

Faith-Health Collaboration to Improve Community and Population Health

Wayne B. Jonas, MD, Samueli Integrative Health Programs; and Rev. Maeba Jonas, MDiv, Johns Hopkins University

August 12, 2019

Introduction

Perhaps there is no larger gap in health care between two professionals trying to help the same sick person heal than the one that exists between the physician/clinician and the chaplain/member of the clergy. The gap does not usually result from animosity, but simply a neglect of serious communication and integration with one another. This faith–health care gap is even wider outside of the hospital, where most of life and health happens.

The physician makes rounds, looking at the physical components of a patient’s illness and body, and ordering tests—but rarely inquiring about their mental and spiritual needs. When a patient inquires about the “why” of their illness, the medical profession answers in terms of risk factors, biochemical mechanisms, and genes. The clinician rarely asks if the “why” might be an existential question: “Why me?” or “How will this affect the meaning of my life?”

Even though 80 percent of patients want to discuss spiritual issues, have prayer and comfort of the mind or soul [1], explore the meaning of their illness, or see a chaplain, most physicians will not ask about these needs. Rounds are finished with discharge planning, but that planning focuses on what will happen the next day or week—even if, for the patient, their illness does not seem to leave much hope for planning a next day.

Later in the day, the hospital chaplain or the community minister, priest, rabbi, or imam may make their rounds, inquiring about any spiritual introspections or reflections the patient might have, exploring the impact of stress from the illness or its treatment, and offering prayer, comfort, and social connection. Properly performed, the role of the chaplain is to assess and support the spiritual health of the patient and never to proselytize, coerce, or otherwise influence the religious beliefs of the patient or the patient’s family. The hospital chaplain might write a note in the chart.

But rarely will they write a note directly to the medical team, discuss the patient’s spiritual needs with others doing rounds, or expect their note even to be read. If a patient has a terminal illness, the chaplain might be called by the medical team, as if the soul matters only when the body is near its final “discharge.”

The doctor asks, “What’s the matter?” and the chaplain asks, “What matters?” Rarely do these two discussions connect, even when the answers to those questions influence each other. The person has been divided into parts—the body on one side and the soul on another—and we wonder why the suffering patient struggles to find whole-person and patient-centered care somewhere in between.

The notion of including a faith-based representative on the care team has been noted elsewhere [2]. In this commentary, the authors describe examples of how those in faith communities and health care sectors can come together and discuss the challenges these different communities have in fully integrating. We then suggest some simple tools that could facilitate better integration between faith and health care communities, toward providing more whole-person care.

Faith and Health Care in Collaboration

The Roundtable on Population Health Improvement at the National Academies of Sciences, Engineering, and Medicine (NASEM) held a workshop in 2018 titled “Faith-Health Collaboration to Improve Population Health” [3] to explore the tension between faith and health care communities and to highlight examples where faith care and health care are being effectively merged so the whole patient can be treated. Communities from across the country presented the successes and challenges they experienced in caring for the whole person in the context of a fragmented health care system.

A variety of approaches were presented, including a faith-community-based residential substance abuse recovery program in Alabama that uses a “life plan”

approach to connect a person's health goals to their life goals, so the physical and the spiritual are explicitly connected. A model from the Memphis Congregational Health Network (CHN) was presented and relayed how the hospital chief executive officer partnered with several faith leaders in the community to leverage hundreds of congregations and their convening power to facilitate access to health care and address health-related social needs. The bonds between the health care and faith communities were both implicit and explicit, and the collaboration between the two groups allowed for the care of both the bodies and spirits of community members. Finally, a community health center board chair presented on how hierarchies of power were flattened at the University Muslim Medical Association Community Clinic in Los Angeles. This presentation illustrated how leadership can emerge at any level, especially when groups intentionally focus on mutually desired goals.

The wide variety of approaches to merging health care and faith showed that many solutions can be developed and implemented and provided a substantial pool of best practices to begin this necessary but challenging work.

Challenges and Questions

Of course, there are challenges to creating faith-health collaborations. One of the major challenges involves definitions and terminology. The concepts of “communities of spirit” and “faith-based,” as well as “whole person” and “integrative health,” are attractive—but these terms need clear definitions. What are the core components of a whole person that need to be addressed if humans are to flourish? Could faith and health care communities establish a simple set of dimensions (like Maslow did in his hierarchy of needs) for what we consider a whole human being? Perhaps clearly agreeing that humans consist of at least mind, body, spirit, and social dimensions is a start. Then we can agree that providing “whole-person integrative health care” means taking all these dimensions into consideration, regardless of one's professional lens.

Having common language for communication between faith and health communities is also key. Do “love” and “social support” intersect and have similar goals? How about “convening” and “community”? A workshop attendee spoke of the continuous challenge of attending to the intangible (e.g., prayer, belonging, compassion) and of needing to highlight the negative

health aspects of activities that can come from both faith and health communities. For example, one speaker pointed out the negative aspects of some religious behaviors, such as “judgment, exclusion, theological ideas that demean . . . or frighten people,” and the negative aspects of medical treatment behaviors that perpetuate the racial and ethnic disparities in poor outcomes and low-quality care. It is critical for both sides to understand their strengths and weaknesses.

