



## Press Ganey Knowledge Summary: Patient Satisfaction with Emotional and Spiritual Care

**OBJECTIVE:** To review the basic components of measuring and addressing patients' emotional and spiritual needs. To provide a basis for understanding patients' perceptions, their emotional and spiritual needs. To describe how to measure and improve the quality of care of these needs.

**BACKGROUND:** Since 1985, Press Ganey has measured patient satisfaction with the experience of care using a holistic perspective derived from well-grounded research in medical anthropology, psychology, sociology and health sciences. Press Ganey began measuring emotional and spiritual care long before the Institute of Medicine made its recommendations and other entities began assessing how well spiritual needs are addressed. Press Ganey has evaluated more than 4,000 articles using evidence-based criteria and conducted interviews with high-performing and most-improved facilities in addressing patients' emotional and spiritual needs.

### SUMMARY:

Press Ganey, a pioneer in quality measurement, heretofore assessed the quality of emotional and spiritual care as one item: "Degree to which staff addressed emotional/spiritual needs" as evidence demonstrated congruence in patients' perceptions of emotional and spiritual needs as well as staff behaviors in caring for these needs.

Beginning with February 2004 reports, the standard Inpatient and Inpatient Pediatric survey question "Degree to which hospital staff addressed your emotional/spiritual needs" will be changed to "Degree to which hospital staff addressed your emotional needs." This change will allow the exclusive measurement of spiritual care using "Degree to which hospital staff addressed your spiritual needs" as a custom question.

To help you make these measurement decisions, this white paper provides a basic understanding of emotions and spirituality, how emotions relate to patient perceptions of their experience, what patients' emotional and spiritual needs are and what staff can do to address these needs.

Original research findings may also help broaden understanding of the patient's perspective on emotional and spiritual care:

- Patients place a high value on their emotional and spiritual needs.
- Addressing emotional and spiritual needs is a top priority for quality improvement in the U.S., Australia and Canada.
- Evidence exists to indicate a relationship between patient satisfaction with emotional and spiritual care and profitability.
- Patient demographic variables do not predict satisfaction in "...emotional and spiritual needs."
- All patients possess emotional and spiritual needs, regardless of how unexpected or traumatic the admission.
- Patient satisfaction varies by diagnosis (DRG) to a great extent, even within major diagnostic categories (MDC).
- A small but meaningful difference in patient satisfaction exists between religious and non-religious hospitals.

Potential solutions, suggestions and additional resources are also discussed.



### What are emotions?

Emotions are collections of chemical and neural responses generated by the brain affecting the brain and the body. *Primary emotions* are fundamental responses universally experienced by everyone: happiness, sadness, fear, anger, surprise and disgust. *Social emotions* are more diverse and complex subsets of the primary emotions; they include embarrassment, jealousy, guilt, pride, etc. These emotions accumulate to create *background emotions* or moods which linger for longer periods; they include anxiety, depression, calm, malaise, etc. (Damasio 1999).

### What is spirituality?

Spirituality is the individualized, subjective experience of and from which a person derives purpose, meaning and hope (Miller & Thoresen 2003).

### How are emotions created?

Current research in emotions and cognitive science has modeled the factors involved in creating an emotion (Figure 1).

