Can Chaplains Survive and *Thrive* with P4P?

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In the near future, almost all US health care professionals—doctors, nurses and members of the ancillary disciplines, including chaplains—likely will be paid based on quality of performance, i.e., pay for performance (P4P), by achieving evidence based, best practice, desired outcomes that have a positive impact on institutional bottom lines. This article describes the context, implications for chaplaincy, progress to date and next steps for professional chaplaincy to survive and thrive with P4P.

**The United States health care system has become** too complex and costly. Inefficiencies, a difficult-to-manage clinical knowledge base and a reward system that is not focused on patient needs all hinder improvements in the safety and quality of care and threaten the nation’s economic stability. To achieve higher quality at lower cost requires commitment to the incentives, culture and leadership that foster continuous learning as the lessons from research and patient care experiences are systematically captured, assessed and integrated into the health care delivery system. In other words, impending reimbursement issues relate directly to pay for performance (P4P).

A primary reason for the momentum of P4P is the upward spiraling of health care costs. In 2008, US health care spending per person was more than double the median in other leading economies. Articles written in 2011 anticipated that this number would top $2.7 trillion, about $8,650 per person or roughly $1 of $6 in the economy. The Medicare Office of the Actuary has projected that these costs will reach $4.6 trillion in 2020, accounting for about $1 of every $5 in the economy.

**Implementing P4P**

Over one hundred private and federal P4P pilot programs are going forward in health care. Furthermore, all state Medicaid programs are operating one or more P4P initiatives and nearly 85 percent of states are moving toward operating Medicaid P4P programs. Several large insurers, including UnitedHealth Group, WellPoint and Aetna, are incorporating P4P values in their payments to doctors and hospitals. For example, Aetna now offers a fee to primary-care practices that meet certain improved care standards.

In 2012, Partners HealthCare, which owns the Brigham and Women’s Hospital plus seven other hospitals and is affiliated with dozens of eastern Massachusetts clinics, negotiated new contracts with Medicare and BlueCross BlueShield linking financial reward to clinical performance. Thus, as Brigham and Women’s exceeds its cost-reduction and quality-improvement targets, it may keep more money. Missing the targets results in a loss of tens of millions of dollars—a radical shift. Previously hospitals and medical groups mainly had a landlord-tenant relationship with doctors. Now what is done behind closed doors is their business too.

In 2012, after numerous challenges by states, the United States Supreme Court found *The Patient Protection and Affordable Health Care for America Act* of 2010 mostly constitutional. It is being implemented in phases.

- 2011 – Independent Payment Advisory Board recommended ways to improve health outcomes for patients.
2012 – Programs and controls that improve quality outcomes for patients and encourage more accountability among health care professionals began to go into effect. Prior to the end of 2012, states may create online insurance marketplaces to be fully operational in 2014. Otherwise, the federal government will administer this aspect.⁷

2015 – Medicare will begin rewarding the quality of care rather than the amount of services, according to Title III A I 3007, which states in part that the Secretary (of Health & Human Services) will establish a payment modifier based upon the quality of care furnished compared to cost, including appropriate measures (measures that reflect health outcomes) of the quality of care. Beginning on January 1, 2015 a payment modifier will be applied with respect to all physicians and groups of physicians.⁸

The following will apply to Medicare beneficiaries:

- Discounts will continue to provide savings on prescription drugs.
- Part D prescription drug coverage gap (the doughnut hole) will continue to be phased out.
- Wellness visits will continue to be provided and preventive services will cost less.

In addition, more than three million uninsured Americans between age 50 and 64 will be covered under Medicaid, and the Medicare Trust Fund’s solvency has been extended for eight years.

Even if the Affordable Care Act is repealed, its impact will continue to be powerfully felt. For example, at this writing Republican Medicare proposals are much the same as those of the Affordable Care Act regarding limiting the overall growth of Medicare spending, increasing the contributions of upper- and middle-class Americans and raising the eligibility age.⁹ Given this evidence of the arrival of P4P, what are the implications for chaplaincy?

