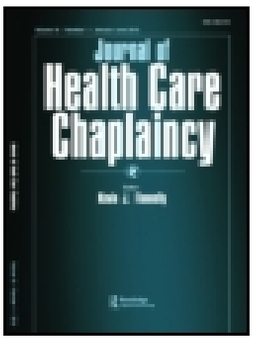

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Management and leadership competencies among spiritual care managers

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ABSTRACT

Both the healthcare and religious landscapes in the United States are rapidly changing. Despite the dynamic environment that spiritual care managers face, many do not receive management training prior to assuming their roles and many receive little or no training once they are in their roles. This study used mixed methods to examine the applicability of the National Center for Healthcare Leadership (NCHL) competency model to spiritual care manager roles. Interviews were conducted with 10 spiritual care managers across the country, using a Behavioral Event Interviewing (BEI) methodology. Interviews were quantitatively analyzed by using Natural Language Processing and qualitatively analyzed by thematic approach using NVIVO. The results found the EXECUTION domain to be the most discussed theme, followed by RELATIONS, TRANSFORMATION, and BOUNDARY SPANNING. Collectively these analyses suggest the NCHL Leadership Competency Model can provide a useful framework for understanding the roles and development needs of spiritual care managers.

KEYWORDS

Competency model; healthcare chaplaincy; management and leadership competencies; mixed methods research

Introduction

Competent leadership is essential for any organization to achieve its mission, especially in a changing and challenging environment. We are in the midst of especially challenging times for managers of spiritual care programs in healthcare settings. The shift in healthcare delivery from in-patient services to population health is accelerating. The costs of delivering care must be contained while quality continues to improve. Every discipline must be able to show how they contribute to these goals. Spiritual care has historically been exempt from some of these pressures, but that is quickly changing (Handzo, Cobb, Holmes, Kelly, & Sinclair, 2014).

While the healthcare landscape is undergoing rapid change, so is the religious landscape in the US. One of the most impactful changes is the increase in the proportion of people who report no religious affiliation: approximately 40% of people under 30 in some national surveys (Pew Research Center, 2019). However, on these same surveys, many people report having rich spiritual lives (Pew Research Center, 2019), and face

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serious spiritual/existential questions when experiencing illness or other life crises (Weber, Pargament, Kunik, Lomax, & Stanley, 2012).

Most healthcare chaplaincy managers are promoted into their roles from clinical practice or chaplaincy education. In many cases, they receive little or no training in management prior to assuming their new role, and may receive little or no training once they are in their new role; thus, many learn management skills by trial and error. Absent a systematic approach to hiring and development, some managers are more successful than others in developing the competencies required of effective managers and leaders, resulting in substantial variation in effectiveness of the chaplaincy departments these managers lead (Cadge, 2012). Based on a study of chaplaincy programs in 17 leading US hospitals, including interviews with their chaplaincy managers and staff chaplains, Cadge (2012) identified three types of chaplaincy departments: professional, traditional, and transitional. Four of the 17 departments were categorized as professional, where chaplains were well-integrated in their institutions. In these hospitals, chaplains were salaried employees, followed protocols that meant they were always present for some situations (e.g., code blue), members of the interdisciplinary care team, part of many hospital committees, and oriented to patient/family care as a first priority. Transitional departments (3 of the 17) were in the process of becoming professional. Among the factors associated with the chaplaincy department type, Cadge observed "professional and transitional departments have … grown and became integrated into their hospitals through the efforts of managers who became familiar with the language and priorities of the healthcare system. These managers then developed strategies to build their departments" (p. 119). Cadge also observed that these effective chaplaincy managers did this work individually and through informal networks, without any formal training or particular courses.

Since the time Cadge's research was conducted, very little additional work has emerged around the competencies required for effective leadership of spiritual care programs, and there are few established programs to help current or prospective managers develop those competencies. An important exception is the efforts of a task force in the National Association of Catholic Chaplains (NACC) who developed a description of Spiritual Leadership Competencies for Pastoral Care (NACC, 2009). Their work identified ten competencies, including Leadership ("skills and ability to set the goals of a department and inspire/direct the staff to achieve" them); Organizational Dynamics ("knowledge of and ability to navigate and maneuver within the structural, cultural, and power relationships within an organization to achieve desired outcomes"); and Strategic Planning ("capable of creating the new and different—to be actively involved in setting short term goals while at the same time being future oriented to establish long term goals"). Other competencies in the statement include finance, personnel management and professionalism.