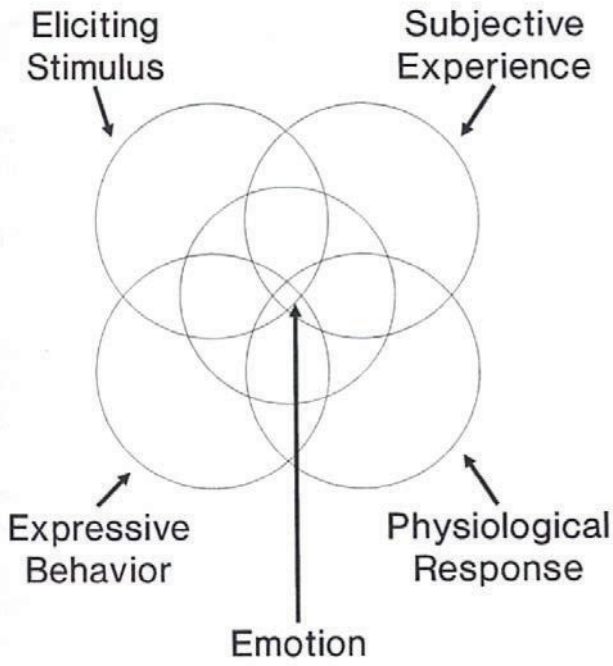


Figure 1 (from Kihlstrom et. al. 2000).

Spirituality and spiritual practices help create emotions through eliciting stimulus, expressive behavior, physiological response and subjective experience.

For example, consider the elicitation of the relaxation response through prayer:

*Eliciting stimulus:* Chaplaincy visit. Eventually asks the patient if she would like to pray.

*Subjective experience:* Patient appreciates the visit, the attempt to meet spiritual needs and would like to pray.

*Expressive behavior:* Repeated prayer (phrases)

*Physiological response:* Relaxation response elicited. Anxiety level, heart rate, oxygen flow, etc. affected.

*Emotion/Emotional state:* Positive, peaceful, content, etc.

The intersection and reinforcing interactions between eliciting stimulus, expressive behavior, subjective experience and physiological response to induce emotion explains how emotions can be affected individually (passed from person to person) and on a macro-scale as an infectious contagion (a gathering of friends creating an atmosphere engendering infectious happiness despite prior emotional state). It also explains how patient satisfaction with emotional/spiritual needs can be influenced by every encounter throughout the hospitalization experience.

### How do patients’ perceive their emotional and spiritual needs?

Patients largely do not perceive a distinction between an “emotional need” and a “spiritual need.” Perceptions of



emotional well-being, spiritual well-being, psychosocial health, mental health and physical health intermingle into a vision of a single self. While spirituality occasionally evokes the religious, actual identified *needs* appeal to the same broad psychological concepts:

- Search for meaning
- Hope
- Alleviation of fear
- Alleviation of loneliness
- Transcendence
- Desire to maintain religious practices
- Presence of God

Caring for patients’ emotional and spiritual needs invokes identical behaviors among staff:

- Caring
- Comfort
- Support
- Sensitivity
- Empathy
- Affirmation
- Attentiveness to unique needs

The patients’ evaluations of emotional and spiritual care as a single construct (i.e. “Degree to which staff address emotional/spiritual needs) is solidly grounded in cognitive science, psychology, emotions research and how patients actually perceive these needs.

**Importance of emotional and spiritual needs**

Patients place a high value on their emotional and spiritual health and well-being. This is evidenced by the rank of “Degree to which staff address emotional/spiritual needs” near the top of the National Inpatient Priority Index every year since 1998. Recent Press Ganey research reveals that this prioritization supersedes nationality and the structure of healthcare systems – emotional/spiritual

needs ranked first on the Inpatient Priority Index for the United States, Canada and Australia in Q1 2003 (Williams 2003).

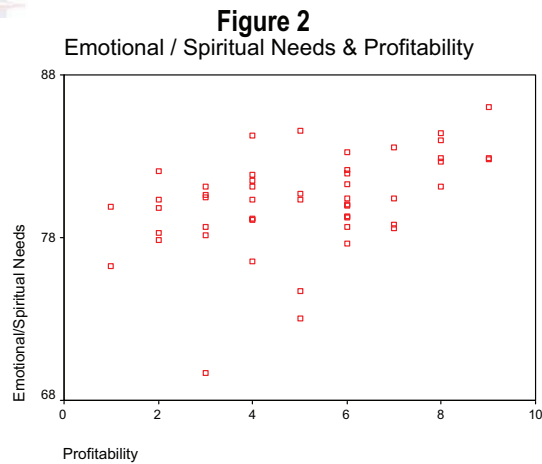
**Emotional/spiritual needs and profitability**

Press Ganey conducted a study to determine whether or not any relationship existed between facility patient satisfaction scores in emotional/spiritual needs and profitability.

