A Time for Compassion:
A Lifeline During the Pandemic

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For some time now it has been clear that there is no one in this country or around the world untouched by the COVID-19 pandemic. As the English poet John Donne wrote 400 years ago, “Any man’s death diminishes me, because I am involved in mankind.”

The need to acknowledge, to mourn, and, ultimately, to heal – this is the reality we live with, and our ongoing challenge.

It is up to us to remember and honor those who have passed away from coronavirus, those struggling right now with this illness, and those who are working every day to save lives and comfort those in pain.

As organizations committed to bringing comfort and some measure of peace to individuals facing illness, loss, and other situations of spiritual distress, HealthCare Chaplaincy Network and the Spiritual Care Association have a role to play to begin the process of healing.

After the tragedy of 9/11, in many places there sprung up memorials, spontaneous or planned, for those who died on that day. Thus far, we have not seen such an outpouring for people who have succumbed to COVID-19 – perhaps because it is ongoing, or because of its seemingly amorphous progression through the population. Or, maybe we are simply still overwhelmed.

Nevertheless, HCCN and SCA are taking a step in this direction. As so much of our public life is lived online – more so under the current circumstances – we are starting there. We have introduced a new Web destination, LightaCandleMemorial.com, where anyone can memorialize and honor a loved one whose life has been claimed by coronavirus. The site also pays tribute to the dedication and sacrifice of health care professionals who have given their lives in responding to the pandemic. We seek to acknowledge those who have survived the virus as well, or who are currently diagnosed, and those researching life-saving treatments and vaccines.

Any visitor can light a virtual candle and post a name and photo of a family member, friend, or colleague. These will live on a wall of remembrance, each individual represented by a flame that will not be extinguished.

LightaCandleMemorial.com was created in conjunction with a virtual event we are holding on November 17, 2020, for health care providers in the metro New York area and surrounding states. These are communities where HCCN’s chaplains are stretching their own capacities to offer comfort and meaning for patients in isolation, and to connect them with their families who are desperate to give them love and support. The event, Lighting the Darkness – An Evening of Gratitude and Remembrance, gives local hospitals the chance to honor staff members who have passed away due to coronavirus, and to bring healing to staff who have lost friends and colleagues. It also allows families to publicly acknowledge the loss – and heroism – of their loved ones.

In carrying the responsibility of caring for the human spirit, the chaplaincy profession continues to make a profound difference in the lives of those affected by this pandemic. We are deeply grateful for the privilege of lending our presence to relieve suffering and do everything we can to light the way ahead.
To all healthcare workers, first responders, essential workers, and chaplains who are working to keep us safe and healthy around the world

Your selflessness and tireless efforts during the COVID-19 pandemic are what give us hope that tomorrow will be brighter.

Thank you for getting us closer to that moment.
A Time for Compassion: A Lifeline During the Pandemic
By The Rev. Susan Wintz, BCC

Experiencing health issues and afraid of getting COVID
Feeling alone and sad because of isolation
Fear for father who was diagnosed with COVID
Unable to attend religious services
Expressing a sense of helplessness because social restrictions make it impossible for family members to visit mom in assisted living facility
Stating life has become meaningless
Feeling overwhelmed as a front-line worker

These are just a few of the spiritual issues of callers to the Spiritual Care Association’s A Time for Compassion website. When the COVID-19 pandemic began, the Spiritual Care Association was the first chaplaincy organization to respond, leading the profession in providing resources to chaplaincy professionals and the public.

Its first initiative was to develop, in just four days, a completely new website: A Time for Compassion (https://www.atimeforcompassion.org), which offers a variety of resources to help persons, family members, and staff cope with this crisis, including an option to access individual support from a Board Certified Chaplain by phone, email, or video chat. The telechaplaincy service associated with A Time for Compassion is staffed by 35 SCA board certified chaplains. Chaplains are available by phone, email, or a scheduled video chat, and over 150 calls have been received to date.

Studies that have emerged since the beginning of the pandemic have shown it is having a significant impact on individuals’ well-being and mental health across the world. Measuring the pandemic’s impact and designing interventions is underway, and it is a top priority for researchers (Psychology Today, Psychiatry Research). In one survey study that included 1,441 respondents from during the COVID-19 pandemic and 5,065 respondents from before the pandemic, depression symptom prevalence was more than threefold higher during the COVID-19 pandemic than before. Lower income, having less than $5,000 in savings, and having exposure to more stressors were associated with greater risk of depression symptoms during COVID-19 (Ettman, et al.). In another study, common risk factors of heavier psychological burden included being women, being nurses, having high risk of contracting COVID-19, having lower socioeconomic status, social isolation, and spending longer time watching COVID-19 related news. Protective factors included having sufficient medical resources, having up-to-date and accurate health information, and taking precautionary measures.

The studies concluded that the pandemic has caused heavy psychological impact among medical workers and the general public (Psychiatry Research). Many of the anticipated consequences of quarantine and associated social and physical distancing measures are themselves key risk factors for mental health issues. These include suicide and self-harm, alcohol and substance misuse, gambling, domestic and child abuse, and psychosocial risks such as social disconnection, lack of meaning or anomie, entrapment, cyberbullying, feeling a burden, financial stress, bereavement, loss, unemployment, homelessness, and relationship breakdown (Holmes, et al.).

Spiritual distress or struggle is also on the rise due to the pandemic. It arises when a person’s basic belief system is shaken, and it can take place whether they are religious or not. People in spiritual distress often no longer believe the world is a safe place. They might lose hope and have a difficult time finding meaning and purpose in what is happening to them (Hall). Patients and families are experiencing severe spiritual suffering related to COVID-19. Healthcare providers are distressed by the suffering and dying of their patients, and by ethical challenges around limited resources and difficult treatment choices (Roser).

The A Time for Compassion website was modeled on HealthCare Chaplaincy Network’s Chaplains on Hand telechaplaincy website, with additional resources developed especially in response to COVID. Chaplains are available by phone, email, or a scheduled video chat, and over 150 calls have been received to date. A senior staff member of SCA serves as the clinical supervisor.

The chaplains were asked to submit follow-up reports that identified the major spiritual needs and mental health issues of callers. Many of the anticipated consequences of quarantine and associated social and physical distancing measures are themselves key risk factors for mental health issues.
addressed in their provision of care to callers. From the most prevalent, those issues included:

- Anxiety
- Helplessness
- Moral injury/compassion fatigue
- Social isolation/lack of connection with others
- Loss of coping skills
- Questioning presence of God/the Divine
- Fear of contracting COVID
- Non-COVID medical issues of self
- Non-COVID medical issues of family member
- Search for meaning
- COVID illness of family member
- EOL decision for family member
- COVID death in family/grief
- Suicidal ideation
- Faith community closed; feeling isolated and unable to take part in community practices
- Without current support group for addiction

While several callers identified that they had a history of participation in a particular religious tradition, the majority described themselves as “more spiritual than religious.” Many also stated that the pandemic and associated stressors had raised questions about meaning and purpose for them personally, for their families, and for their understanding of society and the world. The age of callers ranged from 20s to 80s, for the most part evenly divided across the age spans.

Chaplains provided a number of interventions, including active listening, ritual such as prayer and meditation, and assisting callers in naming and reframing their concerns. They also provided resources ranging from online assistance to referral to local mental health, social, and religious organizations, depending on the caller’s identified needs.

A particular issue was that of families who were unable to be with loved ones who were ill with the COVID virus while hospitalized, including those who died. There have been profound images throughout media reports of patients dying with no family present in the ICU, and with desperate and compassionate attempts by clinicians to respect the sacred time of dying (Ferrell, et al.).

In addition, other COVID-related practice resources were provided.

As clinical staff working with the SCA health care partners pivoted rapidly and effectively to adjust their practice to the new realities—which differ significantly across our institutions—clinicians on the SCA leadership team quickly assessed requests from the field for educational programs and support materials. Several were rapidly rolled out, all available for free on the Spiritual Care Association at https://spiritualcareassociation.org/coronavirus

- A four-part webinar series, Chaplaincy in Times of Crisis: Lessons from the Front Lines
- A webcast, Coronavirus Strategies for Spiritual Caregivers Dealing with the Chaos of Coronavirus and other Infectious Disease Threats
- Chaplaincy in the Time of COVID-19, a downloadable education resource
- Coronavirus: Strategies for Spiritual Caregivers Dealing with the Chaos of Coronavirus and other Infectious Disease Threats, a PowerPoint Presentation
- A resource list: Strategies for Spiritual Caregivers Dealing with the Chaos of Coronavirus and other Infectious Disease Threats

As the pandemic continues, the Spiritual Care Association and HealthCare Chaplaincy Network continue these programs and are working to develop additional resources as needed.

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**References**

- What Are the Mental Health Effects of COVID-19? Psychology Today. 8/27/2020
- Prevalence of Depression Symptoms in US Adults Before and During the COVID-19 Pandemic. Ettman, et. al JAMA Open 9/2/2020
- The psychological and mental impact of coronavirus disease 2019 (COVID-19) on medical staff and general public – A systematic review and meta-analysis. Psychiatry Research 9/2020 [Is this not the same bullet as the second one above?]
- The Covid-19 pandemic tests everyone’s spiritual wellbeing, atheists and believers alike. Hall. Think. NBC News. 9/21/2020
- The Corona pandemic as a challenge for spiritual care. Roser, et. al. 3/30/20
Thinking About Becoming a Health Care Chaplain?

The Health Care Chaplain Division of the Spiritual Care Association focuses on the spiritual dimension of professional health care chaplains in a number of varied clinical settings. SCA, in partnership with its 60-year old affiliate, the HealthCare Chaplaincy Network (HCCN) supports the advancement of health care chaplaincy and spiritual care as an integral aspect of whole person care for all.

**Benefits of Membership**

- Belong to a supportive professional community that welcomes both novice and seasoned health care chaplains
- Access to current best-practice standards of spiritual care for those of all faiths and no faith preference. Be notified of new research publications related to spiritual care
- Discounted price for online professional educational courses
- Three free Spiritual Care Grand Round Webinars annually with CEU credit
- Discounted registration for the Annual Caring for the Human Spirit® Conference
- Free electronic subscription to the Journal of HealthCare Chaplaincy
- Free subscription to the Caring for the Human Spirit® Magazine
- Free Spiritual Care Tip of the Day emailed to you
- Free access to over 15 years of PlainViews® articles and archives
- Membership directory and networking opportunities
- Opportunities to present at a national level and/or publish an article or be featured in our various publications
- SCA Membership card will be mailed to you

To become a member or for more information, visit [www.spiritualcareassociation.org/health-care-chaplains](http://www.spiritualcareassociation.org/health-care-chaplains)
Caring at Home: Palliative Care Telechaplaincy

By Judy Fleischman, BCC, MDiv, MS

During this time of pandemic, HealthCare Chaplaincy Network partnered with a large healthcare provider to introduce chaplaincy care to its in-home palliative care program in several states through telechaplaincy by phone. This initiative benefits from HCCN’s years of investment in developing a community-based telechaplaincy program, Chaplains On Hand. As a clinical consultant, I helped grow and refine best practices for this program before shifting recently to focus on this palliative care initiative.

Integrating telechaplaincy in any context is a matter of timing and attunement. Remarkably, as we were preparing to roll out these services in March 2020 to several states in the southern U.S., COVID-19 required most of the multidisciplinary team to transition to telemedicine. I was aware of some of the challenges, having attended HCCN’s Caring for the Human Spirit conferences, which at times have showcased the integration of telemedicine, notably in palliative and hospice care. During one such keynote by Mike Rabow MD, FAAHPM, he referenced a paradigm of “relationship centered care.” RCC in health provides an alternative framework to patient-centered care for
understanding how relationships can influence healthcare experiences and outcomes. How one maintains and grows such relationships is a core theme in transitioning to a telemedicine context.

I soon discovered that many palliative care visits since March have been by phone. Interdisciplinary teams meet by phone/video conference. This allows for physicians, nurses, and social workers who are local to where patients reside to meet with the chief medical officer, palliative care director, and chaplain, who all live in different parts of the country. Such teams are possible in this age of telemedicine.

I have worked closely with HCCN’s clinical director, consulting staff, and palliative care program director to establish and adapt protocols and infrastructure to meet the immediate needs of patients, their families, and the care team, while also planning for longer-term integration. We considered at the outset what would be helpful initially and then how best to integrate telechaplaincy over time. The first element we introduced was a chaplaincy summary note for each patient visit, which details a spiritual assessment (issues, intervention, and outcome), as well as a spiritual care plan and recommendations for the team. In subsequent visits, this format is maintained with details appropriate to follow-up care.

