Vision
July/Aug 2017
Volume 27, No. 4

A publication of the National Association of Catholic Chaplains

Interdisciplinary Teams: The Whole and the Parts

Chaplains' interdisciplinary role has made progress – by David Lichter..... **2**
Physician and chaplain team up for patients with heart failure – by Sage Olnick and Lindsay Castle..... **5**
Chaplain and case manager collaborate on difficult patient – by Kevin Stephenson..... **7**
Chaplains need skill and confidence to write effective chart notes – by Gordon Hilsman..... **10**
Pediatric team of specialists help each other work better – by Jim Manzardo..... **12**
Breaking the sound barrier: Chaplains, speech therapists help stroke survivors – by Janet Ronchetti..... **15**
Transdisciplinary care: The next frontier – by Linda F. Piotrowski..... **17**
Behavioral health patients in the emergency department get interdisciplinary approach – by Anne Millington..... **20**
The interdisciplinary team model: Clinician perspectives – by Gary Weisbrich..... **23**
How do others on the team use chaplains? – by Julianne Dickelman..... **26**

Research Update

Interdisciplinary chaplains: Perspectives from research – by Austine Duru..... **28**

Book review

Book review: Doubt becomes opportunity to grow in faith..... **31**

Chaplains' interdisciplinary role has made progress

By David Lichter
Executive Director

Five years ago, an NACC certified member, who then led a major healthcare entity, told me an observation about other NACC members that she had received from other healthcare leaders. The message was this: "Are we perceived as competent in our field? Yes. Are all of us comfortable and confident in contributing on interdisciplinary teams? No."

I mentioned that encounter in the March/April 2012 issue of *Vision*, which also covered the topic of chaplains on interdisciplinary teams. Over the past five years, much has been done to foster and support our contributions to these teams. Certainly our chaplains working in palliative care have been and continue to be pioneers in the field. The Supportive Care Coalition's priority to foster and strengthen *"*the presence of spiritual care in palliative care team practice and promote deeper spiritual engagement with patients and families, and within the interdisciplinary palliative care team*"* led to their pilot project on integrating spirituality in goals of care that involved several of our members (supportivecarecoalition.org/index.php/our-priorities/spirituality-in-goals-of-care). This pilot project provided very helpful insights into the value of chaplains on the interdisciplinary teams.

When the Common Standards were revised in 2016, the fourth area of competence that had been titled "Profession" was renamed "Organizational Leadership Competencies (OL)." The OL2 remained the same as the prior version, "Establish and maintain professional and interdisciplinary relationships," and the NACC sub-competencies (OL2.1) remained the same, "Demonstrate the ability to build peer relationships for the purpose of collaboration and active participation in the creation and maintenance of a healthy work environment." However, we added one more sub-competency that summarized a couple of the USCCB National Certification Standards: (OL2.2) "Demonstrate skills in organization, conflict management, leadership, or supervision of others." While it includes four diverse organizational skills, I wonder if conflict management and leadership can be two competencies that most apply to our role on interdisciplinary teams.

Some members have told me how instrumental they were in resolving differences on their interdisciplinary team due to their appreciated relational skills. Others comment on how the leadership in spiritual care has been more desired and respected. These are wonderful signs of advancement.

I think that perhaps the most significant contribution on the interdisciplinary team is the writing and sharing of our charted notation, especially when we have developed the art of expressing our contributions in "common terms" to use the language of our colleague Gordon Hilsman, in his book, *Spiritual Care in Common Terms.*

In 2012, I referred to Dr. Christina Puchalski's invitation/challenge to us chaplains when she spoke at our 2011 conference in Milwaukee. I repeat them here, as I believe they remain a good list for us to ponder. Her call to chaplains included:

- Be leaders in interdisciplinary spiritual care implementation.
- Educate the other members of the team.
- Teach courses in medical and nursing schools.
- Teach your colleagues why and when they should refer to you and then provide feedback to them about what to do next for their patients.
- Develop formation tracks in medicine, nursing, and other professional areas.
- Develop accountability measures for your profession.
- Do research: come up with creative ways to lift the stories of what we all do within a research-oriented world.
  (www.nacc.org/docs/conference/2011/NACC%20GWish%20may%202011.pdf)

We are grateful to all our members who contributed on this topic of contributing to the interdisciplinary team. Their content evidences the development in the field.

Five years ago, I was surprised a bit by my own conclusion. I offered several "what if's" that still hold possibility. Are we in a better place now five years later to realize these or something similar?

> *The NACC continues to explore ways to provide education and training for our members in this critical area. I look forward to our members' feedback and suggestions. Would it not be wonderful if several of our members who*

are working on interdisciplinary teams would offer to provide case training to our members with their teams? What if we were to have at least quarterly webinar training through case study on how this interdisciplinary teamwork unfolds? What if our webinars became the model for interdisciplinary team ongoing education? What are your thoughts and dreams?

I would enjoy hearing "your thoughts and dreams."

Physician and chaplain collaborate for patients with heart failure

By Sage Olnick and Lindsay Castle

Patients diagnosed with heart failure face many challenges. They must overcome major lifestyle changes including fluid restriction, sodium restriction, new medications, frequent provider visits, and hospitalizations. At Lancaster General/Penn Medicine Hospital in Lancaster, PA, the interdisciplinary team recognizes that patients with heart failure may feel isolated, anxious, angry, sad, and overwhelmed. One way to address patient's physical, emotional, and spiritual needs is physician and chaplain collaboration.

When a middle-aged woman was admitted with newly diagnosed heart failure, We (Dr. Lindsay Castle and Chaplain Sage Olnick) partnered to provide her with whole-person care. She had no earlier symptoms of heart disease and self-identified as an independent and active person. While a new diagnosis of heart failure would be challenging for most, this was especially difficult for her, as her mother had died just a few months prior to her hospitalization. Further, she was the primary caregiver for several of her grandchildren, who lived with her. Much of her life, she had cared for others and anticipated the second era of her life to be spent on traveling, enjoying new and old relationships, and taking up new hobbies. All this changed when she was told her heart failure was severe and she would likely need to be evaluated for a heart transplant.

