November 2015 Article of the Month

This month's article selection is by Chaplain John Ehman,
University of Pennsylvania Medical Center-Penn Presbyterian, Philadelphia PA.

Gomez-Castillo, B. J., Hirsch, R., Groninger, H., Baker, K., Cheng, M. J., Phillips, J., Pollack, J. and Berger, A. M. "**Increasing the number of outpatients receiving spiritual assessment: a Pain and Palliative Care Service quality improvement project**." *Journal of Pain and Symptom Management* 50, no. 5 (November 2015): 724-729.

COMMENT and SUMMARY: This months article reports a quality improvement project at the National Institutes of Health Clinical Center and should spur thinking in pastoral care departments about interventions with and alongside of clinicians that may improve the incidence of spiritual assessment and chaplaincy referrals. The idea of covisits with clinicians especially invites further exploration. The project used CPE interns in addition to staff chaplains --a fact not noted in the article but conveyed informally to our Network by co-author John Pollack, Chief of the Clinical Center's Spiritual Care Department.

The authors took advantage of a searchable electronic medical record system adopted in July 2013 by the institution's Pain and Palliative Care Service (PPCS), and in light of a September 2013 audit of documentation that "revealed a low completion rate for some components of spiritual history," "...this PPCS spiritual care quality improvement (QI) project was designed and implemented with the goal of minimizing delayed or missed opportunities for the provision of spiritual care by improving spiritual assessment for all new PPCS outpatients" [p. 725]. Data from two consecutive samples of new patients referred to the PPCS and seen in an outpatient clinic were analyzed for the periods of 7/1/13-9/30/13, involving 47 patients for a baseline, and 12/1/13-2/28/14, involving 32 patients to assess the effectiveness of successive interventions implemented during October and November of 2013.

> The first intervention, which was conducted during October 2013, consisted of engaging clinical and spiritual care stakeholders. This began with reviewing baseline data on percentages of all new outpatients receiving spiritual assessment, followed by discussing potential causes for this low completion rate. In addition to re-emphasizing with PPCS clinical providers the breadth of spirituality issues, the following concerns and process issues were identified, including initial appointment time constraints (patient schedules), symptom focus/priority during initial consults, staffing availability, clinic flow (communication with clinic coordinator whether clinician and chaplain have seen patient), and different aspects of spiritual health history elements spread across several sections of EMR templates. [p. 726; and see also p. 728 regarding "encouraging clinicians to establish a trusting patient-clinician relationship that would allow patients to share spiritual concerns with them"].
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> The second intervention was performed during November 2013, in conjunction with the director

> and staff members of the Spiritual Care Department. This intervention consisted of chaplain covisits with palliative care clinicians for all new outpatients within their first three visits and/or intervening hospital admissions. The patient was informed of all members/ disciplines in the outpatient pain and palliative care team (nurses, physicians, chaplain, recreation therapists), and that various team members would introduce themselves during the interview process or at subsequent visits. The chaplain then joined the patient interview at the beginning or in progress during the first clinic visit. Spiritual assessment was incorporated into the interview process as a conversation between patient and clinician and/or chaplain. One month was allowed for all staff (clinicians, chaplains, and volunteer clinic coordinators) to become oriented to the new clinic process and to allow for establishing a new clinic flow before postintervention data collection.... [pp. 726-727]

Among the findings, there was a significant increase in FICA spiritual histories (72% postintervention vs. 49% at baseline) and fully complete psychosocial evaluations (75% postintervention vs. 38% at baseline). Overall, documentation showed that 78% of new PPCS outpatients had either FICA spiritual histories or chaplain covisits postintervention, compared to 55% at baseline, and spiritual assessments were concentrated in the patient's first clinic consult --a point that the authors believe "indicates that the initial consult may be a critical (and sole) opportunity to assess spiritual needs" [p. 728] for this population. The authors also note generally the value of chaplains' involvement in the initial clinic encounter:

> [H]aving a chaplain's consult at the point of entry [for the patient] is important because it assures proactive spiritual care. Also, early provision of spiritual support is important because spirituality has been shown to affect health care decision making and may aid in patient and family preparedness for urgent medical situations and changes in disease status. [p. 727].

