Brief Quality Improvement Report

Increasing the Number of Outpatients Receiving Spiritual Assessment: A Pain and Palliative Care Service Quality Improvement Project

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Abstract

Background. Spirituality is a patient need that requires special attention from the Pain and Palliative Care Service team. This quality improvement project aimed to provide spiritual assessment for all new outpatients with serious life-altering illnesses.

Measures. Percentage of new outpatients receiving spiritual assessment (Faith, Importance/Influence, Community, Address/Action in care, psychosocial evaluation, chaplain consults) at baseline and postinterventions.

Intervention. Interventions included encouraging clinicians to incorporate adequate spiritual assessment into patient care and implementing chaplain covisits for all initial outpatient visits.

Outcomes. The quality improvement interventions increased spiritual assessment (baseline vs. postinterventions): chaplain covisits (25.5% vs. 50%), Faith, Importance/Influence, Community, Address/Action in care completion (49% vs. 72%), and psychosocial evaluation (89% vs. 94%).

Conclusions/Lessons Learned. Improved spiritual assessment in an outpatient palliative care clinic setting can occur with a multidisciplinary approach. This project also identifies data collection and documentation processes that can be targeted for improvement. J Pain Symptom Manage 2015;50:724–729. *Published by Elsevier Inc. on behalf of American Academy of Hospice and Palliative Medicine.*

Key Words

Spirituality, spiritual assessment, quality improvement, palliative care

Background

The importance of spirituality in health care has increased in recent years. Researchers and clinicians now recognize spirituality as a patient need that requires special attention, particularly for an interdisciplinary palliative care service. Spirituality has been defined by the National Consensus Project for Quality of Palliative Care as "the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred."[1] Salient evidence has shown that patients with serious life-altering illnesses and those at the end of life may experience an intensified desire to access and enrich the spiritual aspect of their lives. According to the National Comprehensive Cancer Network, religiousness and spiritual support have been related to improved patient satisfaction with medical care.[2]

Conversely, spiritual distress is associated with poor physical outcomes and higher rates of morbidity. In addition, lack of spirituality in seriously ill patients

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may lead to greater emotional distress, higher indices of pain and fatigue, increased burden of illness, and a lower quality of life.[3,4] Because of the clinical relevance of spirituality and its well-documented effects on health outcomes, it is essential that all health care professionals of a palliative care team (physicians, nurses, chaplains, therapists, and social workers) receive the proper training in addressing patients' spiritual concerns. Also, it is important that team members work together to make spiritual assessment part of the routine patient evaluation and to provide adequate spiritual care.

In July 2013, the Pain and Palliative Care Service (PPCS) at the National Institutes of Health Clinical Center transitioned to a searchable electronic medical record (EMR) system for outpatient clinic encounters. In September 2013, a documentation audit revealed a low completion rate for some components of spiritual history. Therefore, 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.

As per the Consensus Conference Report,[5] spiritual assessment of patients ranges from preliminary screening/triage by interdisciplinary team staff to structured spiritual history taking by health care providers and in-depth chaplain assessment/consult. In this report, the term spiritual assessment is used to refer to structured spiritual history taking and/or chaplain consults.

Measures

The QI project was carried out in an outpatient clinic providing PPCS consultations to a broad range of patients with serious life-altering illnesses, including cancer, endocrine or immune system, neurologic or genetic diseases. The providers included clinician members of the PPCS team (physicians, nurses, and fellows), the chaplains from the Spiritual Care Department, and the volunteer clinic coordinators. The medical records of 79 new outpatients with serious life-altering illnesses were reviewed for this project.