Together, we created a safe space for the patient to explore her grief and anxiety related to her diagnosis and recent losses. Verbally processing her suffering, anxiety, fear, hope, and the unknown helped her to feel less burdened. With her physician and chaplain present to bear witness and join in her suffering, her belief that God is always present with us was reinforced. Through collaborative care, we built a trusting and supportive relationship with the patient. This trust enabled the patient to articulate her hope, fear, goals, and values, which in turn allowed the interdisciplinary team to develop a plan of care that met her wishes.

Physician-chaplain collaboration has many benefits. It lets the provider deliver patient-centered care. A physician's time is limited, and interaction with the patient generally focuses on the diagnosis and plan for treatment. Often, patients share their fears and concerns, and these are often acknowledged by healthcare providers but rarely fully explored. But in collaboration, Dr. Castle and Chaplain Sage communicate about the emotional needs of patients. Often, Chaplain Sage

brings specific barriers to care to Dr. Castle's attention, including financial concerns, lack of social support, and prior challenging experiences with illness. If the emotional health of the patient is not addressed, results can include poor medication compliance, missed office visits, and recurrent heart failure hospitalizations.

Chaplain Sage has learned that collaboration with physicians fosters relationships and builds trust. Deepened relationships between chaplains and physicians further integrate the chaplain on the heart failure team, creating more referrals and more collaboration. Similarly, when the chaplain knows about the patient's plan of care, she is better positioned to offer insight about the patient's spiritual health and make spiritual recommendations.

The benefits to the larger interdisciplinary team include continuity of care. Patients with heart failure develop a long-term relationship with each member of the team, including the chaplain, which helps the patient to feel supported. When a patient with heart failure is admitted to the hospital with fluid overload, it is comforting to see familiar faces of team members.

A chaplain can also offer support to members of the interdisciplinary team. As an active and integrated team member, the chaplain can relate to the daily experiences, stressors, risks for compassion fatigue, and need for resiliency. The chaplain can then offer support that is tailored to the needs of the team, further exemplifying that the spiritual domain of health is a central aspect of whole person care.

While there are many benefits to collaboration, there are challenges. Being physically present on the unit and at team meetings makes the chaplain's integration and availability crystal clear. It's plausible that collaboration between the chaplain and physician may be difficult if the chaplain is not as accessible or available.

The team at Lancaster General/Penn Medicine Hospital has learned that dedicating a full-time chaplain to the heart failure team has improved the quality of care provided to patients. Our collaboration is an example of how physician and chaplain collaboration can have a deep impact on the quality of whole-person care for patients with heart failure.

Sage Olnick, MDiv, RN, is a staff chaplain and Lindsay Castle, DO, is a cardiologist at the Heart Group of Lancaster General Health/Penn Medicine in Lancaster, PA.

Chaplain and case manager collaborate on difficult patient

By Kevin Stephenson

I participate daily in multi-disciplinary team meetings on my assigned floors as a chaplain. The goal within our health system is to provide a holistic approach to patient care that will sustain the healing process after medical discharge.

An RN case manager makes sure the patient is on track with the medical treatment plan and is responsible for the overall patient care and medical interventions. The licensed clinical social worker is responsible for discharge planning and the psychosocial issues that surround the patient's medical recovery. The physical therapist is responsible for mobility issues.

Recently, the team asked me to intervene for a married mother of five school-aged children. She home-schooled all her children, including one who was disabled. The patient's husband was away on active military duty. The normal length of stay for her type of surgery is four to seven days, but she had already been in for 15 days. The nursing staff reported that the patient continually called out for pain medications. The physical therapist reported that the patient refused to comply with rehabilitation work due to complaints of pain and nausea — which the therapist questioned. The patient was also receiving wound care for the surgery. Her primary nurse complained of the patient repeatedly calling for nursing attention. The nurse also complained that the patient repeatedly urinated in her bed and refused to use the bedside commode.

"She's using every excuse not to go home," the case manager told me. "The nursing staff considers her a one-and-done patient," meaning that a nurse will generally care for the patient one time and then request removal. It appeared pastoral care services were needed for both the patient and the staff members caring for the patient.

I entered the patient's room and asked her how she was coping with her illness. "I think about my kids and my husband," she said. "I need to get better for them. I am all they have. But it is very hard doing this all by myself sometimes."

"What do you mean by 'all by myself'?" I asked.

“Well, my husband is an active-duty military man, and he is currently out of the country. So much of the time, I am all by myself with my five children, and it is very hard. He can be called out of state or country at any moment. No one seems to understand that. It is very hard being a military wife and mother.” She began to cry.

“Have you shared this concern with anyone?”

“No. I am a military wife, and I should be able to cope with everything. It is what is expected. But I cannot cope with it all,” she said, still weeping.

“It sounds like you have been struggling with this for a while,” I said. “What does your husband think about all of this?”

“He is dedicated military officer, and he thinks I should just handle things when he is on duty. But I get really depressed and feel like I cannot go on like this. I think that is why I am so sick. I cannot manage my children like I need to, and I feel all alone without my husband.”

“So, you feel if you had better support at home from others,” I said cautiously, “you would heal faster and able to manage your family?”

“Yes. I cannot go home like this. I will just get worse.”

I asked if I could tell the case manager about her situation. She agreed and asked if I could pray with her.

“Yes, I can,” I said. “Do you have people praying for you back home?”

“No, not really. No one really knows what is going on with me. I don’t want people to get the wrong idea about me in the military.”

“I understand your need for privacy,” I said. “It takes a lot of courage to share what you just did and strength to endure what you have gone through. Let us pray.”

When I left her room, I immediately went to the case manager’s office to debrief. We realized that wives of active-duty military personnel had unique needs, and our hospital was seeing more of these cases. Based upon my report, the team decided to arrange for outpatient home-based nursing psychiatric care for the patient. This nurse could privately address the psychiatric, emotional, and

physical needs of the patient and her family. Our case manager presented the discharge plan to the patient. The patient approved the plan and was discharged within days.

Kevin Stephenson, LPC-S, is a staff chaplain at Ascension/Saint John Health System in Tulsa, OK.

Chaplains need skill and confidence to write effective chart notes

By Gordon Hilsman

Many chaplains are quietly apprehensive about actually joining an interdisciplinary team. They have many questions: Do I have the time to dedicate myself to what it takes to join that team? Could I actually become a member of that particular team? Do I even want to practice in that way?