*Methods:* Data was obtained from Expanded Modified Medicare Provider Analysis and Review (MEDPAR) and the Press Ganey national inpatient database. The states of Connecticut, New Jersey and Rhode Island were selected because they represent the most comprehensive picture of competition within a single market in the Press Ganey database; the sample included 76% of all hospitals over 100 beds and 91% of all large or mid-sized teaching hospitals. Although the most complete market snapshot available, the sample being only three states is a limitation.

*Results:* Controlling for case-mix index, bed size, teaching status and percentage of Medicare and Medicaid patients, aggregated hospital performance in satisfying patients’ emotional/spiritual needs exhibits a moderate, positive relationship with profitability ( $r = 0.38, p = 0.002; n=82$ ). The relationship between patient satisfaction with emotional/spiritual needs and profitability was even stronger among mid-sized and large teaching hospitals ( $r = 0.44, p = 0.002; n = 49$ ) (Figure 2).

*Conclusion:* The best data available indicate the existence of a significant relationship between satisfying patients’ emotional/spiritual needs and hospital profitability, especially for teaching hospitals having more than 100 beds.



### Demographic variables not predictive

Analysis of the Press Ganey national inpatient database shows that patients' satisfaction with the degree to which staff addressed emotional and spiritual needs is not predicted by demographic variables such as age, gender, length of stay, or self-described health status. *Facility scores in emotional/spiritual needs are not driven by patient demographics.*

### All patients possess emotional and spiritual needs

Analysis of the Press Ganey national inpatient database also demonstrates that patients' satisfaction with the degree to which staff addressed emotional/spiritual needs is not predicted by whether this was the patient's first hospital stay, whether the admission was through the ER and whether the admission was unexpected. Regardless of the prior experience or the relative seriousness of admission, *all patients consider their emotional/spiritual care needs as important and deserving of attention.*

### Patient satisfaction varies by DRG

Patient satisfaction with the degree to which staff addressed emotional/spiritual needs varied significantly by DRG. Patients in some DRGs (e.g. chemotherapy w/ acute leukemia) rated their satisfaction with emotional/spiritual care exceptionally high while others (e.g. male reproductive cancer) rated extremely low (see Clark, Drain & Wolosin, 2003). *Patients with different diagnosis may possess different emotional and spiritual needs or receive different emotional and spiritual care.*

## Religious hospitals and non-religious hospitals

The modern quality paradigm views outcomes as resultant from structure and process. Therefore, in evaluating the outcome of patient satisfaction with emotional/spiritual care, it is important to consider structure. The most basic structural question in this regard is "Do religious-affiliated acute care facilities perform better in meeting patients' emotional/spiritual needs?"

"Degree to which staff addressed your emotional/spiritual needs" (January-December 2002)			
	Mean	SD	N
Religious Hospitals	81.54	3.14	331
Non-Religious Hospitals	80.59	3.91	1157

Patients' aggregate evaluations of the quality of emotional/spiritual care in religious hospitals was 0.95 [ $t(1,488) = 4.56, p < 0.001$ ] greater than among non-religious hospitals. While the  $t$ -test indicates that the difference is statistically significant, calculating the effect size (ES) will quantify the practical significance of the difference (ES scale is 0-1; where an ES of 0 is no difference, 0.2 is small, 0.5 is medium and 0.8 is large). With an ES = 0.24, the gap between patients' satisfaction with the quality of emotional/spiritual care at religious hospitals over non-religious hospitals is small, but meaningful.

Some focus groups and anecdotal evidence indicate that patients who select a religiously affiliated hospital possess greater expectations for emotional/spiritual care and hold staff to a higher standard. Hypothetically, as a group, religious hospitals may hurdle this raised bar through a stronger predisposition to direct staff time and resources to meeting patients' emotional/spiritual needs. Religious hospitals may also be more predisposed to having a dedicated chaplaincy or pastoral care department.



