Patient Centered Care & Spiritual Distress: Patients Inspire further research in Nurses ability to identify Spiritual Distress in Home Based Palliative

Original research

Spiritual distress: symptoms, quality of life and hospital utilisation in home-based palliative care

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ABSTRACT

Objectives The purpose of this study was to use a spiritual screening question to quantify the prevalence of spiritual distress (SD) in a large cohort of seriously ill patients at admission to home-based palliative care (HBPC) and to examine the associations between SD with symptom burden, quality of life and hospital-based utilisation up to 6 months after admission to HBPC.

Methods Data for this cohort study (n=658) were drawn from a pragmatic comparative-effectiveness trial testing two models of HBPC. At admission to HBPC, SD was measured using a global question (0–10-point scale: none=0; mild=1–4; moderate-to-severe=5+); symptoms and quality of life were measured with the Edmonton Symptom Assessment Scale (ESAS) and PROMIS-10. Hospital utilisation was captured using electronic records and claims. Median regression and proportional hazard competing risk models assessed the association between SD with symptoms and quality of life, and hospital utilisation, respectively.

Results Nearly half of the patients/proxies reported some level of SD. Increasing SD was significantly associated with higher symptom burden (increase

Key messages

What was already known?
- Spiritual distress negatively impacts seriously ill patients.

What are the new findings?
- Spiritual distress is common in home-based palliative care and is associated with symptom burden and poor mental well-being, but not with hospital utilisation.

What is their significance?
- Clinical: Spiritual distress should be addressed in clinical settings.
- Research: Methods for assessment and management of spiritual distress need to be established.

continuum of serious illness.[1–4] Astrow *et al*[5] found that in a large ethnically, linguistically and religiously diverse sample of patients receiving care in a haematology-oncology clinic, nearly 80% reported at least one spiritual need. High spiritual needs are associated with less satisfaction

Presented by Dr. Bethany Turner, MA, MC, EdD
2022 Caring for the Human Spirit Conference

Participants in Presentation will…

- ❑Expand awareness of international interest in identifying Spiritual Distress in Palliative Patients among nurses.

- ❑Introduction to recent Research published March of 2020 titled “Spiritual distress: symptoms, quality of life and hospital utilization in home-based palliative care” : The purpose of this study was to use a spiritual screening question to quantify the prevalence of spiritual distress (SD) in a large cohort of seriously ill patients at admission to home- based palliative care (HBPC) and to examine the associations between SD with symptom burden, quality of life and hospital-based utilization up to 6 months after admission to HBPC.

- ❑Explore one vetted tool that nurses found simple to operationalize, patients/caregivers directed screening and provided a measurable solution to generate referrals and outcomes.

- ❑Receive foundation for future research.

Spiritual Care Trivia

1. In what year is the first record of Clinical Spiritual Care documentation at Mass General?
   a) 1908
   b) 1821
   c) 1925
   d) 1940
2. In what year did Clinical Pastoral Education officially start in Boston?
   a) 1914
   b) 1936
   c) 1925
   d) 1940
3. Who was the 1st Physician Champion of CPE who said, “the spiritual dimension should be included in interprofessional care: clinically trained chaplains should be part of the treatment team and document their experiences in medical records.”
   a) Richard Cabot
   b) Russel Dicks
   c) Arthur Lucas
   d) William Bryan
4. Who was the first female to be the Director of Clinical Training in New York in 1932?
   a) Margaret Grun Kibben
   b) Dr Helen Flanders Dunbar
   c) Ellen E Gibson Hobart
   d) Dianna Polman Bell

Learn this and more at https://www.ncbi.nlm.nih.gov/books/NBK565690/ .

4 Tiers of Palliative Medicine:

Prognosis of 12 Months for Less

- In Patient Palliative Care- Patient admitted to Hospital or Facility for Care.
- Outpatient Clinic Palliative Care- Patient who receives care from Clinic either in person or Video/Telehealth
- Home Based Palliative Care- Patient receiving care in the home from interdisciplinary care team.
- Hospice Care- Patient receiving care in the home from interdisciplinary are team (Physician, RN, LCSW, Chaplain, CHHA)with a prognosis of 6 months or less.

