The Context of Religious and Spiritual Care at the End of Life in Long-term Care Facilities*

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Despite the increasing numbers of Americans who die in nursing homes (NHs) and residential care/assisted living (RC/AL) facilities, and the importance of religious and spiritual needs as one approaches death, little is known about how these needs are met for dying individuals in long-term care (LTC) institutional settings. This study compared receipt of religious and spiritual help in four types of LTC settings: NHs, smaller (<16 beds) RC/AL facilities, traditional RC/AL facilities, and new-model RC/AL facilities. Data were also available for religious affiliation of the facilities, size, and provision of religious and hospice services. Controlling for such factors, the importance of religion/spirituality to the decedent was the strongest predictor of the decedent's receipt of spiritual help. In addition, new-model RC/AL facilities were significantly more likely to provide help for religious and spiritual needs of decedent residents than other RC/AL types, but did not differ significantly from NHs.

Modern medicine acknowledges the role of "spiritual and other forms of caring" beyond the traditional medical role (Institute of Medicine 1997:74) and

attention to spiritual needs and the provision of spiritual care for seriously ill and dying patients in health care settings recently have been advocated by the Institute of Medicine (1997), the National Hospice and Palliative Care Organization (NHPCO n.d.), and the Joint Commission on Accreditation of Health care Organizations (JCAHO 2008). One reason for this new thrust is that the nature and location of the dying experience have been changing over the past years. In the nineteenth century, death was an at-home, largely acute phenomenon, whereas after the mid-twentieth century, it became more often hospital-based for those dying from chronic diseases (Kaufman 2005). Most recently, this trend to death as an institutional experience has moved to long-term care (LTC) facilities including nursing homes (NHs) (Shield, et al. 2004). Although understanding and improving the quality of end-of-life care in LTC facilities has gained increased attention (Institute of Medicine 1997), there is little or no empirical evidence examining how organizational and individual factors relate to the meaning or receipt of spiritual care in these settings.

Data recently obtained by the Collaborative Studies of Long-term Care (CS-LTC) make it possible to explore the provision of spiritual care among dying residents in NHs, smaller residential care/assisted living (RC/AL) homes, traditional RC/AL homes, and new-model RC/AL homes (Zimmerman, et al. 2001a, 2001b, 2003). This research shows, for example, that spiritual support is tied to better perceived overall care during the period before death (Daaleman, et al. 2008). The study provides a multiperspective account of the dying experience by family members, staff, and administrators of the facilities soon after the deaths of residents. As this is the first large-scale comparative study of these types of organizations, it may shed new light on the ways in which religious and spiritual care are provided, and may vary by organizational setting.[1]

ORGANIZATIONAL FACTORS AFFECTING CARE AT THE END OF LIFE

Modern-day health care largely takes place in formal organizational settings. It was the limitations of such settings in providing for the spiritual needs of

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[1]It should be noted that this paper does not address ongoing debates over how to conceptualize "spirituality," nor the role of religion versus spirituality at the end of life. This is not because the debate is unimportant; quite the contrary, it has occasioned important and lively interdisciplinary debate for decades (e.g., Kennedy and Cheston, 2003; Koenig, 1997; Nelson et al., 2002; Walter, 1997; Weiland 1995; Sulmasy 2002). Instead, the available data do not lend themselves to such discourse. For the purposes of this study, we understand "religion," with Weiland (1995:589), as reflecting formal or institutional belief in God, whereas "spirituality" may or may not be experienced or expressed as part of traditional religious practice. However, elements of religion may be manifested in the spiritual, in at least some sense of that term. For that reason, and because of the question wordings in the data available for this research, we address the study's focus as the receipt of help for religious and spiritual needs at the end of life.

