Though families of patients who die in hospitals receive many hours of care from chaplains, no systematic feedback about this care is available through satisfaction surveys. In response, chaplains at Hennepin County Medical Center (HCMC), Minneapolis, MN, initiated a process improvement project to obtain this information. This article describes methods chaplains might use to demonstrate their effectiveness in improving patient/family satisfaction despite a resource-limited environment. The reader will learn how securing a grant, assembling a task force and building interdepartmental collaboration achieved mission alignment and accountability for HCMC’s chaplaincy department.

“HOW DOES OUR WORK CONTRIBUTE to the bottom line?”

There is no getting away from this question at Hennepin County Medical Center (HCMC), a Level 1 Trauma Center, public safety net and teaching hospital with 469 beds. Recently, the hospital has had some tough years trying to live up to its mission to “ensure access to healthcare for all.” The economy has not been kind to our patients, no matter what their circumstances—rich, poor, insured or uninsured.

No hospital department has escaped a strategic cost management program. HCMC receives taxpayers’ money to help support the care provided and must account for how it is spent. At the same time, HCMC has set goals for achieving higher patient satisfaction scores using Press Ganey surveys. The corporate message is clear: “Do more with less, work smarter, focus on value-added service.”

Our chaplaincy department is expected to perform and give evidence of results. If your hospital is not already at this point, it will be soon. Even faith-based hospitals are no longer allowing chaplaincy to operate without accountability and quality improvement.

What follows is an account of how our department is working with a management paradigm that demands tangible proof that any service offered provides measurable benefits to the patients, their families and the organization. We needed to show that the care we provide is valued by patients and families. Our efforts have been part process improvement and part informal research. One component could become the basis for a formally designed research study, but we are limited for now to using our findings internally. In this article, we share examples of the methods we are using in our hospital to demonstrate chaplaincy contributions to patient/family care. We think these methods could be implemented by any chaplaincy department, regardless of size or existing resources.

Our chaplaincy department has less than five FTEs, and our director is a nurse administrator with several other departments to manage. As we sought a quantitative way to measure and report our qualitative care, patient satisfaction scores seemed the simplest approach. We already knew from practical and clinical experience that chaplains affect patient satisfaction by strengthening
emotional and spiritual support. Press Ganey’s research links emotional with spiritual care and points to chaplains as drivers of patient satisfaction in these areas. In addition, raising our hospital’s satisfaction scores in the area of emotional support had become a top concern for administration.

Despite their research favorable to chaplaincy care, Press Ganey also presented our biggest barrier. In practice, the result of collapsing spiritual into emotional support was that chaplains were forgotten as contributors to this important institutional goal. Our chaplaincy department had already experienced deep financial cuts in 2003, and the infrastructure needed to collect and report our contributions to the hospital also was eliminated in this budget reduction. Most pertinent, Press Ganey surveys are not sent to the families chaplains spend the most time with—those whose loved ones die at HCMC. There were almost 500 families a year, and thousands of hours of chaplain care, whose story would never be heard unless we did something about it.

**Devising a plan to elicit evidence**

We decided to do what Press Ganey did not—telephone family members of patients who died at our hospital and ask permission to interview them about their experiences.

We framed our process improvement project as Plan-Do-Study-Act (PDSA), a method that every health care administrator could understand. This is an accepted process for trying something new to see how it works without committing too many resources. We presented our idea as a pilot for eliciting feedback.

Using the PDSA process, we proposed to obtain one month’s list of patient deaths, look up the family contact information, telephone and request permission to conduct a short interview about the family’s experience at HCMC. Responses would be reviewed and incorporated into an ongoing plan to better meet the needs of future patients/families. This approach is similar to case study research: select a group of similar cases, collect information using a tool (survey or interview), analyze the results and use those results to improve outcomes. Repeating the process allows for continuous improvement. This process is also similar to what one researcher is calling “practice-based evidence for clinical practice improvement,” a method of health services research which “incorporates clinicians’ practical knowledge throughout every step of the process” with the aim of “transform[ing] research findings into practice.”