Pain and Spiritual Distress at End-of-Life

Kathryn Lee Robinson, MSN, RN, CHPN School of Nursing, University of San Diego, San Diego, CA, USA

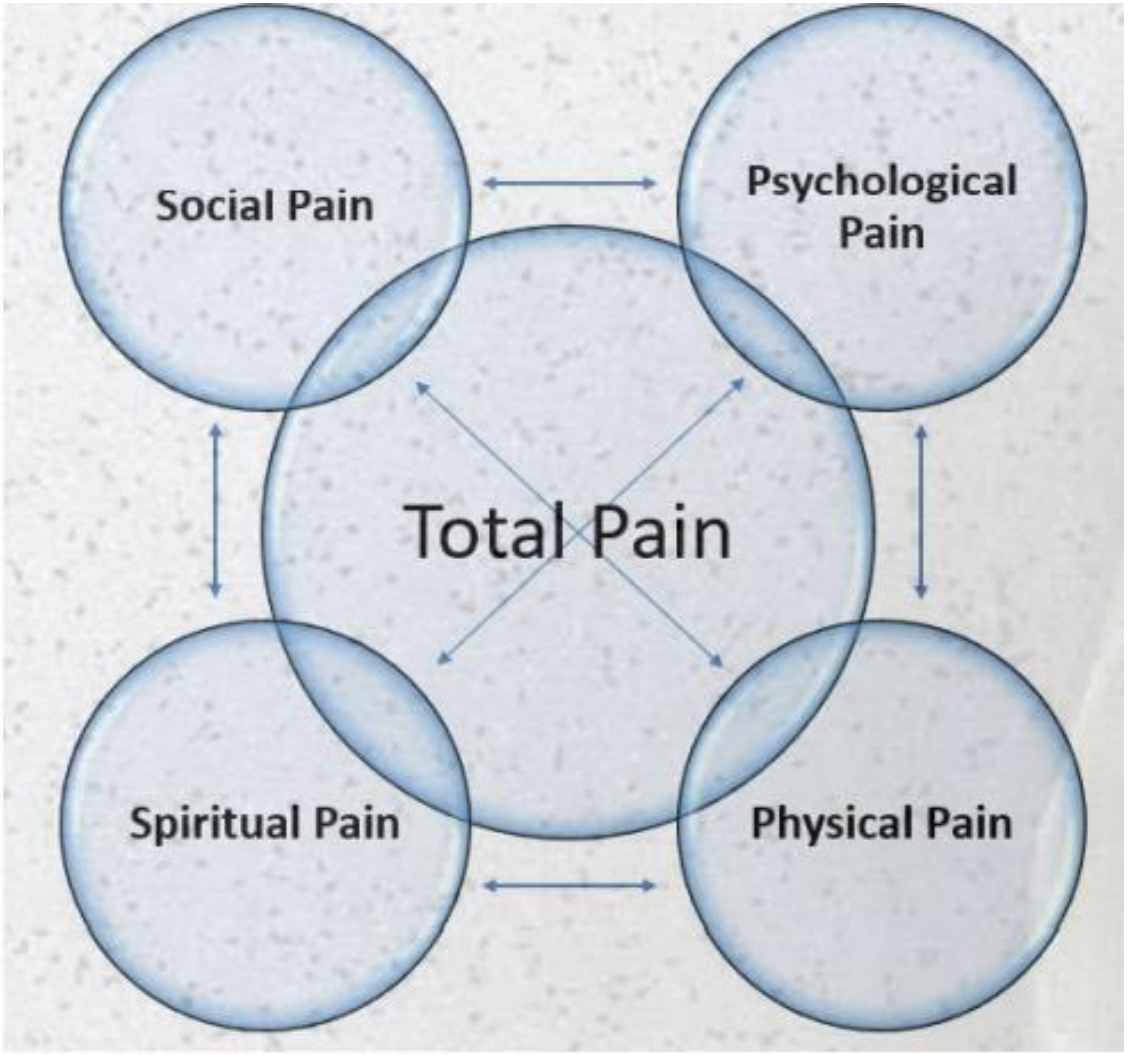


Figure 1. The total pain experience, based on Dame Cicely Saunders' Total Pain Theory (Mehta & Chan, 2008)

Theme: Relationship Between Spiritual Distress and Well Being, Symptom Management & A need for more research.