dying patients that in part inspired Dame Cicely Saunders to found the hospice movement in Britain (Sinclair, et al. 2006). To Dame Cicely, the dying patient needed spiritual as well as physical, social, and psychological help in the approach to death (Lattanzi-Licht 1998). Looking at care for the aging in general, Rumbold (2006:34) argues that "attention needs to be paid to the spirituality of the settings in which these older people are located." But what is so organizationally limiting about health care settings for this purpose? One answer can be found in the work of Max Weber. Weber saw bureaucracy as the quintessential modern organizational form, one which ideally removes purely personal elements from decision-making (Weber 1947). To the extent that the modern hospital and other facilities for the aging are bureaucratic in Weber's sense, they may de-emphasize the humanistic elements of love, spirituality, and "home" that had been rooted in hospitals and hospices since their founding in the Middle Ages (Risse 1999). This may help explain the current ambivalence and even hostility among Americans to those places in which they increasingly come to receive care at the end of their lives. Furthermore, although polls consistently report a large percentage of Americans favor dying at home, more than 70 percent do not get to do so (Institute of Medicine 1997). Where people die is largely a function of geography; their end-of-life care is shaped by the habits of their local health care system or hospital. Certain specific organizational characteristics of LTC facilities, to which we turn next, may further our understanding of this reality.

Organizational Characteristics of Long-term Care Facilities

According to one U.S. government definition, "a nursing home is an establishment with three or more beds that provides nursing or personal care services to the older population, infirm, or chronically ill" (Federal Interagency Forum on Aging-Related Statistics 2000). Additionally, they have the capability to provide skilled nursing care. Over the years, another supportive LTC setting for dependent adults has arisen which is not required to have a nursing presence. These variously named RC/AL facilities espouse a philosophy of consumer independence, dignity, privacy, decision-making, and autonomy (Mollica 2001:15). In general, RC/AL facilities are licensed by the state to provide a sub-NH level of care, with room, board, 24-hour oversight, and assistance with activities of daily living (Park, et al. 2006). There are many similarities between RC/AL facilities and NHs and, as importantly, there are differences between RC/AL facilities (Zimmerman, et al. 2003).

The CS-LTC is designed to capture this variation between different types of RC/AL facilities. First, the CS-LTC identified *smaller* (fewer than 16 beds) RC/AL facilities, as it was expected that size would be correlated with a variety of organizational characteristics. For example, smaller facilities tend to be managed by individuals rather than corporations and have a more homelike atmosphere (Morgan, et al. 1995). Second, the study characterized *new-model* RC/AL as having 16 or more beds, being built after January 1, 1987, and

meeting at least one of the following additional criteria: (1) at least two differ-
ent private pay monthly rates, depending on resident need, (2) 20 percent or
more of its resident population requiring assistance in transfer, (3) 25 percent
or more of its resident population incontinent daily, or (4) either an RN or an
LPN on duty at all times. The third category of "all other" RC/AL facilities
was referred to in the CS-LTC as *traditional* RC/AL homes (Zimmerman, et al.
2001a, 2001b:120). All three types of RC/AL facilities tend to provide a more
homelike environment than NHs, based on such criteria as allowing for per-
sonal pictures and mementos and providing noninstitutional furniture (Sloane,
et al. 2001).

The goals of RC/AL—which include "providing a homelike environment,
independence, autonomy, and privacy" (Zimmerman, et al. 2003:108)—suggest
that they may be more congenial to residents' spiritual needs than NHs, which
are more bureaucratic. This may be especially true for new-model RC/AL
homes because they facilitate maximum individuality or for smaller facilities
because of their more homelike atmosphere. If we consider what Thomas
(1994) calls "the Eden alternative"—which surrounds residents with plants,
animals, children, and other living things—we find that new-model RC/AL
facilities were the most "Edenized" in terms of the presence of plants, ability to
get access to the outside, and attractiveness of the outdoor area, and smaller
facilities had the largest number of dogs, cats, and children in evidence
(Sloane, et al. 2001). Based on this, *we hypothesize that the spiritual needs of
dying residents will be most successfully met in RC/AL facilities, especially new-model
facilities*.

The sociological literature on organizations has long acknowledged that
the sheer size of an organization can affect people's responses to it. Most influ-
ential is Blau's (1970) theory of structural differentiation, which proposes that
as an organization grows in size it grows in the number and complexity of sub-
units. Recent research addresses the relationship between organizational size
and issues such as board size, structure, and formalization in nonprofits
(Cornforth and Simpson 2002). Consistent with earlier research, size correlates
with complexity. In the case of RC/AL facilities or NHs, the impact of size
might be contradictory: the potential impersonality of a larger institution
might limit addressing the spiritual needs of residents, while at the same time,
a larger institution might be capable of providing structurally related care such
as church services or on-site chaplaincy that would enhance spiritual care.
Because of its theoretically mixed effects, *facility size is not hypothesized to relate
to meeting spiritual needs*.

