Total score greater than 2. Refer for spiritual care consult.

noting that she would pray for hours for the needs of others. The chaplain interpreted this practice as indicative of a struggle relating to the need for and practice of self-care, and engaged the patient in reflections on biblical references to the body as a "temple" and deserving of care. The patient responded to this reflection, and worked at using her faith resources for her own well-being as well as that of others.

The chaplain also heard the patient's reticence to rely on medical interventions, as the patient said she understood such reliance to be evidence of lack of faith. The patient specifically struggled with using a continuous positive airway pressure (CPAP) to provide better rest at night. The chaplain led the patient in reflecting on the biblical creation accounts, and the possibility that technologies like the CPAP were works of God's creation, as well, and intended as a tool for us to care for the rest of God's creation. Through subsequent visits the patient expressed her gratitude for the positive framing, and indicated she was able to be more engaged in her care, including the CPAP, and a better understanding of the relationship between diet and health.

The patient completed a routinely generated spiritual screen during her fourth week in RCM and after 3 weeks of chaplain visits. Her total spiritual distress score at this time was 8, higher than the initial screening. She said in meetings with the chaplain, however, that this was a result of positively engaging her issues and concerns, and not due to a negative impact of the chaplain's visits. In fact, she showed a significant commitment to the spiritual care offered, indicating in a last visit that she wished she could remain in the program just for the spiritual care aspects, and saying she felt it was a unique contributor to her self-compliance and monitoring.

The patient completed RCM in late-summer, 2021. Upon completing RCM, the patient demonstrated an ability and willingness to monitor independently. The discharge note specifically mentioned that the patient expressed appreciation for the chaplain's participation in her care.

Summary of the Spiritual Care Impact on the Case

The interview with the Case Manager (CM) assigned to the team noted that, in her role on the interdisciplinary team (IDT), her primary considerations with the case related to the patient's medical concerns, and that the bulk of her contact with the patient was related to remote monitoring of medical indicators. She noted that from her perspective the patient made good progress relating to medical interventions. She indicated that in her general practice she would not look at spiritual care or social work notes without cause. She reported no knowledge of the issues raised within the context of spiritual care, and said that in reviewing the case she would have imagined the chaplain's concerns directed primarily at the patient's need for social supports.

The CM expressed appreciation for chaplain availability, especially for patients who have an underlying spirituality, assuring that spiritual needs can be met in an appropriate manner. She said she would be very likely to reach out to spiritual care supports if she felt it was indicated in future cases. The CM seemed mostly unaware of the content of spiritual care interventions, but appreciative of their effects, and of the positive value to the patient as expressed in the discharge note. Asked about the role of spiritual care she said, "It needs to continue," reflecting on the role it has played in other outpatient contexts in which she worked. "I definitely see it with engagement, when the patient is really engaged," as in the case of this patient.

Spiritual Care in the Context of Managed Care of a Medicare Advantage Program

Ascension Complete is a collaboration between Ascension and Centene to provide care management to an MA population. In 2020, Spiritual Services was invited to present a proposal for integrating spiritual care into the care management team for patients with complex medical conditions. Approved by the Centers for Medicare & Medicaid Services in the fall, 2020, the benefit was initiated on January 1, 2021, focusing on those patients qualifying for Chronic Condition Special Needs Plans (C-SnPs).

The same screen utilized in the RCM program was integrated into the Health Risk Assessment (HRA) completed by all patients upon enrollment, and updated at least annually. Because of peculiarities of the electronic medical record system used for the program, the screen generates a referral to spiritual care when a score of 1 or greater is indicated.

In addition, chaplains have participated in regular training calls with the care management team, providing opening reflections, and reinforcing chaplain availability both for patients and for members of the care team. In this context chaplains have provided specific training for care managers regarding how to identify signs that the patient is experiencing spiritual distress and encouraging them to initiate direct referrals when indicated.

Chaplains have also participated in weekly patient rounds instituted to provide more focused care for patients involved in long hospitalizations, significant stays in skilled nursing facilities, and patients involved in behavioral health care management. Chaplains have been able to provide spiritual care consultations on difficult and high management

cases, encouraging other members of the care team to consider the potential of spiritual distress for patients and family members. For example, the chaplain suggested a spiritual care consult for a patient whose husband expressed concerns regarding his ability to provide adequate care for his wife were she to return home, but articulating some guilt at the possibility of long-term care.

Ascension Complete serves a patient population of 4,718 members in seven states (Texas, Indiana, Kansas, Michigan, Illinois, Florida, and Tennessee). Estimated patient needs for spiritual care supports were set at 1.65% of the population, based on the number of members with qualifying conditions in care management, and the anticipated rate of positive Spiritual Distress Screens drawn from literature (King et al., 2017) and experience using the screen in the outpatient setting. Through the first 10 months of 2021, actual referrals exceeded that estimate. Ninety spiritual care referrals were generated (1.9% of the total patient population) either through the HRA or direct referral from care managers. Complete spiritual assessments were completed on 42 of those referred, with follow-up visits to address the identified spiritual needs or concerns. The remaining 48 cases either were lost to follow-up (after three unsuccessful attempted contacts), refused spiritual care, or felt their concerns were addressed in the first visit and did not express need for assessment of spiritual concerns.