True membership is not merely being named on a list somewhere, or being assigned to that team by your director, or being greeted warmly by the team members. Actually contributing on a frequent basis to the core work of that team, including notes in a patient's medical record, is what constitutes belonging.

And what often keeps chaplains on the periphery is lack of confidence — confidence in oneself, one's pastoral identity, and one's ability to stand with other team members as valued professionals able to make regular contributions to the primary work of that team and hospital unit. In my recent book, *Spiritual Care in Common Terms*, I use the following story to illustrate this difficulty.

> A management development program being used by a medium-sized healthcare system asked employees several pointed questions in order to give feedback to department directors on their leadership. One of the questions to staff members was, "Do you believe that your work contributes to the mission of this healthcare system?" The spiritual care director was more than appalled when several of the questionnaires from her chaplains answered the question flatly, "no." They did not see their care of patients' inner world, ultimate concerns, and challenges to their very core making a contribution to their healing. "Why is this hospital paying you then?" she asked the entire staff. A great teaching moment had erupted. If spiritual care does help patients heal, then its caregivers' notes belong in the charts. If not, then why are they working there?

Hospital chaplaincy has been changing rapidly for over a decade. What may be required for employment now may be quite different from what was needed for chaplaincy certification. It is easy to lose confidence when some tasks, such as charting, are expected to relate effectively to an interdisciplinary team more than they were even 15 years ago.

Gaining confidence is however, not the core problem. Confidence without competence is dangerous. It is sometimes easily recognized by astute team members as adolescent bravado, foolhardiness, and pretentiousness. If there is no meat to interactions with IDT staff members, cheery posturing will soon fade. Inspiring confidence in other staff members about your effectiveness will likely require observable expertise.

How, then, does one develop competence in team communication? The same way one gains expertise in athletics, music, nursing, and other professional fields — with practice and direct feedback from a mentor and/or peers.

If you want to continually improve your concise recording of patient narratives and useful descriptions of patients' human spirit situations, reach out to some colleagues and show your chart notes to one another for feedback. If that isn't done in your department, form your own group.

Three things to avoid when you do that: processing a single note too much, too deeply or too personally; allowing yourself to get too hurt by critiques of your notes; and defending a note you are presenting rather than exploring it. This is an art you are trying to improve. Art improves with practice and feedback. Make up your mind to enjoy peer interactions about your notes, get what you can from it, and commit yourself to learning as a delightful experience.

Gordon Hilsman, BCC, is an ACPE supervisor and the author of Spiritual Care in Common Terms (www.amazon.com/Spiritual-Care-Common-Terms-Effectively/dp/1785927248/)

Pediatric team of specialists help each other work better

By Jim Manzardo

Answering a charge nurse's page, I arrive to find Dr. Lisa, the medical director, still on service from an overnight shift, holding the hands of a deeply anguished mother whose child is at death's door. Later, seeing this same doctor, I affirm her fine chaplaincy work.

At a quarterly gathering of pediatric critical care fellows that I facilitate, I listen intently as a first-year fellow speaks of how his nearly all-consuming schedule robs him of time with his family. His peers show great empathy, identifying with his struggle, and they tell him that it will get better.

In my office, shared with my social work, child life, music therapy, and case manager colleagues, we wrestle with another case of a chronically vented toddler whose very stressed parents are trying to learn all the care needed to take their child home and who may wait months before some home nursing can be set up.

An hour after prolonged resuscitation efforts by more than a dozen doctors, nurses, and respiratory therapists (while the family and I watch just outside the door), our team gathers to share what went well, what did not, what we could do better in the future, how well we worked together. And with a minute of silence, we honor the life of the deceased child.

This pediatric ICU, this psychologically, physically, and spiritually stressful environment, this sacred place of intensive caring where together we witness the breadth of human suffering, the human body's marvelous natural healing processes, the amazing collaboration, focus, and dedication of brilliant minds, profound compassion, and parents' sacrificial love, is where I have been truly privileged to work for the past two and a half years.

The 40-bed unit, staffed by teams of doctors, nurses, nurse assistants, pharmacists, nutritionists, interns, a social worker, a child life specialist, a chaplain, a music therapist and case managers, serves newborns to adolescents and young adults, who have been diagnosed with rare syndromes, cancer, and every kind of life-threatening disease. They have experienced traumatic brain injuries, cardiac and respiratory arrests, stem-cell, liver and kidney transplants. Many of them, especially former neonates, are chronically vented. On any given day, the majority of the patients are sedated, intubated and/or minimally interactive. We average

about 40 deaths and more than twice as many resuscitative events per year. The patients and families come from all ethnic, religious, cultural, and socioeconomic backgrounds and from a vast geographic area, including other countries.

By having more time and availability to be with traumatized and grieving parents, I help the medical team stay focused on caring for the patient in critical situations. As staff members struggle with parents' care decisions, lack thereof, or their inability to accept that their child is dying, I help them to understand more fully the larger reality of the family's circumstances. Through my spiritual assessments, I inform the team when, for example, a parent's guilt is preventing them from making a decision, or the feeling that removing their child from the ventilator would be tantamount to killing their child.

In situations of religious expressions that trouble or confuse staff, I try to offer spiritual interpretation. For example, once a Pentecostal family, on learning their daughter was nearly brain dead, spent 45 minutes with their pastor encircling the girl and commanding her in the name of Jesus to rise from the bed. I suggested to the staff that the parents were responding, yes, from grief and shock, but also from a faithful obedience to Jesus, who commanded the widow's recently deceased son to rise up. Finally, I provide staff members space to vent their frustrations, their grief, the helplessness they feel when medical interventions are futile or following the death of a child.

As a pediatric chaplain, the bulk of my clinical work is with patients' parents — mostly because the patients are sleeping, playing a game, watching TV, being sedated, or feeling too sick to engage. So I confess that I have often entered a room and immediately directed my attention to the parents, without acknowledging the heavily sedated or neurologically devastated patients. But some of my nurse colleagues have modeled for me respect and care of the non-interactive patients by speaking to them, calling them by name, and telling them each intervention they are doing. These nurses' examples have been important reminders of how to care for every patient.