We established a maximum of three visits for each referral. Follow-up beyond these visits requires a new referral. The patient might at some point transition upstream to an in-home chronic care program or downstream to home-hospice care, in which case the palliative care team no longer provides care. This adds a layer of complexity in considering a patient’s care goals and how best to transition.

I discovered in some of the first team meetings that educating colleagues about spiritual screening and nuances of assessment was important. In doing so, I offered examples of interventions and outcomes so colleagues better understood how these relieve spiritual pain, for example, and thus can help identify and meet QOL care goals. Some of these learnings for the team were through experiencing the interventions directly. This grew as nurses began to share their concerns and questions about how spiritual care integrates with overall care goals. They were encouraged to learn how to support spiritual care goals. During one such meeting, I spoke of the benefit of a particular spiritual intervention for a patient with complicated grieving whom we were discussing.

A nurse practitioner caring for this patient asked about how, as she put it, “this works.” I guided her and the rest of the team in an intervention of breath-centered prayer called “Attuned Breath Centering,” which brings together intention and attention in a particular way to relieve spiritual pain in the present moment as an adaptive resource for the patient. I explained how the intention of hope is activated on the in-breath by bringing in the patient’s response to the question “What keeps me going?” and how together, hope and purpose activate a sense of belonging, which relieves and prevents a common form of spiritual distress, this being fear of abandonment.

As team members experienced this benefit, I emphasized the additional benefit of utilizing short, easy-to-remember phrases voiced by the patient. This intervention provides ongoing spiritual resourcing, which relieves spiritual pain. This could be monitored and even measured over time with a spiritual pain index. The NP then said, “Wow! I want to try this with some of my patients!” I encouraged her and identified the chaplain as the spiritual specialist who can coordinate ways for everyone on the team to meet spiritual needs of the person in their care.

I spoke of this in the context of a patient who identified hope as feeling “cared for” by the PC team. This encouraged colleagues to affirm with the patient individually and as a team that she is cared for by the team. This illustration proved helpful, and after that I received more referrals. I also educated team members on the principles of spiritual screening. This contributed to moving away from an exclusively close-ended “do you want to see the chaplain?” to a more open-ended introduction of the chaplain to the patient and their family as providing emotional and spiritual support, with particular emphasis (when appropriate) to common issues such as indicators of grief, social isolation, and loss of meaning and purpose. Along with this, if there was a change in prognosis or some other shift in care context, we spoke of reintroducing chaplaincy to those who initially declined it. This too led to more referrals.

Colleagues now better understand chaplaincy taxonomy and the purpose of spiritual assessment and care planning, which includes identifying spiritual issues, interventions, and outcomes as well as recommendations to the team when appropriate. Charting and care planning have required adaptation because I do not have direct access to the EMR at the moment. I receive and exchange updates from nurses
and social workers by secure email within the organization's network. My notes are made available to the team as a consult visit summary note, which is entered into the EMR by a nurse, who is primary liaison with the chaplain.

As the patient census is rapidly growing, a key issue is streamlining conversations regarding each patient's care. We are exploring ways to do this that are aligned with the patient's care goals and palliative care best practices. This will continue to be an issue as the program expands to palliative care teams in other locations. One strategy emerged as a social worker who had worked closely with a chaplain in a prior job reached out by email to welcome me. She asked if it would be helpful if she shared her visit note since I did not have access to the EMR. I enthusiastically said yes, please. As more team members were looped into the conversation, several nurses began to share aspects of their notes. This is one example of productive adaptation, which also promotes a personal warmth in colleagueship as we voiced our concerns and suggestions to one another. To do so by email can be challenging, so I am glad for the willingness of team members to connect this way, as it expands our capacity for nuanced collaboration. This in turn builds resilience, which is key as the patient census grows.

A poignant example of partnership was when I received a referral to a woman in her 70s whose health was declining, with a possible transition to hospice being considered by the team. During our second visit, she spoke of experiencing “a lot of pain in a lot of places,” and when I asked her to rate these, she said 7 out of 10. I asked her if there was somewhere in her body where she did not feel pain. She said the palm of her hands. This led to a breath-centered prayer of “Lord, in the palm of your hand” as she placed her hand on her heart and began to tell me of her many years of volunteering at her Baptist church and teaching children there—as well as her children and grandchildren—the song, “He’s Got the Whole World in His Hands.”

Her tone shifted and soon we sang together. I asked her to rate her pain. It had decreased to 3. In subsequent visits, she spoke of the loss of one of her daughters in recent years and how it had been haunting her, fearing she abandoned her as a caregiver. She then embarked on a journey of forgiveness, and it culminated with singing this same song. As I shared these developments with the team and how her fear worsens at night, her primary nurse said she would call in the evenings and sing this song with the patient, adding it would be a privilege as it had special meaning for her as well. These interchanges began in the team meeting and continued in email interchanges as, eventually, this patient was able to discuss with her primary caregiver, her surviving daughter, the possibility of hospice care and was able to transition to this. She felt forgiven and died within days of the transfer.

My enduring hope is that such healing journeys continue to be made possible by the integration of telechaplaincy in palliative care. This is a priority during this time when social and spiritual isolation are on the rise. As telemedicine grows, so too can telechaplaincy in expanding the reach of compassionate, relationship-centered care.
STORIES FROM THE FRONTLINE: SCA CHAPLAINS & COVID-19

As we rang in 2020, few of us could imagine the ways in which the impending COVID-19 pandemic would test us both as individuals and as a nation. Through it all, SCA members have been demonstrating in new and powerful ways the contributions that spiritual care and chaplaincy care make to health care. For this issue, The Rev. George Handzo spoke to four SCA Board Certified Chaplains around the country about their experiences during the pandemic, the most challenging and rewarding aspects of their work, and the learnings that will continue to inform their practices into the future. We thank them — and all of our SCA members — for their tireless efforts to serve those who need their compassion and care now and into the future.

GH: Tell us about your role at Palladium Hospice and Palliative Care, Charles.

CP: Palladium Hospice and Palliative Care have offices in Mississippi, South Carolina, and Georgia. I supervise 11 chaplains in all of those areas, and I also carry a revolving patient load of approximately 42 patients in the Biloxi area. I provide education and training, continuing to move our discipline into balanced spiritual care and clinical practice, along with documentation and regular informed literature reviews.

GH: In the midst of all this, the pandemic hits. The South was perhaps not affected right away, but it was devastating when COVID-19 made its way down to you. How did that change your life and what you do every day?

CP: Probably, the most significant change in what I do is the increase in visit frequencies with patients and their families. Pre-pandemic, maybe only one required routine visit or 5 PRNs (as needed visits) per month were needed. Now, I’m doing an average of 2 required regular visits and 7 PRNs because there’s an increased isolation feeling. As you know, the antidote for that is contact and connection. And that connection should be with someone who genuinely cares, so that’s been a big one. Another change probably involves functioning as a bridge of communication within the facilities between patients and their families. That is perhaps a very significant change because many of the patients in nursing homes, assisted living facilities, and personal care homes are the patients I tend to. Those facilities restrict the entry of family members except in cases where the patient is actively dying. My team and I will contact the patients’ families to talk with their loved ones by phone or video as part of our scheduled visit routine with those patients.

GH: That’s often what we hear with hospice. What’s been your experience? Do you have people in long-term care facilities, or facilities where that kind of visiting
has been restricted to outside hospice providers? Do you have patients who are saying “no, don’t you come to my house?”

CP: As far as the facilities go, it depends on that particular facility leadership. They take their guidance, and then they look at what tier they’re in and then determine access entry. When the pandemic first started, facilities began restricting access to all personnel who were considered non-essential. Both social workers and chaplains were placed in that category, and it was disheartening not to have access to our patients. However, our team and our company’s leadership saw that it was an opportunity to educate about the benefits of holistic care. Together, we were able to showcase the importance of social workers and chaplains in ensuring that patients are getting the quality care that hospice and palliative care professionals provide. With ongoing discussion, many of the facilities’ leadership came to understand and subsequently amended the initial decision to categorize social workers and chaplains as non-essential. Though not all facilities have granted access, the vast majority have, but those that have not do not authorize entry for any of the disciplines. In essence, it’s a win-win victory because practitioners of psychosocial and spiritual care practices are now viewed in lockstep with the registered nurses and hospice aides on our teams. There are some patients that I have worked with who are home-based. Their families have said they don’t want visits, and we respect that, so we’ll do a telehealth visit instead.

GH: Do you do that by phone or video? How does that work?

CP: Both. Some of the families are elderly and aren’t necessarily tech-savvy, so then we have a pleasant little conversation by phone. We chart it as telehealth. But for those who do have folks that are around my age in their household that can use FaceTime, we utilize that because, of course, in hospice, our primary desire is to do in-person visits. That’s the closest we can get to face-to-face, and that’s just the way of the world now.

GH: The big debate now is what the “new normal” is going to be. What’s your take on that?

CP: I believe that both of them will remain in place regarding the changes that I had mentioned (increased number of visits and visits via phone and video). I say that is because it is about good reflective practice. The desire is to make a connection by any means necessary. With the limitations, both ways have revealed that increased visitations are beneficial to building upon established rapport. For example, after a spiritual care expert conducts a spiritual assessment, they become a tent peg amid strong winds, so to speak, for the patient. We’re reducing the length of time between visits, and the patient receives care by every member of my IDT (interdisciplinary team) daily, which is good. It ensures regular contact and observation. Likewise, with the phone and video, the family feels more engaged and informed regarding the patient’s care plan. We often think, in many instances, of the family as a part of the IDT. Even though they’re not sitting in meetings with us regularly, they regularly visit a patient every time we see a patient. I think this should continue since sometimes family members live at a distance or are working and don’t necessarily have the time to make an hour and a half drive to a facility to see their loved one regularly. So, we stand in; this is what we do every day. I think it’s going to be normal, and I think it reveals a lot of excellent practice.

GH: Tell us about how staff care has changed during the pandemic.

CP: Well, it’s changed for the better because, as you know, brothers are born through adversity. So, it has brought my team very close in the midst of all this – my chaplain team and my local staff. For interdisciplinary team meetings, we have maybe two or three people in the actual conference room (masked up, of course!), and we’ll have the rest of the team via Zoom, and we rotate. And as a Chaplain, I’m the moral and ethical standard of my team, so I regularly check in with individuals. I do in-services with them to keep that energy moving in the right direction. And the stress is high sometimes, especially in this business when you have losses. I must position myself so that I can be fluid enough to adjust to tending to grief issues that my staff might have when we, for example, have lost a baby through infant demise. I talk with my regional administrator, who’s my team leader, as she’s trying to manage all of our patients while also addressing her team and her nurses. Not to mention, she may be stressed out because she has kids at home that she’s caring for that can’t go to school. There are so many facets to this, but it keeps me actively involved and showcasing to the world how vital spiritual care is, especially chaplaincy.

GH: Another thing our colleagues talk a lot about is touch and presence. It’s the hallmark of what we do, but COVID-19 has changed that. There’s no touch in the home or out. How do you think that has changed the patient relationship, if at all?

CP: I regularly use PPE; I touch my patients. I feel that touch is so, so important and that it should not be lost. Now, for every chaplain, it’s their ministry, and you have to use wisdom to maneuver through that. However, I exercise a lot of trust. I know, having worked in other healthcare areas, that as long as I’m donning my proper PPE and wearing it correctly, I have a good foundation for protection. I look at the fact that my nurses and my aides do it all the time. They’re regularly cleaning patients and doing all those things, so why shouldn’t I hold my patient’s hand as long as I’m gloved? Why shouldn’t I get close if I have my N95 mask on? As far as contact, there are
things that we do that must not be lost. And the ministry of presence? Yes. It is vital to what we do, but it must be purposeful. I gauge to see if it’s beneficial for me to be close or to touch, and if it is, then I will do so. Otherwise, I will keep my distance and respect the guidance that’s been set out.

GH: You have a family. Is that something you think about?

CP: I do. All the time. I feel as though if I’m caring for myself, then I’m caring for them. What that means is that I have to be smart. I have to wear my protection, but self-care is also caring for my family. It doesn’t just end with me putting on my PPE. It has to include a balance between my exercise, my diet, my spiritual fitness. I have to be able to be informed and knowledgeable about what’s going on in the world and to be able to communicate that clearly to my family. But it’s always before me that there is a possibility that I could contract something, but I feel as though it’s no different than any other day, any other risk. It’s just, this one is pretty intense and is taking lives. The thing that I have to keep in mind is making sure that I’m regularly washing my hands, staying informed, am following the CDC’s recommendations on social distancing, I make sure that I protect myself. The last thing is that if I permit myself to express my emotions regularly and freely with a balance of grief and laughter, that is also vital to making sure that I can care for myself and protect my family.