Spirituality and Distress in Palliative Care Consultation

Abstract
Background: One's spirituality or religious beliefs and practices may have a profound impact on how the individual copes with the suffering that so often accompanies advanced disease. Several previous studies suggest that negative religious coping can significantly affect health outcomes.
Objective: The primary aim of this study was to explore the relationship between spirituality, religious coping, and symptoms of distress among a group of inpatients referred to the palliative care consult service.
Design: Pilot study
Setting: The study was conducted in a large academic medical center with a comprehensive Palliative Care and Home Hospice Program.
Measurement: (1) National Comprehensive Cancer Network Distress Management Assessment Tool; (2) Pargament Brief Religious Coping Scale (Brief RCOPE); (3) Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being (FACIT-Sp); (4) Puchalski's FICA; and (5) Profile of Mood States—Short Form (POMS-SF).
Results: The 31 subjects surveyed experienced moderate distress (5.8 ± 2.7), major physical and psychosocial symptom burden, along with reduced function and significant caregiving needs. The majority (87.2%) perceived themselves to be at least somewhat spiritual, with 77.4% admitting to being at least somewhat religious. Negative religious coping (i.e., statements regarding punishment or abandonment by God) was positively associated with distress, confusion, depression, and negatively associated with physical and emotional well-being, as well as quality of life.
Conclusions: Palliative care clinicians should be alert to symptoms of spiritual distress and intervene accordingly. Future research is needed to identify optimal techniques to address

Judith Hills, Judith A. Paice, Jacqueline R. Cameron, and Susan Shott. Journal of Palliative Medicine. Aug 2005.782 788.http://doi.org/10.1089/jpm.2005.8.782
Published in Volume: 8 Issue 4: August 29, 2005

Theme: Role of Nursing in Assessing and Addressing Spiritual Distress

"We really should talk about how time constraints preclude applying the skills we were taught, to deal with spiritual distress, but I have to run."

The power of consoling presence - hospice nurses' lived experience with spiritual and existential care for the dying

Abstract
Background: **Being with dying people is an integral part of nursing, yet many nurses feel unprepared to accompany people** through the process of dying, **reporting a lack of skills in psychosocial and spiritual care, resulting in high levels of moral distress, grief and burnout**.
The aim of this study is to describe the meaning of hospice nurses' lived experience with alleviating dying patients' spiritual and existential suffering.
Methods: This is a qualitative study. Hospice nurses were interviewed individually and asked to narrate about their experiences with giving spiritual and existential care to terminally ill hospice patients. Data analysis was conducted using phenomenological hermeneutical method.
Results: The key spiritual and existential care themes identified, were sensing existential and spiritual distress, tuning inn and opening up, sensing the atmosphere in the room, being moved and touched, and consoling through silence, conversation and religious consolation.
Conclusions: Consoling existential and spiritual distress is a deeply personal and relational practice. Nurses have a potential to alleviate existential and spiritual suffering through consoling presence. By connecting deeply with patients and their families, nurses have the possibility to affirm the patients' strength and facilitate their courage to live a meaningful life and die a dignified death.
Keywords: Dying, Spiritual and existential care, Hospice nursing, Consolation, Phenomenological hermeneutical study

Tornøe, K.A., Danbolt, L.J., Kvigne, K. *et al.* The power of consoling presence - hospice nurses' lived experience with spiritual and existential care for the dying. *BMC Nurs* **13,** 25 (2014). https://doi.org/10.1186/1472-6955-13-25

Theme: Interdisciplinary Assessing Spiritual Distress & Need for more Research

The difficulties assessing spiritual distress in palliative care patients: a qualitative study

Abstract

This paper reports on a focus group study aimed at exploring the difficulties that palliative care healthcare professionals encounter while assessing the spiritual distress of their patients. Three focus groups were conducted in a hospice (*n* = 15). Participants were all healthcare professionals working in the hospice in-patient unit. Interviews were taped and later transcribed. The data was analyzed through content analysis. Emergent themes included**: lack of vocabulary around spiritual issues**, personal issues surrounding death and dying, training issues, fear of being unable to resolve spiritual problems, time constraints and difficulty separating spiritual and religious needs. Participants provided a number of recommendations for improving care.

This pilot study has generated useful data in relation to how spiritual care of patients might be improved. Despite the abundance of academic publications and policies on spirituality, this area is not integrated well into palliative care.

S.Q. Abbas & S. Dein (2011) The difficulties assessing spiritual distress in palliative care patients: a qualitative study, Mental Health, Religion & Culture, 14:4, 341-352, DOI: 10.1080/13674671003716780

Theme: Wholistic Care

The Experience of Spirituality in the Lives of Hospice Patients, Re-enforce clinical definition of Spirituality as Meaning, Purpose and Connection.