The PPCS team was interested in the percentage of patients with completed spiritual assessment or chaplain referral within the first three PPCS outpatient visits or during subsequent hospital admission after the first or second outpatient visits. Hospital admission charts were included because many patients are seen before or during clinical trials in which patients transition frequently between outpatient and inpatient status. All PPCS clinician and chaplain providers follow patients in both outpatient and inpatient settings. Three PPCS visits were allowed for completion of spiritual assessment because of limited time on a single visit and patient comfort/trust in exploring spiritual issues on an initial visit.[6] A review of medical records and documentation of spiritual assessment took place at baseline and after the interventions. All consecutive new outpatients referred to the Pain and Palliative Care Clinic during the following three month periods were selected: July–September 2013 (baseline cohort, $n = 47$) and December 2013–February 2014 (postintervention cohort, $n = 32$). A three month time frame was chosen to allow for sufficient sample size of new patient consults (Fig. 1). The proportion of new outpatients receiving spiritual assessments preintervention and postintervention was calculated, and significance testing was based on *P*-values for *Z* tests for differences in population proportions.

For spiritual assessment purposes, domains of spiritual pain included individual and community issues, inner resources, and general issues of meaning, as well as religious needs.[4] Spiritual pain has been described by some patients as feelings of despair, regret, anger, guilt, isolation, loss, or anxiety.[7] Two spiritual history assessments were used to evaluate spirituality: 1) Faith, Importance/Influence, Community, Address/Action in care (FICA)[8] and 2) psychosocial history relevant to individual, community, or inner resource issues that may relate to manifestations of spiritual pain. Several aspects of the psychosocial evaluation that relate to spiritual resource issues included the following elements: coping, family impact of illness, sources of stress, sources of support, and losses (Fig. 2). The FICA spiritual history tool, developed by Puchalski and Romer,[8] helps identify spiritual pain related to issues of meaning and religious needs. Obtaining a patient's spiritual history helps in understanding the patient's issues related to meaning and purpose, hope, suffering, transcendence, values, and beliefs.[3] Acknowledging those issues may help clinicians develop a more comprehensive individualized treatment plan. Besides the identification of patient' spiritual distress by clinicians, a more in-depth spiritual assessment may be performed by a chaplain. Thus, a review of the patients' charts included a percentage of patients who received chaplain consults or if referrals were made and documented by members of the PPCS team.

Interventions

The interventions for this QI project were designed based on best practices in accordance with the Joint Commission on Accreditation of Healthcare Organizations guidelines[9] and the National Consensus Project

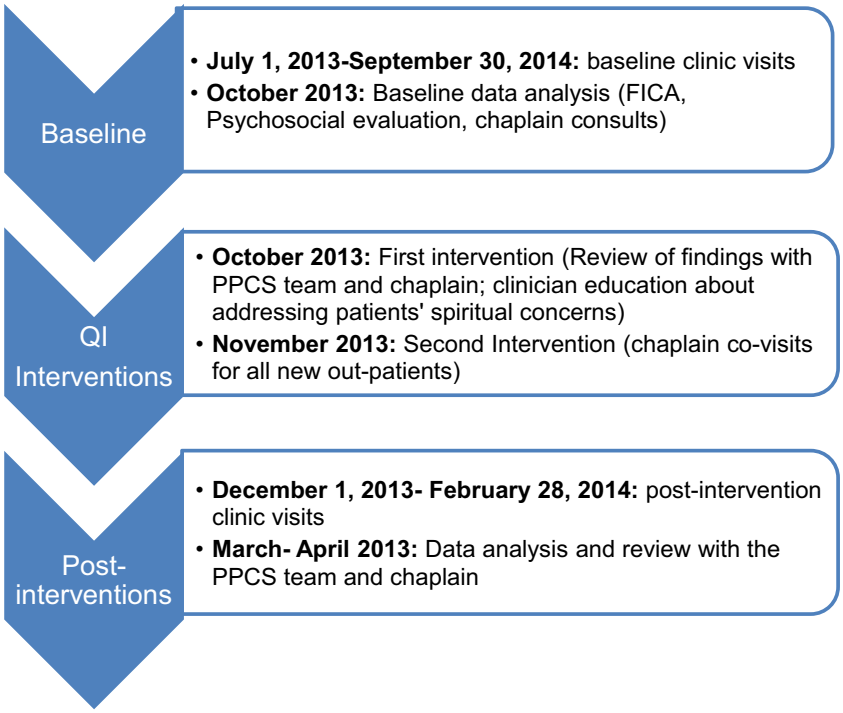

Fig. 1. QI project timeline. QI = quality improvement; FICA = Faith, Importance/Influence, Community, Address/Action in care; PPCS = Pain and Palliative Care Service.