GH: There’s been a lot of discussion about bereavement rituals and funerals. In some communities, funerals are a crucial part of the bereavement process. Tell us about what’s happening where you are.

CP: In hospice, the bereavement process begins upon admission. We do pre-assessment for bereavement. We are already in the process of gauging where families sit and what their baseline is for that. As far as ceremonies, upon the certification of death, we begin the active process of increasing visitation to families and celebrating their loved one’s life. What that entails isn’t just the funeral, but making the initial condolence connection, acknowledging the loss. Through the midst of this, I have found that many families have already gone through the process of accepting the loss of their loved one, and they communicate that. Many of the patients I have here in the South have outstanding support both by church and family, and that also helps because all I need to do is fold into that. The challenge has been the distance. There have been virtual funerals. My company just did a rollout of a series of three programs in three different states (Mississippi, South Carolina, and Georgia) to celebrate the lives and to honor all the patients that we’ve had under our care. They each had the same theme, but three different regional chaplains led them. These were Facebook live events that restricted in-person participation to 5 people. The program included reading the patient’s names, the ringing of a bell after each name, and the lighting of a candle for each patient. We do whatever it takes to acknowledge and make the connection that what we do is so vitally important — acknowledging the life of a loved one. Recognizing and honoring a loved one’s life under our care is one of the most important things that we do.

GH: Let’s talk about training for yourself or your staff (both chaplain and non-chaplain). Looking back, what do you wish you and they had had in terms of training and preparation that you’d want to work on going forward.

CP: First, I believe that the amount of information and training during the pandemic has exceeded the pre-pandemic norm in both quality and quantity. Being actively involved in the Spiritual Care Association, College of Pastoral Supervision and Psychotherapy, and the National Hospice and Palliative Care Organization have kept me very much up to speed on discussions and best practices. So, it’s imperative for me to highlight that. Many universities seem to be in lockstep.

As far as regular, continuous education, it has been a blessing to see all of the Zooms, all of the virtual activities that have taken place. It’s also been wonderful to have support groups in those areas to talk to chaplains from across the country and form relationships. I feel like that is probably the best thing to come out of this. There are terrific, selfless, loving people that do this work, and it is an honor to be a chaplain in this day and age.

Rebekah Wagner, BCC, APBCC is the Director of Pastoral Care at Owensboro Health in Western Kentucky, where she leads a team of 4 full-time and 7 PRN chaplains. She’s been a chaplain for the last 11 years, working in both hospice and hospital systems. She is a BCC with both APC and SCA, and an APBCC with SCA. A recent transplant from Milwaukee, Wisconsin, Rebekah was a licensed physical therapist before she became a chaplain.

GH: Tell us about your career before chaplaincy, Rebekah.

RW: I was a physical therapist for 26 years. So my passion is how spirituality needs to be integrated into clinical medicine, because unless we are caring for the whole person, we really aren’t promoting health and healing — we’re really just addressing illness and disease.
GH: How is this pandemic impacting your system and the practice for you and your staff?

RW: In a lot of ways, we’ve been very fortunate. We’re in the middle of the country, so things came a little later here, and even when they did come to us in Owensboro, the peaks have not been the kind of peaks you’ve seen in the urban areas. Certainly, Louisville and Lexington have been hit much harder. The greater challenge here is that we cover 17 counties and many of them are very rural. So, when patients do get sick, they often need to travel hours away from their homes to be here. The other issue is, because it’s a very faith-based, family-driven culture, it’s been really difficult for people to have their loved ones here in the hospital hours away, and even if they could get here, they couldn’t be with them. As has happened in many hospitals, we did just recently get permission for family members to come in at end of life for COVID-19 positive patients. It’s been a process of advocating for that and for health care generally coming to a better understanding of how to prevent the spread of this virus. Interestingly, the way that it got done here was that I’ve been doing moral resilience rounding with the CCU (critical care unit) nurses. In talking with them about the moral distress that they were experiencing in caring for these patients (including end of life care), being the only person at the bedside was causing significant moral distress. That seemed to be a concern that helped the administration see how hard it was for the nurses, and it led to the willingness to allow patient family members to be there at end of life.

GH: Explain to us more about the moral issues for nurses and caregivers in these circumstances.

RW: In the conversations I’ve had with the nurses who work in the COVID unit, I seek to find a way that the conversation helps me understand what is morally distressing to them. “What haunts them about doing their work?” “What do you take home at night with you?” When I was talking with the nurses, they said it’s the fact that they get to know these families and they’re talking to them on the phone while their loved ones are here, and then ultimately when the patient is dying, they’re sitting at the bedside with the phone with the family member talking to their loved one, and it’s just them holding everything together. There’s no clergy allowed, their family isn’t there, and really the stress of holding all of that space for the family, for the patient, and for the nursing care is just a burden, a heaviness. There’s a cost that people start feeling. They also feel bad that they’ve gotten so connected to these patients and to these families and never have seen them in person. So they feel that there’s a grief and bereavement that not only the families have, but that they have that doesn’t have a natural ritual to mark this loss. Typically, when patients die in the ICU, the family would come in, nurses would be able to spend time with them, express their condolences, and then feel like at least they’ve completed their job. But in a lot of ways this feels like there’s no way to express the condolences and to allow for them to look in somebody’s eyes and say, “I am so sorry for your loss.” It feels like they just can’t get that emotional connection that they would like to have with people. Because of the limitations of gathering, you just move on to the next patient, which is always a morally distressing issue in CCUs or EDs. The idea of how to acknowledge that this person’s life has ended, and that they were an important person in somebody’s life, and that dignity and respect has been paid to them, is complicated within the “new normal.”

GH: Speaking about rituals, can you explain a little bit about the “pause ritual” and what you and your staff have done to address that?

RW: The pause ritual is a timeout for the staff, and family if they’re present, at the occurrence of a death, especially after a resuscitation event that was unsuccessful. They take a moment to acknowledge that this person was someone’s mother, father, brother, or sister, and that their lives have meaning. Rather than just moving on from the death, it signifies the importance of that person’s life by taking a pause, usually only 15 to 20 seconds. There isn’t anything that specifically needs to be said, it’s showing respect and dignity for that life that has now ended. We are currently in conversations with the ED staff about integrating the pause because the deaths that happened down there specifically are always by definition, unexpected. We haven’t been able to address use of “the pause” in the CCU at this time, but it is certainly another area where it would be helpful. One way that we have addressed the need for acknowledgement of the life of the person who has died during this COVID time is to remind the nurses to call the chaplain when a patient is being coded or dies. Since there were no family members present, they had assumed that there was no reason to call a chaplain. They were happy to hear that the chaplains would like to come in and support the staff and the family via phone if that is where they are. There are often misunderstandings about the role of the chaplain and that there is no need to call the chaplain if there isn’t family present. We are committed to support of staff as much as to the patients and families.

GH: How are you working to keep your staff healthy during these trying times?

RW: I think that the most important part of keeping the chaplain staff healthy has been management by walking around, making sure that I’m fully physically present with them, hearing their stories, connecting with them. Fortunately, we are all physically present here, so we have that advantage over some areas where all of their chaplains have
GH: Can you tell us how you’re taking care of yourself during the pandemic? How are you practicing self-care?

RW: You know, the interesting thing was that I kept thinking about how I might do that, and I’ve had some victories, and then there are some times when I’ve caught myself being “the pot calling the kettle black.” My primary thing is nature, it’s the way that I refresh and renew, and we were able to purchase a small waterfront property on the Ohio river. I don’t know that I would have made it through all of this if I didn’t have the ability to go there on evenings and weekends and get in a kayak or just sit next to the water and watch the birds. For me that is absolutely necessary for my well-being. What took me by surprise was that last week I discovered that I had a physical accumulation of stressors in my body. I felt fine emotionally and spiritually, but I was naïve to think that it wasn’t taking a physical toll, and so when I crashed and burned last week I was still in denial that I was really tired. I felt like I was holding it together, so I think that that has been the biggest lesson: We can feel like we’re doing okay emotionally, we can feel that we’re doing okay spiritually, but our bodies, sometimes they’re just the weak link. It isn’t that I’ve been working extra hours or that I haven’t been sleeping, I think it’s just the accumulated time of extended stress, and my body just said, “okay, you’re all done, just stay in bed for a couple days.” So I do think that’s probably a good wake-up call for me that even when we think we’re doing ok, there still is a cost to all of this.

GH: Tell us about PIH Health Good Samaritan Hospital and the community that surrounds it in downtown LA.

MB: PIH Health Good Samaritan Hospital is situated in an inner-city environment, different than some suburban hospitals whose colleagues have had issues too, but they don’t seem to have the same mix of issues. I would say any inner-city hospital would be similar to our situation. We’re at the downtown end of Wilshire Boulevard, where there’s a redevelopment and gentrification of parts of downtown going on right now with extraordinary property prices. And, the catchment area of PIH Health Good Samaritan Hospital has for decades included many working-class families, a fair number of undocumented immigrants and refugees, a very large number of

The Rev. Michael Bell, an Episcopal priest, is Director of Spiritual Care Services for PIH Health in California with oversight of chaplaincy teams at three different hospitals (PIH Health Good Samaritan Hospital in downtown Los Angeles, PIH Health Whittier Hospital and PIH Health Downey Hospital). In addition to a BA in English and Philosophy from Texas A&M University at Commerce, Michael received a Master of Education degree at Harvard University Graduate School of Education, a Master of Theological Studies degree from Harvard Divinity School, and additional post-graduate work at the Episcopal Theological School at Claremont. He is an SCA Board Certified Chaplain. Prior to becoming a chaplain, Michael held consulting and program leadership positions at MG Taylor Corporation, Pfizer, and Kaiser Permanente.
people living on the streets, folk with a variety of mental health issues, etc. We serve in this nexus of great wealth as well as poverty, so there’s tension and conflict, and a lot of needs to be met.

In terms of COVID-19, one of the challenges that PIH Health Good Samaritan Hospital faces is that we serve a larger—some have said disproportionate—share of people that are not insured, are under- and unemployed, etc. What that means is a lot of money spent and not as much collected back from insurance. We can get reimbursed less for the same procedure at our hospital than our neighbors just a few miles away. While that was already an unfortunate reality, it’s even more pronounced during COVID-19; though we have received some federal relief funds because we’ve been a “hot spot” during COVID-19. Additionally, we are primarily a community of color and a community in which multi-generations live together and many people in a household have to go out to work (can’t isolate and work from home). So, over these months we have seen multi-generation infections in households where we’ve served grandparents, son, niece, etc., as all get sick. The staff of PIH Health Good Samaritan Hospital is also very diverse and commuting from all parts of Los Angeles. We’ve had infections among the staff, and thankfully most all our colleagues have come back to work, even though not all are free of the consequences of the virus – both emotionally and physically.

**GH:** And what has that meant for spiritual care? How has spiritual care changed since March?

**MB:** My perspective might be a bit myopic because I’ve not been in communication with a lot of colleagues to compare notes, but I’m guessing some of what I say, you’ll hear from other people. I don’t think the things I’ve noticed that have changed are unique to hospitals in just our system.

Pre-COVID, chaplains and spiritual care providers might have presumed that we’re in more stable watercraft as we approach others who are capsized and taking on water, or who are drowning or treading water. Now, however, we’re all riding these rough seas as well at the same time. So spiritual care in this time can be much more emotionally laborious while we’re trying to tend to our own trauma, distress, and fear while simultaneously helping others — no one is immune. There’s no safe haven, no place to turn that’s reliably calm and steady. And as for those who appear to be calm and steady on the surface, we as chaplains often get the privilege and the burden of knowing that behind the scenes, they’re not. I think of other front line care providers who will talk to me and break down in ways that they’re not willing to do in front of their staff because they feel they have to keep up the appearance of sturdiness. And while that’s true generally, since March this has happened with increased frequency and intensity. So that’s one major thing that has changed since March — we’re all experiencing personally higher levels of fatigue, distress, and trauma at the same time, and yet as spiritual care providers, we’re having to rally to be present for other people. Further, it can feel additionally burdensome when an internal voice tells me I ought to be better at this or that I should know how to cope with 2020 better.