Abstract
Addressing the spiritual needs of patients is a crucial dimension of holistic healthcare, but perhaps the most neglected. Interpretive phenomenology was used to explore the experience of spirituality in the lives of hospice patients. Semi structured, in-depth interviews were conducted with six hospice patients. A four-member interpretive team analyzed the data using the strategies outlined by Diekelmann, Allen, and Tanner (1989). The participants told rich stories about events that occurred throughout their lives. The nature of the stories suggested that the beliefs, values, and experiences that were important to them throughout their lives were also important to them as they were dying. The interpretive team concluded that participants' spirituality was shown not by how they described their spiritual life, but rather by the way they organized their life narratives. An overall theme of "dying the way you lived" was identified. Two subthemes of "who is in charge" and "connecting and disconnecting" emerged from the data, suggesting that beliefs about control and the pattern of relationships with others, God, and environment give meaning and coherence to the way individuals understand the unfolding of their lives. The findings indicate that providing spiritual care for hospice patients involves forging meaningful connections, respecting the patients' choices for managing their dying, and eliciting stories about life and death in order to understand their unique and personal spiritual needs.

Addressing the spiritual needs of patients is a crucial dimension of holistic healthcare, but perhaps the most neglected. [1] Research findings indicate that nurses often lack a clear understanding of patients' spiritual needs, that they plan and implement spiritual interventions on the basis of their own beliefs and values rather than those of the patient, and that they frequently report feeling unprepared to address spiritual needs. [2–6]

Nurse researchers and theorists lament the lack of conceptual clarity related to the concept of spirituality, and note that definitions of spirituality vary widely in the literature. [1] Martsolf and Mickley, [7] however, have identified five attributes often used in describing spirituality. These attributes, described in Table 1, include meaning, value, transcendence, connecting, and becoming.

P. Stephenson, C. Draucker, D. Martsolf. (2003) The Experience of Spirituality in the Lives of Hospice Patients. Journal of Hospice & Palliative Nursing, vol 5, Issue1, p51-58.

Theme: Holistic Care & Symptom Management

Terminal restlessness as perceived by hospice professionals

Abstract

Any hospice professional can identify the syndrome known as terminal restlessness, and all would agree that it is extremely distressing to patients as well as their families and care-givers. Often, caregivers cannot ameliorate the anguish many patients experience at life's end. Many clinicians assert that the causes are physical resulting from medication toxicity, organ shutdown and the associated metabolic changes, pain, urinary or fecal retention, dyspnea and related hypoxia, and sepsis. Yet, many also credit psychosocial and spiritual distress as precipitating factors.

The purposes of this study were twofold: to compare the perceptions of practicing hospice clinicians with the literature related to terminal restlessness, and to determine if their experience with terminal restlessness agreed with the components of the one established scale for terminal restlessness found in the literature.

In general, the study findings corresponded to the literature in regards to frequency, definition, causes, and behavioral manifestations of terminal restlessness. The clinicians in the study supported the impact of psychosocial and spiritual causes of terminal restlessness and defined the phenomenon in terms of time period; emotional, physical, and spiritual distress; changes in consciousness; and increased activity. However, the study did not support the inclusion of impaired consciousness and withdrawal as comprised in the terminal restlessness scale.

Keywords restlessness, delirium, terminal care, palliative care

B. Head, Annatje Faul (2005) Terminal restlessness as perceived by Hospice Professionals. American Journal of Hospice and Palliative Medicine, vol 22, Issue4, 277-282.

Theme: Need for Research

Addressing Spirituality in Pediatric Hospice and Palliative Care

Abstract:
Hospice and palliative care principles mandate clinicians to provide "total" care to patients and their families. Such care incorporates not only physical, emotional, and psychosocial care, but spiritual care as well. Even though considerable attention has been directed to spiritual issues for adult patients in hospice and palliative care, spirituality in pediatric palliative care has been virtually neglected. The need for guidelines to assess spirituality in this population was identified as a priority issue by members of a subcommittee of the Children's International Project on Children's Palliative/Hospice Services, created under the auspices of the National Hospice Organization. Committee members, based on their clinical, research, and personal experiences, identified several aspects relevant to spirituality in general, and to spirituality in pediatric palliative care in particular, and developed guidelines for clinicians in pediatric palliative care. The purpose of this paper is to share the results of this committee's work and, in particular, to present their guidelines for addressing spiritual issues in children and families in pediatric hospice and palliative care.