The medical team's scientific intelligence, practical understanding of the human body, open communication, and commitment to treat each child with dignity motivate me to be more articulate about my patient encounters and deepen my surrender to mystery. The ways the fellows and nurses look out and care for each other remind me to be less of a lone ranger and more of a team player.

Sharing an office with my social work, music therapy, child life and case management colleagues allows us to freely discuss patients we follow, to gain

insights from each other's unique perspectives, and to regularly encourage, vent, laugh and cry with each other — in essence, to be fully human without pretense.

Our brief, same-day, post-code interdisciplinary gatherings — with shared facilitation by doctors, nurses, and myself — connect us like a family of equals around the dinner table, through open, honest, and critical reflection of what just happened, expression of feelings, affirmation, and humble silence. As we listen to and are vulnerable with each other, we are reminded that each person plays a vital role in our care for each child and family.

Jim Manzardo, BCC, is a chaplain at Lurie Children's Hospital of Chicago, IL.

Breaking the sound barrier: Chaplains, speech therapists help stroke survivors

By Janet Ronchetti

“There is an invisible cord around my throat, making talking feel like I push against tight rubber bands in order for words to emerge. I have to tell myself what it is I want to say and sometimes, if I’m weary, the combination of having to direct my thinker and having to work to get things spoken results in a bunch of blah. Or nothing.”

This is how Helen Harlan Wulf describes her struggle to regain speech following her own stroke in *Aphasia, My World Alone*. While stroke symptoms such as loss of mobility, numbness or weakness, facial droop, and loss of coordination can be corrected through physical and occupational therapy, survivors often find the journey of recovering their words exhausting and frustrating. Deep-seated emotions and feelings may go unexpressed due to the lack of words, and spiritual healing goes unaddressed.

To give voice to both the stroke survivor’s audible voice and inner world, chaplains and speech therapists of the Alexian Brothers Rehabilitation Hospital implemented a new Communications Support Group, co-facilitated by both a speech therapist and a chaplain. The typical group is restricted to six patients to ensure that everyone has an opportunity to share. Speech therapists identify patients who would benefit from group interaction or those who may be struggling with emotional issues. In this group setting, patients are encouraged to search for and use words expressing what their unique stroke feels like for them. They also share how having a stroke has impacted their life and what goals they are working toward.

The group explores feelings of sadness, anger, and guilt, and we discuss coping strategies. Reframing thoughts and feelings are introduced. For example, patients are invited to view themselves not as burdens to their loved ones — a common fear of many stroke survivors — and instead think of family members’ offers of assistance as demonstrations of love and caring. As patients share, the speech therapist offers helpful suggestions on speech mechanics and tips on pronunciation, enunciation, volume, and eye contact.

Pairing chaplaincy and speech therapy has resulted in many benefits. First, relationships between patients and their therapists and chaplains deepen, yielding enhanced trust and communication. Patients feel cared for, listened to, and are

less hesitant to ask questions about their medical situation or care plan. Second, the one hour spent in the Communication Support Group counts toward the mandatory three hours of therapy required each day in the acute care rehabilitation hospital setting, and is billable time for the therapists. Attendance is indicated on each patient's daily therapy schedule, and staff is scheduled to help get patients to and from the group. This benefits not only speech therapists, but also physical and occupational therapists who might be scheduled to meet with the patient immediately afterward. Third, observing one-on-one interactions between attendees helps chaplains identify which patients may need follow-up support visits to explore new areas of spiritual distress or to continue an important discussion point started in the group setting.

However, the greatest benefit of this new approach of chaplains and speech therapists working together lies in the freeing of stroke survivors' suppressed feelings. I remember one 58-year-old professional woman who had a calm, reserved demeanor, was soft-spoken and could best be described as gracious. She presented as an individual who, while struggling with how a stroke had changed her life, seemed to be coping positively with the support of her family and friends. But her calm was shattered in group as she broke down with heaving sobs. She suddenly came in touch with all the anger she was harboring because of the stroke — anger that had gone unrealized and unacknowledged. With follow-up chaplain visits, she was finally able to experience, explore, and understand the source of her anger, which contributed significantly to her spiritual healing.

Janet Ronchetti, M.Div., BCC, is the chaplain manager at AMITA Health Alexian Brothers Rehabilitation Hospital in Elk Grove Village, IL.

Transdisciplinary care: The next frontier

By Linda F. Piotrowski

It seems to me that when we chaplains long for interdisciplinary care, we're not really sure what we are longing for. When I participated in the ACE Project (a National Cancer Institute transdisciplinary palliative care education program) designed to serve psycho-social-spiritual professionals, we were asked to reflect upon what we believed about ourselves as professionals.

The ACE Project team issued a challenge in the form of a moral imperative: Each of us was accountable for creating meaningful change on behalf of the vulnerable populations that we served. That meaningful change was to include advocating and working not for interdisciplinary care but for transdisciplinary care.

The following might be helpful in defining terms and helping to decide where we are located in our ministry, as well as what would help our patients/residents and their loved ones:

Transformation in Palliative Care

Traditional Multidisciplinary Practice
(Typically a reactive, physician-led model with ad hoc membership using a consultative format.)

Interdisciplinary Team
(More "proactive" model; theoretically recognizes contributions of all, but is typically MD-RN-based and physician-led.)

Transdisciplinary Team
(Systems theory; shared team vision; recognized role overlap, integrated responsibilities, training, leadership, and decision-making.)

Larson, 1993
ACE Project, 2007

Multidisciplinary, interdisciplinary or transdisciplinary? Palliative care and hospice have an ideal setting for developing team practice. Meetings of as many healthcare provid-

ers as possible are scheduled regularly. All team members are expected to contribute from their area of expertise.

However, reimbursement for services, scheduling, patient volumes, etc., all contribute to the failure to create space for team meetings, which are considered a luxury. If you are not within a setting that provides you the opportunity to be a part of an interdisciplinary or transdisciplinary care team, do you just throw up your hands and give up?

I do not believe that interdisciplinary or transdisciplinary care happens only when the disciplines involved in the care have regular team meeting. I believe it happens when we join with other disciplines to provide care that addresses the patient's complex needs.