Outside of the spiritual care profession, a number of healthcare leadership models have been developed. A particularly comprehensive model is maintained by the nonprofit National Center for Healthcare Leadership' (NCHL), currently in version 3.0 (NCHL, 2018). The NCHL model was developed using behavioral event interview methods (Boyatzis, 1982), and is organized according to a seven-domain framework (see Figure 1). Development of the model was informed by four streams of relevant science:

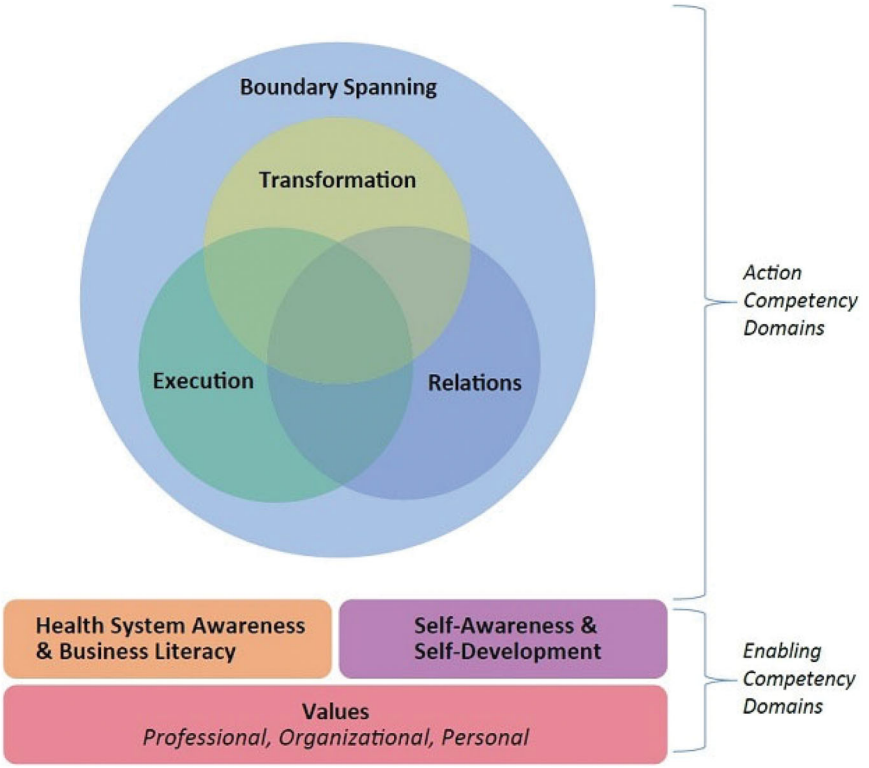

Figure 1. NCHL Health Leadership Competency Model 3.0 (NCHL, 2018).

(1) research on leadership theory and leadership competencies in applied settings (Yukl, 2012); (2) reviews of the emerging knowledge base about neuropsychological correlates of leadership (Waldman, Balthazard, & Peterson, 2011; Boyatzis & Jack, 2018); (3) theoretical and conceptual reviews of corporate social responsibility, including the role of professions (Groves & LaRocca, 2011; Susskind & Susskind, 2015); and (4) systematic reviews of leadership development in practice and higher education settings (Day, Fleenor, Atwater, Sturm, & McKee, 2014; Day & Dragoni, 2015; Slavich & Zimbardo, 2012). The "action" domains include competencies that leaders need for success in their direct work (NCHL, 2018). On the other hand, the "enabling" domains include self-awareness and professional knowledge-related competencies that can heighten the potency of the "action" domains (NCHL, 2018). Recent research has found the NCHL model crosswalks robustly against numerous other healthcare leadership models, suggesting it may have utility as a "common language" or framework to bring together multiple leadership models across disciplines (Garman, Standish, & Wainio, 2019).

The original NCHL validation study did not include chaplaincy managers. In light of the critical importance of leadership for effective spiritual care programs, the aim of the present study was to examine the applicability of the NHCL model to spiritual care leadership roles.

Methods

This study involved a partnership between researchers involved with healthcare leadership and healthcare chaplaincy. The researchers collaboratively created a topic guide, informed by the expertise of the healthcare chaplains, and utilized this guide to develop interview questions, implement a participant recruitment strategy, conduct participant interviews, and analyze the data. A parallel mixed-methods design was employed, in which both quantitative and qualitative approaches were conducted in parallel and an analysis of each approach was completed separately. Results from these separate analyses were then compared to develop overall concepts and themes pertaining to model applicability.