B. Davies, P. Brenner, S. Orloff, L. Summer, W. Worden (2002) Addressing Spirituality in Pediatric Hospice and Palliative Care. Journal of Palliative Medicine, vol 18, Issue 1, p59-67.

Theme: Global Interest, RN & Physician Training, Need for Research

Perceptions and practices of spiritual care among hospice physicians and nurses in a Taiwanese tertiary hospital: a qualitative study.

Abstract

Background: Spiritual care is frequently cited as a key component of hospice care in Taiwanese healthcare and beyond. The aim of this research is to gauge physicians and nurses' self-reported perspectives and clinical practices on the roles of their professions in addressing spiritual care in an inpatient palliative care unit in a tertiary hospital with Buddhist origins.

Methods: We performed semi-structured interviews with physicians and nurses working in hospice care over a year on their self-reported experiences in inpatient spiritual care. We utilized a directed approach to qualitative content analysis to identify themes emerging from interviews.

Results: Most participants identified as neither spiritual nor religious. Themes in defining spiritual care, spiritual distress, and spiritual care challenges included understanding patient values and beliefs, fear of the afterlife and repercussions of poor family relationships, difficulties in communication, the patient's medical state, and a perceived lack of preparedness and time to deliver spiritual care.

Conclusions: Our study suggests that Taiwanese physicians and nurses overall find spiritual care difficult to define in practice and base perceptions and practices of spiritual care largely on patient's emotional and physical needs. Spiritual care is also burdened logistically by difficulties in navigating family and cultural dynamics, such as speaking openly about death. More research on spiritual care in Taiwan is needed to define the appropriate training, practice, and associated challenges in provision of spiritual care.

Keywords: Cancer, Oncology, Hospice, Spirituality, Psychosocial care, Asia

Tao, Z., Wu, P., Luo, A. *et al.* Perceptions and practices of spiritual care among hospice physicians and nurses in a Taiwanese tertiary hospital: a qualitative study. *BMC Palliat Care* **19,** 96 (2020). https://doi.org/10.1186/s12904-020-00608-y

Theme: Global Interest, Holistic Care, RN & Physician Training, Need for Research

Recognizing spirituality: the impact of training on healthcare professionals supporting patients' spiritual needs

Abstract

Background Supporting patients spiritually as they approach the end-of-life is vital. If spiritual needs are unmet, patients are at increased risk of poorer psychological outcomes, quality of life is diminished, and a reduced sense of spiritual peace ensues. Yet many healthcare professionals feel unprepared to appreciate, assess and tackle patients' spiritual issues. Cheshire & Merseyside Palliative & End of Life Care Network has run the 'Opening the Spiritual Gate' course, across the UK for a number of years, to address this training need. This aims to increase awareness of spiritual and religious needs and facilitate recognition of spiritual distress.