The recent turn toward practice-based evidence is a significant recognition that randomized controlled trials may not supply answers to many practice questions in an interdisciplinary milieu. Dr. Donald M. Berwick, director for Centers for Medicare and Medicaid Services, champions this more pragmatic approach to improving clinical practices. Berwick believes that “patients and families may bring useful knowledge to care if they are invited to do so.” Our study goal was precisely this—to invite families to share what kinds of support were helpful and what were not. Our department director supported our pilot and helped us by opening different organizational doors. We connected and collaborated with staff throughout HCMC, both those whose assistance we needed and those who might be helped by our findings.

The departments we met with in designing our process included performance, measurement and improvement; patient advisory committee; diversity; electronic health record; and interpreters. These departments included professionals from nursing as well as physicians, therapists, informatics specialists and most importantly, patients. Their input and advice helped us gather cross-disciplinary support, interest and investment in our findings.

**Interview strategy**

Truthfully, a chaplaincy department covering a trauma center 24/7 with fewer than five FTEs has no resources to spare. We needed an inexpensive method to gather information quickly as well as
an efficient way to elicit information from family members who were non-Caucasian and/or non-English speaking. Research shows that minority cultures do not respond to printed surveys. Larger trauma hospitals are moving toward telephone surveys in order to get input from minority patients. One of our goals was to surpass the hospital’s percentage of Press Ganey surveys returned. Telephone interviewing would be one way to accomplish that.

We also needed to determine how to construct the survey questions. Despite the drawbacks of the Press Ganey surveys, their data illustrate trends well because they use a Likert-type scale. After checking other studies to determine the effectiveness of such a scale in telephone surveying, we designed six scaled and two open-ended questions. (See Attachment A.) Our goal was to learn how families experienced different disciplines as well as overall care provided during the dying process.

Our survey included questions that did not focus on chaplaincy alone for two reasons. First, we needed support and buy-in from hospital administration, so we added some questions they recommended. We also wanted to understand trends in family members’ satisfaction with end-of-life care not necessarily impacted by chaplain presence.

We also asked the Patient Advisory Committee for recommendations. In addition to research questions, the members, all of whom are former patients, wanted grief support to be part of the call. Also, they did not like the word survey and suggested that we use a different word. Interview became the accepted term. The diversity consultant made suggestions about how to respectfully introduce the subject of death to some of our families. HCMC interpreters not only supported the aims of our project but offered their time and interpretation/cultural skills to communicate with non-English speakers. We were aware that these considerations added several variables to the interviews that risked producing less reliable data. This is discussed further in the section on limitations.

Our electronic health record did not automatically generate a report of patient deaths, so we asked the information technology department to help us compile a monthly list. The report includes length of stay, unit, and age—all useful data to point out where our resources are most needed and during what months. After this infrastructure was in place, we selected one month and began the interview process.

Based on recommendations from the Patient Advisory Committee, two chaplains signed condolence cards, which were mailed to survivors two weeks before telephone interviewing began. The same chaplains then attempted to make the forty-six telephone contacts. Thirty-two interviews were completed, almost 70 percent of the total, a response rate that exceeded the percentage of Press Ganey survey returns for HCMC by more than 40 percent. We graphed our findings and wrote an analysis, which we e-mailed to administrators and presented to several committees focused on patient satisfaction.

In presenting our results to these hospital decision makers, we utilized published research to help interpret the feedback we had received. Scores were similar for both emotional and spiritual care, which may suggest, as Press Ganey claims, that patients do not differentiate much between these supports. Even though Press Ganey surveys do not include a separate question about spiritual care satisfaction, our data showed how chaplains affect perceptions of emotional support through questions about family members’ direct experiences with chaplains. In addition, we learned that when a family member felt the chaplain only slightly met needs, s/he also felt overall spiritual and emotional support was less available. (See Attachment B.) This observation suggests there may be some correlation between perceptions of effectiveness of chaplains and the overall experience of spiritual/emotional support. Published research finds that “family members were more satisfied with spiritual care if a pastor or spiritual advisor was involved in the last twenty-four hours of the patient’s life.” In short, our data demonstrate that chaplains affect family members’ satisfaction with the care of their loved ones at the end of life.
**Limitations**