Chaplains' covisits occurred in 50% of cases postintervention. That is double the incidence prior to this Quality Improvement project but still suggests challenges for the overall strategy of chaplains' involvement and spiritual assessment. For example:

> Timing was an issue in some cases. There were some very time-limited medical appointments that prevented the opportunity for spiritual assessment. In other cases, the patients' physical pain was a factor that was not conducive to completing a spiritual assessment at the initial PPCS outpatient appointment. In addition, chaplain staffing issues occurred at times where follow-up chaplain consults coincided with new patient consults; as a consequence, some patients missed the opportunity for a chaplain covisit during the initial outpatient appointment. [p. 728]

The authors address a number of limitations but conclude that "our findings indicate that an interdisciplinary approach to spiritual assessment is effective in improving the quality of outpatient spiritual assessment in a short period of time" [p. 728]. Remember that this QI project was implemented quickly and seems to have positively affected clinic work-flow that has practical implications for patients. However, for this reader's research perspective, the larger importance of this article is that it models and sets up some rich ideas for chaplains to consider for future study. For instance:

- It demonstrates some of the dynamics of mining data from electronic medical records systems: in this case the electronic medical record made the collection of some data convenient (e.g., the incidence of spiritual assessments) but there were also blind spots (e.g., the system used here did not record follow-up visits for spiritual care).
- One outcome of the interventions here seems to have been that spiritual assessments previously completed only in part were subsequently completed fully. What precisely is involved in this difference, and what quality of content tends to emerge in the more complete assessments?
- It pairs an educational intervention for clinicians with a process by which clinicians may work along side of chaplains. While in this case, "the independent effects of the two interventions were not easy to discern" [p. 278], future research could focus not only on the distinction but on the clinicians' experience.
- Chaplains' covisits with clinicians (in some instances here involving CPE Interns) would be a rich area for study in and of itself. The chaplain's own sense of the covisit experience could be explored in contrast

to a larger *rounding* type of clinical multidisciplinary activity. What educational value could this experience have for CPE students?
- How might the covisit strategy play out in an inpatient setting and beyond the palliative care context, and how might it have ripple effects for referrals to chaplains and for follow-up visits. Also, how might covisits affect patient satisfaction? Our authors do state, after all, that the covisit intervention "was chosen because religiousness and spiritual support have been related to improved satisfaction in medical care..." [p. 727].
- The authors comment that, in contrast to a spiritual assessment that employs separate FICA and psychosocial assessments, an "integrated spiritual distress assessment tool may ease spiritual care triage and planning" [p. 728]. What might be the potential in creating a new integrated spiritual distress assessment tool tailored to the chaplain-clinician covisit process?
- The timing and staffing issues discovered through the implementation of this project are relevant to the methodology of future studies, but they are also worthy of investigation as issues in the operation of pastoral care departments.

Two final comments of concern: First, there are apparent errors in Figure 1 [p. 726], which gives a 2014 rather than 2013 date for the conclusion of baseline data, and in Table 1 [p. 727], which is based on 78 total patients instead of the 79 described in the text. Also, the interchangeable use of the terms *consult* and *covisit* when referring to chaplains' activities [e.g., p. 727] may be confusing. However, this reader especially appreciated the authors' good clarification of the potentially ambiguous term of *spiritual assessment* [p. 725].

Suggestions for the Use of the Article for Student Discussion:

This relatively brief article might help students consider the research aspect of quality improvement projects. It may also help them think about a multidisciplinary process for spiritual assessment and support within palliative care --and then beyond to other contexts. A principal area for discussion could be the idea of covisits with clinicians, whether it is appealing and what all could be involved in doing this. What are the upsides and downsides that come to mind? Does an educational intervention like the one here with clinicians seem feasible at your ACPE center? What questions does the article raise that could be the basis for new QI projects or more involved research? (For example, see the list in the section above.) What data may be already routinely be collected in your institution that could be used in a project? Students might look at the FICA spiritual history tool [--see Related Items of Interest, §III (below)] and discuss how information from such a history might be useful for a chaplain.

Related Items of Interest:

I. Our featured article makes several references to reports of "consensus" conferences [--see pp. 724 and 725], specifically the National Consensus Project for Quality Palliative Care: Clinical Practice Guidelines for Quality Palliative Care and the article by Puchalski, C., et al., "Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference." For more on the wider context of these reports, see our June 2014 Article-of-the Month page, especially its related Items of Interest §I.