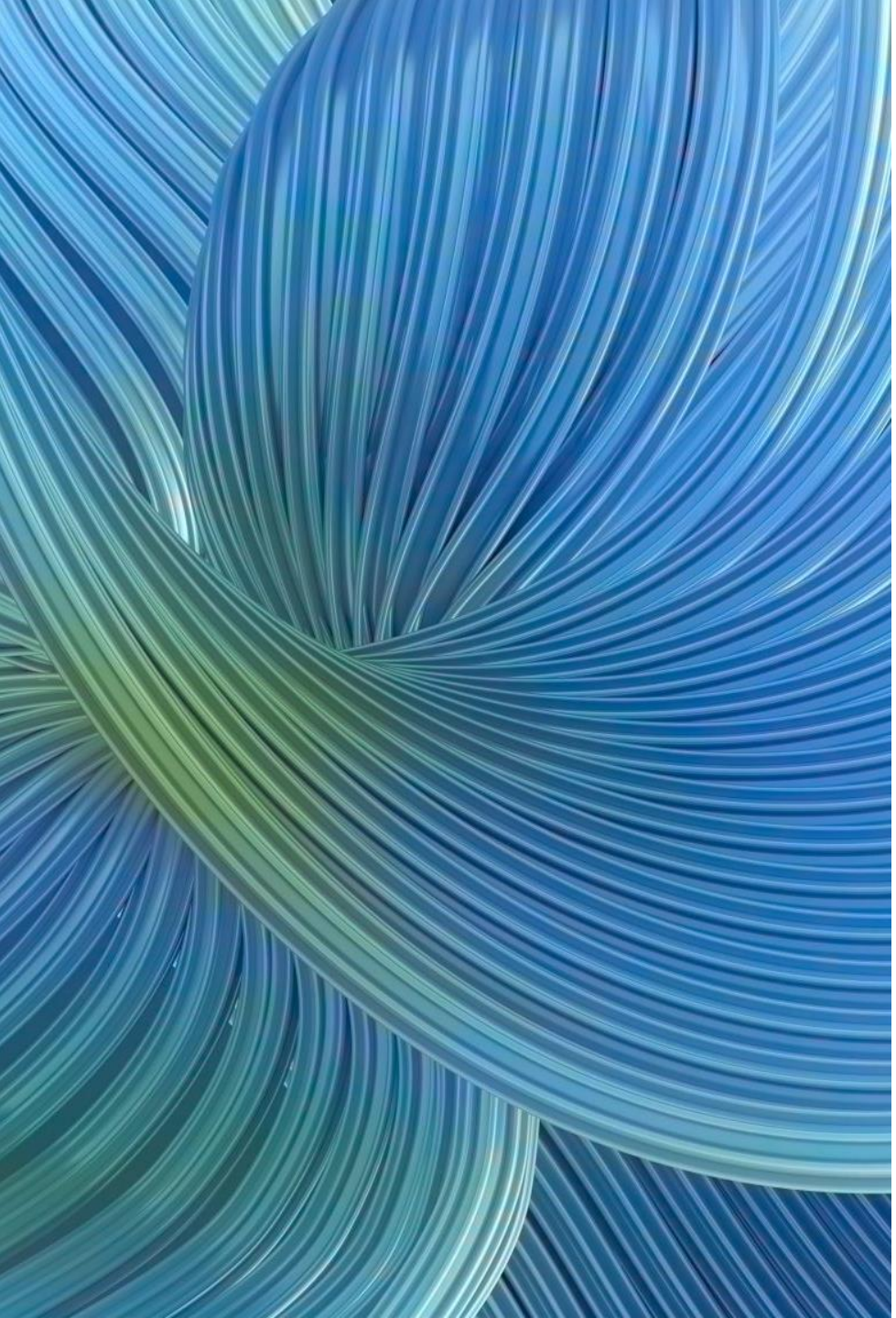
Aim To explore participant perceptions of spiritual care and the impact of the training on their clinical roles after completing the course.

Methods A qualitative methodology was adopted, using digitally recorded semi-structured interviews. Purposive sampling of healthcare professionals who had undertaken the course, in either the North West or South West of England between 2015–2017, resulted in 21 participants. Data were subject to thematic analysis.

Results All participants reported on the value of the course and the impact on their clinical roles, including being better able to recognize when spiritual distress may be evident. Two main themes were identified; *recognizing spirituality,* containing sub-themes of what spirituality means and what matters, and *supporting spiritual needs* with sub-themes of recognition of spiritual distress, communication skills, not having the answers and going beyond the physical.

Conclusions The course is clearly effective in preparing staff to recognize opportunities to provide individualistic spiritual care. Acknowledging that spiritual care is as important as physical care, and having the skills to address it, is vital for delivery of best holistic care

Groves K, Jack B, O'Brien M. Recognizing spirituality: the impact of training on healthcare professionals supporting patients' spiritual needs. *BMJ Supportive & Palliative Care* 2019;**9:**A70-A71.



Finding Meaning in Life…

"In the United States, the ranking for what makes life meaningful for people surveyed were, in order: family, friends, material well-being, occupation, and faith.

American respondents also cited spirituality and faith as a source of meaningfulness in life more than any other nation surveyed. Fifteen percent of Americans cited religion whereas the next highest was New Zealand at 5%. Only in Japan did respondents not find religion and spirituality as a source of meaningfulness at all.

Health was something else respondents said was meaningful in their lives."

https://www.abc4.com/news/pew-study-looks-at-what-people-say-makes-life-meaningful/

Recap of Interest/ Themes

- Relationship between Spiritual Distress & sense of "well-being"- 87.2% identified as Spiritual and susceptible to distress.
- Nurses "feel unprepared"/uncomfortable to assess and "lack vocabulary."
- Nurses report "**a lack of skills in psychosocial and spiritual care, resulting in high levels of moral distress, grief and burnout."**
- Symptom burden associated with Spiritual Distress.
- International Interest & Need for Research
- Patients say Well-Being and Health in Top 5 priorities.