for Quality Palliative Care guidelines.[1] Given the importance and potential impact of spiritual distress on the physical health of seriously ill patients, the interventions centered on improving the understanding and process for spiritual assessment, that is, what providers can do to improve patient spiritual assessment. A Plan, Do, Study, Act (P-D-S-A) QI framework was used, based on guidelines outlined by the Institute for Healthcare Improvement.[10]

FICA
Faith
Importance/Influence
Community
Address/Action
Psychosocial history
Coping
Cultural issues of note
Education/employment
Family issues/impact of illness
Living situation
Losses
Marital status/children/pets
Recreation/exercise
Sources of stress
Sources of support

Fig. 2. NIH Clinical Center spiritual and psychosocial assessment. NIH = National Institutes of Health; FICA = Faith, Importance/Influence, Community, Address/Action in care.

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.

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 (December 1, 2013 through February 2013; Fig. 1). This intervention was chosen because religiousness and spiritual support have been related to improved satisfaction in medical care according to the National Comprehensive Cancer Network Guidelines.[2] Thus, having a chaplain's consult at the point of entry 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.[2,3]

Outcomes

Basic demographics and outcomes of this QI project are shown in Table 1. A total of 79 outpatient medical charts were reviewed. Forty-seven consecutive new patient charts were used for baseline data analysis, and 32 consecutive new patient charts were reviewed for postintervention data analysis. FICA was considered complete if faith, importance/influence, and community elements were documented and incomplete if two or fewer items were recorded. Psychosocial evaluation was considered complete if four of five elements regarding spiritual pain (coping, family impact of illness, sources of stress, sources of support, and losses) were documented and incomplete if three or fewer items were recorded.

Table 1
Outcomes and Demographics

Patient Information	Baseline *N* (%)	Postintervention *N* (%)
N	47	31
FICA	23 (49)	23 (74)
Fully completed	13 (28)	15 (48)
Partially completed	10 (21)	8 (26)
Psychosocial evaluation	42 (89)	30 (97)
Completion of 4 of 5 elements	18 (38)	24 (77)
Partially completed	24 (51)	6 (19)
Chaplain consults	12 (25.5)	16 (52)

Demographics	*N*
Gender	
Male	44
Female	34
Age categories (yrs)	
0–4	0
5–14	6
15–34	16
35–54	33
55–74	22
≥75	1
Race	
Asian	3
Black/African American	11
White	59
Multiple race	2
Unknown	3
Ethnic group	
Hispanic	5
Non-Hispanic	71
Unknown	2

FICA = Faith, Importance/Influence, Community, Address/Action in care.

The percentage of patients who completed the FICA spiritual history tool significantly increased after the interventions (baseline vs. postinterventions: 23 of 47 [49%] vs. 23 of 32 [72%], $P = 0.04$). Completion of a psychosocial history after the interventions remained high (baseline vs. postinterventions: 42 of 47 [89%] vs. 30 of 32 [94%], $P = 0.50$). Finally, the percentage of new outpatients who had a chaplain covisit doubled after the interventions (baseline vs. postinterventions: 12 of 47 [25.5%] vs. 16 of 32 [50%], $P = 0.03$).

Among the patients who had an FICA history documented, there was an increase in the number of patients with fully completed FICAs; however, this finding was not statistically significant (baseline vs. postintervention: 13 of 47 [28%] vs. 15 of 32 [47%], $P = 0.08$). There was no significant increase in patients with a partially completed FICA history (baseline vs. postinterventions: 10 of 47 [21%] vs. 8 of 32 [25%], $P = 0.70$).