Another thing I’ve noticed is that I’m dropping more of my pretense of “having it all together / under control” and being more personally disclosive, vulnerable and open than I might otherwise be with staff colleagues, which seems to help normalize our collective angst and invites even more authentic and honest conversation with them about what we’re all going through. Just the other day I was in the hallway with several staff, we were having a somewhat typical collegial conversation, and as soon as I broke the ice and mentioned that I’ve found it helpful to speak with a therapist through our EAP (employee assistance program) that changed the whole conversation. They opened up about deeper things they were experiencing. For that moment in the hallway the four of us were sharing a really cathartic experience that might not have otherwise happened.

Also, now there’s an added layer of assessment that I’m doing in all my conversations with staff, chaplains, administrators, patients, and families. I find myself listening even more for where they might be in their trauma response or moral distress in addition to whatever is being explicitly discussed… and in myself as well. How are we living with grief? What’s going on with their partner who I might happen to know has COVID-19? It’s another layer of listening that maybe you’re always kind of doing, but it feels heightened and more demanding in multivalent focus.

Personally, something else that has changed since March, which I’m embarrassed to admit, is that I can find myself begrudging seeing other people having a good time or enjoying themselves. That’s sad. For instance, when talking with friends who haven’t been struggling with COVID daily in a healthcare setting, or aren’t living in a COVID hot spot or a city with protests and civil unrest, or who say they’ve been “bored” working from home all this time, it feels like I’m having to straddle two realities, and I feel resentment well up in me. Even worse is when well-meaning friends send pictures of themselves and others socializing in close proximity without masks. Simultaneously I hear in my head “Good for them for enjoying some sort of normal again!” along with “What they hell are they thinking?!” Additionally, I get tired of sounding like a broken record and feeling that I’m continuing to bring dark clouds to the conversation when I’m asked “How are you?” and attempt to respond to that question authentically. Lately, I’ve found myself saying that answering that question honestly feels like a killjoy and I suggest that we pivot to a different conversation. Cognitively, I can recognize some of the trauma
responses in what I’m describing here, but emotionally it’s harder to navigate in the moment and has a cumulative effect that feels demoralizing inside.

Finally, on a practical level, a clear change since March has been the prolific use of telephone and web chats (to the point of almost ridiculousness) for everything: staff meetings, CPE, didactics and conferences, baptisms, rituals around death, etc. Though part of me can be hopeful about the adaptive changes for the good that might come from the more prolific use of technology to facilitate conversations, I’m also acutely aware that in our area not everyone has a smartphone or internet service at home, nor have they ever had to set-up a webchat account. So, since March there’s been an added layer of effort with some patients and families trying to help people get up to speed on Zoom, doxy, etc. Beyond technological challenges, since March we’ve also been without the added in-person support from our volunteers and CPE interns. Some have volunteered to offer “tele-chaplaincy,” calling patients and families to share conversation. This has been helpful, but it’s not the same as the ability to respond to urgent calls in person, or round proactively with staff as well as patient in-person visits. In addition to lacking the additional labor/support that they provide, not having the volunteers and interns around in person means we’ve been lacking some of the camaraderie and mutual support that buoys us.

GH: You talked about therapy. What else have you and your staff done for yourselves and for your colleagues that’s maybe been a new way to work out the grief and loss and stress that’s around you.

MB: I would start with the bigger comment that what’s morally distressing for me is that it feels like we ought to be doing more, but just don’t have the bandwidth for it most days. It feels like we ought to be offering staff more support services, grieving ceremonies, etc.

Or that we should put together some programmatic intervention that might help. The reality is that we’re not. Neither I nor my teammates have the collective energy, time, or momentum right now to do much more than we’re already doing. We’re just hanging on right now and trying to keep ourselves afloat day by day, aware that everything since March has taken a toll on us as well — body, mind, heart, and soul. If someone else can come in and offer an in-service or support program, that’d be great…. oh wait… everyone else is running thin as well. So, we’re still doing the things we do normally — personal check-in’s with staff, Tea for the Soul, etc. — and doing them a little more frequently. We’ve made a point of visiting staff on the COVID-19 units and giving them at least as much of our attention as we’d typically give the patients. We’ve been reminding colleagues that it’s okay not to be okay as we continue to leverage the person-to-person relationships we already have.

Quick anecdote: Several months ago, for our chaplaincy team at PIH Health Good Samaritan Hospital, I invited staff from the L.A. County Mental Health Department who specialized in trauma to offer us an in-service on psychological first aid techniques and mental health triage in the wake of trauma. It turned into a support session for us as chaplains, which was helpful. That actually turned out to be what we needed that day, even if it wasn’t what some of us were wanting or expecting. We were reminded that we need to tend to ourselves in order to be available to do that work with other people. And, in the immediate wake of one of our colleagues dying, I partnered with HR to host some support sessions for both day and night shift with a mental health professional from our employee assistance program. Of course, the distress following that is the recognition that we need more than quick interventions — what we’ve all been going through will take longer to process and metabolize and needs to be tended to through multiple modalities.

A personal moment of reckoning was having two different staff members from two different hospitals say to me in their own ways, “Michael, until we see you do a better job of taking care of yourself, it’s hard for us to feel authorized to do the same for ourselves. We hear you telling us to take care of ourselves, but we need to see you do it.” That challenged me in a healthy way. It took me almost six weeks to find an available therapist who was a good match. In the meantime, I took a few days off here and there, and as soon as I started taking days off, that encouraged more of my staff to start taking PTO as well. As a Director, I’m also being more flexible with our staff schedules and case load expectations. We also try to be observant of each other’s dispositions and lovingly inquire when someone seems “off.”

I’ve noticed in myself and among my teams that we’ve manifested our stress in a variety of ailments that seem to have all presented in the recent months. If we wondered how chronic stress messes with our immune systems, GI tracts, etc., we simply need to look to each other lately as case studies. Another challenge is that though our impulse endures to celebrate things with each other (birthdays, etc.), as well as encourage each other to take breaks and go do something rejuvenating, the reality is that right now it’s difficult or unadvisable to engage in some of the things that we used to depend on to recharge our own batteries, refresh, and reset for another week. It’s hard to plan ahead and look forward to a vacation or a social gathering, for instance. So, our coping and tending to our wellness has become very focused to one day at a time.

GH: Before we go, are there any other victories you want to discuss, anything that you’re hopeful about?

MB: As a healthcare system, I’m hopeful that we will continue to invest time and energy in technology to facilitate communication with
families across distances and languages. Use of tablets and webchats have been vital during this time, for sure; and could continue to improve our continuum of care after this pandemic. I’m also hopeful that more of us are now more aware of resilience and how that needs to be and can be cultivated. Hopefully, this insight can mitigate some of the fatigue and burn-out inherent in the demanding work of full-time healthcare chaplaincy.

David Hottinger, M.Div is the Manager of the Spiritual Care Department at Hennepin County Medical Center in Minneapolis, Minnesota. Prior to working at Hennepin, David was an Adjunct Professor of Healthcare Ethics at Saint Catherine University in Minneapolis. He also served as a Chaplain at the Hospice of the Twin Cities. David received his Master of Divinity degree from Harvard Divinity School and BA degrees in Government and Religion from Oberlin College. He is also an SCA Board Certified Chaplain.

GH: Tell us more about Hennepin. What is the role of a “safety net hospital” in a large city like Minneapolis?

DH: We’re a very mission-focused organization. Our mission is to serve everyone with exceptional care without exception. As a safety net hospital, our prime focus is people who come from uninsured or underinsured backgrounds, really vulnerable populations, from those experiencing homelessness, to refugees, to people who have been historically disenfranchised. On a given day, probably about 60 percent of our patients are people of color or indigenous people. About 60 percent of our patient population are on Medicaid and get their health insurance through the federal government and the state. Another 20 percent are Medicare patients. So, less than 10 percent of our patients are privately or commercially insured patients, and that leads our hospital to have a very different feel than some of our neighboring healthcare systems in town. We take our mission very seriously, and it’s sometimes challenging because we’re not only addressing our patients’ medical problems — and they often have very complex medical needs when they walk in the door, often because of their historically disenfranchised status (many live in food deserts and have poorer outcomes because of that) — but we’re also addressing people’s deeper life traumas, including mental illness, addiction, poverty, housing and food insecurity. So that’s a very different dynamic than walking into maybe a university hospital or the Mayo Clinic, which have a very different population base than we do. But I think that’s the gift of Hennepin, and that’s why those of us who choose to be there are there, but it’s often a challenge. We’re stretched in terms of our resources — both human and financial — and we do a lot with a lot less resources than some other places in town and around our state.

GH: I’ve been to Hennepin, and when you walk in, you immediately see a very interesting demographic that you don’t see everywhere, especially one you don’t expect in the middle of the Midwest.

DH: Well, that’s exactly right. Due to the Lutheran immigration service, we have the largest Somali population in the United States. And they’re represented not only in the patient population but on our staff. We have a growing Latinx community and a very large Ethiopian, Eritrean, and Liberian community. Minneapolis has become a melting pot of many different backgrounds, and that’s been a blessing. But we’ve also had our share of challenges. Minneapolis is where the George Floyd murder took place, and he died at our hospital. A couple of years ago, I was involved when a young black man was killed by a suburban police officer; he also died at our hospital. We have been on a journey as a healthcare system to become much more culturally responsive and anti-racist, and it’s been a journey because even though we have a
dive staff on the one hand, some of that diversity is not in the areas where we need it to show up in terms of leadership, physicians, and nurses. There’s not a huge diversity pipeline there. It’s a problem that we’re facing throughout the whole United States. So a big part of what I’m doing right now, along with others in our hospital system, is engaging in a series of conversations with different members of our community about how we can build trust, because the trust is sometimes not there in our communities. While we pride ourselves on our mission and we think we’re doing all of this awesome work, the experience of many of our patients doesn’t mirror that. I think a big impetus right now for our spiritual care team is being engaged in those conversations and making it very clear that we want to take the need for safety seriously. Safety is not just physical safety and emotional safety, it’s cultural safety and spiritual safety, and when people walk in our door, we want to ensure that their beliefs and practices and histories and traditions are going to be respected and honored. I would say that the three groups I’ve been most engaged with have been the Somali community, the American Indian community and the African-American community. We’re trying to build our own spiritual care team in a way that would also be more reflective of the patients and families and communities we serve. A frustration I’ve had about the way professional chaplaincy has evolved over the decades is that we have created barriers that are almost reflective of some of the barriers in medicine. We have a largely white, middle class population of chaplains when it comes time to recruit and hire, and we need to change that, and we’re working hard to do that here. I can count four African-American chaplains in all of Minnesota, and Hennepin has two of them. It does not reflect the community.

**GH:** Add to the challenges you’re experiencing, COVID-19. Tell us a bit about how that’s impacted your daily life at the hospital.

**DH:** The epidemic is very tied to what I’ve been also saying in terms of equity and racism, because COVID-19 in our experience here in Minnesota has unveiled the disparities we already knew existed. But they unveiled them in a very stark way because in our hospital, the majority of our COVID-19 patients have been from mostly minority communities, particularly Somali, Spanish-speaking, and African-American communities. I think as a hospital system in general we have risen to the occasion and done really well. But I’m sure I’m not alone in saying one of the biggest challenges has been family presence, and the lack thereof, that we’ve had to impose with visitor restrictions. When you are already trying to build trust and work with families to enhance communication, and then you add in “oh, by the way, we have to do this by an iPad,” or “oh, and we may have to do this on an iPad using a video interpreter on another iPad,” or “no, you can’t come in and actually see your loved one as you make these decisions, but we can send a picture of them or you can look at them over video screen,” that equation has posed real challenges to our team, and also to our physician and nurse colleagues. It’s getting a little bit better as we open up more. It’s also hard when you’re dealing with communities that have a very different sense of family than what we typically see in Minnesota. Some families have 40 people that want to come in and take turns keeping vigil, and we have to say, “I’m sorry, but you can have a total of six people rotating two by two, and there’s no place for you to wait in the hospital as you do this.” That has caused — I don’t think it’s too strong of a word to say — some moral injury for our physicians and my spiritual care team. These are things we know we have to do to protect our patients and families, but there’s a cost to it that has fallen on some shoulders unevenly. That’s been one of our biggest struggles.