Chaplains not only served as interviewers but also began the conversation by offering grief support, which had the potential to influence responses. We discussed the tendency for the interviewees to feel obligated to make only positive comments and decided to emphasize how much they could help us if they were honest with revealing negative experiences as well as positive experiences. Our training in remaining non-defensive and accepting proved beneficial in our interviews when family members shared criticism. Still, it is not clear to what extent our approach influenced their responses. One recent article on chaplaincy research points out seven types of “self-report bias.” It is possible that “social desirability,” which is the tendency for people to provide answers they view more socially expected or acceptable, may have been in operation. In addition, our request for possible negative experiences may have invoked an “extreme response style,” which is the inclination of responders to pick the more extreme choices on the scale even though their actual view is more moderate.

We recognize that having chaplains conduct these interviews does make the feedback we gleaned from families vulnerable to influence. Further, our study represents internal process improvement data; thus we did not go through the Internal Review Board (IRB) process. As a result, we may not share the comments and observations received outside of HCMC, and our specific data may not be generally applied to other settings. However, our approach serves our current department objectives: offering grief support to surviving family members, putting their knowledge at the center of our project, improving our clinical practice and demonstrating the efficacy of chaplaincy to our administration. The interviews and analysis are cost-effective and relatively easy to implement. We hope that in sharing our methods, other departments may be able to implement similar processes.

At the same time, we need researchers of chaplaincy care to design studies to address these limitations. Currently, the Center to Advance Palliative Care (CAPC) is working with Press Ganey in designing a bereavement survey to measure family satisfaction in hospitals when a palliative care program is involved. Perhaps it is time for us as professional chaplains to similarly identify and pool our resources and research expertise to plan a multi-site study to provide more reliable methodology and findings in regard to how our care affects patient satisfaction. Certainly, our department and hospital would be willing to participate.

**Obtaining a grant to continue the project**

HCMC administrators were interested in and impressed with our findings and wanted us to continue. However, there were no funds available to pay a part-time chaplain to continue the project: collect survivor information, make telephone calls, offer grief support and track responses.

We applied to the Hennepin Health Foundation, writing a grant proposal that built on our interview pilot. (See Attachment C.) Foundation leaders recognized the potential of further expanding the network of grief support that we had created and suggested a hospital-wide Task Force on Grief and Loss to establish a more integrated approach to supporting families of patients who die at HCMC. The foundation provided funds to continue our project and also to form a task force made up of physicians, the chief nursing officer, social workers, nursing directors, performance improvement managers, foundation officers and chaired by our lead chaplain.

As a companion to the family interviews, the task force recommended surveying HCMC clinical staff, physicians and residents in order to develop an organization-wide consensus on changes and improvements needed for better grief support. With assistance from the hospital’s performance improvement specialists, we designed a short questionnaire accessible either electronically or on paper. In this way, we hope to get everyone’s commitment when the work of making and enforcing changes in our care delivery begins.
We are now half way through our project. Each quarter, we submit a report to the foundation tracking our findings. We have hired a part-time professional chaplain to conduct the interviews and to record the data. While our interview questions help us track our effectiveness in caring for those who experience the death of a loved one, we also glean valuable qualitative input from their comments and stories.²³

We passed our first test when we convinced administrators to support us in our grant application for this project. Now we have a year to find out whether offering good grief support makes a difference in whether family members will recommend HCMC. From our initial pilot, we predicted the answer would be yes. Halfway into the project, we have found that those who receive effective grief support from chaplains do in fact tend to recommend our hospital. While we recognize that self-report bias may affect our outcomes, we also maintain that we are eliciting information that the hospital would not otherwise have.

Further, this project has expanded to focus attention on improving supportive care for families of dying patients on all inpatient units. Our efforts have publicly linked us to a major HCMC initiative that focuses on patient and family-centered care. Through increased patient satisfaction scores, HCMC increases its reimbursement from Medicare each year—a direct effect on our bottom-line.²⁴ Still it’s not just about the budget, although funding is vital. As chaplains, we nurture the heart of what makes HCMC special in Minnesota—its mission of caring for all. This project addresses both margin and mission.