To better understand patients' perception of the source of emotional/spiritual care, we also compared correlations of patients' ratings of degree to which staff addressed emotional/spiritual needs and different dimensions of the hospitalization experience using the standard questions to calculate section scores.

If patients' expectations and perceptions of emotional and spiritual care differ for religious hospitals vs. non-religious hospitals, then a comparison of the correlates of patients' ratings would also demonstrate significant variance. The null hypothesis is, if patients' hold identical expectations irrespective of the religious affiliation of the facility, one would expect to see no significant difference between what dimensions are associated with patients' satisfaction with emotional and spiritual care.

Between religious and non-religious hospitals, only two dimensions of the hospitalization experience differ significantly in their relationship to patients' evaluations of the degree to which staff met their emotional and spiritual needs: Nursing and Personal Issues. The latter involves the items previously determined to be most highly correlated with emotional/spiritual needs (i.e. response to concerns/complaints, involvement in treatment decisions, and sensitivity to the inconvenience of hospitalization). Thus, the components of personalized care tend to find increased covariance and interdependency in non-religious hospitals. The results also indicate that in non-religious hospitals, patient perceptions of the quality of nursing care and the quality of emotional/spiritual care are more closely associated with each other. A multitude of theories could be posited to explain this difference (e.g. patients in non-religious hospitals have a greater reliance upon nurses for emotional/spiritual care than in religious hospitals) but cause and effect cannot be inferred from these associations.


Relationships between "Degree to which staff met emotional/spiritual needs" and standard question section scores.(Jan.-Dec. 2002)				
	Religious Hospitals	Non-Religious Hospitals	Z-test*	p
<b>NURSES</b>	0.83	0.91	-3.1	0.001
<b>ADMISSIONS</b>	0.68	0.76	-0.59	0.276
<b>ROOM</b>	0.72	0.78	-0.63	0.261
<b>MEALS</b>	0.64	0.73	-0.55	0.293
<b>TESTS &amp; TREATMENT</b>	0.83	0.88	-1.60	0.055
<b>VISITORS &amp; FAMILY</b>	0.84	0.90	-1.28	0.101
<b>PHYSICIAN</b>	0.66	0.69	-0.16	0.436
<b>DISCHARGE</b>	0.83	0.84	-0.25	0.403
<b>PERSONAL ISSUES</b>	0.91	0.96	-8.3	<0.001
<b>OVERALL ASSESSMENT</b>	0.83	0.87	-1.0	0.16
<b>N</b>	331	1157		

Survey Responses Highly Correlated with 'Degree to which Staff Addressed Emotional/Spiritual Needs' (R > 0.65) (Jan.-Dec. 2001)		
Question	Pearson's Correlation	N
15. Response to concerns/complaints made during your stay	0.75	1212147
i6. Staff effort to include you in decisions about your treatment	0.731	1205854
12. Staff sensitivity to the inconvenience that health problems and hospitalization can cause	0.729	1263285
O2. How well staff worked together to care for you	0.649	1320218
11. Staff concern for your privacy	0.645	1307143

### Emotionally salient situations and actions

The most highly correlated items to "Degree to which staff addressed your emotional/spiritual needs" indicate emotionally salient situations where staff actions may affect patients' satisfaction with emotional and spiritual care to the greatest extent:

1. Response to concerns/complaints made during your stay
2. Staff effort to include you in decisions about your treatment

- 
3. Staff sensitivity to the inconvenience that health problems and hospitalization can cause
  4. How well staff worked together to care for you
  5. Staff concern for your privacy

These situations translate into emotionally satisfying organizational actions which would meet patients' expectations in the aforementioned highly emotional situations:

1. Patients' and/or families' needs are handled in a timely, considerate and empathetic way
2. All tests, interventions, and treatments are explained in an emotionally sensitive and supportive decision-making process
3. Staff demonstrably provide empathetic emotional support
4. Staff work together to orchestrate resources to meet patients' needs.
5. Staff respect patients' confidentiality and physical privacy

(See Clark, Drain & Malone, 2003).