Potential interview participants were identified with the help of the Transforming Chaplaincy Advisory Group, and ultimately included 12 managers from eight different healthcare organizations from across the United States. Potential participants were contacted via email to request their participation in an hour-long interview about spiritual care leadership. After a week, follow-up emails were sent to non-respondents. Within two weeks of the initial contact, ten of the twelve chaplaincy managers (83%) agreed to participate. To ensure consistency, all interviews were conducted by the same member of the research team, using methods adapted from Boyatzis (1982). The interview protocol was designed to elicit information relevant to the Action Domains of the Leadership Model. All ten interviews were conducted within the same one-month time span.

There were two primary phases to each interview. During the first phase, participants responded to background questions about the nature of their work, including their job titles, job experience, and the primary goals within their roles. During the second phase, participants were asked to identify six critical incidents associated with their work, in which their actions or decisions led to either favorable (three incidents) or unfavorable (three incidents) outcomes. For critical incidents with favorable outcomes, questions pertaining to context of the situation, the task that the interviewees were trying to accomplish, actions that the interviewees took, and the result of the situation were asked. For critical incidents with unfavorable outcomes, one additional question was asked: "If you found yourself in a same situation again, what alternative action would you take?" For each critical incident question, two to three follow-up questions were asked to help add descriptive detail to decisions, behaviors, and outcomes. With the consent of the interviewees, all interviews were audio-recorded. Recordings were then transcribed verbatim with the assistance of a professional transcription company.

Quantitative analysis

For the quantitative analysis, descriptions of spiritual care managers' behaviors contained within the transcriptions were identified and coded. A total of 175 code-able behavioral descriptions were identified in this step. Examples of these behaviors include "builds relationships with PRN staff chaplains," "hires employees who are fully certified and credentialed," and "coordinates with the leadership group to figure out a way to initiate the program." Descriptions were reviewed against the current version of the NCHL competency model (version 3.0) and, where possible, statement matches were coded according to the current NCHL competencies by a human coder. To help validate

the matching process, a separate coding was completed using the Natural Language Processing (NLP) methods described in Garman, Standish, and Kim (2018). This approach involved creating a quantitative scoring for the similarity of word patterns between text blocks—in this case, the behavioral descriptions and the NCHL competency descriptions—and then identifying the best fit based on a statistical assessment of commonality and relative frequency of word use within the descriptions. Results of the program coding were compared to the human coding, and differences between the two were reconciled through third-party review. By pursuing an alternative coding procedure, we were then able to compare similarities and differences across the two approaches and create a more robust set of findings through the reconciliation of the human/NLP discrepancies.

Qualitative analysis

To ensure important contextual themes were also captured from the interviews, a separate qualitative analysis was conducted by two of the researchers. Each researcher independently coded the same transcript using NVivo 12 software (NVivo; QSR International Pty Ltd. Version 12, 2018). An introductory codebook was then collaboratively developed between the two researchers from their codes. The researchers then used this codebook to independently code half of the interviews. The responses were then compared to establish inter-rater agreement, using the Kappa statistic. The Kappa was calculated by comparing the points of agreement in coding, the points of disagreement, and the total possible agreement within the initial code. The Kappa coefficient between the two coders was 0.64, which is considered a good level of intercoder agreement (McHugh, 2012).

The remaining interviews were then coded using the final codebook, with each line of transcript coded to capture competencies that were embedded in the conversation between the interviewer and the interviewee. For this step, we used the constant comparative method (Kolb, 2012), which is used to constantly compare each of the nodes that human coders code. Through NVivo, researchers can create nodes, which allows them to locate emerging ideas, patterns, and themes. These nodes were then organized into thematic categories, and similar thematic categories were divided into major themes using NVivo.

Results

Of the ten managers participating in this study, seven (70%) identified as female, and the remaining three (30%) identified as male. The average length of time in their management positions was 6.5 years. The median was 4.2 years, in a range from nine months to 24 years. Five of the managers (50%) worked at academic medical centers; the remaining five worked at faith-based health systems.

Quantitative findings

The results of the behavioral statement mapping process are summarized in Table 1. The behavioral statements mapped to 27 of the 28 competencies with the NCHL model;

Table 1. Chaplaincy manager behavioral statements compared to the National Center for Healthcare Leadership competency model.