Some of the facilities in the study were affiliated with religious traditions.
Graber and Johnson (2001:46) suggest that "church-affiliated NHs provide
better care than proprietary facilities." Thus, *an obvious hypothesis is that spiritual
care is provided to a greater extent in religiously-affiliated facilities*. This could be a
function of either a religious ethos within the facility (a treatment effect) or
greater religiosity of those residents (a selection effect).

METHODS

Identification and Recruitment of Study Facilities and Subjects

The CS-LTC includes 230 RC/AL facilities and NHs recruited from four states (Florida, Maryland, North Carolina, and New Jersey) in a stratified random sample initially established in 1997. As noted earlier, the CS-LTC facilities include NHs and three types of RC/AL facilities: (1) "smaller" facilities with fewer than 16 beds; (2) larger "new-model" facilities tending to have nursing support available and provide services to an impaired population; and (3) larger "traditional" facilities that do not meet the new-model definition (Zimmerman, et al. 2003). All RC/AL facilities in the sample provide room, oversight, at least one meal per day, and varying levels of support with activities of daily living. Details and an overview of the recruitment of facilities for the CS-LTC study are described elsewhere (Zimmerman, et al. 2001a, 2001b). In all, 31 NHs, 101 smaller RC/AL facilities, 40 traditional RC/AL facilities, and 58 new-model RC/AL facilities participated in the current study.

At the time of facility recruitment, a facility liaison was identified and was thereafter contacted monthly by telephone to determine whether any residents had died in the preceding 30 days. During these monthly decedent calls, the facility liaison reported details about residents who had died since the previous contact, including demographic characteristics and information to determine eligibility. To be eligible, residents had to have died in the facility, or within three days of leaving the facility by transfer or discharge to another health care facility. In addition, resident deaths were eligible only if they were living in the facility for at least 15 days in the last month of life; anything shorter than this period was determined too short to adequately reflect the provision of end-of-life care in that facility. If the decedent was eligible, the facility liaison was asked to provide the name and contact information of a family member or responsible party who was most familiar with the decedent's care in the last month of life. A total of 1,020 deaths from 164 facilities were eligible by these criteria. Once eligibility was determined, a condolence letter and consent form introducing the study were mailed four weeks after the date of death to the deceased resident's identified family member.

Data Collection

Interviewers followed up at least six weeks after the date of death to obtain verbal consent and conduct a structured telephone interview with family members; interviews lasted approximately 45 to 90 minutes. The content of the instrument was primarily closed-ended questions covering various aspects of the decedent's life in the period immediately before death. In all, family interviews were completed for 451 (44 percent) of the eligible decedents from 128 facilities. Reasons for nonresponse included being unable to conduct the interview within the required six-month timeframe (40 percent of missing cases), refusal (38 percent), no family member available or familiar with the

resident's care (17 percent), and other (5 percent). We also collected facility-level data via telephone interviews with facility administrators. After eliminating cases for whom data on all variables and covariates were available, the final decedent sample for this paper is 395 (39 percent of eligible decedents).

Independent Variables

Key independent variables included the *type of facility* (as operationalized above) and the facility's *religious affiliation*. Religious affiliation was measured with the question: "Is it affiliated with a religious organization?" (1 = yes). Additional questions about the religiously related services provided by the institution included "one-to-one religious advice or counseling by clergy (not including religious services)" (1 = yes) and "religious services" (1 = yes). Because hospice is an organization that emphasizes the spiritual component of end-of-life care (Bradshaw 1996; Lattanzi-Licht 1998), we also looked at provision of "hospice services" (1 = yes) and existence of "hospice unit, meaning dedicated beds" (1 = yes).

Control Variables

Organizational level. In the current study, organizational size is partially conflated with facility type. The average number of beds in the "smaller" RC/AL category is 9.7, whereas "traditional" RC/AL facilities average 52.8 beds, "new-model" RC/AL facilities 69.8 beds, and NHs 104.5 beds. To ensure that our results for facility type are not simply a function of facility size, the number of beds in a facility was introduced as a control variable in the final models.