Implications for chaplaincy

Evidence of the P4P reality elsewhere is apparent. In a report commissioned by the National Health Service (UK), Dr. Harriet Mowat and her team made clear predictions about the future of health care chaplaincy in the United Kingdom, with strong implications for health care chaplaincy in the United States. This report notes the following:

- National Health Service (NHS) now requires health service treatment to be evidence based in order to be resourced.
- Hospital chaplaincy is now in a political environment wherein value for money is how chaplains are to be judged.
- Identification of chaplaincy core tasks and skills as positioned in a modern health care system is key to such judgment.
- The distinction between religion and spirituality requires a more robust approach to a chaplaincy evidence base.
- Health care chaplains must show that their interventions result in desired outcomes.
- A secure future and positive potential for chaplaincy is tied to creating a better knowledge base about practice.¹⁰

Within the United States, Army and Navy chaplaincies have engaged in projects focused on outcomes as follows:

- Establish the costs of specific spiritual care interventions and services.
• Develop a nomenclature for the various services chaplains provide related to medical care that may be used for longitudinal studies and ultimately tie chaplains’ work to outcomes.

**Internal philosophical/theological issues**

With acknowledgment to Carroll Wise, Gregory Stoddard and Jean Burns-Haley, the author defines professional spiritual care (interchangeable here with professional religious care and pastoral care) as follows:

The act of embodying the inner meaning of faith in interaction with persons at the point of their need via appropriate ritual, affective, rational, verbal and non-verbal means by certified caregivers who masterfully integrate empathy, technical skills, intuition, spontaneity and openness to guidance from the deep sources of faith, all toward achieving the maximum possible healing, supportive, educative and challenging outcomes.\(^{11}\)

Is such spiritual care deserving of the title *profession*? Among the key traits that the historian Paul Starr identified as a defining characteristic of the professions are the manner in which the profession accumulates relevant knowledge, organizes that knowledge in theoretical structures, validates it through systematic processes and communicates it to members of the profession for achieving consensus on practice.

Sociologists tend to agree that a profession is an occupation that requires a base in technical, specialized knowledge arrived at and validated through systematic processes.\(^{12}\) Additionally, Raymond de Vries, Nancy Berlinger and Wendy Cadge have found that chaplaincy’s issues in moving from occupation to profession are several:

• No clear jurisdiction.
• Disagreement within the occupational group.
• Self-definition.
• Challenging others’ turf.
• Taking over “dirty work.”
• The “theology problem.”
• Lack of agreement on best practices.
• Many credentials, but no licensure.
• Soft skills.
• Salaried, yet responsible to patients.
• Self-interested at the expense of public interest.\(^{13}\)

In order to make this transition, these writers believe that chaplains must accomplish the following:

• Translate the meaning and value of chaplaincy work into language hospital administrators and others in decision-making positions can comprehend.
• Develop research questions toward yielding reliable information about the chaplain’s contribution to health care.
• Seek examples of individual chaplains or chaplaincy departments that are proficient translators in order to analyze what makes them good at explaining the value of their work.
• Encourage potential chaplaincy department leaders to receive training in health care organization and management.

Professional chaplaincy standards of practice

Professional spiritual care associations are giving serious attention to standards of practice. In the fall of 2009, members of the Spiritual Care Collaborative plus the Association of Professional Chaplains (APC), affirmed the Standards of Practice for Professional Chaplains in Acute Care that were developed by a task force convened by the APC Commission on Quality in Pastoral Services and comprised of certified health care chaplains from these professional organizations.14 Standards of Practice for Professional Chaplains in Long-term Care Settings followed in 2011, and a task force currently is at work to develop Standards of Practice in Hospice.

 Completed documents are available on the APC website (www.professionalchaplains.org). Especially noteworthy is Standard 12, Research: The chaplain practices evidence-based care including ongoing evaluation of new practices and, when appropriate, contributes to or conducts research (italics added).