Domains	Percent	Competencies	Percent
Action Domains			
Execution	33%	Accountability	5%
		Achievement Orientation	5%
		Analytical Thinking	2%
		Communication Skills 1 (Writing)	5%
		Communication Skills 2 (Speaking/facilitating)	0%
		Initiative	7%
		Performance Measurement	3%
		Process & Quality Improvement	3%
		Project Management	3%
Relations	18%	Collaboration	5%
		Impact and Influence	4%
		Interpersonal Understanding	3%
		Talent Development	3%
		Team Leadership	5%
Transformation	11%	Change Leadership	4%
		Information Seeking	2%
		Innovation	3%
		Strategic Orientation	2%
Boundary Spanning	11%	Community Collaboration	5%
		Organizational Awareness	4%
		Network/Relationship Development	2%
Enabling Domains			
Health System Awareness/Business Literacy	11%	Financial Skills	2%
		Human Resource Management	7%
		Information Technology Management	2%
Self-Awareness & Development	14%	Self-Confidence	4%
		Self-Awareness	3%
		Well-being	7%
Values	2%	Professional and Social Responsibility	2%

Values are percent of the 175 behavioral statements that reflect each competency/domain.

speaking/facilitating skills from the EXECUTION domain was the only competency from the model not represented in the statements. At the domain level, the EXECUTION domain represented the largest proportion of behavioral statements, accounting for approximately one-third of the mappings. RELATIONS was the next most frequent domain, mapping to 18% of the behavioral statements, followed by TRANSFORMATION and BOUNDARY SPANNING, which each represented 11% of the statements.

Qualitative findings

Qualitative analyses were used to identify key themes from the Behavioral Event Interviews. The key themes included three competencies from the EXECUTION domain: *achievement orientation, analytical thinking* and *initiative*. Many of the chaplains described these three competencies while they were discussing events with favorable outcomes, often related to implementing new programs or classes within their departments or healthcare organizations. As indicated by the chaplains, successful implementation of these programs required critical skills in analytical thinking, taking initiative on projects that they set their minds to, and being driven enough to take additional steps to achieve the goals that they had. For example, one chaplain stated, "While it was difficult to get everyone engaged enthusiastically, after constantly

reminding them about our end goal, we were finally able to get the course started." Another indicated, "Because I saw nobody stepping up and volunteering, I took the initiative to volunteer myself to get the event going."

From the RELATIONS domain, *collaboration* and *team leadership* were the most frequently identified competencies by the qualitative analysis. All of the chaplains interviewed for this study were in positions managing staff members and overseeing daily operations. An important part of these roles involves working with junior members of the department while providing insightful feedback. Examples from the interviews included giving detailed instructions and providing on-the-job demonstrations. In addition to working with their own staff, chaplain managers also worked closely with people outside of their departments. Interviewees noted that collaborating across departments can be difficult at times due to differing goals and competing priorities, and effective approaches to team leadership are important to success. As two of the chaplains stated, "As a manager, you need to find different ways to collaborate with different departments because the funding is not going to readily be available" and "It can be difficult working with people outside of your department. However, it really is up to you, as a manager, to find a way for these groups to work because the very success of the project might depend on you."

The one key theme arising from the TRANSFORMATION domain was *change leadership*. Chaplaincy managers working within the context of large healthcare organizations have many constraints that need to be addressed, including the regulatory, business, political, demographic, and ethno-cultural ramifications of their decisions. Many chaplaincy managers noted that these constraints often limited organizational success, and presenting clear and compelling alternatives challenging the status quo was important for successfully accomplishing their goals. As one chaplain stated, "I made a case for a new position" through such a process, which led to the development of new courses, accreditation, and a renewed sense of respect for chaplaincy within the hospital.

Lastly, the key theme from the BOUNDARY SPANNING domain was network/relationship development. This particular competency was mentioned most frequently by all managers and throughout both favorable and unfavorable events. Many of the events pertaining to unfavorable outcomes dealt with managers experiencing difficulties developing or maintaining relationships with key leadership members within their organizations. Chaplaincy managers also expressed the need to sustain good relationships with their supervisors so they could achieve their goals of building their programs. The need for these relationships was frequently identified by the chaplain managers, who stated: "I built a relationship with her (the supervisor) and was able to ask clarifying questions" and indicated that without positive relationships with the supervisors "we couldn't have classes and there was no leader."