How can you influence patient care in a positive and collaborative way? The first step is to assess yourself and your own practice.

Ask yourself:
- Am I a professional healthcare clinician?
- Am I committed to lifelong learning, increasing my knowledge and professional skills?
- Do I team up with other members of the healthcare team?
- Do I advocate for change?
- Do I use the results of research to inform my practice?
- Do I know basic principles of pain and symptom management?
- Is spiritual assessment and documentation a part of my practice?
- How intentional am I about communicating my spiritual assessment, care planning, and documentation with the team?
- Do I address the multidimensional aspects of suffering?
- Do I advocate for families using spiritually and culturally relevant rituals in the healthcare setting?
- Do I manage the personal and professional impact of chronic compassion fatigue in myself and others?

What other aspects of care, professional development and engagement do you need to assess in order to improve?

Once your self-assessment is complete, you are ready to develop a plan for engaging with others in your setting in order to provide the best care possible. One way to do

this is to choose one area where you want to step out of your comfort zone in order to improve your practice. Use the S.M.A.R.T system of goal setting (www.smartsheet.com/blog/essential-guide-writing-smart-goals).

Creating a culture of interdisciplinary/transdisciplinary care does not require a regular meeting schedule. S.M.A.R.T. goals can assist in initiating change. Find a mentor and someone from one or two other disciplines to engage with you in your effort.

Reach out to doctors, nurses, social workers, therapists, and volunteers to work on a patient care project. Each time we join together with another healthcare professional, we demonstrate our credibility as well as cultivate our own confidence in our competence as clinicians, researchers, and advocates. Before you know it interdisciplinary/transdisciplinary care will become a part of your institution's culture of care.

Linda F. Piotrowski, BCC, is a retired palliative care chaplain at Dartmouth Hitchcock Medical Center in Lebanon, N.H.

Suggested resources

Larson, D. (1993), *The helper's journey: Working with people facing grief, love, and life-threatening illness.* Champaign, IL, Research Press.

Module 1, *Notes from Moral Imperative to Improve Palliative Care,* ACE Project, City of Hope, 2007.

Piotrowski, L. (2011) Chapter 7, "A Transdisciplinary Approach to Spiritual Care" in *Spirituality and End-of Life Care,* part of the "Living with Grief" series published by the Hospital Foundation of America, edited by Kenneth J. Doka and Amy S. Tucci.

Piotrowski, L. (2011) Chapter 50, "Teamwork in Palliative Care: Social Work Role with Spiritual Care Professionals" in the *Oxford Textbook of Palliative Social Work,* edited by Terry Altilio and Shirley Otis Green, Oxford University Press.

Piotrowski, L. (2012) Chapter 18, *Transdisciplinary Relationships in Professional Spiritual & Pastoral Care: A Practical Clergy and Chaplain's Handbook* edited by Rabbi Stephen B. Roberts, Skylight Paths Publishing.

Behavioral health patients in the emergency department get interdisciplinary approach

By Anne Millington

The patient had been suffering from behavioral health and substance abuse issues, and the emergency department, although clearly not the right place for him, was where he was "boarding" now. But where could he go? The social worker and a case manager raised possibilities — an inpatient psych unit, a detox facility? But as the chaplain for the Care Integration Program, I had more information. I had asked the patient about his hopes, about what he was praying for, and he told me it was to move to a different city, where he currently had a very solid job opportunity waiting for him. As a result, the care integration team immediately pursued follow-up care options to ensure he could take this job and have professional support in his new city.

I have been honored to serve as a member of the Care Integration Program, an interdisciplinary group set up to serve the growing number of behavioral health patients arriving at the emergency department at Beth Israel Deaconess Hospital-Milton in Massachusetts. Behavioral health patients are frequently in serious crisis, maybe suffering from acute schizophrenia, manic depression, suicidal thoughts, drug and alcohol abuse, and many more complex issues that emergency departments are generally ill equipped to manage. Inpatient psychiatric facilities and other placement options may be limited, and with no other appropriate alternatives, behavioral health patients can well turn into emergency department "boarders," having a prolonged stay — even up to 21 days and longer — in the emergency department, their only safe haven if no other option is available. This benefits no one, as behavioral health patients cannot receive the specialized care they need. Meanwhile, emergency departments become more crowded, and the overall environment becomes less conducive to care for everyone.

Funded by a $2.1 million grant from the state of Massachusetts' Health Policy Commission, the BID-Milton care integration team consists of a nurse director, two social workers, a music therapist, a chaplain (me), an emergency department physician and nurses, a pharmacist, a security officer, as well as administrative and analytical support personnel. Behavioral health patients receive a bundle of services to reduce their risk of symptom escalation, including more timely crisis

evaluation, insurance verification, and care transition management; therapeutic interventions (such as cognitive behavioral therapy), medication management, music therapy, faith counseling, peer services, familial counseling and support. The physician, nurses, and social workers meet regularly, and additional meetings also occur regularly for the whole C.I. team.

When a patient is discharged, the team develops a return care plan to expedite future treatment, ensuring patient and staff safety and facilitating timely patient access to behavioral health services. In addition, the team provides a "warm hand-off" to all receiving providers and follow-up by a community behavioral health navigator (a social worker who follows the patient into the community and helps him/her access services) and a peer worker (a person with "lived" experience with a behavioral health disorder). Through medical charting and additional technologies, C.I. team members coordinate to provide active and ongoing patient support. Members also get daily census reports and a real-time dashboard of core patient indicators. "Tiger Text" secure/encrypted texting ability enables us to provide timely clinical interventions and rapid interdisciplinary input.

As the chaplain, I encourage patients to reflect on their spirituality and its presence in their current circumstances. I focus on questions such as: What are their hopes? Their regrets? Their dreams? Where is God in their lives? If they do not believe in God, who or what brings meaning to their lives? In the time I have spent with behavioral health patients, I have come to appreciate how much spiritual healing is possible, even for patients whose reality is very troubling and even quite distorted. One woman was inconsolably upset that her boyfriend had just shot her ex-husband and her two children. But in reality, her boyfriend had not seen her in 10 years and had certainly not shot her ex-husband and children, who were very much alive and well and had taken a restraining order out against her. Even though her despair was not grounded in reality, I was able to bring some comfort and peace to her within the parameters of her world, mainly by entering that world and companioning her in her sadness and anger over losing these important family relationships, and permitting her feelings of abandonment.