Individual level. Several demographic factors that may differ among residents must be controlled because they are known to be associated with religious or spiritually related variables, such as religious affiliation or religious participation. *Age* is one such factor, since older individuals obtain many of their spiritual and social needs from interactions in religious activities and through religious organizations (Koenig, et al. 2001). *Gender* is another, since women {0} are more religiously active and report higher levels of religiosity than men (Levin, et al. 1994). Finally, *race* may be a factor, as faith is often found to be individually and socially more important to African Americans (Levin, et al. 1995; Strawbridge, et al. 1997) and there are more minorities in NHs than in RC/AL facilities (Zimmerman, et al. 2001a, 2001b). Recent research finds that these factors are of weak or mixed importance, however, especially insofar as they have been hypothesized to moderate (interact with) the effect of religion/spirituality on health (Musick, et al. 2004). Here multivariate analyses are only able to capture the distinction between non-Hispanic whites and all other groups because of the small and uneven number of cases in those groups.

An additional individual-level characteristic is whether or not the resident was cognitively impaired in the month preceding death. Responses of staff to a multiitem inventory were used to construct a dichotomous variable (0 =

impaired/1 = intact). Initial analyses were carried out to see if impaired and intact decedents had received help to an equal degree. Family responses indicated that the intact residents (23 percent of the sample) received help for their spiritual needs significantly more often ($p = .01$) than the impaired residents (77 percent) in the month before death. However, in a large majority of both groups, help was received for spiritual needs (82 percent and 69 percent, respectively). Therefore, in order to provide the most inclusive picture of the data, responses from both groups were combined in subsequent analyses.

A final individual characteristic that might produce spurious effects of facility type or facility religious affiliation is the importance of religion or spirituality to the decedent. If, in fact, decedents or their families selected facilities on religious grounds, or facilities restricted entry to those of their own religion, the facility might spuriously appear to provide more spiritual care. In the final analyses, a question on the importance of religion/spirituality to the decedent (determined by the responses of family members) was included as a control for possible selection bias. Note that in this case the question explicitly referred to "religion/spirituality" for completeness. We will return to this issue in the Discussion section.

Dependent Variable

Proxy responses were also used for the decedent's receipt of help for spiritual needs in the last month of life. The actual wording of the question was: "I would also like to know about the support [resident] received for [his/her] spiritual needs during the last month of life. Did [resident] get help with [his/her] spiritual needs?" The response categories were "yes" (=1) and "no" (=0).

Analytic Plan

For all analyses we used generalized estimating equations (GEE) (Diggle, et al. 2002) applied to logistic regressions, controlling for within-facility clustering using GEE empirical standard error estimates and exchangeable correlation matrix. A zero-order analysis assessed the relationship between facility type and receipt of help for spiritual needs. It was followed by consideration of the linkage between religious affiliation of facility or religious practices and hospice care and facility type. Logistic regression models were then specified in which facility type, religious affiliation, and controls were added as predictors of receipt of help for spiritual needs.

RESULTS

Table 1 summarizes characteristics of the final sample according to facility type. All facility types had predominantly female and non-Hispanic white patients, and average decedent ages across the facility types were similar. Note, however, that there was more cognitive impairment in NHs ($p < .05$) and that

TABLE 1 Decedent Demographics, Cognitive Status, and Religiosity, by Facility Type and Overall (N = 395)