Discussion

Challenges facing healthcare organizations and the changing religious demographics of the country make managing a spiritual care program very demanding. Research that can inform the preparation of spiritual care managers can help ensure their success. In this project, we tested whether the competencies described in the NCHL Leadership

Competency Model may apply to spiritual care management. Using data from Behavioral Event Interviews with ten spiritual care managers we found evidence that the Model demonstrated construct validity. Specifically, we found statements for all domains in the model, as well as 27 of the 28 competencies.

Three competencies were identified relatively frequently, each of which each had 7% of the behavioral statements: Human Resource Management, Initiative, and Well-being. The relatively high number of statements that addressed Well-being seems consistent with the emphasis in chaplaincy training on self-care. It is less clear how chaplaincy training or practice may have helped managers develop competencies in Human Resource Management and Initiative. The managers' statements reflected lower frequency of competencies (2% of the statements) for seven competencies including Analytic Thinking, Strategic Orientation and Information Technology Management. This may reflect the fact that these are not competencies that would normally be addressed in chaplaincy training or practice. It is surprising to us that none of the behavioral statements related to the Speaking/facilitating competency, as this is an area where chaplains receive specialized training. Similarly, chaplaincy training and practice emphasizes Professional and Social Responsibility and Self-awareness, so the level of statements identifying these competencies (2% and 3%, respectively) was lower than we expected. One possible explanation is that the nature of the questions may have implicitly focused interviewee's attention on Action Domains, such that competencies like Self-awareness in the Enabling Domain did not come into focus. Further research is needed to expand our understanding of which competencies are more or less common among spiritual care managers.

The findings from this study should be read in light of several important limitations. One major limitation was that the interviews were conducted with relatively small convenience sample of spiritual care managers. Second, the methodology provides only a sampling of managerial activity, and as such, the behavioral statements may not represent the full range of the work of spiritual care managers.

While further research is needed to confirm and extend the findings from this study some preliminary suggestions for practice can be noted. The first suggestion relates to self-assessment. Chaplains who are preparing for leadership roles can examine the competencies and identify those where further development could be particularly helpful. Similarly, chaplains who are already in management roles can examine the competencies and identify strengths and areas for growth. For both groups, it may be particularly useful to solicit feedback from one or more colleagues who are well acquainted with the manager and his/her work as third-party perspectives are typically more accurate than self-assessments (Sitzmann, Ely, Brown, & Bauer, 2010).

A second suggestion builds on Cadge's (2012) observation that only a small proportion of the spiritual care programs she observed (four of 17) met her criteria for the "professional" type. This finding points to the potential for management and leadership education to help managers of spiritual care programs develop excellent programs. One such program is the Spiritual Care Management and Leadership program, which is co-led by Transforming Chaplaincy (www.transformchaplaincy.org) and the Health Systems Management Department of Rush University.

A third suggestion relates to the leadership of professional chaplaincy organizations. In most cases the voluntary and paid leadership of these organizations also have had no

formal training in management and leadership. Advancing the integration of spiritual care in healthcare has always been challenging. Cadge (2019) has reviewed the strategic planning efforts of the Association of Professional Chaplains, the largest organization of professional chaplains, over the past 50 years and found a number of their efforts produced limited results. Management and leadership education may help ensure well-managed professional chaplaincy organizations that are able to develop and implement the strategic vision needed in these challenging times.

As this was the first project to examine competencies in spiritual care managers in healthcare, there are many areas for additional research. Given the limited size of our explanatory sample, confirming these findings with a larger and more representative sample of spiritual care managers would be a particularly helpful next step. Research should also examine factors that may be associated with variations in spiritual care managers' competencies, including training, experience, and institutional context. Lastly, future research could assess spiritual care managers for their level of competency in the areas that have been explored in this study and examine which competencies are associated with objective measures of success in their roles.

In conclusion, this study provides preliminary evidence that NCHL Leadership Competency Model is applicable to spiritual care management and leadership. As healthcare organizations continue to experience pressure to pursue higher quality and manage expenses, the importance of strong and effective leadership of spiritual care programs is likely to grow in the years to come. In pursuing this research, we sought to make a contribution to the evidence base supporting effective leadership. The competencies identified through this work can provide initial guidance to current chaplaincy leaders as well as educators preparing future chaplaincy leaders for service roles.

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