### **What Are Patients' and Families' Emotional and Spiritual Needs?**

Taylor (2003) and Ross (1997) found patients' expectations for emotional and spiritual care to be extremely modest:

- Kindness
- Respect
- Talking & listening
- Authenticity
- Physical presence
- Timely responses to requests
- Mobilizing religious & spiritual resources
- Quiet space for reflection or prayer
- Information about church or chapel services
- Transportation to the chapel

### **Spiritual Resources**

Patients frequently desire several common spiritual resources during their stay that the hospital can provide or facilitate access to (Moadel *et al.* 1999; Shahabi *et al.* 2002; Tatsumura *et al.* 2003).

- Personal or unique faith
- Prayer
- Scripture reading
- Prayer or dialog with fellow church members
- Counseling from chaplain or leader of faith
- Attending a religious service
- Daily spiritual experience
- Meditation
- Spending time at a location of spiritual energy (e.g. church, specific geographic location, or nature settings), and
- Help or counseling from ancestors

### **Nursing Interventions**

Sheldon (2000) outlines several spiritual care interventions that nurses are capable of (after proper assessment). These include:

- Provide privacy, if appropriate
- Conduct life review or faith history
- Encourage storytelling of one's spiritual life.
- Suggest the patient keep a journal.
- Read a Bible story and discuss it as it may apply to patient
- Observe relationships with family
- Offer to pray with a patient/family
- Refer patient to a spiritual care coordinator or clergy
- Facilitate spiritual practices or rituals
- Include patient's spirituality / beliefs in plan of care
- Listen to patient
- Be open to patient's questions
- Provide spiritual reading or videos, as requested
- Convey a respectful, empathic, supportive, nonjudgmental attitude in regard to patient's beliefs
- Offer group support, if available.



## **Pediatric Patients**

Children also possess unique spiritual and emotional needs. Children can experience emotional and spiritual distress as frequently and deeply as adults. Children hold powerful images of religious figures and can benefit from visits from chaplains, pastoral care professionals or their local religious leader. In addition to other suggestions, several interventions apply specifically to pediatric settings, including (Davies *et al.* 2002; Feudtner *et al.* 2003; Kemper & Barnes 2003):

- Minimize separation from parents
- Minimize separation from personal items of emotional attachment
- Minimize disruption to children's routines
- Limit the number of caregivers to help develop trusting relationship(s)
- Appropriate referrals to chaplains/pastoral care
- Red wagons for transportation
- Teddy Bear or other comforting stuffed animal
- Pen Pals with other patients in hospital or other children at other hospitals
- Consider pre-operative role-play with children to help prepare them for procedures
- In case of life-threatening or life-limiting illnesses, consider a special care plan designed to provide comprehensive emotional and spiritual care (e.g. make memories, special spiritual rituals, etc.).

## **Chaplains/Pastoral Care Teams**

Chaplains and pastoral care professionals are highly skilled, well trained and best equipped to provide complex spiritual care (Vandecreek & Burton, 2001). All staff need to be aware and capable of making timely referrals to chaplains and pastoral care (Astrow *et al.* 2001). Yet all patients possess some basic emotional and spiritual care

requirements and simple needs (see above) which, through everyday actions and care, can be addressed by healthcare professionals.

Chaplains and pastoral care professionals cannot be saddled with exclusive responsibility for patient satisfaction with the degree to which *staff* addressed emotional and spiritual needs, especially when the number of patients visited is inherently limited. Rodrigues and colleagues (2000) report only 1 chaplain or pastoral care professional exists for every 64 patients in U.S. hospitals. Our qualitative research found that the highest percentage of admitted inpatients visited by a chaplain, resident chaplain or other pastoral care professional at a single hospital was 40%. Effective and satisfying emotional and spiritual care requires proactive collaboration between nurses, physicians and chaplains/pastoral care professionals (Vandecreek, 1997).