Effectiveness studies overview

Literature reviewers at HealthCare Chaplaincy grouped the limited available research on chaplaincy effectiveness into two categories: patient satisfaction studies and outcome studies of specific chaplaincy interventions. The patient satisfaction studies were stronger methodologically, showing that chaplain visits have a positive effect on overall patient satisfaction. In general, the studies do not indicate how the patient benefits from the chaplain visits, or whether the same results could have been achieved by visits from other professionals or trained volunteers. The outcome studies are very few in number and most have serious methodological shortcomings. All of these studies were found to be in need of targeted and enhanced replication; most provided only suggestive findings and conclusions.15

Nonetheless, effectiveness has been discerned in the educational realm. One study assessed the efficacy of an eight-week Spirituality Teaching Program to treat unipolar major depression using a randomized controlled, assessor-blinded trial design. This program was found to significantly reduce depression severity and increase response and remission rates.16

One reason for the difficulty in measuring spiritual care effectiveness may be described as philosophical, even theological. It has been said—and perhaps more often left unsaid but adamantly believed—that it is not even possible, much less right, to try to deconstruct the Mystery that is operative in spiritual care.

In the United States, professional spiritual care is historically and philosophically positioned solidly at the center of the narrative based practice model (NBP). In NBP, practitioners interpret the client’s problems with elements of that client’s individual story. Anecdotal experiences and intuition are primary in clinical decision making.17 In contrast, the call to demonstrate effectiveness is being issued from an evidence based practice model (EBP), which is understood to be a thoughtful integration of the best available evidence, coupled with clinical expertise.18

At its best, EBP does not assume that all clinical observation is totally objective and therefore should, like all scientific measurements, be reproducible. Even evidence-based clinicians uphold the importance of clinical expertise and judgment.19 The challenge is to see this urgent task as an integrative process that can weave with strands of both NBP and EBP into a profoundly healing fabric from the best threads of science, art and the Mystery.
Effectiveness research and study models

Five recent chaplaincy effectiveness research examples have been gathered and analyzed by George Fitchett and Sr. Patricia Murphy for APC Webinar Journal Club II sessions. Chaplains are strongly encouraged to participate in this important educational experience.

Margaret Richardson and two colleagues at Hennepin County Medical Center, Minneapolis, MN, secured a grant, assembled a task force and built interdepartmental collaboration in order to achieve mission alignment and accountability for the chaplaincy department and to demonstrate their effectiveness in improving patient/family satisfaction despite a resource-limited environment. Their methods included designing six scaled and two open-ended questions to learn how families experienced different disciplines during the dying process.

Results showed that scores were similar for both emotional and spiritual care, which was in accordance with Press Ganey claims that patients do not differentiate much between such supports. While this article is a must read for every professional chaplain who wants to address the impact on the bottom line, this example also illustrates the difficulty of isolating the spiritual dimension.

VA chaplains developed specific script for use on an intensive care unit over a three-month period and increased the completion rate of advance directives by over 400 percent compared to the previous three months. This was named as a best practice by the Veterans Affairs National Chaplains Center. Further, a “chaplain advance care planning note” was created for patients who did not want to complete an advance directive but verbalized what they valued in terms of advance care planning. This allowed the chaplain to document their wishes, which were then available to other disciplines.

This partial listing of efforts represents a pioneering and helpful beginning. However, the bulk of the work necessary for chaplains to survive and thrive with P4P remains to be undertaken.

Recommended next steps for chaplains

Become P4P educated

Develop and execute a realistic plan to learn as much as possible about P4P and its impact. Chaplaincy-specific opportunities exist within the Spiritual Care Collaborative. Take advantage of educational experiences offered by the aforementioned professional associations at annual and regional conferences, as well as in the webinar format. Educational offerings on P4P beyond chaplaincy include such titles as The HCAHPS Handbook: Hardwire Your Hospital for P4P Success.

Expect gradual adjustment

The implementation of the P4P model is well underway; however, it is a process that is strongly resisted. During the transition, it is essential to continue carefully quantifying and reporting in accordance with administrators’ instructions.

Utilize self-supervision

Beyond quantification, chaplains need to make a conscious effort to improve the quality of caregiving day-to-day. Obviously, it is mandatory that careful attention be given to ongoing casework on a routine basis for the sake of clients and for the quality of care, but now there is another very compelling reason to do so as this will be the basis for justifying the existence of professional chaplaincy in the P4P world.