Case Study

Allan is a White man in his late 80s living in the Midwest. He is married, though his wife has moved to an assisted living facility to accommodate her care needs. His primary concerns relating to medical and behavioral health relate to urinary incontinence and depression, which he reports he has struggled with on and off throughout his life. Raised on the East Coast, he indicated he had spent his career in numerous institutions of higher learning in various administrative roles. He identified a personal Christian faith and spoke of connection to several mainline protestant congregations throughout his life but said he did not consider himself "religious" so much as a seeker of truth. His HRA indicated levels of concern for loss of meaning and joy and religious and spiritual struggles as "somewhat," scoring 3 and warranting a referral for spiritual care. In her referral the care manager noted evidence of spiritual concerns that were raised in the course of her care relating especially to Allan's passion for the educational needs of Native American people, and elaborate plans to address those needs. She noted that he had concerns that he would not be able to implement his designs before his death. The care manager noted as well an elevated Patient Health Questionnaire-9 (PHQ-9) score, a recognized screening tool for depression. Her referral noted a possible connection between the patient's scores and his expressed spiritual concerns. Allan agreed to contact with the chaplain.

Allan presented as a very articulate man, with a wide and varied life experience centering on his work in higher education. He spoke of concerns relating to loss of bladder control that interrupted his sleep, compounded by self-identified memory issues that complicated his self-care. He mentioned that his wife also had medical complications that had resulted in her moving to an assisted living context 3 years ago. At that time, he said, he was still walking 3 miles a day or more, but said "I'm not able to get much past the bathroom these days."

Allan noted that he was working to develop a non-profit organization to address the needs of Native Americans in several Midwestern states, and spoke with passion regarding his concerns. He noted that the organization had been granted 501C3 status, but that he was concerned as to who would carry on his work "when I am gone." He mentioned one son, who was an occasional caretaker for Allan and his wife, but noted that his son had significant behavioral health needs that were not adequately addressed.

There were a total of three chaplain visits with Allan over the course of 2 months. At the conclusion of the third visit, Allan acknowledged progress on his concerns, and requested a follow-up in 1 month. After four attempted contacts, the chaplain closed Allan's care plan with a note encouraging re-referral as indicated. The chaplain visits focused on concerns for loss of dignity, meaning and purpose, and concern for well-being of loved ones.

Summary of Spiritual Care Impact on the Case

Over the course of spiritual care visits, Allan's PHQ-9 scores moderated from a high of 12 (indicating moderate depression) to 3 (not clinically significant). In a subsequent care management visit, he reported that he enjoyed the spiritual care visits, and that "it is helpful to discuss his feelings to someone." He noted that he had started a balcony garden with his son, and in a subsequent visit noted that his son was providing helpful supports and that they were "enjoying their time together." He affirmed that he had not pursued behavioral health counseling, indicating the spiritual care supports were sufficient. He excused himself from the care management call because he wanted to attend a bread making class offered by the assisted living team.

In a follow-up interview with the care manager, it was noted that the patient had made good progress during the term of spiritual care, which seems to have been maintained following the chaplain encounters.

She noted that the patient had expressed interest and appreciation in the availability of spiritual care, and noted the improvement in the patient's PHQ scores. She suggested that the improvements seemed to be in response to the shared interventions of care management and the chaplain, given the patient's personal spiritual grounding. She noted the patient had been involved in case management for over a year before she initiated spiritual care as a way of assisting the patient in "getting his feelings out and feeling validated." She identified the social supports and "having someone else to talk to" as significant in Allan's progress in care.

The care manager said she felt one of the primary benefits of spiritual care is in the ability to "spend more time" with the patients, and hear the more complete story of the patient's life. Generally, she said, she wished spiritual care were available to a broader segment of the patient panel, especially related to grief issues. She noted she has mostly graduated Allan from care management, and that she "never would have thought she would have gotten there without spiritual care support." She also noted appreciation for the spiritual care supports for other members of the care team, and especially as a part of the multidisciplinary team. "It makes it feel less like we are on an island when providing care."

Discussion

The spiritual care within the population health and managed care setting described by these two cases illustrates how chaplains can make important contributions to patient care in this setting. As witnessed by other members of the health care teams, chaplains are able to connect with and address patient needs not only in the spiritual realm, but providing direct benefit to the patient's emotional and physical suffering, allowing them to participate more fully in their own care planning, and be more effective in accomplishing goals of care.