Because I have no other agenda than to listen and explore, behavioral health patients have at times shared with me formerly uncovered facets of their lives

and experiences that have made a critical difference in clinical outcomes. Also, I have become more visible and thus more integrated with health care teams throughout BID-Milton, and I have found that I receive more clinician requests to visit patients in every area of the hospital.

The care integration program has become a model for other programs seeking to offer integrated services to behavioral health patients. The program gives them quicker access to the clinical services they need, and emergency room service for other patients greatly improves. The program has reduced emergency department length of stay for "boarding" behavioral health patients, in spite of an increase in patient volume, a shortage of inpatient psychiatric beds, and a statewide opioid crisis. In 2016, its first year, the program achieved a 20% reduction of behavioral health patient length of stay, reversing what had been a 30% increase in 2015. This greatly improved emergency department accessibility; previously, behavioral health patients accounted for 1% of emergency department patient registrations yet consumed 11% of resources.

Going forward, the C.I. team will continue to provide organizational development and training for staff to manage behavioral health patients more safely and effectively. The program was recently implemented on the BID-Milton inpatient floors for certain medical and surgical patients who also have behavioral health conditions, and we will seek funding opportunities to expand the program to all complex patient populations.

I am truly honored to serve on the team, and I have great respect for my colleagues' commitment to caring for behavioral health patients. Recently I complimented our C.I. director of care for her efforts to "help the hopeless." She looked me straight in the eyes and quickly responded, "To me, no one is beyond hope." Truly, people can and do recover, particularly with the compassionate commitment of clinicians who believe in them. As a Catholic, I see the care integration team exhibiting day in and day out the cherished values of Catholic social teaching, including a belief in universal human dignity, a preferential treatment for the poor and marginalized who are also the face of God in our world, and a fierce commitment to the common good.

Anne Millington is a chaplain at Beth Israel Deaconess Hospital in Milton, MA.

The interdisciplinary team model: Clinician perspectives

By Gary Weisbrich

Every care team strives for whole-person care, but it is not easy. What makes the palliative care model unique is that it gets dedicated resources, and the institution commits to a champion on the executive level.

Designated professional clinical specialties are consulted throughout the day in a team setting. Besides the physician and advanced practice nurse, other specialties might include pharmacy, social work, and spiritual care. In larger hospitals, a designated team is the gold standard, but smaller hospitals usually borrow clinicians from these different specialties to facilitate goals of care conversations.

I asked clinicians on our palliative care team at Providence St. Patrick Hospital in Missoula, MT, to share their thoughts:

> "In the daily huddle, each patient is discussed, and each team member offers a unified, thoughtful approach based on their expertise and experience. For example, pain issues are explored with the pharmacist offering specific medicines. Physicians weigh in with their experience regarding the patient's reactions to and family feedback about certain medications. Spiritual Care offers insights into the family dynamics and spiritual/religious distress that may intensify pain levels. This reveals sensitive issues of which the whole team must be aware to ease and calm. In addition, team members support one another in dealing with sensitive and often frustrating circumstances." — Terri Tremper, BCC palliative care
>
> "We know in palliative care that each domain in terms of a patient's health/illness experience is critical to achieve "healing" even in the face of progressive, terminal disease. While each person on the team might be an expert in one of those domains (i.e. physical, spiritual, social), it is hard for any one person to be an expert in ALL domains. We also know that a person's physical symptoms may be directly impacted by spiritual distress or social issues (or vice versa), and so if we are not addressing all of the different aspects of care, we really aren't likely to meet the needs of the patient or family, at least not in a timely manner. As a care provider, I value

the talents of my co-workers (in other disciplines) and know that as a team we can provide so much more to those we serve." — Judy Gustafson, nurse practitioner

"I've experienced palliative care in both the individual provider role along with interdisciplinary teams, and it's clear that each discipline gets a different view of how best to serve the patient. Without other disciplines, those recommendations are lost. Studies have demonstrated how the support of the team also helps the team members avoid burnout. This has been true for me with the teams I've interacted with." — Dr. Nick Furlong, physician

"As an interdisciplinary team, we work together to identify and address individuals' needs, whether physical, emotional, spiritual, cultural, or otherwise. By drawing on our strengths as specialty caregivers and providers, we develop whole-person care plans, assuring we address symptom management, spiritual support, advance care planning, and other care needs unique to individual patients and their families." — Jennifer Paul-Detienne, RN

"I treat physical pain and symptoms. However, I also care for patients experiencing emotional and spiritual pain. Sharing our perspectives in our meeting gives us better insight to address these different but related pain issues and come up with the best way to care for the patient." — Brittany Hobbs, pharmacist

"The interdisciplinary team demonstrates that the whole is greater than the sum of its parts. As individual practitioners in palliative care, we each have our own view of patients, family dynamics, of medical conditions, of existential distress. Sometimes I'm aware of my limitations as a medical provider, but more often I need the input of the other members of the team to help illuminate the entire experience of the patient and family." Dr. Chris Jons, physician and medical director

Our team meets every morning to review the current patients and the new referrals. We begin with a time of meaningful reflection. We take turns with a quote, question, or brief reflective story. Today, the question was, "In the past

week recall an experience or encounter that has affirmed your work" and then "recall an encounter that has challenged your resolve to give whole-person care." Our challenges included feeling overwhelmed and not having enough time to give quality care; not feeling effective; or realizing that a patient would be best cared for in hospice but knowing that they are not yet ready for that. Our affirmations included returning from vacation and feeling rejuvenated; feeling like we helped make a patient's goals a reality; experiencing a sacred encounter with a World War II veteran; and advocating for an inmate to see her family and partake in a meaningful religious ritual prior to dying. Finally, we share the burden of what is discussed in the patient goals of care meetings. Carrying this alone accumulates and takes a toll; sharing eases the burden.