Repeatedly returning to the “why” of any collaboration is essential. Isn't the answer to that “why” always to enhance the health, well-being, and human flourishing of all people? Another workshop attendee commented on the moral incongruity of faith-based health care organizations acting on “the impulse to garner resources and market share in communities at the expense of resources for other key determinants of health, such as adequate housing, education, and so forth”—contributing to a health care industry that struggles to improve population health. That observation is key to better aligning resources to help population health strategies succeed.

Do health care and faith-based care have a common moral basis that guides both fields toward enhancing population health and well-being? Or do they have different goals that conflict and interfere with each other, leaving the person to contend with only the negatives from both faith care and health care? Hospitals may find themselves in competition with faith-run community health centers (e.g., competition for patients who could visit the emergency department or use primary care services). This competition puts the two immediately at odds, rather than fostering collaboration that could be mutually beneficial.

If faith-based health care prevents the need for high-cost medical industry in the same city, will the more powerful health care organizations restrict the growth and delivery of faith-based health care? So often, world-class health care organizations and hospital systems sit right in the middle of settings for some of the worst health disparities in the country. This is a health-faith issue that needs to be more explicitly addressed. The authors of this manuscript believe that faith-health collaborations should talk about the imperatives of both the faith and health communities—be they moral or economic—and how those imperatives can be leveraged to work together on a larger scale to ensure universal access to whole-person health and well-being services for all.

We are left with many more questions than answers but have proposed some practical steps to move such collaborations forward.

Practical Steps

How can the gap between medicine and faith be more widely and rapidly bridged without falling into the silos of medical dogma and denominational competition? Are there tools that both faith-based and health care providers can implement now, even if there is not an environment of explicit faith-health collaboration? The authors believe there are and we offer four suggestions that any provider—in either community—can use.

- Creating universal faith-health action tools:** Mandy Cohen, North Carolina secretary of health, told a story at the workshop about not thinking to ask a patient who was losing weight if she was getting enough to eat during a medical visit and how food security and other social determinants have come to be understood to be as vital to good health as medical attention. Communities of faith often address food insecurity and may address this directly but not link it back to a health issue. Thus, both health and faith communities have a common goal. The disconnect described by Dr. Cohen led the authors of this manuscript to think about the need for universal faith-health action tools. National leaders (e.g., Joint Commission, Centers for Disease Control and Prevention, Veterans Health Administration) could develop a set of core questions related to whole-person care that both health care and faith-care organizations can use with their clients at a local level. This could facilitate communication and action within and between their communities.
- The Personal Health Inventory:** An example of one of these tools is the rollout of the Personal Health Inventory (PHI) across the Veterans Health Administration [4]. The PHI begins by asking each person what matters in their life and then explores the connection of that “spiritual” question to their behavioral health and applicable social determinants of health. Other examples of screening tools for health-related social needs are available [5]. This or a similar tool should be adopted more broadly, outside of the Department of Veterans Affairs, and
- could be the first universal tool for both faith and health communities to use. Embedding it nationally, for example, as an implementation tool aligned with the upcoming Healthy People 2030 indicators, might be an ideal location guiding multi-sector integration for population health.
- The HOPE Note:** Helping people develop a life plan informs a second universal tool for health care and faith-care organizations to jointly use. The HOPE Note [6] is a set of questions to assist in developing a health-life plan for any person. It is a tool that is increasingly being used in primary care and community clinics and allows for not only whole-person integrative health encounters, but also the creation of a life-health plan that considers both physical and spiritual needs [7]. If necessary, more detailed information about a patient’s spiritual-health connection can be assessed with other tools like FICA (faith and belief, importance, community, address in care) [8] or the 7 by 7 Model for Spiritual Assessment [9]. Support to help patients address their personal health determinants is being provided in a variety of ways—such as with life coaches, health coaches, or care coordinators, and by using group visits, tele-health, and other behavior change technologies. The authors of this manuscript believe that addressing personal health determinants and taking a life-long view of whole-person health is critical.
- Community Wellbeing Coordinators:** The navigators and community coordinators of the CHN, described at the workshop, are an example of a third universal tool around which health care and faith-care could to join together. Hot-spotting involves data-driven targeting to a specific zip code where many patients reside to improve care quality—including by addressing health-related social needs specific to that community (for example, providing transportation to a health clinic if the community does not have one). These can improve health, while also lowering costs. Personal contact by a trained community health worker or similar personnel are two essential elements to the success of the CHN and the Methodist Health-care model approaches described at the work-

shop [10]. These types of people and processes are likely key to any successful faith-health community action plan.

Finally, communities need simple approaches for measurement and feedback of progress toward value. The authors of this paper extended the formula for value first established by Porter: health and well-being outcomes plus patient and provider experience divided by cost [11]. The larger this number, the better the value. Rapid and continuous measurement and feedback on value (along with information on how all members of the team—provider, caregiver, chaplain, community member, and patient—contribute to this value) should be part of any national faith-health measurement of population health. Such a measurement approach could become a National Well-Being Index, equivalent to our Gross National Product for all to see, aspire to, and improve together [12].

