Spirituality as a Source of Resiliency in African American Patients with Serious Illness

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OVERVIEW

- Background (2 mins)
- Current Work in Spirituality and AA Health (7 mins)
- Comments/Questions (3 mins)

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BACKGROUND

- Nearly 7 in 10 African Americans (AA) Medicare beneficiaries have ≥2 chronic conditions (Centers for Medicare & Medicaid Services, 2021)
- Early palliative care participation ↑ goals of care communication, ↑QOL, ↓symptom burden (Bakitas et al. 2020)
- Only 8.2% AA Medicare beneficiaries use hospice (Rhodes et al., 2006)
- Lack of culturally-responsive care practices = Disparity in AA palliative care use (Ejem et al., 2019)

BACKGROUND

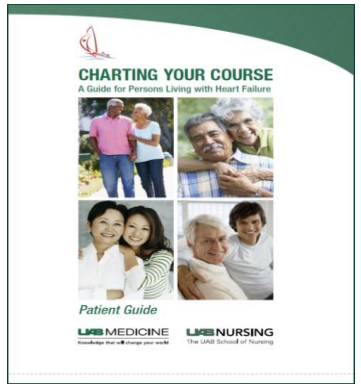
- Nearly 65% of hospitalized older adult experience spiritual distress
- Patients who endorse higher levels of spiritual distress are also more likely to report ↑ levels of pain, depression, anxiety, resting heart rate, and suicidal ideation
- Patients and families consistently express that spirituality is an important component of their health

Hall, Hughes, and Handzo, 2019; Siddall et al. 2017; Hui et al., 2011; Abu-Raiya et al. 2015; Krause et al., 2016

DIVERSITY SUPPLEMENT: SPECIFIC AIMS

- Explore how reciprocal relationships may influence patient well-being and family caregiver (FCG) burden with a particular focus on the sociocultural aspects of AA race and spirituality

- Sub aim: Understand the religious and spiritual (R/S) beliefs and preferences of AA patients and FCGs in treatment discussions with clinicians



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Domain 1
R/S Beliefs in Living with Illness

Themes

- 1a. R/S a source of strength (coping)
- 1b. R/S is separate from illness

Domain 2
Discussion of R/S in Clinical Encounters

Theme

- 2a. R/S not discussed in clinical encounters

Domain 3
Ideal Discussion of R/S in Clinical Encounters

Patient-derived Themes

- Pt 3a. R/S should not be discussed
- Pt 3b. R/S should only be discuss if patient initiates it

FCG-derived Themes

- CG 3a. Provider R/S communication not a priority
- CG 3b. Providers should be open to discuss R/S with patients
- CG 3c. Providers should engage in R/S with patients

DIVERSITY SUPPLEMENT: KEY TAKEAWAYS

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Exploring Culturally Re Responsive Religious and Spirituality Health Care Communications among African Americans with Ad vanced Heart Failure, Their Family Caregivers, and Clinicians

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Rachel Wells, PhD, RN,[1] Raegan W. Durant, MD, MPH,[3] Olivio J. Clay, PhD,[4] Amanda Brandon, PhD

A wide spectrum of beliefs exists between patients and FCGs concerning ideal R/S discussion in clinical encounters

Differences should be considered in the design of palliative care interventions aimed at improving communication among patient, FCGs, and clinicians

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S.C.O.P.E.
Spiritual Care in the
OutPatient Environment

STUDY PURPOSE

Develop and conduct a small-scale feasibility trial of a culturally-responsive Spiritual Care and Assessment Intervention (SCAI) with African American (AA) patients with chronic illness at Cooper Green Mercy Health Services Authority (CGMHSA).

PHASE I STUDY

1) Elicit perspectives of chronically-ill older AA patients, FCGs, primary care key constituents (n=24) on patients' illness-related spiritual concerns and distress, and potential desired spiritual support resources for outpatients at CGMHSA; and 2) the potential content, format, and delivery of a culturally responsive SCAI

PATIENT/ CAREGIVER/ PROVIDER INTERVIEW GUIDE

1. Please describe for me your religious or spiritual beliefs.
2. What role, if any, does spirituality or religion play in your life as a whole?
3. What role does spirituality or religion play in your life as a [patient/caregiver/provider]?
4. What are your thoughts on clinicians including R/S in patient care? How should it be done?
5. So, when you hear the word "hope", what comes to mind?
6. What gives you hope?
7. What are your personal goals outside of [your health/ your professional role]?
8. What are your goals related to [your health/ your professional role]?

PRELIMINARY RESULTS: PRACTIONERS

It's like politics. You don't wanna talk about stuff like that.

We want to definitely make sure that they feel …open to discuss those beliefs with us, and then we pretty much partner with them in developing that plan of care.

I do think …patients that feel that they can't bring religious beliefs up in a care setting because that relationship can be perceived as very sterile…most of the time that wall gets broken down in really acute, serious illness.

I think [R/S] are aspects that are probably more patient-drive…if someone doesn't have any religious beliefs or religiosity, I wouldn't keep bringing it up.

It's a disservice…every part of a person should be an equal part of that person. … [S]pirituality, my healthcare, my mental health care, and my socioeconomic status—all of those should be equally considered in any kind of treatment that I receive.

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THANK YOU!

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