## **Trends**

An increasing number of medical and nursing schools provide doctors and nurses with training in spiritual care (Graves, Shue & Arnold, 2002; Levin, Larson & Puchalski, 1997; Puchalski & Larson, 1998). Patients, families and caregivers now expect nurses and physicians to provide spiritual care (Koenig, 2002; Taylor, 2003). Increased awareness of possible religious and spiritual pathologies has led to recognition of a need for clinicians to assess, understand and support or moderate patients' spiritual and religious beliefs, practices and values (Koenig, McCullough & Larson 2001; Koenig, 2002). These and other trends amass to place an increased emphasis on measuring the quality of care for patients' spiritual needs – distinct from care for emotional needs *despite* the high interrelationship between perceptions and behaviors related to the quality of care in addressing emotional and spiritual needs.



## Meeting Your Needs for Emotional and Spiritual Care Measurement

As your partner, Press Ganey hears and understands your performance measurement needs. Beginning with February 2004 reports, the standard Inpatient and Inpatient Pediatric survey question “Degree to which hospital staff addressed your emotional/spiritual needs” will be changed to “Degree to which hospital staff addressed your emotional needs.” This change will allow the exclusive measurement of spiritual care using “Degree to which hospital staff addressed your spiritual needs” as a custom question. If you would like to add this custom question or revise the text of the current “emotional/spiritual” question on your questionnaire, please contact your Press Ganey account manager.

You also may consider adding custom questions—or an entire custom section—devoted to your chaplaincy or pastoral care department to aid quality improvement. Do not forget the value of patient comments in qualitatively assessing performance. With Press Ganey’s introduction of real-time comments, clients now have the ability to track patients ratings and comments online using InfoEDGE.

### Solution Suggestions

Ultimately, patients’ satisfaction with the emotional and spiritual experience of care represents an aggregate of the interactions and encounters throughout the entire hospitalization. Globally optimizing these everyday encounters to positively affect patients emotionally and spiritually will likely result in larger improvements in patient satisfaction than single interventions or a focus on extreme cases. The following are questions to ask yourself as you evaluate your performance in meeting patients’ emotional and spiritual care needs.

1. Do we have *effective* customer service behavioral standards in place that address privacy, respectful communication, kindness, etc.?

2. Do we systematically and frequently elicit and meet patients’ emotional and spiritual needs with screening questions like “How are you feeling?” “We care about your emotional and spiritual well-being. Do you have any needs or request that I can help with?”
3. Are we conducting Emotional or Spiritual Assessments or taking Spiritual or Faith Histories in order to understand patients’ preferences and assess needs? Are we connecting with patients? Are we reassessing or reconnecting patients on at least a daily basis? Are we understanding and reaching *all* patients?
4. Do we have an *effective* service recovery process? Have we trained all staff in service recovery? Do we have a service recovery or general discretionary fund?
5. Do we know how to communicate empathically to demonstrate to patients that you understand and empathize? Does everyone know how to communicate in ways that calm and soothe angry or upset patients?
6. Do we have a chapel or meditative place? Do patients know about it? Do we tell them when services are? Do we offer to take patients to the Chapel? Do we have and do patients know about religious programming on our T.V.?
7. What do staff know about your patient population’s culture, spiritual beliefs and related emotions? What are your organizational learning needs?

### Future Research

The emotional and spiritual care of patients receives more research attention than any other individual measure of patient satisfaction with the experience of care. Other articles are available and more research will be forthcoming from Press Ganey Research & Development. Review the articles below and contact your account manager for the latest information. **Thank you** for all you do in caring for patients.