As can be seen in these cases, spiritual care can be beneficial for persons with expressly religious perspectives and affiliations, but has benefit for those, like Allan, who are not strongly affiliated with any religious tradition, but resonate with spiritual themes and respond to spiritual appropriations of what might otherwise be understood in terms of behavioral or mental health modalities. Chaplains are, by training and professional certification, equipped and committed to care for patients regardless of their religious or spiritual orientation, and can benefit patient care even for patients with no religious commitments.

The cases also illuminate the importance of spiritual care for the other members of the IDT. Although the value of care is most often calculated in terms of its "patient-facing" benefits, these cases show that the work of the team is enhanced by the inclusion of spiritual care, both in providing more in-depth and intensive contact with the patient ("getting their feelings out" and helping patients feel "validated") but also in providing support for the care managers in complex cases.

As the majority of care offered in the cases presented was set in a context of virtual care, these cases provide anecdotal evidence to support the growing research on the efficacy and acceptability of virtual care in the chaplaincy arena (Sprik et al., 2020). The feedback from the CMs, in fact, expands on this research, suggesting that chaplain presence on the IDTs provides a "bridge" between what are often felt to be islands of interest in the virtual work world, engaging not only the patient, but members of the care team in mutual support.

Perhaps the greatest challenge in moving into this new arena of care will be the development of appropriate metrics by which to measure the true effectiveness of spiritual care interventions. The field is in the process of identifying appropriate approaches to measuring outcomes associated with spiritual care (Damen et al., 2020; Handzo et al., 2014). That work will apply as spiritual care becomes more integrated in outpatient, managed care and home health contexts. A useful approach for spiritual care in managed care, and perhaps other settings, may be to combine proximal measures of spiritual distress or well-being (e.g., Spiritual Distress Screen, described in Table 1, which seeks to quantify spiritual well-being discreetly) and distal measures of emotional well-being, quality or life or functional status (e.g., the PHQ-9 or Generalized Anxiety Disorder-7 [GAD-7], identifying emotional states, which might be concomitant with spiritual well-being), as hinted at in these cases. Moreover, as is accepted in the world of care management, overall patient improvement rather than changes in specific indicators may be the best tool by which to assess the impact of spiritual care.

Perhaps the greatest challenge in moving into this new arena of care will be the development of appropriate metrics by which to measure the true effectiveness of spiritual care interventions. The field is in the process of identifying appropriate approaches to measuring outcomes associated with spiritual care.

An additional challenge is the question of when spiritual care interventions are "complete" in this new arena of care. As noted with Angela and Allan, the patient often simply stops receiving calls from the attending chaplain. Completion of care related to specific care pathways drawn from explicit assessment of spiritual needs is one potential way to guard against either premature termination or unlimited spiritual care engagement.

What will not change in the near future is the trend by which patient care is increasingly delivered in population health and managed care settings, and more closely tied to the patient/population than to a clinic, hospital, or institution. These cases indicate patient spiritual needs related to their health do not disappear simply because they are not admitted to inpatient care. They also demonstrate that effective, and efficacious care is possible within the team setting, using remote technologies, and that this care ultimately benefits not only the patients, but the care team as a whole.

Implications for Case Management

The cases presented suggest inclusion of spiritual care in the care management/population health approach to patient care is viable and valuable both for the benefit of the patient and the functioning of the care team. Inclusion of spiritual care provides unique tools, especially for patients with spiritual or religious inclinations, to address ongoing health concerns and means for reinforcing beneficial health behaviors that complement the patient's spiritual or religious beliefs. It also provides different modalities for the care team's understanding of a patient's motives or actions, which might otherwise remain obtuse. For example, in the RPM case, the chaplain's insights regarding the patient's reticence to engage treatments as a "lack of faith" provided for more effective management of the patient's needs, in ways that were consistent with her fundamental beliefs. Finally, chaplain participation in the work of the IDT provides support for the members of the team if and when their own spiritual or religious concerns may influence a patient's care. Chaplain participation on the team can help care providers in better understanding their own resources and reservations in providing patient care.

Conclusion

These cases suggest several next steps in the integration of spiritual care in the population health and care management context. First, it would be helpful to identify and illuminate similar initiatives, and to compare their relative effectiveness and merits. Increased sharing of cases such as these will encourage continued innovation.

Second, as programs such as these establish a longer track record, there will be opportunities for qualitative and quantitative assessment of the efficacy of spiritual care as a component of the care management team. Specific investigation of care managers' awareness, use, and acceptance of spiritual care, and their confidence in assessing spiritual needs and either addressing or referring for care would be beneficial. A systematic evaluation of patient response to spiritual care interventions would be helpful as well.

Finally, it would be helpful to continue to hone and develop tools for the effective screening and assessment of spiritual needs within the population health and managed care setting. Validating available resources and adapting tools from other contexts would also require further assessment of the accuracy and precision of tools such as the Spiritual Distress Screen in Table 1. In addition, development of recognized and effective pathways to address identified spiritual concerns will be significant both for effectively communicating the chaplain's role to other members of the care team, and for assisting chaplains in better integrating their work into the larger efforts of the IDT.

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