One step is to obtain a second opinion for a current situation. To do so, access the ACPE Research Network Spiritual Care Initiative for Professional Excellence (www.acperesearch.net/IIP) and select KNOWLEDGE BASE OF SAMPLES. In the table of contents, find the most appropriate category, note
the page number of the sample most like the current situation and scroll down to that page to find and read the selected sample.

Keep in mind those insights and ideas reported in the applicable sample deemed worthy to apply in your current situation, but avoid offering copycat or cookie cutter responses. Record your experience in the Spiritual Care Situation Summary (SCSS) format and submit it electronically as directed.25

**Demonstrate, replicate and communicate effectiveness**

The journey toward improving the quality of care and getting the demonstrated results necessary to remain on the payroll in the P4P world requires careful attention to the effectiveness of interventions. It is the opinion of this author that only the recipients of the care have the authority to say whether what was done and/or said with them was helpful.

One effectiveness measurement option is a freely available 12-statement spiritual care survey (SCS) that clients complete immediately following a typical chaplain visit. SCS was developed for a grant proposal and is an adaptation of the patient related outcome measures survey (PROM), a thoroughly researched document created by Mowat Research in Scotland.26 Consultation and support for this and other options is available from the Spiritual Care Initiative for Professional Excellence (SCIPE).27

Once a particular intervention is deemed effective by the recipient, the next step is to repeat it in another situation. Once the replication is rated as effective for a statistically sufficient number of times, it may be designated as an evidence-based best practice.

Yet another step is necessary. These evidence-based practices must be communicated to administrators and colleagues using appropriate P4P language, e.g., cost-effective, knowledge base, desired outcome, evidence-based best practice. Only when that is successfully accomplished, will professional chaplaincy have won the right to stand alongside medicine, nursing, social work and other health care disciplines as full professional partners in the P4P environment.

**Conclusion**

Can chaplains survive and thrive with P4P? Yes, but the clock is ticking. A colleague has concluded that if professional spiritual care does not find a “middle course” that produces a way to be true to its heritage and practice (NBP) while also producing evidence of its effectiveness (EBP), no one will fund it. The religious communities no longer have the resources; health care—and other— institutions will insist on evidence demonstrating its effectiveness.28

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3. Lucian L. Leape and Donald M. Berwick, “Five years after ‘to err is human’: What have we learned?” Journal of the American Medical Association (JAMA) 293 (May 18, 2005): 2384-90.


10 Harriet Mowat, The Potential for Efficacy of Healthcare Chaplaincy and Spiritual Care Provision in the NHS (UK), (Aberdeen, Scotland: Mowat Research, 2008), 11, 16-17, 21, 49.


14 The Spiritual Care Collaborative is comprised of five professional chaplaincy associations: American Association of Pastoral Counselors (AAPC), Association for Clinical Pastoral Education (ACPE), Canadian Association for Spiritual Care (CASC/ACSS), National Association of Catholic Chaplains (NACC) and National Association of Jewish Chaplains (NAJC).


19 Greenhaigh, "Narrative based medicine."

20 The series, conducted by George Fitchett DMin PhD BCC and Sr. Patricia Murphy PhD BCC, both of Rush University Medical Center, Chicago, IL, is available at http://www.professionalchaplains.org/APCStore/productslist.aspx?CategoryID=APCWebinars&selection=1.


22 Ibid., 24.


24 Quint Studer, The HCAHPS Handbook: Hardwire Your Hospital for P4P Success (Gulf Breeze, FL: Firestarter, 2010). Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) was initiated by the Centers for Medicare & Medicaid Services in partnership with the Hospital Quality Alliance as well as other agencies committed to health care quality improvement.

25 Copies of the SCSS form are available at mariejohn50@att.net.


27 The Spiritual Care Initiative for Professional Excellence (SCIPE) carries forward the work of the Ideal Intervention Project (IIP) by planning, developing and executing the communicative, financial and procedural processes necessary to achieve two closely linked primary goals: professional spiritual care excellence and a strong position for professional spiritual care in the P4P culture. For details, contact the SCIPE coordinator at mariejohn59@att.net.