Conclusion

Even while still in progress, our effort already has reaped many benefits. At the administrative level, additional chaplain hours dedicated to grief support are now included in our budget. We founded an interdisciplinary Task Force on Grief and Loss, chaired by our lead chaplain, which not only receives the quarterly interview reports but also is charged with making recommendations. Decision makers understand the task force’s mission and appreciate the difference chaplaincy care makes for patients, families, staff and the organization.

At the staff level, our intense collaboration with performance and improvement staff has cemented chaplaincy’s alliance in the drive to increase all of the hospital’s satisfaction scores: (patient, family, employee, physician). Throughout HCMC, staff members learn from and help each other daily as we put families at the center of care. While individually anonymous and ostensibly focused on patients and families, the staff and physician survey on grief support has opened dialogue about needs for human touch and caring, which are experienced by all. Chaplaincy is becoming an important nexus for these discussions.

Finally, our family interviews have revealed stories we have been privileged to hear. While the criticisms are enormously helpful to us in finding out what we need to improve, there is no substitute for learning about what our hospital did well. Our colleagues in administration and on the front lines treasure these stories. They want to hear how their work is meaningful.

This project has visibly aligned chaplains with HCMC’s mission, values, and objectives. Resources are being made available so that we may continue to improve our care for patients and their families. We still need the resources to conduct a publishable study with data generalized to other settings. We need to discover a way to make our data less vulnerable to charges of influencing responses while honoring and supporting family members’ grieving process. We need to develop safeguards for those whom we interview so that we can share their recommendations with a wider audience. Finally, we need an electronic health record capable of producing reports that reflect our time and interventions.

Our greatest accomplishment thus far has been the opportunity to re-interpret and re-cast what “patient and family satisfaction” really means. It is not merely a score that earns Medicare
reimbursement although that is a worthy incentive. Satisfaction is about honoring the humanity and individuality of each patient and his/her family. Applied judiciously, patient satisfaction focuses on the moral center of health care—healing, relieving suffering and respecting human dignity.


5 Going Lean in Healthcare.


8 Ibid., 1.


11 See the 2004 telephone survey of minority patients’ results conducted at Massachusetts General Hospital under the direction of the Patient Experience and Access to Care Subcommittee of the Committee on Racial and Ethnic Disparities. www.mghdisparities.org (accessed June 25, 2009).


14 Thanks to HCMC interpreters Sandra Zapata, Safia Mohamud and Annie Oettinger.


18 Ibid.

19 Ibid.


21 A format for the task force charter is available on request.

22 A copy of the staff survey is available on request.
Chaplains who contributed to this project also include Myo-O Habermas-Scher, Soto Zen Buddhist tradition; Ann Romanczuk MDiv MSW, Unitarian Universalist Church; Katharine E. Stebinger, MDiv, Episcopal Church; David Hottinger MDiv, United Church of Christ; Ronald Keith MDiv, Christian Church (Disciples of Christ); and Patricia Jimenez, MDiv, Unitarian Universalist Church.

Attachment A – Interview format

Hello, this is _______________ from Hennepin County Medical Center.

Grief Support
We want to extend our condolences to you as we know your loved one died here recently. You were listed as an emergency contact (or family member). How have you been doing? Do you feel you have the support you need during these first months of loss?

Interview
While we wish to respect your cultural, religious and personal beliefs, we would like to include your opinion to improve the way we serve families whose loved ones die at our hospital. Would you be willing to help us by talking to us about your experience here? Your responses are anonymous.

(Response choices for questions 1-6 are as follows: not at all, slightly, moderately, very much, not certain, does not apply.)

1. To what degree did HCMC staff address your emotional needs?
2. To what degree did HCMC staff address your spiritual needs?
3. To what degree did you feel your faith and cultural practices were respected and supported by HCMC staff?
4. To what degree did you feel the nurse(s) involved in the care of your loved one responded to your needs and concerns?
5. To what degree did you feel the doctor(s) involved in the care of your loved one responded to your needs and concerns?
6. To what degree did you feel the HCMC chaplain(s) involved in the care of your loved one responded to your needs and concerns?
7. Is there anything else about HCMC care that you expected but did not receive?
8. Was there anything in particular about HCMC care that was especially helpful?

