

HANDZO CONSULTING

Integrating spirituality into healthcare.

The Case for Spiritual Care

It is commonly accepted that health care in the United States is in crisis. It is the most expensive health system in the world and its health outcomes are in many cases far inferior to those of countries spending far less. Moreover, Americans are largely dissatisfied with their access to care, the rapidly rising cost of care, and the way they are treated by the health care system. Another notable finding is that a very large percentage of the health care dollars are spent on a very small percentage of patients. These patients tend to be older, poorer, and have multiple chronic illnesses. Further, a great deal of this expenditure is near the end of the patient's life and seems to produce little or no benefit either in terms of the patient's length of life or the patient's quality of life.

One positive development in the health care system over time has been the increased focus on patient and family satisfaction now subsumed under the rubric of patient experience. Currently, 30% of a hospital's incremental Medicare reimbursement is determined by its score on the government mandated patient experience survey.

Another ongoing shift is that hospitals are increasingly paid, not for services delivered such that each test and admission can be billed, but in bundled payments where the hospital receives a set amount for treating a certain illness or condition. By example, in the past if a cardiac surgery patient was readmitted shortly after discharge, the hospital received payment for that readmission. Under current regulation, if that readmission is deemed preventable, the hospital will not receive payment. While the causes of readmission are multifaceted, good communication with the patient and family is clearly one major variable.

This new emphasis has forced a major increase in a hospital's attention to patient experience and patient needs. It is now clear that this attention not only results in higher patient satisfaction scores, but also in better health outcomes and less use

of health care resources, especially at the end of life. Specific findings relevant to this business include:

1. Communication with the patient and family is foundational especially in terms of being able to listen to and elicit the patient and family's health care wishes and goals.
2. Sensitivity to the patient and family's culture is critical to both a positive patient experience and good communication.
3. Religious and spiritual beliefs and values are often the major influence on patient health care choices.
4. New research suggests that patients who report that their spiritual needs were met near the end of life have higher satisfaction, their families are more satisfied, and the patients are likely to spend less time in an intensive care unit and thus use less health care dollars near the end of their life.
5. Overall, the findings seem to suggest that, when patient and family needs and preferences are elicited and taken into account, patients are more compliant with their treatment plans, more satisfied with their care, and use less health care resources. Thus, it appears that the goals of improvement in patient satisfaction and the reduction in health care costs are not mutually exclusive as often thought but complementary. It appears that better communication with patients and families leads to patients managing their care better so they do not need as much emergency or aggressive care and to patients preferring generally to use less expensive aggressive care at the end of life.

All of the above has driven the proliferation of palliative care as a model for dealing with these issues. Begun as a team-based method for helping patients and families at the end of life, palliative care is now widely recognized as the major modality for dealing with the issues defined above. Currently a majority of hospitals in the US have palliative care teams and the number is rising exponentially. The foundational principle of palliative care is to match patient and family goals of care to the health care team's treatment plans. Palliative care teams now operate in emergency rooms and intensive care units as well as on regular medical and surgical hospital units.

Unlike medical professionals, professional chaplains are taught listening skills as part of their training. They are taught to help the patient and family articulate for themselves their own beliefs, values and preferences without seeking to impose any beliefs or other agendas. The Joint Commission which accredits most US hospitals has called professional chaplains the “culture brokers” in the health care system with the training to work with people of any culture and belief system. All models for palliative care mandate a chaplain as the spiritual care lead on the team. Thus, integrating a program of spiritual and religious care led by a professional chaplain would seem to offer significant benefits in the current health care environment.

However, professional health care chaplains have remained a significantly underutilized resource in the economy of US health care for a number of reasons.

1. Health care decision makers remain largely uninformed about the skills and competencies professional chaplains possess. They are unaware that professional chaplains possess training well beyond the training of community clergy in skills like listening, cultural competence, and integration with the health care team.
2. Some decision makers who are looking for chaplains to make more of a contribution do not know how to recruit chaplains with the right skills.
3. Chaplains, by and large, have been unable and often unwilling, to make the business case to their administrators about the contributions they can make. The professional chaplaincy community is fractured and cannot speak with one voice on the value chaplains can contribute.
4. The evidence base for the efficacy of professional chaplaincy is almost nonexistent.