II. For more on the potential relationship between chaplain visits and *patient satisfaction*, see our February 2015 Article-of-the Month page, which includes links to other pertinent Article-of-the Month pages.

III. For more on the FICA spiritual history tool, see our August 2010 Article-of-the Month page. The FICA tool is available online from the George Washington Institute for Spirituality and Health.

IV. The following is a brief report (in the form of a letter to the journal editor) of a Quality Improvement project that was carried out by two chaplains -- the lead author being a CPE Resident -- at a palliative care clinic through Yale-New Haven Hospital (New Haven, CT). Note the positive effect when the chaplain was introduced by a medical provider.

> Glombicki, J. S. and Jeuland, J. "**Exploring the importance of chaplain visits in a palliative care clinic for patients and companions**." *Journal of Palliative Medicine* 17, no. 2 (February 2014): 131-132. [Data were obtained from 21 outpatients and 12 of their companions during clinic visits. Among the findings: patients and their companions valued a chaplain's visit as part of their "overall visit" (average of 3.93 on a 5-point scale). If a medical provider introduced the patient or companion to the chaplain, the chaplain's visit was rated at an average of 4.38 vs. 3.43 for when there was no such introduction. Also, "Data suggested that 12.82 minutes was considered 'enough' time for an outpatient visit, challenging previous studies' hypotheses that SRE [i.e., spiritual, religious, existential] support in outpatient settings may be difficult due to complexity of providing SRE with limited time" [p. 131]. Analysis of comments by the patients and companions also suggested a handful of themes regarding how chaplains were positively valued: chaplain visits are different from other fields, the visits were helpful in the expression of thoughts and feelings, the visits were generally valuable in the outpatient setting, the visits give an additional layer of support, and the visits communicate encouragement. Illustrative quotes are given in a table [--see p. 131].]

V. The following article looks at chaplains' experience of participating in a research project that was exploring a spiritual assessment intervention with palliative care outpatients.

> Kestenbaum, A., James, J., Morgan, S., Shields, M., Hocker, W., Rabow, M. and Dunn, L. B. "**'Taking your place at the table': an autoethnographic study of chaplains' participation on an interdisciplinary research team**." *BMC Palliative Care* 14 (2015): 20 [electronic journal article designation]. [(Abstract:) BACKGROUND: There are many potential benefits to chaplaincy in transforming into a "research-informed" profession. However little is known or has been documented about the roles of chaplains on research teams and as researchers or about the effects of research engagement on chaplains themselves. This report describes the experience and impact of three chaplains, as well as tensions and challenges that arose, on one particular interdisciplinary team researching a spiritual assessment model in palliative care. Transcripts of our research team meetings, which included the three active chaplain researchers, as well as reflections of all the members of the research team provide the data for this descriptive, qualitative, autoethnographic analysis. METHODS: This autoethnographic project evolved from the parent study, entitled "Spiritual Assessment Intervention Model (AIM) in Outpatient Palliative Care Patients with Advanced Cancer." This project focused on the use of a well-developed model of spiritual care, the Spiritual Assessment and Intervention Model (Spiritual AIM). Transcripts of nine weekly team meetings for the parent study were reviewed. These parent study team meetings were attended by various disciplines and included open dialogue and intensive questions from non-chaplain team members to chaplains about their practices and Spiritual AIM. Individual notes (from reflexive memoing) and other reflections of team members were also reviewed for this report. The primary methodological framework for this paper, autoethnography, was not only used to describe the work of chaplains as researchers, but also to reflect on the process of researcher identity formation and offer personal insights regarding the challenges accompanying this process. RESULTS: Three major themes emerged from the autoethnographic analytic process: 1) chaplains' unique contributions to the research team; 2) the interplay between the chaplains' active research role and their work identities; and 3) tensions and challenges in being part of an interdisciplinary research

team. CONCLUSIONS: Describing the contributions and challenges of one interdisciplinary research team that included chaplains may help inform chaplains about the experience of participating in research. As an autoethnographic study, this work is not meant to offer generalizable results about all chaplains' experiences on research teams. Research teams that are interdisciplinary may mirror the richness and efficacy of clinical interdisciplinary teams. Further work is needed to better characterize both the promise and pitfalls of chaplains' participation on research teams.]