One of the things I wish we had received more training on as a chaplain, as a spiritual care leader, is moral injury. I’ve learned a lot more about it over the years — including the last six months — because it’s also been a big topic among our physician colleagues who look to the spiritual care team to help address some of that from a spiritual perspective. Having those conversations has been really fruitful, and I would say that one of the greatest breakthroughs I’ve seen is the level of collegiality we have achieved with our physician colleagues during COVID-19. We’ve achieved the level of parity that we’ve been working toward in the last couple of years, but things have really accelerated because of our role providing staff support to them. I serve on a couple of interdisciplinary teams that helped do staff support, and they include psychiatrists, psychologists, and chaplains. We do Zoom calls with them to do some coaching about self-care, spiritual distress, moral injury, and trauma-informed care. So, we have a new level of respect and collegiality. I think we’ve always been seen as important to staff members in terms of the care we provide to our patients, but now we have become an essential element to their own self-care and that’s been pretty exciting.

**GH:** I’ve seen recent European and US data that supports what you’ve just reported, but there are others who’ve been furloughed or marginalized, and there’s talk of them being cut. You’re at an institution that would certainly have every financial excuse to cut chaplains, and yet that’s not entering their consciousness. What’s the difference?

**DH:** To look back maybe a decade before I arrived at Hennepin, we became protocol-based back in the late ’90s. That means chaplains are going to the emergency department...
for every trauma or medical emergency that comes in. Chaplains are attending every code blue or medical emergency in the hospital. Chaplains get an automatic consult when there’s going to be an end of life situation. Chaplains are invited to every care conference on the ICUs. When I was a new staff chaplain, it was made clear to me that “you either show up and are competent or we have to find someone else,” so there was a high standard placed on our ability to show up and operate within an interdisciplinary team as an equal with our physician and nurse and social work colleagues. I think with COVID-19, things were changing at warp speed — how we were doing medicine — and there was this sense of disaster everywhere. I think one of the advantages we had on our team is we’ve all had a lot of that emergency preparedness disaster training. Being at a level one trauma center, we go to all of that training, and so we knew how to show up, use our skill set, and be useful, be creative in the resources we were putting out. We created the video blessings, and prayers for different groups. We suited up, showed up, and knew what to do. We weren’t just flies on a wall being a non-anxious presence. We were in a major leadership transition at that point, had a brand-new CEO, and we had a chance to show her what we were made of.

**GH:** Tell us more about the video blessings you mentioned. It’s a great example of stepping up and doing something that not only gets the administration’s attention, but that benefits the institution.

**DH:** We had pre-existing relationships with people in our communications departments, in the c-suite, in HR, who were all moved off campus while we were still working on campus. That became an issue: Who’s physically here? Who has to do things by video? We had to get creative to keep people in touch. They always say in emergency preparedness training that disaster’s not the time for the fire chief to meet the police chief for the first time. You work really hard to build that credibility and those relationships, and we already had those. So, when the moment came, we said, “We all have iPhones. Can we just do a video blessing and put this up on our website?” And they said, “Sure, we have a YouTube channel, we have a Twitter feed, what else would you like to do?” There was a vacuum waiting to be filled, and some of that vacuum was filled by our HR colleagues who had their own spin on wellness and resiliency. We had our psychology and psychiatry colleagues who were looking at things from more than a strictly mental health perspective. But the spiritual care team had already worked with all those teams to provide staff support, and we said, “Okay, what can our contribution be that’s unique and going to be welcomed?” We began to have small vigils in the spiritual care center. We began to offer consultations by phone or iPad with people who wanted to talk, and we leveraged the technology that we all knew how to use. We did a video blessing where one of our communications team members came down with an iPhone, we stood in front of a pretty piece of art, and a couple of us read a blessing that one of our chaplains wrote. It went out to the whole organization, about 7,000 people, many of whom weren’t on campus. People were scared everywhere, inside and outside the hospital, so it was just providing a little bit more reassurance that we as an organization care about you as a person and here’s a tangible blessing. It was a very multi-faith piece. We created another blessing for the community that was put on our website and was more patient- and community-facing. We also did a written version for when we had to turn visitors away. People received a blessing with some information about how they could contact their loved one. We facilitated communication between families and patients using iPads and iPhones a lot, especially in that first month or two. A unique thing we began to do is partnering with our employee health to begin to do phone calls to all of our employees who were sent home with COVID-19 or were out because of potential exposure, and we did hundreds of calls to say, “We’re just calling to check in on you and see how it’s going.” That went over really, really well. Maybe too well; we got a little overwhelmed and had to scale back a bit because we’re a small team of 8 staff chaplains.

**GH:** Tell us about what you’re doing to encourage self-care for your staff.

**DH:** As a result of COVID-19, there’s heightened focus on self-care, and I think that’s been a positive thing. We’ve had some people on our team teetering on the edge of burnout. I’ve certainly noticed that among physicians and nurses when, for a couple of months, our medical ICU really felt like a war zone since it is our primary COVID-19 unit. You could just feel the weight of what people were experiencing and feeling, so there’s been a heightened focus on self-care. On my team, we’ve got people who have lots of different ways of going about practicing self-care. We’ve got some chaplains who don’t fit “the mold”; they’re not going to go on a retreat or talk to a therapist, but instead, they’re going to run 15 miles a day or go play music at night. We have some others that are more the contemplative type. I think one of the challenges of COVID-19 has been the way it’s taken away from some of my team, who are external processors, the ability to be together and process things the way they used to. Before, they’d gather in a room at the change of shift, which is supposed to take about 15 minutes, but it could go on for an hour. They needed to be there for one another, and now we have to meet and social distance ourselves in a fairly busy hallway, and I can see how that’s really wearing on some people.

But we’ve been really intentional with each other about checking in and saying “Hey, how’s it going?” We have a kind of new language and we’ve inculcated it over the last
couple of years with trauma informed care. One of the tools we teach on this trauma informed care team that I’m part of is an analogy called “rider and the horse.” It’s how your thinking brain (the rider) and survival brain (the horse) help one another. When that rider or thinking brain goes offline, as it does when you’re under intense stress (and I think it did for a lot of people during the height of COVID-19), you’ve got to find a way to get that thinking brain and survival brain back together. On our team we’ll say, “Hey, you know, it seems like your rider might be a little off its horse today. What can I do to help you get re-regulated?” We use this language of co-regulation which has come out of trauma-informed care as well, and I think having that neurobiological basis of coping with stress and trauma is key for chaplains to know. It’s especially important when talking to our clinician colleagues.

HOSPICE CHAPLAIN CREED

I am a Hospice Chaplain.
I am a spiritual leader and a member of an interdisciplinary team.

I am an ambassador for peace and comfort.
I serve the patients and families who have chosen my company.

I will always place a patient’s and family’s needs first.
I will always be accepting of all people.
I will always compassionately care for the terminally ill.
I will always honor and support my fellow teammates.

I am spiritually sound, and proficient in my tasks and skills.
I will always maintain faith, practice, and beliefs.
I am a witness and a positive contributor to the quality of life.

I am an advocate for respect and dignity.

I am a Hospice Chaplain.

— Charles Parker

I am a Hospice Chaplain! Such a statement is made with pride and with awe, knowing that my journey to this vocation was challenging. President Theodore Roosevelt said, “Nothing in the world is worth having or worth doing unless it means effort, pain, difficulty… I have never in my life envied a human being who led an easy life. I have envied a great many people who led difficult lives and led them well.” My travel to hospice chaplaincy began by sitting on a rack at Fort McCoy, WI, preparing to forward deploy to Afghanistan. My answer to accept the call to ministry was specific to chaplaincy. But I was young and had no idea that there were various types of chaplains in the world, so I set my sights towards being a military chaplain. Upon completion of my expeditionary duties, I returned home and enrolled in seminary.

Additionally, my pastor took me under his wing and developed me into an effective associate pastor. It seemed like forever, but I graduated with a handful of years of bi-vocational pastoral experience but with no hopes of ever being a military chaplain. “What was God doing?” I would ask myself. “Why am I not good enough to be a military chaplain?” With low self-worth, it felt as though I had confused my calling. Such a moment in time was a very lonely place to be because none of my fellow clergies could understand my struggle.

Being a military man, I took action and volunteered as a correctional chaplain. “Perhaps this is what the Lord wants me to do,” I said to myself. So I thrust myself into serving and supporting inmates. It seemed as though there was a need, so I became convinced that prison chaplaincy was the way to go. My weeknights, along with some weekends, involved service work and correctional chaplaincy training. It was tough but gratifying, so I applied to be a Veteran Affairs (VA) Prison Chaplain. Well, even with years of pastoral experience and correctional chaplaincy hours, it was not enough. Once again, my hopes were dashed, and so began the self-deprecation as a result of the disappointment. Not
liking the music of that pity-party, I left that mindset, prayed, and sought wise counsel.

Over a cup of coffee, a close friend and pastoral colleague mentioned to me an opportunity to enroll in Clinical Pastoral Education (CPE). He had expressed a desire to participate in the courses himself to enhance his ministry skill set but did not have the time. I had no idea that such a program existed, nor did I fully understand what it was all about. My friend provided me a name and a number of the individual leading the course. Weeks later, after speaking to that CPE Supervisor, there sat a confused, uncertain, bi-vocational pastor with a desire to be a prison chaplain. Or so I thought.

CPE helped me become more self-aware and further cognizant of my true calling to clinical chaplaincy. Upon completion of over 17 years of active military duty, I embraced my calling and found myself employed and serving with barrier-breaking chaplains, emergency room warriors, oncology champions, skilled nursing heroes, and palliative care troopers. Each of those wonderfully compassionate people contributed to my professional development, which led me to my passion for providing spiritual care for terminally-ill patients and their families. I realize today that my journey needed to be challenging. The path needed to include all of the setbacks, uncertainty, and pain. Therefore, my experiences can inform my practice. We know that the military is essential, and when a threat is imminent, our attention is on the stages that follow. Likewise, healthcare is unquestionably essential but overlooked until a tragedy occurs. In the era of COVID-19, these truths are all the more apparent.

There is no doubt that we are at war. Our enemy is unseen, and the weapons used are called anxiety, fear, isolation, and uncertainty. In response to this attack on our personhood, the aggressive response demands the utilization of peace, encouragement, connection, and hope. Waking each day as hospice chaplains, we must equip ourselves with these weapons. Through morning rituals like prayer and meditation, our uniform is the Spirit of Hope that motivates us to be instruments of comfort to our patients, their families, our Interdisciplinary Teams (IDTs), and our organizations.

I contend that we win the battle in our minds and hearts. Further, we can take comfort in knowing that caregivers of every discipline work together for the good of all humanity. Specific to hospice, spiritual care specialists must be compassionate along with being informed regarding admission criteria to bereavement, pain observation, stages/types of grief, and how to develop an effective spiritual care plan. These are extremely important because the collective journey of that patient and family may consist of emotional battle scars. Thus the benefits to authentic holistic care make themselves known. The role of the hospice team is not limited to direct patient care but demands education for the community about the benefits of choosing the right provider.

Together, the IDT can showcase the effectiveness of collaborative coordination of care and eliminate the stigma that hospice care is all about death. Hospice care is all about the quality of life, and what an honor it is to have a hand in providing that type of assistance.

Charles James Parker, MDiv, EdD, APBCC-HPC is the former Lead Chaplain for Palladium Hospice and Palliative Care, now known as Traditions Health. Dr. Parker has over 12 years of ministry experience, and he has earned both an MDiv in Chaplaincy and a Doctorate of Education in Pastoral Counseling. His research focus has been self-care and self-compassion, and he has published on these topics in the Journal of Health Care Chaplaincy. Dr. Parker is an SCA Board Certified Chaplain and an Advanced Practice Board Certified Chaplain in Hospice and Palliative Care. He is also a volunteer for the SCA Time for Compassion program and serves on the NHPCO Spiritual Care Steering Committee.
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Telechaplaincy
Why is it Important and How is it Best Done?
Introduction — The Case for Telechaplaincy

This document represents the consensus of a panel convened by the Spiritual Care Association on the process and practice of telechaplaincy (Appendix 1). While there have been several reports representing the practice of individual chaplains and one focused on the experience in Australia, this document represents the first time a group of experts including non-chaplains examine the evidence and report a consensus opinion. The document can be seen as consisting of two primary emphases. We believe it is important to reaffirm what is currently understood to be best practice in health care chaplaincy. This affirmation underlines that those processes and practices are equally applicable, and in some cases more so, for telechaplaincy than in face-to-face contacts. Second, there clearly are processes and practices that differentiate telechaplaincy visits from face-to-face visits. One way to summarize this difference is to suggest that while much about the practice of telechaplaincy is the same as face-to-face chaplaincy and requires the traditional knowledge and skills, there is much that is new and requires new knowledge and skills. In this document, we will name the former but focus on amplifying the latter.