Transitioning to patients, we identified a woman who was having breakthrough pain. The bedside nurse didn't want to give too much pain medication. The patient wanted her pain to be controlled and yet remain awake enough to visit with her family, which is a tough balance. This provided an opportunity for our pharmacist, physician, and nurse practitioner to devise a new pain plan. The whole palliative team got some education about different pain medications and the use of opioids — something not necessarily taught in nursing school. In this situation, the concern for addiction was less of an issue than controlling the pain. The nurse practitioner and pharmacist touched base daily regarding the new pain regimen. The palliative care RN asked the spiritual care provider about the patient's continued agitation and existential concerns that were causing spiritual and emotional pain. When the chaplain visited, the patient said, "I am not afraid of dying. Yet, if I were honest, I am a little afraid of the unknown." We openly talked about her concerns, and she said, "I am going downhill physically and emotionally." One of her goals was to receive anointing and a small piece of Communion. The chaplain consulted the music clinician, who offered soothing harp music. This model of care allows for the whole person to be touched, body, mind, and spirit.

The PC-IDT model uses multiple specialties to care for the patient/family using a truly integrated plan of care. Whole-patient care can be a reality because the body, mind, and spirit are treated as one — one team focused on one patient, collaborating with a shared vision.

Gary Weisbrich, BCC-ACHPC, is manager of spiritual care at St. Patrick Hospital in Missoula, MT.

How do others on the team use chaplains?

NACC member Julianne Dickelman, BCC, a chaplain educator at Providence Healthcare in Spokane, WA, asked members of her interdisciplinary team to share their thoughts about how they use chaplains to care for patients. Their responses follow.

The case manager

In my role as a RN Care Navigator, I see not only medical challenges working with patients following their hospitalizations, but a great need for their emotional and spiritual health.

I refer one or two patients daily to chaplain outpatient services. I explain their role to the patient so they understand what they can provide. I almost always receive a call from the patient later expressing gratitude for the call, stating how much they appreciated the support and time given to their needs. If needed, a chaplain home visit may be offered.

The circumstances that I refer have ranged from an overwhelmed wife caring for her husband after his cancer diagnosis, to a chronically depressed widower who cannot control his diabetes because food has become his drug. Some patients resisted seeking behavioral health services, but after speaking with the chaplain reconsidered or returned to their church family for additional support.

One 80-year-old woman lost both her adult children to a rare genetic disease that had required her 24/7 care since their birth. After the second child died, she became suicidal, since her world had fallen to pieces. She lost her home, was listed incorrectly as deceased by Medicaid, and was unable to get her prescriptions. The chaplain contacts were imperative for this woman to move forward in her life. She has her insurance and medications back, and lives in assisted living surrounded with others to bring her back to life.

The two chaplains I primarily work with are approachable and positive. Every patient has been treated professionally with respect and caring. The chaplains' work reflects the Providence mission and values we all strive to follow. Our medical providers have been extremely positive toward this program, and we look forward to increasing our partnership with the chaplain team.

— Debra Breckenridge, RNCN

The registered nurse

As a registered nurse with an internal medicine practice, I have had several opportunities to refer patients to outpatient chaplains. I appreciate their presence on the care team because they have different resources than I do as a RN, and they bring a different perspective to the care of the patient. Often, they may have more time to spend with the patient than the primary care team, and they can address needs that cannot be treated with traditional medical care.

On one occasion, a patient's son had recently committed suicide in a very public way. The patient had worked through some of her grief, and did not feel she was ready to attempt therapy. But she wanted some type of support. I felt the intervention of a chaplain would be a positive resource for her

Another patient had experience a traumatic illness with new physical disabilities, and long-term recovery with uncertain prognosis for regaining previous functions. In addition, she and her husband had recently lost their home. Because of her new disabilities and the location of her new apartment, she was homebound for several months. The chaplains worked with the patient through multiple home visits and provided resources to support both the patient and her husband.

A third example is a man who was admitted to the hospital for alcoholism. His wife had left him because of his drinking, and he lives in a very isolated area with several animals to care for. He was very upset by his potential divorce, and was having great difficulty caring for himself after returning home. He had home health care assigned for PT, OT, & RN. But he was also referred to the chaplain, who arranged to visit in person once weekly, and to follow up by telephone once weekly to help him navigate his newly sober lifestyle. This is not the type of support that a primary care physician could offer.

I am very thankful to have chaplains on our team, as it fills several gaps in primary care, and a chaplain referral is often the perfect solution to a patient situation.

— Deb Baldwin, RN

Interdisciplinary chaplains: Perspectives from research

By Austine Duru

Over the years, chaplains' presence on interdisciplinary teams has been encouraged and welcomed. This is particularly crucial in the hospice setting, where end-of-life conversations draw on specific skills of chaplains. The research article *Communication Dynamics in Hospice Teams: Understanding the Role of the Chaplain in Interdisciplinary Team Collaboration,* published by Elaine Wittenberg-Lyles, et. al., (2008) in the *Journal of Palliative Medicine*, focuses on hospice interdisciplinary teams (http://online.liebertpub.com/doi/abs/10.1089/jpm.2008.0165). It explores how hospice chaplains see and understand their roles and asks whether the experiences of chaplains are similar across hospice teams. The findings suggest that chaplains foster interdisciplinary communication while experiencing role conflict with other members of the team.

The Role of Chaplains within Oncology Interdisciplinary Teams by Shane Sinclair and Harvey M. Chochinov (2012), in the *Current Opinion in Supportive and Palliative Care,* offers a systematic review (https://www.researchgate.net/publication/221978270_The_role_of_chaplains_within_oncology_interdisciplinary_teams) of the role of chaplains/spiritual care professionals within oncology interdisciplinary teams. The review defined four focus areas: "basic concepts of spirituality within the healthcare domain; the relevance of spirituality within cancer care; the role of spiritual care within interdisciplinary cancer teams; and the current status of spiritual care professionals in interdisciplinary cancer teams." Although the evidence points to greater recognition of spiritual care professionals as essential members of the interdisciplinary oncology team, this review concludes, "Full integration of spiritual care professionals within the standards practice of oncology interdisciplinary teams is lacking." (A full version of this article is available from the publishers at a minimal cost or through institutional subscription.)