Recently, the NASEM Committee on Informing the Selection of Leading Health Indicators for Healthy People 2030 showcased several well developed approaches to such a National Well-Being Index, including insights from The Wellbeing Project in Santa Monica, CA; the Robert Wood Johnson Foundation's Culture of Health Action Framework; ReThink Health's Community Health Measurement approach; and, the Well-being in the Nation (WIN) Measurement Framework by IHI's 100 Million Healthier Lives [12, 13].

As community, government, and business leaders become aware that health and well-being come primarily from factors outside the medical environment, more partnerships between faith-based and health care organizations like those presented at this workshop will hopefully emerge.

References

1. Anandrajah, G., and E. Hight. 2001. Spirituality and medical practice: Using the HOPE questions as a practical tool for spiritual assessment in office practice. *American Family Physician* 63(1):81-88.
2. Gunderson, G., S. Magnan, and A. Baciuc. 2018. Faith-based assets and multi-sector community teams tapping into deeply woven roots. *North Carolina Medical Journal* 79(4):236-237. <http://www.ncmedicaljournal.com/content/79/4/236.full> (accessed July 18, 2019).
3. National Academies of Sciences, Engineering, and Medicine. 2018. *Faith-health collaboration to improve population health: A workshop*. <http://nationalacademies.org/hmd/Activities/PublicHealth/PopulationHealthImprovementRT/2018-MAR-22.aspx> (accessed July 25, 2019).
4. Veterans Health Administration. 2017. *The personal health inventory*. https://www.va.gov/PATIENTCENTEREDCARE/docs/PHI_Short_508.pdf (accessed July 25, 2019).
5. Billioux, A., K. Verlander, S. Anthony, and D. Alley. 2017. Standardized screening for health-related social needs in clinical settings: The accountable health communities screening tool. *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington, DC. <https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf> (accessed July 25, 2019).
6. The HOPE note toolkit. 2018. Alexandria, VA: Samueli Integrative Health Programs. <http://drwaynejonas.com/resources-old/hope-note/> (accessed July 18, 2019).
7. Fitchett, G. 2002. *Assessing spiritual needs: A guide for caregivers*. Lima, OH: Academic Renewal Press. https://books.google.com/books/about/Assessing_Spiritual_Needs.html?id=ds0JAAAACAAJ (accessed July 25, 2019).
8. Puchalski, C., and A. L. Romer. 2000. Taking a spiritual history allows clinicians to understand patients more fully. *Journal of Palliative Medicine*, 3(1) 129-137. <https://smhs.gwu.edu/gwish/clinical/fica/spiritual-history-tool> (accessed July 25, 2019).
9. Fitchett, G. *Wondering if it's time to give up: A case example of the 7 by 7 model for spiritual assessment*. Chicago, IL. http://www.ups.upenn.edu/pastoral/cpe/fitchett_7x7model_article.pdf (accessed July 25, 2019).
10. American Hospital Association. *The Congregational Health Network at Methodist le Bonheur Healthcare*. <https://www.aha.org/case-studies/2013-01-01-congregational-health-network-methodist-le-bonheur-healthcare> (accessed July 25, 2019).
11. Porter, M. E. 2010. What is value in health care? *The New England Journal of Medicine* 363(26):2477-2481.
12. *Well-being in the Nation (WIN) Measurement Framework: Measures for Improving Health, Well-being, and Equity Across Sectors*. 2019. Facilitated by 100 Million Healthier Lives with the National Committee on Vital and Health Statistics. www.WINmeasures.org (accessed July 25, 2019).
13. National Academies of Sciences, Engineering, and Medicine. 2019. *Informing the selection of leading health indicators for Healthy People 2030*. <http://nationalacademies.org/hmd/Activities/PublicHealth/PopulationHealthImprovementRT/2018-MAR-22.aspx> (accessed July 25, 2019).

tionalacademies.org/hmd/Activities/PublicHealth/LeadingHealthIndicatorsForHealthyPeople2030.aspx (accessed July 25, 2019).

DOI

<https://doi.org/10.31478/201908a>

Suggested Citation

Jonas, W. B. and M. Jonas. 2019. Faith-health collaboration to improve community and population health. *NAM Perspectives*. Commentary, National Academy of Medicine, Washington, DC. <https://doi.org/10.31478/201908a>.

Author Information

Wayne B. Jonas, MD, is Executive Director, Samueli Integrative Health Programs. **Rev. Maeba Jonas, MDiv**, is Assistant Chaplain, Johns Hopkins University.

Conflict-of-Interest Disclosures

None to disclose.

Correspondence

Questions or comments should be directed to Wayne Jonas at wayne@drwaynejonas.com.

Disclaimer

The views expressed in this paper are those of the authors and not necessarily of the authors' organizations, the National Academy of Medicine (NAM), or the National Academies of Sciences, Engineering, and Medicine (the National Academies). The paper is intended to help inform and stimulate discussion. It is not a report of the NAM or the National Academies. Copyright by the National Academy of Sciences. All rights reserved.