There are several important realities about telechaplaincy that need to be affirmed.

1. Telemedicine and with it telechaplaincy is here to stay in the US as a major feature of delivering health care.

2. While there are situations in which face-to-face encounters for both physical and spiritual care will remain the preferred or necessary option, several factors including patient satisfaction, cost, increased access and perhaps even efficacy make telechaplaincy not only a viable option but the preferred option in some situations.

3. Telechaplaincy should meet all of the Standards of Practice and indicators of quality care that apply to in person chaplaincy

Delivery of medical care in contexts other than face-to-face visits has existed for decades in the US. It has been common for physicians to talk with patients and family members on the telephone- responding to minor medical issues, adjusting medications, and delivering the results of tests. Outside of physical care, telepsychiatry is known to have been practiced for at least a half a century. Chaplains have long interacted with patients and family members by telephone for various purposes including routine follow-up on discharged inpatients and delivering bereavement care to families. As health care systems have grown in size and complexity, some smaller remote locations within a system have been challenged to provide on-site chaplain presence. Thus, telemedicine and telechaplaincy are not new. What is new is the many drivers that are allowing and demanding this mode of delivery and the sophistication of the technology available to deliver it.

In this guidance, we will differentiate four conditions that dictate some-variations in practice. Video visits in which the patient or loved one and the chaplain can see each other are different from audio-only visits (telephone) although both are considered telechaplaincy. Telechaplaincy visits with inpatients, whether they be in a hospital or a long-term care facility, are different from visits with patients and their caregivers who are visited in their homes.
What is Quality Spiritual Care in Health Care?

Although this document focuses on chaplaincy delivered virtually, that delivery incorporates and assumes the best practices developed for face-to-face chaplaincy. While many who utilize this document will be very familiar with these practices, some may not be so they are summarized here as preamble.

Any telechaplaincy intervention should adhere to all of the standards and quality indicators that would be expected of an in-person visit. The Standards of Practice (SOP) of the Association of Professional Chaplains can be used as a guide for basic practice irrespective of whether one is board certified or not and irrespective of whether the visit is done face-to-face or with technology (Appendix 2). The Spiritual Care Association behavioral indicators of a quality visit are the only evidence-derived indicators of overall relational presence and clinical acuity and are a useful model (Appendix 3).

Of special note are the standards that mandate assessment and documentation. The chaplain should follow the same guidance that they use in documenting in person visits. All telechaplaincy visits should be documented. At this point, it is anticipated that virtually all health care institutions will have specified any special requirements for documenting telehealth visits. As a general rule, chaplains should follow the documentation guidelines of their employing institution.

Chaplains should abide by Joint Commission standards and normal process of clinician visits including verifying the patient’s name, using the process defined by their organization, introducing themselves with their full name and title, telling the patient or family member why they are visiting, and asking permission to visit.

The explicit goal of many institutions is to provide the same quality of care for all patients across all treatment locations. For chaplains, a set of evidence-based quality indicators for spiritual care can be found in Appendix 4. There may be a temptation to ignore some indicators that seem not to apply or cannot be achieved in the virtual setting. An example is the quality indicator that mandates “sacred space”. However, Chaplain Carl Magruder of Resolution Care in California has suggested and demonstrated a practice in which he lights a candle at the beginning of a video call to make the call a sacred event. Thus, while there may be circumstance in which a specific guidance cannot be applied, that decision should not be made without considerable thought. Chaplains need to work over time to devise creative options for observing normal practices.

Much of what is done by health care chaplains today follows the generalist-specialist model fully defined in the National Consensus Project for Quality Palliative Care Clinical Practice Guidelines for Quality Palliative Care (NCP). These guidelines describe how the professional chaplain functions as the spiritual care specialist on the interdisciplinary health care team. The NCP Glossary should be used as reference. Several key definitions are listed in the glossary at the end of this document (Appendix 5). Note particularly the definitions of “spirituality” and “professional chaplain”. Those not familiar with this model or document should become familiar with at least Domain 1 which describes the staffing of the team including chaplains and Domain 5 which describes spiritual, religious and existential care. It cannot be overemphasized that guidelines and standards such as the SOPs and NCP guidelines apply in all setting of care including telechaplaincy.
How is Telechaplaincy Deployed Today?
Below are three examples of how telechaplaincy is being utilized. These examples are presented to help understand the various ways that telechaplaincy is being used.

**Empath Health/Suncoast Hospice, Florida**
Suncoast Hospice continues to build its capacity for telechaplaincy. Implementation has challenges that are unique to each care setting in hospice. Our short-term stay, inpatient care centers have presented the fewest barriers to implementation because there is a full complement of staff who are able to facilitate video calls between patients and their family members or between patient and physicians or chaplains. For chaplains who visit patients in their homes, many are still doing in person visits. For home patients who prefer not to have in person visits, a family member or friend can often serve as a “tech liaison” in the home to facilitate telehealth visits. Even for these patients, however, there is some occasional resistance from patients who say it is easier to just talk on the phone. Once they experience a successful video encounter, they usually see the benefit. The biggest challenge is in nursing facilities. While many of the facilities have restricted chaplains from making in person visits, the facility staff is often too busy to assist with facilitating telechaplaincy visits. Frequently, only the hospice RN is permitted to conduct in person visits. However, relying on the hospice RN to facilitate the telehealth visit for the chaplain has its challenges as well because the nurse doesn’t have time to stay and make sure the connection goes through and the patient is able to interact. Furthermore, facility patients who are living with some form of dementia often have difficulty interacting with someone communicating with them on a tablet. Despite these challenges, hospice staff continue to adapt and learn, and we are seeing a dramatic increase in the use of telehealth across disciplines.

**Memorial SloanKettering Cancer Center (MSKCC), New York**
As of 2016 data: 20% of all MSKCC patients were admitted to Memorial Hospital while the other 80% were treated solely as outpatients. Patients were initially informed of chaplaincy through flyers distributed in outpatient clinics. They could then choose to contact chaplains as they saw fit. Referrals are now made to chaplaincy upon patient request or through spiritual screening done on first contact. Patients can be contacted by phone or video. Eventually, the volume of these calls has increased to the point where chaplains are now full time on site at three different outpatient treatment centers and inpatient chaplains are assigned to contact patients who are seen at locations not served by an on-site chaplain. Chaplains also contact COVID positive inpatients who screen positive for spiritual distress by telephone. Plans are in process to embed the chaplain referral form in the patient portal so all patients can self-refer on their own initiative.

**University of California- San Francisco (UCSF), California**
This clinic has followed patients virtually for some time across a quite vast geography. The chaplain has supported both patients and their caregivers who are often isolated geographically and the sole care giver for a seriously ill loved one. The chaplain also teaches caregiver coping online in a group context. This clinic is an excellent example of how telchaplaincy can expand access to spiritual care. Examples of her practice include:

1. A long-time older patient now dying in a residential hospice where the chaplain was not allowed to visit in person. The chaplain visited with the patient using a laptop supplied by the sons who were able to visit.
2. A patient with severe chronic pain. The chaplain provided support, prayer, life review and presence by Zoom or telephone to help him through his pain episodes.
3. A patient with a terminal neuro degenerative disease who was considering ending her life under California’s End of Life Options Act.
4. A highly debilitated parent of young children who had aggressively recurrent cancer and was struggling with guilt around leaving her children.
5. The chaplain provided online classes in sustainable caregiving. Many of the caregivers are isolated by geography, by the need to continually care for their loved one, and by COVID. Many of the patients involved
have neuro degenerative disorders which are well-known to have very demanding caregiving needs. Because of the special population treated by this clinic, many of the patients they follow lived very long distances from the hospital.

It is important to emphasize that most or all of these patients would not have received the spiritual support they did or maybe even any spiritual care at all if not for services delivered by telechaplaincy. They were all separated from care by distance from the clinic and/or a high degree of physical disability that would have kept them from coming to the hospital regularly.

**Best Practices in Telemedicine**

Many of the practices that are important in delivering other kinds of health care by video or telephone also apply to telechaplaincy. While we are still learning, there are a few best practices that seem to have emerged that would also seem to apply to telechaplaincy.

Telemedicine does not have a widely accepted definition but a simple one for the purposes of this paper is that telemedicine is any medical intervention or consultation that takes place other than face-to-face.

Much of what constitutes high quality telechaplaincy flows naturally from what is considered high quality telemedicine. Again, while good communication with patients and families has much in common across face-to-face and telemedicine contexts, there are a number of issues that the clinician needs to consider that are different in the telemedicine setting including preparing the patient or family member for how the visit is going to go, preparing one’s own work setting from which the call will be made, and considering carefully what topics are and are not appropriate for the call. A guidance for eFamily Meetings can be found in Appendix 6.

**Confidentiality**

Confidentiality of communication with patients and documentation of that communication have long been a serious concern for professional chaplains. HIPAA has raised that level of concern and made it critical for health care institutions as well. Virtual communication adds another layer of concerns to the issues around confidentiality especially if the chaplain is not making the contact from within the health care institution and/or using personal devices rather than devices provided by the institution. Adding to the potential confusion is that there are an increasing number of platforms on the market for doing these visits and existing platforms are instituting changes aimed at improving the confidentiality of their products.

A good summary of the issues is provided in the following guidance by the American Psychiatric Association to its members.

Having a solid understanding of security issues related to telepsychiatry technology is paramount to a successful telepsychiatry practice. A clinician should bear in mind the following considerations related to security and telemedicine:

- Use a secure, trusted platform for videoconferencing
- Make sure your audio and video transmission is encrypted. The Federal Information Processing Standard (FIPS) 140-2 is used by the United States government to accredit encryption standards. Encryption strengths and types can change.
- Make sure your device uses security features such as passphrases and two-factor authentication. Your device preferably will not store any patient data locally, but if it must, it should be encrypted.¹
- Compliance with HIPAA (Health Insurance Portability and Accountability Act of 1996) is essential. HIPAA sets a minimum federal standard for the security of health information. States may also set privacy laws

¹ This would include any notes taken about the visit during or after the call.
that can be even more strict, so be sure to check any relevant statute for the state in which you practice. Just because software says its HIPAA-compliant isn’t enough.

- Be sure your devices and software use the latest security patches and updates. Install the latest antivirus, anti-malware, and firewall software to your devices. If you’re part of an institution with IT staff, they should approve of and manage your device.

References
1. Practice Guidelines for Videoconferencing-Based Telemental Health (October 2009)
2. Practice Guidelines for Video-Based Online Mental Health Services (May 2013)
3. Realizing the Promises of Telehealth: Understanding the Legal and Regulatory Challenges

Chaplains should consult with their institutions on these issues before undertaking any telephone or video conversations with patients. Some institutions are now providing chaplains a properly secured telephone and/or computer to use in communication with or about patients from off-site locations.

A very helpful tip sheet for creating a supportive telemedicine visit written by staff at University of California- San Francisco who have years of experience with telemedicine is attached (Appendix 7).

Best Practice in Telechaplaincy
As already mentioned, telechaplaincy shares most of the guidelines with telemedicine. However, a few are unique to telechaplaincy. Included here are two examples of guidance from practitioners with significant experience in telechaplaincy. These are not meant to be definitive rules but accumulated wisdom from practitioners in two very different settings.

The guidance below is courtesy of Chaplain Carl Magruder of Resolution Care, Eureka, CA which has been conducting most of their clinical work by telemedicine for a number of years largely in rural settings.

A few simple guidelines can help video conferencing to be an effective way of providing spiritual support.

1. Set up your computer. Your camera should be higher than you think—slightly above your eye level. (The under chin/up nose camera angle is not flattering to anyone.) Your head should almost fill the screen, and almost touch the top of the screen. This also puts you close to the microphone. Your face (not the computer) should be well-lit, and you should not be backlit, so don’t sit in front of a window—sit facing it. Be aware that if you wear glasses, the patient may be able to see anything that is on your screen such as notes you are taking reflected in them. You should have a simple background, rather than cluttered. No specifically religious images or objects should be in the frame—a stylized picture of a tree o.k., a crucifix probably creates a barrier with many patients for an interfaith chaplain. Be prepared to help your patient figure out how to connect. Especially if they are new to telehealth, additional time and direction (over the phone) may be needed at the beginning of the visit including making sure both you and the patient using the same platform. This can be stressful for clinicians, patients, and family members alike and it’s worth acknowledging and normalizing this experience. Be affirming during glitches or “mistakes” that your patient may make, as many less computer familiar people are very self-conscious about their use of the technology. This helps to create a relaxed attitude of safety and trust.
2. You can do a virtual background, using pictures in your computer. To best do this, buy a Chromakey “green screen” sheet or collapsible backdrop on Amazon and hang it up somewhere you can get it perfectly flat. Then go to “Advanced Features” in Zoom and find “Virtual Background.” If your platform allows it, turn off Self View, so that you cannot see yourself, as this is very distracting for some. Others have found it a helpful learning tool—“I realized that what I think of as my ‘listening face,’ also looks a lot like a frown…” one chaplain reported.