	RC/AL <16 Beds		Traditional RC/AL		New-Model RC/AL		Nursing Home		All Types	
	N	%	N	%	N	%	N	%	N	%
Gender[a]										
Male	16	24.6	11	40.7	32	33.3	61	29.5	120	30.4
Female	49	75.4	16	59.3	64	66.7	146	70.5	275	69.6
Race/ethnicity[b]										
White, non-Hispanic	57	87.7	27	100.0	93	96.9	182	87.9	359	90.9
White, Hispanic	3	4.6	0	0.0	0	0.0	4	1.9	7	1.8
Black	5	7.7	0	0.0	2	2.1	19	9.2	26	6.6
Other	0	0.0	0	0.0	1	1.0	2	1.0	3	0.8
Cognitive status[c]										
Impaired	50	76.9	16	59.3	70	72.9	170	82.1	306	77.5
Intact	15	23.1	11	40.7	26	27.1	37	17.9	89	22.5
Importance of religion/spirituality[d]										
Not at all	13	20.0	6	22.2	23	24.0	21	10.1	63	15.9
A little	18	27.7	3	11.1	16	16.7	31	15.0	68	17.2
Quite a bit	15	23.1	5	18.5	17	17.7	39	18.8	76	19.2
Very much	19	29.2	13	48.1	40	41.7	116	56.0	188	47.6
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Age at death (years)[e]	87.1	9.6	87.8	8.6	87.0	7.1	85.1	9.7	86.1	9.1
Importance of religion/spirituality (1–4)[d]	2.6	1.1	2.9	1.2	2.8	1.2	3.2	1.0	3.0	1.1

Statistical association of decedent characteristics and facility type was tested using GEE, applied to logistic or linear models with the decedent characteristic as the dependent variable and facility type as the independent variable. An exchangeable correlation matrix was specified and Wald Type 3 p-values are reported.

[a]$p = .464$ for 3 d.f. overall Wald test for facility type; $p = .621$ for nursing homes vs. all RC/AL types (GEE logistic model).

[b]Due to sparseness of data, the only comparison made was for the association between white, non-Hispanic decedents compared to all others and nursing homes vs. all RC/AL types: $p = .118$ (GEE logistic model).

[c]$p = 0.138$ for 3 d.f. overall Wald test for facility type; $p = 0.032$ for nursing homes vs. all RC/AL types (GEE logistic model).

[d]Coded as 1 = not at all, 2 = a little, 3 = quite a bit, and 4 = very much; $p = .003$ for 3 d.f. overall Wald test for facility type; p = .003 for nursing homes vs. all RC/AL types (GEE linear model).

[e]$p = .284$ for 3 d.f. overall Wald test for facility type; $p = .071$ for nursing homes vs. all RC/AL types (GEE linear model).

the importance of religion/spirituality to the decedent was highest in NHs ($p < .01$).

Table 2 shows the relationship between facility type and whether or not the decedent had received help for spiritual needs in the last month of life. NHs are compared both with individual RC/AL facility types and with RC/AL facilities overall. The overall 1 d.f. difference between NH and RC/AL facilities is significant ($p = .025$), but the only pairwise significant difference is between NHs and the smallest RC/AL facilities. That is, NH residents had, overall, the highest receipt of help for spiritual needs (78 percent of residents received help), which was significant in comparison to the smallest RC/AL facilities (in which 59 percent of residents received help).

The possibility that the trends in Table 2 reflect differences in service provision among the facilities is first addressed descriptively in Table 3, where NHs are compared to each type of RC/AL facility and to RC/AL facilities overall using logistic regression. The data are at a facility level. They show a consistent progression from smaller facilities, to traditional facilities, to new-model facilities, and then to NHs, for each variable (i.e., religious affiliation, counseling by clergy, religious services, hospice services, and provision of a hospice unit) to be more prevalent. In this case, counseling by clergy might refer to either on-site chaplains or community clergy; in the case of hospice, chaplains were assumed to be on staff or on-call. Overall, in the 1 d.f. contrast, NHs are significantly more likely than all RC/AL facilities combined to be religiously affiliated, provide hospice services, and possess a hospice unit. However, in the pairwise comparisons, the NHs differ significantly only from the smallest RC/AL units (e.g., comparing smaller RC/AL facilities to NHs, 3 percent

TABLE 2 Number and Percent of Residents Receiving Help for Spiritual Needs, By Facility Type and Overall ($N = 395$)

| | Received Help for Spiritual Needs | | | |
	n	N	%	p-value[a]
RC/AL <16 beds	38	65	58.5	.010
Traditional RC/AL	17	27	63.0	.177
New-model RC/AL	70	96	72.9	.453
Nursing home	161	207	77.8	Reference
All types	286	395	72.4	.058[b]

[a]Based on GEE applied to logistic regression model with receipt of spiritual help as the dependent variable and facility type as the independent variable. An exchangeable correlation matrix was specified and Wald Type 3 p-values are reported.
[b]3 d.f. overall Wald test for facility type from logistic model; for nursing home vs. all RC/AL types combined, $p = .025$.