Nurses prepared to screen with…

Clinical Outcome Oriented, evidence-based tools:

- "Spirituality is 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 significance of sacred."
- Edmonton Symptom Assessment Scale (ESAS)- Single Questions 0 No Spiritual Distress to 10 Worst Spiritual Distress.
- "Spiritual distress (SD) defined as 'the impaired ability to experience and integrate meaning and purpose in life…', has been associated with worse quality of life, adjustment, well-being, illness acceptance and late enrolment in hospice in patients with serious illness."
- Patients self assessed.

Edmonton Symptom Assessment System: Numerical Scale
Regional Palliative Care Program

*Patients may experience a number of symptoms with their illness. Please complete this survey about the symptoms you are feeling **now**. Circle "0" if you are not having the symptom.*

Please circle the number that best describes:

No pain	1	2	3	4	5	6	7	8	9	10	Worst possible pain
Not tired	1	2	3	4	5	6	7	8	9	10	Worst possible tiredness
Not drowsy	1	2	3	4	5	6	7	8	9	10	Worst possible drowsiness
Not nauseated	1	2	3	4	5	6	7	8	9	10	Worst possible nausea
Best appetite	1	2	3	4	5	6	7	8	9	10	Worst possible appetite
No shortness of breath	1	2	3	4	5	6	7	8	9	10	Worst possible shortness of breath
Not Depressed	1	2	3	4	5	6	7	8	9	10	Worst possible depression
Not anxious	1	2	3	4	5	6	7	8	9	10	Worst possible anxiety
Best feeling of wellbeing	1	2	3	4	5	6	7	8	9	10	Worst possible wellbeing

Puchalski, C., and Ferrell, B., et al., (2009), "Improving the quality of care as a dimension of palliative care: The report of the consensus conference." *Journal of Palliative Medicine,* 12(10), 885-904. DOI: 10.1089=jpm.2009.0142

Puchalski CM, Vitillo R, Hull SK, et al. Improving the spiritual dimension of whole person care: reaching national and international consensus. J Palliat Med 2014;17:642–56.

Bruera E, Kuehn N, Miller MJ, et al. The Edmonton symptom assessment system (ESAs): a simple method for the assessment of palliative care patients. J Palliat Care 1991;7:6–9.

Screening Tools

Table 1

Levels of Clinical Inquiry About Spirituality and Religion

Type of Clinical Inquiry	Clinical Context	Length	Mode	Clinician
Spiritual screening	Initial contact, ongoing reassessment	Brief	Open-ended questions or items with scaled response, goal is to identify patients in need of spiritual care referral	Any clinical care provider
Spiritual history-taking	Initial contact	Brief	Open-ended questions	Clinical medical care provider (e.g., physician, nurse, or chaplain)
Spiritual assessment	Initial contact, ongoing reassessment	Extensive	Conceptual framework guides interview and development of spiritual care plan	Board-certified chaplain or spiritual care professional with equivalent training

Balboni TA, Fitchett G, Handzo GF, et al. State of the science of spirituality and palliative care research Part II: screening, assessment, and interventions. J Pain Symptom Manage 2017;54:441–53

Original research

Spiritual distress: symptoms, quality of life and hospital utilisation in home-based palliative care

Andre Cipta,[1] Bethany Turner,[2] Eric C Haupt,[3] Henry Werch,[4] Lynn Reinke,[5] Richard A Mularski,[6] Huong Q Nguyen [3]

Funding This work was supported through a Patient-Centered Outcomes Research Institute (PCORI) Award (PLC-1609– 36108). Competing interests: None declared.

What was already known?

► Spiritual distress negatively impacts seriously ill patients. What are the new findings?

► Spiritual distress is common in homebased palliative care and is associated with symptom burden and poor mental well-being, but not with hospital utilization. What is their significance?

► Clinical: Spiritual distress should be addressed in clinical settings.

► Research: Methods for assessment and management of spiritual distress need to be established

Objectives: The purpose of this study was to use a spiritual screening question to quantify the prevalence of spiritual distress (SD) in a large cohort of seriously ill patients at admission to homebased palliative care (HBPC) and to examine the associations between SD with symptom burden, quality of life and hospital-based utilization up to 6 months after admission to HBPC.

Methods Data for this cohort study (n=658) were drawn from a pragmatic comparative effectiveness trial testing two models of HBPC. At admission to HBPC, SD was measured using a global question (0–10-point scale: none=0; mild=1–4; moderate-to-severe=5+); symptoms and quality of life were measured with the Edmonton Symptom Assessment Scale (ESAS) and PROMIS-10. Hospital utilization was captured using electronic records and claims. Median regression and proportional hazard competing risk models assessed the association between SD with symptoms and quality of life, and hospital utilization, respectively.