Thank you very much for your help in speaking with us.

Addendum
For the year-long project, the following question was added.

9. Would you recommend HCMC based on your experiences here?
   Yes
   Sometimes
   No
### Attachment B – Interview results

(Note: None of the 32 family members interviewed responded "Not at All" to any of the questions.)

<table>
<thead>
<tr>
<th>Likert Scale Questions</th>
<th>Very Much</th>
<th>Moderately</th>
<th>Slightly</th>
<th>Not Certain</th>
<th>Does Not Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what degree did HCMC staff address your emotional needs?</td>
<td>59.38%</td>
<td>28.13%</td>
<td>6.25%</td>
<td>0</td>
<td>6.25%</td>
</tr>
<tr>
<td>n = 19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To what degree did HCMC staff address your spiritual needs?</td>
<td>53.13%</td>
<td>21.88%</td>
<td>12.50%</td>
<td>3.13%</td>
<td>9.38%</td>
</tr>
<tr>
<td>n = 17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To what degree did HCMC staff respect your faith and cultural practices?</td>
<td>59.38%</td>
<td>15.63%</td>
<td>3.13%</td>
<td>12.5%</td>
<td>9.38%</td>
</tr>
<tr>
<td>n = 19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To what degree did nurses respond to your needs and concerns at the death of your loved one at HCMC?</td>
<td>56.25%</td>
<td>28.13%</td>
<td>9.38%</td>
<td>3.13%</td>
<td>3.13%</td>
</tr>
<tr>
<td>n = 18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To what degree did doctors respond to your needs and concerns at the death of your loved one at HCMC?</td>
<td>50.00%</td>
<td>37.50%</td>
<td>6.25%</td>
<td>0</td>
<td>6.25%</td>
</tr>
<tr>
<td>n = 16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To what degree did chaplains respond to your needs and concerns at the death of your loved one at HCMC?</td>
<td>62.50%</td>
<td>12.50%</td>
<td>6.25%</td>
<td>3.13%</td>
<td>15.63%</td>
</tr>
<tr>
<td>n = 20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Attachment C – Overview of Hennepin Health Foundation Grant Proposal

This project is conceived as grief support for families whose loved ones have died at Hennepin County Medical Center (HCMC) with two additional objectives that make this program innovative:

- An ongoing process of eliciting feedback from families about their experience of care at HCMC, which will be documented and analyzed in order to make continuous improvements.

- The integration and improvement of grief support provided to families throughout the hospital.

Therefore, this project furthers the mission of HCMC in at least three important ways:

- Meets the need for grief support identified in interviews of family members conducted by chaplains and by patients on the Patient Advisory Committee.

- Promotes patient/family satisfaction and measures effectiveness in a patient/family population that is not measured currently by Press Ganey surveys.

- Identifies gaps in the current provision of grief support to survivors.

Analysis of findings from the pilot interview project

Expected outcomes

- Measurement of family satisfaction with care provided to their loved one at death.

- Improvement in family satisfaction after evidence-based grief interventions are provided.

Measurement reporting

Phone calls to family members will be made by a professional interfaith chaplain to provide appropriate grief support. Those consenting to be interviewed will be asked to respond to questions about their experience at HCMC during the death of their loved one. Responses will be documented and graphed to track improvement.

Estimated cost

Start-up costs for the initial year are estimated at $10,000, which includes the following:

- Professional Chaplain – 300 hours

- Printed condolence cards (500) plus postage

- Printed grief resources and postage – distributed as needed

Timeline

The grant will support the Family Grief Support/Quality Improvement Project for one year after which costs will be included in the annual chaplaincy budget.

The Task Force on Grief and Loss, which will function during this time, is charged with collaborating on a hospital-wide vision for grief support for families and making recommendations for improvement.

Outcome reporting plan

Reports will be produced each quarter based on phone interviews with family members.