TABLE 3 Facility Characteristics Related to Religious and Hospice Services, By Facility Type and Overall ($N = 205–214$ facilities)[a]

Facility	RC/AL <16 Beds (n = 91–92)			Traditional RC/AL (n = 35–36)			New-model RC/ AL (n = 49– 56)			Nursing Home (n = 30)			Overall		
	N	%	p[b]	N	%	p[c]	N	%	p[b]	N	%	p[c]	N	%	p[d]
Has religious affiliation	3	3	<.01	3	8	0.06	7	13	0.11	8	27	<.01	21	10	<.01
Provides one-to-one counseling by clergy	49	54	0.03	23	66	0.34	36	73	0.75	23	77	0.20	131	64	0.04
Provides on-site religious services	70	77	0.04	32	91	0.40	46	94	0.59	29	97	0.16	177	86	<.01
Provides/contracts for hospice services[e]	65	71	<.01	26	74	0.05	46	94	1.0	30	100	<.01	167	81	<.01
Has hospice unit[e]	0	0		0	0		4	8	0.49	5	17	0.01	9	4	<.01

[a]Data are derived from administrator interview. While 230 facilities participated in the study, administrator interviews were completed for only 218; the overall range of N reflects additional missing data on some items. All p-values are based on logistic regression with the facility characteristic as the dependent variable and facility type as the independent variable.

[b]Compared to nursing homes.

[c]Nursing homes compared to all RC/AL types combined.

[d]Overall (3 d.f.) test for facility type.

[e]Because the proportion of facilities with these characteristics is 0 or 1 for at least one facility type, exact logistic regression was used.

versus 27 percent are religiously affiliated; 54 percent versus 77 percent provide counseling; 77 percent versus 97 percent provide religious services; and 71 percent versus 100 percent provide hospice).

When we consider the religious aspects of the facilities as independent variables in their own right (Table 4), two components emerge as statistically significant. First, the religious affiliation of the facility has a significant, positive relationship to the decedent's receipt of help for spiritual needs (84 percent in religiously affiliated versus 70 percent in unaffiliated facilities). The provision of hospice services is also significant, indicating that 74 percent of facilities that provide hospice care also provide help for spiritual needs (compared to 55 percent of those that do not provide hospice services). These two religiously related variables will be included in subsequent multivariate models.

None of the preceding findings account for how resident characteristics may relate to the receipt of help, or how any one facility characteristic is significant in the context of the others. One way to explain the importance of the organizational variables is to build multivariate models of, first, organizational characteristics and, second, organizational plus individual characteristics. Table 5 shows the results of such models. Model 1 includes facility type, facility religious affiliation, provision of hospice services (all three of which

TABLE 4 Resident Receipt of Help for Spiritual Needs, By Facility Characteristics

		Received Help for Spiritual Needs		
	n	N	%	p-value[a]
Has religious affiliation				
Yes	61	73	83.6	.043
No	225	322	69.9	
Provides one-to-one counseling by clergy				
Yes	205	283	72.4	.880
No	81	112	72.3	
Provides on-site religious services				
Yes	276	380	72.6	.690
No	10	15	66.7	
Provides/contracts for hospice services				
Yes	270	366	73.8	.033
No	16	29	55.2	
Has hospice unit				
Yes	34	44	77.3	.519
No	252	351	71.8	

[a]Based on GEE applied to logistic regression model with receipt of spiritual help as the dependent variable and the specified facility characteristic as the single independent variable. An exchangeable correlation matrix was specified and Wald Type 3 p-values are reported.