Original research

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- **Population** We included HBPC patients who were 18 and older, living with a serious illness (eg, cancer, heart failure), expected to have a prognosis of 1–2 years, were homebound, and were English or Spanish speakers. Proxy responses were obtained from the primary adult (18+ years or older) family caregiver.
- Home-based palliative care Patients were eligible for HBPC if they had an estimated prognosis of 12–24 months based on the HBPC team's assessment of disease severity and functional limitations, met Medicare guidelines for receipt of home health to include a skilled nursing need and were homebound. HBPC was provided by an interdisciplinary team of physicians, nurses and social workers, supplemented with therapists, home health aides and chaplains as needed.14 15

- Independent variable We assessed SD with a single validated question within 1–2 weeks of admission to HBPC using the following anchors: 0=no SD to 10=worst SD,8 mirroring the format of the Edmonton Symptom Assessment Scale (ESAS). Patients who scored 1–4 were considered to have mild SD and 5 or more, moderate to severe SD.
- Primary patient-reported outcomes We measured symptom burden with the total score of the ESAS8 16 and quality of life, using the PROMIS1017 by surveying either the patient or caregiver proxy on the phone within 1–2 weeks of admission to HBPC.

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- Secondary outcome: patient hospital-based utilization All-cause hospital-based utilization (emergency department visits, observation and inpatient stays) was measured from HBPC admission to when the first event occurred, death or through end of the study period, at which point those patients who experienced neither an event nor death were censored. These data were extracted from the electronic medical records (EMR) or derived from claims

- Covariates Patient (e.g., sociodemographic, religious affiliations, comorbidities) characteristics were derived from surveys, administrative, membership and clinical or program electronic records. Other healthcare utilization prior to and after HBPC admission were also obtained from the EMR or claims

Results:

50% - some Spiritual Distress Associated with Increased Symptom S burden including Pain, Anxiety & Depression

- “Nearly half of the patients/proxies reported some level of SD. Increasing SD was significantly associated with higher symptom burden (increase of 7–14 points on ESAS) and worse mental wellbeing (decrease of 2.7 to 4.6 points on PROMIS10-mental) in adjusted models. Compared with patients/proxies who reported no SD, those with at least some level of SD were not at increased risk for hospital-based utilization over a median follow-up period of 2 months.”

“We found that nearly half of the patients or their proxies reported some level of SD on admission to HBPC based on a single question screener and that SD was strongly associated with worse symptom burden and quality of life, especially, mental wellbeing. However, SD was not associated with increased risk of downstream hospital-based utilization in the months following HBPC admission.”

Limitations:

- ❑ Clarifiers to Question varied.
- ❑ Proxy Response rate.
- ❑ Varied Integrated Spiritual Support
- ❑ Hospital Utilization results may be linked to all participants had opted for Homebased Palliative.
- ❑ All insured patients in integrated system.

While our sample is larger than that of other studies, and goes beyond cancer patients, there are several limitations worth noting. The single item SD question and clarifiers used by the research staff during the survey administration, for example, being at peace, may have been interpreted differently across respondents depending on their religious affiliations. Due to the high proxy response rate (66%), we may have captured caregivers' SD. Patients who had a caregiver and/or relied on a proxy for the surveys were more likely to have worse symptoms and quality of life, depression, anxiety and quality of life, suggesting that patient and caregivers' experiences with spirituality are likely intertwined.20 We had incomplete information on the spiritual support patients received from the health system and community faith leaders and therefore were not able to include in the longitudinal analyses. Finally, our study sample draws from a population of insured patients, receiving care within an integrated delivery system and whose experience with serious illness care may not be broadly generalizable.

Call for more Research!!!

- ❑ International Interest in Nurse shared vocabulary and screening questions.
- ❑ Further vetting of Patient driven self assessment.
- ❑ Replication of study with uninsured or across diverse nonintegrated health systems.
- ❑ Further assessment of Home-Based Palliative with integrated Spiritual Care.
- ❑ Research to assess the patient self rated spiritual distress before and after integrated spiritual support from Clinical Chaplains.
- ❑ Further research on simple screening questions for interdisciplinary clinician use.
- ❑ Research on screening for spiritual distress related to wellbeing question.
- ❑ Further research to define spiritual distress.

Thank you for your time & Questions…