3. Create sacred space. Consider lighting a candle, using a bell, a moment of silence, a short meditation or a few breaths to start your session so that it feels like a sacred space, and is set apart from other practitioners. Look at the little black dot of your camera’s lens and try to watch the screen with peripheral vision while you are talking. The effect of this is that you seem to be making eye contact, whereas if you look at the screen, they will feel like they are talking to someone who is looking at their chin. It is more important to speak clearly than slowly, and to keep the body still in a natural way.

4. Pace yourself. There is a delay on many video connections. This can result in your talking over the person you are meeting with. This is awkward, and can even start feeling combative—or close down tender expression. Pace yourself, taking a breath before you speak. This measured pacing helps your interactions to deepen.

5. Listen. Patients may start the conversation with simple medical problems. Try to capture these quickly and offer assurance of communicating them to the rest of the healthcare team, if that is relevant and possible. It’s ok to take notes but try not to be conspicuous about it. If the medical issues are acute, be prepared to drop the spiritual care meeting and get a nurse or doctor involved right away; for instance, if they are considering a trip to the Emergency Room. If they haven’t brought up any medical/social work problems by the end of our time together, I often conclude a visit by asking, “Is there anything I should communicate to the team?” You screen for social work and medical issues and refer them, just as social workers and nurses will screen for spiritual care concerns and refer them to you.

6. Roll out your own red carpet. Blaze your own trail. Utilize your own metaphors. (Metaphors be with you!) Your fresh perspective means that you will see and perceive things that those before you have not. Don’t be afraid to innovate, experiment, and make suggestions. Zoom is not just a consolation prize for bedside chaplaincy; there are things it does better, in addition to those which are lost (holding a patient’s hand or giving communion. For instance, we often do Dream Foundation grants for parents with costly wishes, or do a Zoom with their daughter in Winnemucca, to answer her questions and heal relationships. I am currently developing a Zoom memorial service format. The spiritual care providers in all traditions are generally encouraged to bring comfort to everyone they can reach, wherever and whoever they are, so don’t think that the ancient teachers of your tradition would not be Zooming away, if they lived in these times. May you be both blessed and blessing in these difficult times. May you pour yourselves out, and also be filled. May you know that you are accompanied in all the places and all the ways that you travel, bringing compassionate care to those in need. May you be free from infection, but especially free from fear. May you both bring and find, inspiration, connection, and healing.

The script on the next page was developed by Chaplains Yusuf Hasan, BCC and Chaplain Resident Zachary Fletcher and used extensively by chaplains at Memorial SloanKettering Cancer Center in New York City during the height of the COVID surge. It is used here with permission.

As mentioned, calls to inpatients whether in a hospital or long-term care facility require somewhat different preparation and introduction. Like regular inpatient visits, the patient may be a referral and may even expect you but not at any particular time. It also may be difficult for them to get to the telephone. They may be medicated. The following is a script from MSKCC to be used with inpatient cancer patients with COVID-19.
WAYS TO APPROACH

• First try calling patient’s hospital landline phone.
• If after two attempts patient doesn’t pick up:
  o Call patient’s mobile phone likely listed in medical record.
  o Call nurse’s station and speak to RN, who likely understands patient’s situation better. They may discover that the phone is inaudible or positioned too far from the bed, or that patient is simply not able to engage. This is an opportunity to collaborate inter-professionally with nursing and even provide staff support.
• Some cases (e.g., end-of-life, non-communicative) require an extra degree of creativity.
  o Call next-of-kin, listed in the medical record, who might know what patient would find comforting. This might include poetry, music, or specific prayers. Be sure to tell family that your call is not an emergency.
  o Contact RN, who can put you on speakerphone or hold phone to patient’s ear.
  o Depending on your context, you may use FaceTime or other visual technology.
• As you might for an in-person encounter, look up patient’s demographics, including religion.
  o When engaging non-English-speakers, best practice is to use an interpreter.

SOME LANGUAGE TO USE

Introduce: “This is Chaplain ____, calling from here at ____. I’m a member of your care team, and can help you with any spiritual or religious concerns you may have. How are you doing today?”

If this is a referral, that needs to be mentioned here

If asked to come upstairs: “I so wish I could come up to be with you. Is there something you would want to talk to me about in person? We’re making calls now in order to be as safe as possible. What can I do for you right now over the phone?”

Consider following patient’s lead about mentioning COVID-19. It may be appropriate to say something like, “Yes, I see you have the virus. What is that like for you?”

Things to keep in mind and validate when speaking with COVID-19 patients:

• Fear of the unknown, fear of being ventilated/intubated, fear/sadness/guilt about family who may have COVID-19, grief, isolation, gratitude, resilience...

IDEAS FOR DOCUMENTATION


• Important to note patient’s inpatient status, in order to differentiate between COVID-related inpatient calls and other (e.g., outpatient) telephone calls your department may make.

Interventions: Provided ____ (opportunity to debrief, grief support, empathetic listening, validation, theological reflection, prayer)

Outcome: Patient ____ (sounded relieved, expressed thanks for being able to process)

Assessment: Patient articulates ____ (being troubled by/resigned to/at peace with recent COVID-19 diagnosis; theological & spiritual concerns; needs, hopes, resources)

Plan: Per patient request, chaplain will... (specific plan, perhaps involving other clinicians)

• Chaplaincy remains available.
Indications For and Against Telemedicine and Telechaplaincy

Telechaplaincy, like telemedicine, has a number of advantages for patients – overcoming access and distance barriers, enabling multiple participants from different locations, the convenience and comfort of being at home, removing the danger of COVID exposure; and for chaplains – potentially lowered costs and reduced time commitment, which increases efficiency and enables more visits.

Probably the most obvious advantage is that it enables health care providers to interact with patients who live at some distance from the health care facility or who have transportation or mobility issues. UCSF is an example in which patients with neurodegenerative diseases who are on quite complex treatment protocols often living quite a long way from the hospital still have the opportunity to interact with a specialized team including a chaplain. For many other patients, the effort required given their illness to come to the hospital, the lack of reliable transportation, and the expense of coming are major barriers to receiving the treatment they need. Many MSKCC outpatients are receiving care in an MSKCC facility but the size of the clinic does not justify the on-site presence of a chaplain. Telechaplaincy fills the gap. UCSF is also an example of being able to provide support and teaching to caregivers who would otherwise not have access to this support.

A factor related to distance is the ability of video platforms to allow people in disparate locations to be included on a call. This feature is particularly useful for family meetings. Close family members who live very far away, even internationally, can now be included in decisions about their loved one and get their information firsthand. Managing this type of call can be challenging. It would seem advisable for someone on the team to gather information on each person who the patient or immediate family wants to be included on the call. What is their relationship to the patient? Is anyone in the immediate family being left out and why? Being fully briefed and prepared for the social realities of the call would seem to be at least as important as being fully aware of the medical realities. This preparation can potentially save a great deal of last-minute discord among the participants. The chaplain might do well to be aware that the state the patient is in is different from the state the hospital or hospice is in and may then have different laws regarding surrogacy for instance.

Empath Health and MSK are also examples of the barriers to in person chaplaincy due to COVID-19 restrictions. MSKCC, like many hospitals, has ramped up the technology available to patients and chaplains so that spiritual care can be conducted by telephone or video. For hospices, like Empath who have patients in nursing homes restrictions on visiting make it difficult for chaplains to visit. More and more patients and families are reticent to admit even health care staff to their homes but welcome telehealth visits. Solutions to these issues are not always readily apparent. The first case cited from UCSF above is an example where the family, who were allowed to visit, facilitated the technology for the chaplain who was not allowed to visit. In the case of a visiting hospice team, the hospice nurse might facilitate the visit for the chaplain.

Many providers including many chaplains seem to presume that patients and caregivers are not going to like telehealth. On the whole, this assumption is turning out to be false. On the contrary, many find it preferable to coming to the hospital. Research is starting to accumulate that suggests that patients and caregivers generally like it. While this positive opinion seems to be often true, chaplains should be alert to the possibility that a given patient or family may believe that the lack of in person contact is another manifestation of a pattern of marginalization they feel by reason of race, economic status, or location. The reason for visiting virtually should always be explained and preferences honored, if possible, for the type of visit.

Visiting with patients virtually in their homes normally seems to be more comfortable for them and facilitates communication. The patient can be physically and emotionally comfortable in familiar surroundings. The visit can be an opportunity to get to know a patient in new ways such as by meeting their pet or seeing pictures of them at other stages of their lives. If the health care provider is delayed, the patient can be relaxing at home.
rather than sitting in a waiting room. If the caregiver is the subject of the chaplain’s care, visiting in the home allows the caregiver to talk to the chaplain without leaving the person they are caring for. It also seems to be that patients feel more attended to since they can see the provider right in front of their face. Both the chaplain and the patient can visit without a mask which increases intimacy and non-verbal communication. Not to be overlooked in this time is the removal of any risk of COVID transition for both patient and chaplain.

Telehealth makes health care delivery, including chaplaincy, potentially less costly. In the time it might take a chaplain to travel to a patient’s house or even to go to a clinic and wait for the patient to be available, the chaplain can possibly see several patients or accomplish other tasks. While we in chaplaincy have traditionally resisted making any claims to cost effectiveness for our services, the efficiency factor would certainly be an inducement for payers. That said, the evidence so far in telechaplaincy for any significant cost savings the evidence is mixed and local. Also a number of leading practitioners in the hospice and palliative care space have made the case that we should be supporting telehealth because it is good care for patients and now also for front line staff, not mainly because it saves money.

Although the advantages to telehealth including telechaplaincy are significant, it is not without its challenges. A major one is lack of access to and use of technology. Many people, especially in rural areas of the US still have little or no access to broadband and even when broadband becomes available in rural areas, it is not always affordable, so telephone becomes the only option. It is important to abide by some of the tips outlined above including checking in with the patient on sound quality and having them set the scene for you in terms of where they are and who else may be listening. While chaplains rely on non-verbal cues that are not visible on a phone call and even sometimes more difficult to discern on a video call, chaplains have reported very meaningful and intimate visits by telephone. Additionally, patients may have physical or cognitive limitations that make phone or video difficult for them.

This issue suggests that chaplains should carefully assess whether the patient has any conditions that would make a call difficult. When such a condition exists, someone else should be present with the patient to help them with the technology and/or communicating on the call. The same would be true is for the patient who is not fluent in English. Understanding the chaplain may then be more difficult in a telephone visit. However, translation services tend to be less available for video platforms than by telephone. Chaplains should be aware of the protocols of their institution for engaging translators including options available to them for engaging translations services over the telephone. As with inpatient visits, use of friends or family members as translators is fraught with difficulties and should be avoided.²

Many chaplains use physical touch to comfort and soothe the patient or loved one. Although this intervention is frequently utilized, clinical benefit has not been demonstrated in research. Further, physical touch can be culturally inappropriate or misinterpreted by the patient. Since it is not an option in a visit that is not face-to-face, chaplains might focus on soothing through tone and pace of their voice and a calm expression. Touch is also often employed by chaplains when the patient becomes emotional. Chaplains should anticipate this kind of occurrence and be prepared with a plan for how they will handle it. Knowing if someone else is with the patient or nearby and can be engaged would also be good preparation. As an alternative, Chaplain Judy Long at UCSF has taught patients the physiology and practice of supportive touch for themselves with good effect.

² On the necessity of having a translator available, the National Hospice and Palliative Care Organization’s guidance to their members states that health care providers “must take reasonable steps to provide meaningful access to individuals with LEP (Limited English Proficient)…. Reasonable steps may include written translations of documents, or oral language assistance from a qualified interpreter, either in-person or using remote communication technology.” This guidance does apply to telemedicine. However, several providers have reported that their translation service vendor is currently unable to provide translation for video conferences.
An issue related to touch is the use of prayer and the administration of religious sacraments. Prayer should not be substantially affected by doing the visits either by telephone or by a video platform. Again, chaplains should pay special attention to their tone of voice, facial expression and whether they want to continue eye contact or bow their heads if that is normal practice. As usual, prayer is often a good opportunity to reiterate a patient’s hopes and needs.