## References

- Clark, P. A., Drain, M., & Malone, M. P. (2003). Addressing patients' emotional and spiritual needs. *Joint Commission Journal on Quality and Safety*, in press.
- Clark, P. A., Drain, M., & Wolosin, R. J. (2003, September 17-18). *Hospitalized cancer patients rate the quality of their emotional/spiritual care*. Paper presented at the Third Outcomes Management Conference: The Quality of Cancer Care: From Evidence to Action, Chicago, IL. Available from: [http://www.pressganey.com/files/clark\\_drain\\_wolosin\\_2003.pdf](http://www.pressganey.com/files/clark_drain_wolosin_2003.pdf)
- Damasio, A. (1999). *The Feeling of What Happens: Body and Emotion in the Making of Consciousness*. New York: Harcourt Brace & Company.
- Davies, B., Brenner, P., Orloff, S., Sumner, L., & Worden, W. (2002). Addressing spirituality in pediatric hospice and palliative care. *J Palliat Care*, 18(1), 59-67.
- Feudtner, C., Haney, J., & Dimmers, M. A. (2003). Spiritual care needs of hospitalized children and their families: a national survey of pastoral care providers' perceptions. *Pediatrics*, 111(1), e67-72.
- Fitchett, G. (2002). *Assessing Spiritual Needs: A Guide for Caregivers*. Lima, OH: Academic Renewal Press.
- Graves, D. L., Shue, C. K., & Arnold, L. (2002). The role of spirituality in patient care: incorporating spirituality training into medical school curriculum. *Acad Med*, 77(11), 1167.
- Kemper, K. J., & Barnes, L. (2003). Considering culture, complementary medicine, and spirituality in pediatrics. *Clin Pediatr (Phila)*, 42(3), 205-208.
- Kihlstrom, J.F., Mulvaney, S., Tobias, B.A., and Tobis, I.P. (2000) "The Emotional Unconscious" in *Cognition and Emotion* (ed.s) Eich E., Kihlstrom JF, Bower GH, Forgas JP, & Niedenthal, PM. Oxford University Press; pg. 63.
- Koenig, H. G. (2002). *Spirituality in Patient Care: Why, How, When and What*. Radnor, PA: Templeton Foundation Press.
- Koenig, H., McCullough, M. E., & Larson, D. B. (2001). *Handbook of Religion and Health*: Oxford University Press.
- Levin, J. S., Larson, D. B., & Puchalski, C. M. (1997). Religion and spirituality in medicine: research and education. *JAMA*, 278(9), 792-793.
- Moadel, A., Morgan, C., Fatone, A., Grennan, J., Carter, J., Laruffa, G., et al. (1999). Seeking meaning and hope: self-reported spiritual and existential needs among an ethnically-diverse cancer patient population. *Psychooncology*, 8(5), 378-385.
- Miller, W. R., & Thoresen, C. E. (2003). Spirituality, religion, and health. An emerging research field. *Am Psychol*, 58(1), 24-35.
- Puchalski, C. M., & Larson, D. B. (1998). Developing curricula in spirituality and medicine. *Acad Med*, 73(9), 970-974.
- Rodrigues, B., Rodrigues, D., & Casey, D. L. (2000). *Spiritual Needs and Chaplaincy Services: A National Empirical Study on Chaplaincy Encounters in Health Care Settings*. Medford, OR: Providence Health System.
- Ross, L. (1995). The spiritual dimension: its importance to patients' health, well-being and quality of life and its implications for nursing practice. *International Journal of Nursing Studies*, 32(5), 457-468.
- Shahabi, L., Powell, L. H., Musick, M. A., Pargament, K. I., Thoresen, C. E., Williams, D., et al. (2002). Correlates of self-perceptions of spirituality in American adults. *Ann Behav Med*, 24(1), 59-68.
- Sheldon, J. E. (2000). Spirituality as a part of nursing. *Journal of Hospice and Palliative Nursing*, 2(3), 101-108.
- Tatsumura, Y., Maskarinec, G., Shumay, D. M., & Kakai, H. (2003). Religious and spiritual resources, CAM, and conventional treatment in the lives of cancer patients. *Altern Ther Health Med*, 9(3), 64-71.
- Taylor, E. J. (2003). Nurses caring for the spirit: patients with cancer and family caregiver expectations. *Oncol Nurs Forum*, 30(4), 585-590.
- VandeCreek, L., & Burton, L. (ed.s) (2001). *Professional Chaplaincy: Its Role and Importance In Healthcare*. New York: The Healthcare Chaplaincy; Available from: [http://www.healthcarechaplaincy.org/publications/publications/white\\_paper\\_05.22.01/](http://www.healthcarechaplaincy.org/publications/publications/white_paper_05.22.01/)
- VandeCreek, L. (1997). Collaboration between nurses and chaplains for spiritual caregiving. *Semin Oncol Nurs*, 13(4), 279-280.
- Williams, A. What Do Patients Want That They Are Not Getting? A Study of Patients from the United States, Canada, and Australia (2003) 5th International Conference on the Scientific Basis of Health Services, Washington, D.C.