Significantly more patients had complete psychosocial evaluation postintervention, 18 of 47 (38%) at baseline vs. 24 of 32 (75%) postinterventions, $P = 0.001$. In contrast, the number of patients who had an incomplete psychosocial history significantly decreased from 24 of 47 (51%) at baseline compared with 6 of 32 (19%) postinterventions, $P = 0.004$.

Overall, most patients had either FICA or chaplain consults (55% at baseline and 78% postintervention, $P = 0.04$). Interestingly, spiritual assessments for most of these patients were conducted during their first PPCS consult (92% and 84% at baseline and postintervention, respectively, $P = 0.33$). Very few patients received spiritual assessment at the second PPCS consult. Unfortunately, there were patients who did not receive either FICA or chaplain consults during the first PPCS evaluation and for some of them that was the only PPCS consult visit.

Conclusions/Lessons Learned

Numerous studies highlight the importance of addressing spirituality and spiritual care for the palliative

care patient. According to Puchalski et al.,[5] spirituality should be considered a patient vital sign that needs to be routinely evaluated and should be included in the overall care planning because of its impact on health outcomes.

Thus, to enhance the quality of palliative care, this QI project focused first on encouraging clinicians to establish a trusting patient-clinician relationship that would allow patients to share spiritual concerns with them. The second intervention, chaplain covisits for all new outpatients, was another strategy to promote spiritual assessment and to address patients' spiritual needs at the outset of their palliative care referral.

Subsequent to the interventions, we observed an increase in the proportions of patients who received spiritual assessments and chaplain consults. The number of completed FICA histories and chaplain consults doubled postintervention. In addition, it was observed that most spiritual assessments occurred on the initial visit, both at baseline and postintervention. This indicates that the initial consult may be a critical (and sole) opportunity to assess spiritual needs because most individuals who did not receive spiritual assessment only had one PPCS consult visit.

Even though the interventions helped improve the quality (completion rate) of spiritual assessment in new outpatients, there were limitations that need to be addressed. First, this study focused on improving a clinical process—completion of a spiritual assessment—but direct impact or connection to patient satisfaction or outcomes cannot be drawn. Second, the FICA history tool is used mostly in the adult population; however, in our sample population we had some pediatric patients less than 12 years of age for which the validity of FICA is not known (Puchalski, MD, MS, personal communication, May 14, 2014). Also, both FICA and relevant psychosocial history were two separate items used in our clinical template documentation. An integrated spiritual distress assessment tool may ease spiritual care triage and planning. Third, the independent effects of the two interventions were not easy to discern. Although the postintervention chaplain consults, FICA completion, and complete psychosocial history assessment all increased by approximately 25%, we do not think this was solely because of the second intervention, that is, the presence of the chaplain during the initial patient visit. The chaplain was usually not present for the entire initial visit, often either entering the interview in progress (and if FICA was already completed, then the chaplain was introduced, the FICA history was summarized and the chaplain briefly visited) or if the chaplain was present at the outset of the interview, they excused themselves after the FICA history was obtained. The relevant spiritual psychosocial history elements were gathered by the clinician most often before or after the chaplain's visit, and the completion rate for this psychosocial assessment also increased postintervention, which would be indicative of the effect of the first intervention, that is, engaging and emphasizing to clinical providers the elements and importance of spiritual assessments.

Other challenges and potential areas of process improvement were also identified. 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.

Another challenge encountered was the fact that the medical records templates for follow-up visits did not have a spirituality section, and if spiritual screening was not completed on the initial visit, it could be overlooked at follow-up. Thus, the low percentage of spiritual assessments conducted after the initial consult may be related to the absence of this spiritual assessment section on our EMR follow-up visit templates.

In spite of the limitations, 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. This QI initiative also helped to identify areas for further improvement such as the need for an integrated spiritual distress assessment tool, refinement of the spiritual findings EMR documentation process, and time and staffing management for appropriate spiritual assessment and triage. All these factors are important for consideration in the development of future QI efforts and plans for spiritual care that may ultimately help patients to better cope with their physical, emotional, and spiritual distress.

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