TABLE 5 Logistic Regression Examining Association of Facility Type and Religious Affiliation with Receipt of Help for Spiritual Needs ($N = 395$)

Characteristic	Model 1: Facility Characteristics Only		Model 2: Facility and Resident Characteristics	
	Estimate (SE)	p-value[a]	Estimate (SE)	p-value[a]
Intercept	0.570 (0.620)	.356	−3.717 (1.575)	.018
Facility characteristics				
Type		.701[b]		.068[b]
RC/AL <16 beds	−0.543 (0.539)	.314	−0.604 (0.691)	.383
Traditional RC/AL	−0.480 (0.578)	.406	−0.647 (0.593)	.275
New-model RC/AL	−0.056 (0.329)	.864	0.466 (0.436)[c]	.284
Nursing home	(Reference)		(Reference)	
Religiously affiliated	0.648 (0.392)	.098	0.632 (0.377)	.094
Provides hospice services	0.313 (0.437)	.473	0.838 (0.618)	.175
Number of beds	0.002 (0.004)	.633	0.004 (005)	.402
Resident characteristics				
Age at death (years)			0.006 (0.015)	.671
Male gender			0.063 (0.289)	.828
Black/Hispanic/Other			1.528 (0.750)	.042
Cognitively intact			0.630 (0.355)	.076
Importance of religion/ spirituality (1-not all; 4-very much)			1.278 (0.130)	<.001

[a]Based on GEE applied to logistic regression model with receipt of spiritual help as the dependent variable and the resident and facility characteristics shown as independent variables. An exchangeable correlation matrix was specified and Wald Type 3 p-values are reported. Because GEE is based on quasi-likelihood, as opposed to maximum likelihood estimation (MLE), there are not readily defined analogs to the fit statistics for MLE.
[b]Overall (3 d.f.) Wald test for Facility type; in Model 1, the p-value for nursing homes vs. all RC/AL types is .339; in Model 2, it is .579.
[c]Model 2 post hoc comparisons between new-model RC/AL facilities and traditional RC/AL facilities significant at $p = .04$; comparisons between new-model RC/AL facilities and <16 bed facilities significant at $p = .05$.

were originally related to receipt of spiritual help), and number of beds. None of these organizational variables in this model is a statistically significant predictor of the receipt of spiritual help. Model 2 adds the importance of religion/ spirituality to the decedent, as well as demographic and cognitive characteristics of the decedent. In this final model, two characteristics the decedent brought into the facility are statistically significant: the importance of spirituality to the person and the person's race/ethnicity. It is more likely that a person for whom religion/spirituality was important would receive spiritual help, and it was also more likely that persons of color (black, Hispanic, or "other") would receive spiritual help.

Interestingly, with the patient composition of the facilities controlled for in Model 2, we find that new-model RC/AL facilities provide more spiritual care than both traditional RC/AL facilities ($p = .04$) and smaller RC/AL facilities ($p = .05$). The new-model's estimated effect in Table 5 is not significantly higher than that of NHs, though.

DISCUSSION AND CONCLUSIONS

In a world in which people increasingly die in institutional settings, what are the best LTC places in which to do so? From a religious standpoint, the answer to this question is likely to take the form of how the spiritual needs of the dying are fulfilled. This investigation began with an interest in examining how organizational and individual factors contribute to the receipt of spiritual help for dying LTC residents. Based on a large-scale study, we compared four types of facilities: NHs, new-model RC/AL facilities, traditional RC/AL facilities, and smaller RC/AL facilities. We expected that RC/AL facilities would be more congenial to residents' spiritual needs, and this would be especially true for new-model RC/AL facilities, because of their presumed focus on patient autonomy and "Eden-like" atmosphere.

A directly relevant sociological factor was organizational complexity, for which we had a proxy measure, the number of beds in the facility. This complexity, however, could theoretically cut two ways. Whereas it speaks to a more bureaucratic structure, it also enables a facility to offer more resources to the residents. In the current context, religiously related resources are particularly relevant. Indeed, we found that larger facilities actually had the most substantial resource environment (Table 3). Because of the fact that complexity cuts two ways, we made no prediction about the effects of organizational size on receipt of spiritual care and in fact found none (Table 5).

Another relevant factor at the organizational level was the religious affiliation of the facility. Although it seemed plausible that religiously affiliated facilities might offer their residents more spiritually sensitive help at life's end, final analyses that controlled for both organizational and individual characteristics showed that two relevant organizational-level variables (religious affiliation and provision of hospice facilities) that had been significant predictors of spiritual satisfaction in Table 4 no longer played a significant role in the full model in Table 5.