## Organizations contributing to this report

*Press Ganey acknowledges and appreciates the contributions of knowledge and expertise from these hospitals' staff, administration and/or chaplains:*

- Baptist Health Medical Center – North Little Rock (North Little Rock, Arkansas)
- Baxter Regional Medical Center (Mountain Home, Arkansas)
- Hoag Memorial Hospital Presbyterian (Newport Beach, California)
- Lake Forest Hospital (Lake Forest, Illinois)
- Lawrence & Memorial Hospital (New London, Connecticut)
- Moses Cone Health System (Greensboro, North Carolina)
- St. Vincent Hospitals and Health Care Services (Indianapolis, Indiana)



## Additional Resources

Baxter Regional Medical Center. “**Forming a Spiritual Care Committee**” *Success Story Finalist*, 2000. Available from: <http://www.pressganey.org/initiatives/stories/ss2000.shtm>

Clark, P. A., Drain, M., & Malone, M. P. **Addressing patients' emotional and spiritual needs.** *Joint Commission Journal on Quality and Safety*, in press, Dec. 2003.

Clark, P. A., Drain, M., & Wolosin, R. J. (2003, September 17-18). “**Hospitalized cancer patients rate the quality of their emotional/spiritual care.**” Paper presented at the *Third Outcomes Management Conference: The Quality of Cancer Care: From Evidence to Action*, Chicago, IL. Available from: [http://www.pressganey.com/files/clark\\_drain\\_wolosin\\_2003.pdf](http://www.pressganey.com/files/clark_drain_wolosin_2003.pdf)

Koenig, H.G. “**Meeting the Spiritual Needs of Patients**” *The Satisfaction Monitor*, July/Aug 2003. Available from: <http://www.pressganey.com/research/resources/satmon/text/bin/178.shtm>

Hansten, R. “**Capturing The Healing Moments**” *The Satisfaction Monitor*, July/Aug 2001. Available from: <http://www.pressganey.com/research/resources/satmon/text/bin/115.shtm>

Press Ganey Client Forum, “**Emotional and Spiritual Needs**” Discussion, 2003. Available from: <https://www.pressganey.com/forum/showthread.php?s=&threadid=281>

Román, C. “**Can Anybody Hear Me? What Patients Say**” *The Satisfaction Monitor*, July/Aug 2002. Available from: <http://www.pressganey.com/research/resources/satmon/text/bin/144.shtm>

VandeCreek, L., & Burton, L. (ed.s) (2001). *Professional Chaplaincy: Its Role and Importance In Healthcare*. New York: The Healthcare Chaplaincy; Available from: [http://www.healthcarechaplaincy.org/publications/publications/white\\_paper\\_05.22.01/](http://www.healthcarechaplaincy.org/publications/publications/white_paper_05.22.01/)

---

### Contact:

Paul Alexander Clark, MPA  
Best Practices Knowledge Manager

### Press Ganey Associates

404 Columbia Place  
South Bend, IN 46601

Ph: 574-232-3387 ext. 249

E-mail: [pclark@pressganey.com](mailto:pclark@pressganey.com)

Website: <http://www.pressganey.com>