The Role of Professional Chaplains on Pediatric Palliative Care Teams: Perspectives from Physicians and Chaplains, by George Fitchett, et al., (2011), published in the *Journal of Palliative Medicine*, investigates how

pediatric palliative care programs deliver spiritual care (http://online.liebertpub.com/doi/abs/10.1089/jpm.2010.0523). This pilot study surveyed over 28 such programs across the United States to investigate the role of professional chaplains in these teams. The results show variations in how the programs use chaplains on their interdisciplinary teams. The study also affirmed, "Chaplains address patients' and families' spiritual suffering, improve family-team communication, and provide rituals valued by patients, families, and staff." This study has implications for chaplains who function in pediatric settings and those who support the delivery of pastoral care in children's hospitals. (A full version of this article is available from the publishers at a minimal cost or through institutional subscription.)

"Taking your Place at the Table": An Autoethnographic Study of Chaplains' Participation on an Interdisciplinary Research Team, by Allison Kestenbaum et al., (2015), in the *BMC Palliative Care*, is sort of a research within a research (https://bmcpalliatcare.biomedcentral.com/articles/10.1186/s12904-015-0006-2). The autoethnographic study is a qualitative research method that "seeks to describe and systematically analyze (*graphy*) personal experience (*auto*) in order to understand cultural experience (*ethno*)." This project evolved while the authors were working on a study titled "Spiritual Assessment Intervention Model (AIM) in Outpatient Palliative Care Patients with Advanced Cancer." This study aims to offer insights into the role of chaplains as researchers, how they function as members of the research team, how chaplain participation influences the research outcome, and how it affects the individual chaplain. The investigators identified three major themes: "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." The authors conclude that as chaplaincy transitions into a research-informed profession, it is important for chaplains to be informed about participating in interdisciplinary research teams in a way that honors their unique expertise and contributions. This study affirms the benefits of chaplain involvement in research and of advocating for chaplains on interdisciplinary research teams to continue to advance the chaplaincy profession. It also encourages professional development through encouraging chaplains to engage in and persevere in research projects.

Video-mediated Communication in Hospice Interdisciplinary Team Meetings: Examining Technical Quality and Content, published in the *AMIA Annual Symposium Proceedings Archives* (2009) by George Demiris, et al., (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2815404/) investigates videoconferencing technology in the work of an interdisciplinary hospice team. The chaplaincy profession has struggled to find meaningful ways to capture the power of presence, often expressed in the deep connections and active listening in the context of pastoral care for patients and families in the moment. This study specifically looks at how the quality of videoconferencing — utilizing videophones — affects the dynamics of communication between members of hospice interdisciplinary teams, the patient, and their family members. The study recorded and analyzed over 70 videophone interventions by the interdisciplinary team. It concluded that videoconferencing has the potential to support the psychosocial needs of the patient/family, but also supports shared decision-making in hospice care. This study provides a glimpse into the nature of what I would like to call "virtual presence," and how chaplain presence can be mediated through a virtual medium, although imperfectly.

Austine Duru, BCC, is the regional director of mission, ethics, and pastoral care at SSM Health in Madison, WI.

Doubt becomes opportunity to grow in faith

Bill Tammeus. *The Value of Doubt: Why Unanswered Questions, Not Unquestioned Answers, Build Faith*. Skylight Paths, Nashville, TN, 2016. 146 pp. $16.99

By Anne M. Windholz

A key moment in any would-be chaplain's training is the pain of a patient, family, or staff member who is questioning not just whether God cares, but whether God exists at all. Among clinicians, such a question is typically categorized as an indicator of spiritual distress or worse: a dangerous failure of faith or even a sign of damnation. Certainly many patients look at it this way. After all, Jesus said, "Blessed are those who have not seen, and yet believe" (John 20:29), not "I've often wondered that myself." The apostle Thomas wins no brownie points for skepticism. Not surprisingly then, patients who are not frightened by their questions (and hence, often angry), speak of their uncertainties in apologetic tones. What they anticipate from a chaplain is judgment.

They are often surprised, therefore, when the response they receive is: "Good question!"

Bill Tammeus in *The Value of Doubt* celebrates all our questions about, for, and to God. He offers a thoughtful, articulate, and engaging exploration of the ambiguities that people from varied faith traditions confront, at one time or another, in their relationship with the Divine. Trained in the Reformed (Presbyterian) tradition and a regular commentator at *National Catholic Reporter,* Tammeus takes on rule-based religious dogmatism with vigor. Without diminishing the physical pain of wrestling with God's absence, God's incomprehensibility, and God's silence (he calls theodicy "the open wound of religion"), he presents compelling arguments for the *growth* in relationship and faith that doubt can spur. Too facilely labeled spiritual distress, what we are often witnessing is spiritual maturing.

For chaplains seeking to serve populations in crisis, Tammeus' slender book provides a treasury of short essays followed by questions for individual contemplation or group discussion. Arguing throughout that we live by metaphor, allegory, and myth, he rejects fundamentalist *fact* in favor of the *truth* of *story*. He dismisses "blind faith" as parallel to Dietrich Bonhoeffer's "cheap grace," embracing instead concepts that are the bedrock of chaplaincy: *companioning*, not fixing, as God's primary role in our lives; *reframing* questions about a world of cruelty in terms of how goodness comes to be in such a place; *ritual* understood as providing, with its "disciplines and boundaries," the "freedom" and "context" for belief; and *presence*, not only in the "thin places" of the earth where

divinity breaks through, but “among the wounded [who] are all around us, waiting for us to mediate God’s healing.”

Attuned to the issues of our time and place, Tammeus offers thoughts on racism, interfaith dialogue, civil discourse, and secularism. He shares his personal delight in music and words: writer Annie Dillard and poet Christian Wiman share page time with theological powerhouses like Jürgen Moltmann, John Philip Newell, and Pope Francis. Far from being mired in the agony of spiritual distress, *The Value of Doubt* is ultimately about joy. The joy we have in our work. The joy we have in daring to ask the sticky questions that bring us into Mystery. And the joy of realizing that just as the questions never end, neither does the love.

Anne M. Windholz, MDiv, Ph.D., BCC, is staff chaplain at AMITA Health Alexian Brothers Medical Center in Elk Grove Village, IL, and also serves at Northwestern Medicine Central DuPage Hospital in Winfield.