Final analyses that introduced decedent characteristics into the equation showed that the strongest correlate of spiritual care was the importance of religion/spirituality to the decedent. A smaller but also significant correlate was race/ethnicity: non-Hispanic whites were less likely to receive spiritual care in their final month of life. With all resident and organizational factors controlled, the relationship of facility type to receipt of care showed new-model

RC/AL facilities to be more likely to provide spiritual help, as compared to both traditional and smaller RC/AL facilities.

The generally weak effect of facility type can be seen as a positive finding from the standpoint of applied organizational issues: What may appear to be very different organizational forms do not differ substantively in their delivery of spiritual help, once characteristics of the residents are taken into account. However, there are a number of limitations in this study, to which we now turn.

Limitations

Proxy data. These are common in studies of the period surrounding death, because the identity of the decedents cannot be ascertained until after death. This study was exceptional in that it had three proxy perspectives on the decedent or the setting: the family, the staff, and the administrator of the facility. Here we used family data to ascertain the decedent's spirituality and whether or not s/he received help for spiritual needs; we used staff data to assess the decedent's cognitive status; and we took facility data from the administrator. Despite this methodological strength, the question of the validity of proxy data remains. Under the circumstances all we can say is that proxy responses have their limitations.

Religion or spirituality? The wording of the items we relied on in this study left a certain ambiguity as to whether religion or spirituality or both account for the observed effects. In particular, the decedent characteristic that was most potent in predicting receiving help for spiritual needs was worded in terms of "importance of religion/spirituality." That said, much of the literature in the hospice and palliative care traditions now emphasizes spirituality as the more inclusive category, whereas religion is a factor for some but not all patients (e.g., Sulmasy 2002). Thus, the question asked of family members here, regarding the importance of "religion/spirituality" to the decedent, would be an appropriate one to capture the spiritual aspect of impending death. The question does not, however, allow us to say with certainty which element is more important to any given decedent or family member. Hence we have chosen to refer to "religious and spiritual" care in the title of this paper to caution the reader.

Cognitively intact versus impaired decedents. A substantial majority of these decedents were judged to be cognitively impaired by staff during the month before their deaths, and this was especially true in new-model RC/AL facilities and NHs. Therefore it could justifiably be asked exactly how spiritual care would be provided to such an individual. Unfortunately, there are insufficient data available to address this question. In the interest of completely representing the available sample, we analyzed the impaired and non-impaired decedents together, but separate study of these groups would be another direction for research, and could be considered as part of future directions, to which we now turn.

Future Directions

In looking ahead, we must recall that the current study relied on a limited number of measures from a closed-ended survey instrument, with many dichotomous response categories. For example, because the dependent variable (help with spiritual needs) was a closed-ended item, we do not know what proxy respondents had in mind when they answered it. Indeed, when queried by respondents about the meaning of this item, interviewers are trained to respond, "Whatever it means to you." Future qualitative research should build upon the findings of this study to guide and fine-tune open-ended questioning to understand better what respondents mean when they report receipt of help with spiritual needs, the importance of religion/spirituality, and other subjective events and conditions.

Overall, we find that between 59 percent (in smaller RC/AL facilities) and 78 percent (in NHs) of decedents received help for spiritual needs, with the importance of religion/spirituality being most highly related to having received help. New-model RC/AL facilities and NHs provided more such care than other facility types, but it is not clear which organizational characteristics were most important to the decedents receiving spiritual care. For example, in spite of the fact that they lacked a series of organizational resources (Table 3), smaller RC/AL facilities did not fall significantly behind any other facility type in our final model except for the resource-rich new-model RC/AL facilities. It may well be that other organizational characteristics, including the source of spiritual support, are the important drivers in the provision of help for spiritual needs.

Finally, the recent movement toward a new, relationship-based culture of aging can be seen as a special form of, and emphasis upon, the communal and non-institutional (Pioneer Network n.d.). It is at least imaginable that the important task of the facility within which end-of-life care is received is to facilitate a sense, not of Eden revisited, but of communally bearing the burden of the other (Bonhoeffer 1954). It is one task of future sociological research to learn about this burden and how it relates to end-of-life care.

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