Sacraments in the Christian tradition can be a major concern especially at the end of life since most sacraments involve the chaplain or clergy touching the patient in some way. However, it has generally been true for many years that receiving a sacrament directly is not required as long as the patient has the intention to receive or participate. Thus, a Roman Catholic patient who intends to receive the Eucharist but cannot swallow is counted to have received. Most sacramental denominations have reaffirmed this understanding. Thus, the Eucharist can be received during a telechaplaincy visit. While most denominations have reaffirmed this understanding to members, especially for Roman Catholic patients it is recommended to confirm this practice with the local diocese and, if possible, to have an official statement from them to show families who may be doubtful lest they suspect that the hospital or hospice is not respecting their needs. The same process is generally the case with end of life sacraments. That said, there have been examples of Roman Catholic priests willing to go into isolations rooms and hospitals that have allowed a sterile swab or cotton ball dipped in oil to be brought in for an anointing. Thus, it is important to consult personally with the priest who may be called upon to see these patients. Finally, many end-of-life rituals involve the praying of standard prayers or reading of particular texts. At this point, denominations that observe these rituals have made tapes easily available for this purpose.

Despite all of assurances that chaplains may be able to give patients about virtual sacraments, it may be very difficult emotionally for patients and families to accept that this process is an adequate substitute for what they have been taught all of their lives. Certain beliefs such as healing by laying on of hands for instance may be very difficult for a patient and family to reconcile with this new reality. Chaplains need to be prepared to help patients and loved ones deal with the loss and even anger this situation brings.

One of the most tragic consequences of this pandemic is that many people do not get a chance to say goodbye to their loved ones before they die. They see them when they first take them to the hospital and then never see them again. The consequences of this kind of loss are well known and beyond the scope of this document to describe. However, literature is beginning to emerge on processes to address it. Frydman and colleagues have published a nicely done ritual specifically to help families say goodbye. The Chaplaincy Innovation Lab also has resources to help with funeral ideas.

A major indirect consequence of the pandemic and the switch to telechaplaincy is the impact on the delivery of spiritual care to staff. Much has been written and more is certainly coming on the impact of this pandemic on the health of health care providers. While chaplains often participate in or lead regularly scheduled group activities, those have mostly switched to video formats so chaplains can continue to participate. What staff talk about most often in terms of chaplain support is the casual, short contacts often known as “drive byes”. Of necessity, these visits suffer when chaplains are not as present on the nursing units. While they are likely not totally replaceable, chaplains should give thought to how to replace these visits in the context of their own institution. Emails or even text messages can substitute to some extent. In some places, chaplains have been able to offer inspirational thoughts at the beginnings of virtual team meetings or through institutional staff communication channels. Chaplains at Hennepin Health in Minneapolis wrote and recorded a short blessing for staff which plays routinely over the staff inhouse TV channel.
Finally, it is becoming clearer that the phenomenon known as “Zoom Fatigue” is real and needs to be taking into consideration by chaplains. Chaplains who spend a lot of time in video meetings and patient visits should build in appropriate breaks for themselves as described in the guidance from UCSF above.

**GUIDANCE SUMMARY**

1. All best practices and standards of practice in chaplain clinical care still apply. Some, due to the patient’s increased ability to monitor the chaplain’s voice tone and facial expression, require even more attention than in a normal in-person visit. Practices such as good spiritual assessment and documentation are mandatory.

2. Attention to telehealth etiquette is critical including properly preparing the space the chaplain is in and setting expectations for the visit. Assessments should be made ahead of time to discover and plan for issues including language barriers, difficulties with technology, and disabilities that make it difficult for the patient to have a conversation by telephone or video.

3. Creative solutions may be needed in some cases to make sure that spiritual care of institutional staff does not suffer because the chaplain is not as present on the nursing units.

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**Appendix 1**

**Expert Panel**

Chaplain Jim Andrews, APBCC- Director, Hospice Division, Spiritual Care Association; Director of Spiritual Care, Suncoast Hospice Empath Health, Clearwater, Fl.

Chaplain Jill Bowden, BCC, Director Chaplaincy Service, Memorial-Sloan Kettering Cancer Center, NY, NY. (HCCN)

Rev. Thomas DeWitt, BCC – Faculty, SCA University of Theology & Spirituality

Dr. Erik Fromme, MD.- Senior Scientist, Faculty, Serious Illness Care Program, Ariadne Labs, Boston, MA

Rev. Eric J. Hall., D.Th, APBCC- President and CEO, HCCN

Rev. George Handzo, APBCC- (Facilitator) Director, Health Services Research & Quality, HCCN

Chaplain Judith Long, Symptom Management Service & Parkinson’s Disease Supportive Care Clinic, University of California, San Francisco,

Dr. Jennifer P , Lundblad, Ph.D, MBA, President & CEO, Stratis Health, Bloomington, MN

Chaplain Carl Magruder, BCC, Director, Spiritual Support Services, Resolution Health, Eureka, CA.

Rev. Kevin Massey, BCC, System Vice President, Mission and Spiritual Care, Advocate Aurora Health, Downers Grove, IL kevin.massey@advocatehealth.com

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**Appendix 2**

**Association of Professional Chaplains: Standards of Practice for Professional Chaplains**

Preamble: Chaplaincy care is grounded in initiating, developing, deepening and closing a spiritual and empathic relationship with those receiving care. The development of a genuine relationship is at the core of chaplaincy care. Relationships underpin, even enable, all the other dimensions of chaplaincy care to occur. It is assumed that all of the standards are addressed within the context of such relationships. 1
Section 1: Chaplaincy Care with Care Recipients

Standard 1, Assessment: The chaplain gathers and evaluates relevant information regarding the care recipient’s spiritual, religious, emotional and relational needs and resources.

Standard 2, Delivery of Care: The chaplain develops and implements a plan of care to promote the well-being of the care recipient.

Standard 3, Documentation of Care: The chaplain documents in the appropriate recording structure information relevant to the care recipient’s well-being.

Standard 4, Teamwork and Collaboration: The chaplain collaborates, within the chaplain’s scope of practice, with other care providers to promote the well-being of the care recipient.

Standard 5, Ethical Practice: The chaplain adheres to the APC Code of Ethics and other codes of ethics as required by the chaplain’s professional setting to guide decision-making and professional behavior.

Standard 6, Confidentiality: The chaplain respects the confidentiality of information from all sources, including the care recipient, legal or organizational records, and other care providers in accordance with federal and state laws, regulations and rules.

Standard 7, Respect for Diversity: The chaplain models and collaborates with other care providers in respecting and providing sensitive care regardless of diverse abilities, beliefs, cultures or identities.

Appendix 3

Spiritual Care Association — Clinical Behaviors

- Chaplain introduced him/herself including full name and title and explained the purpose of the visit.
- Chaplain states chaplain role, clearly, succinctly and without use of jargon.
- Chaplain used culturally appropriate language.
- Chaplain demonstrated active listening.
- Chaplain demonstrated supportive responses.
- Chaplain uses appropriate non-verbal practices that reflect and mirror the affect of the person including:
  - Engaging and maintaining eye contact as is culturally and therapeutically appropriate
  - Maintaining appropriate posture
  - Using appropriate tone of voice
  - Chaplain exhibits appropriate attire and hygiene

- Chaplain demonstrates respect for the dignity and worth of the person/caregiver.
- Chaplain does not impose his/her doctrinal positions, religious or spiritual beliefs, or practices on the person/caregiver.
- Chaplain respects the spiritual/religious/emotional/ physical boundaries of the person/caregiver
- Chaplain acknowledges spiritual, religious, existential and cultural cues in a non-judgmental manner.
- Chaplain assesses as appropriate importance of religion, spirituality, existential, and cultural beliefs and values or lack thereof held by the person/ caregiver.
- Chaplain assesses as appropriate for spiritual/ religious/existential/cultural needs, hopes and resources or lack thereof
• Chaplain established a relationship in which the person/caregiver verbalizes their issues and concerns
• Chaplain invites expression of genuine emotional quality.
• Chaplain invites candor and free expression of values, commitments and meaning, as well as concerns, worries and disappointments.
• Chaplain enters into the suffering and distress of the person vs. inviting conversation about the person’s suffering
• The chaplain summarizes the visit for the person and lets them know what they can expect from the chaplain or other appropriate interdisciplinary team members

Appendix 4 Quality Indicators
Recommendations

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Metric</th>
<th>Suggested Tools</th>
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<tbody>
<tr>
<td><strong>1. Structural Indicators</strong></td>
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<tr>
<td>1.A Certified or credentialed spiritual care professional(s) are provided proportionate to the size and complexity of the unit served and officially recognized as integrated/embedded members of the clinical staff.</td>
<td>Institutional policy recognizes chaplains as official members of the clinical team.</td>
<td>Policy Review</td>
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<td>1.B Dedicated sacred space is available for mediation, reflection and ritual.</td>
<td>Yes/No</td>
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<td>1.C Information is provided about the availability of spiritual care services.</td>
<td>Percentage of patients who say they were informed that spiritual care was available</td>
<td>Client Satisfaction Survey</td>
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<tr>
<td>1.D Professional education and development programs in spiritual care are provided for all disciplines on the team to improve their provision of generalist spiritual care.</td>
<td>All clinical staff receive regular spiritual care training appropriate to their scope of practice and improve their practice.</td>
<td>Lists of programs, number of attendees and feedback forms.</td>
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<tr>
<td>1.E Spiritual care quality measures are reported regularly as part of the organization's overall quality program and are used to improve practice.</td>
<td>List of spiritual care quality measures reported.</td>
<td>Audit of organizational quality data and improvement initiatives.</td>
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<td><strong>2. Process Indicators</strong></td>
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<tr>
<td>2.A Specialist spiritual care is made available within a time frame appropriate to the nature of the referral.</td>
<td>Percentage of staff who made referrals to spiritual care and report the referral was responded to in a timely manner. Percentage of referrals responded to within Chaplaincy Service guidelines.</td>
<td>Survey of staff. Chaplaincy data reports</td>
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<tr>
<td>2.B All clients are offered the opportunity to have a discussion of religious/spiritual concerns.</td>
<td>Percentage of clients who say they were offered a discussion of religious/spiritual concerns</td>
<td>Client Survey</td>
</tr>
<tr>
<td>Quality Indicator</td>
<td>Metric</td>
<td>Suggested Tools</td>
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<tr>
<td>2.C An assessment of religious, spiritual, and existential concerns using a structured instrument is developed and documented, and the information obtained from the assessment is integrated into the overall care plan.</td>
<td>Percentage of clients assessed using established tools such as FICA, Hope, PC-7, AIM or Outcome Oriented models with a spiritual care plan as part of the overall plan of care.</td>
<td>Chart Review</td>
</tr>
<tr>
<td>2.D Spiritual, religious, cultural practices are facilitated for clients, the people important to them and staff</td>
<td>Referrals for spiritual practices</td>
<td>Referral Logs including disposition of referrals.</td>
</tr>
<tr>
<td>2.E Families are offered the opportunity to discuss spiritual issues during goals of care conferences</td>
<td>Percentage of meeting reports in which it is noted that families are given the opportunity to discuss spiritual issues</td>
<td>Chart Audit</td>
</tr>
<tr>
<td>2.F Spiritual care is provided in a culturally and linguistically appropriate manner. Clients values and beliefs are integrated into plans of care.</td>
<td>Percentage of clients who say that they were provided care in a culturally and linguistically appropriate manner. Percentage of documented plans of care that mention client beliefs and values.</td>
<td>Client Survey Chart audit</td>
</tr>
<tr>
<td>2.G. End of life and Bereavement Care is provided as appropriate to the population served.</td>
<td>Care plans for clients approaching end of life include document attention to end of life care, A documented plan for bereavement care after all deaths.</td>
<td>Chart audit</td>
</tr>
<tr>
<td>3. Outcomes</td>
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</tbody>
</table>
| 3.A Clients spiritual needs are met                                               | Client-reported spiritual needs documented before and after spiritual care.                   | • Spiritual Needs Assessment Inventory for Patients (SNAP)
• Spiritual Needs Questionnaire (SpNQ)                                               |
| 3.B Spiritual care increases client satisfaction                                  | Client-reported satisfaction documented before and after spiritual care.                       | • HCAHPS #21
• QSC                                                                                   |
| 3.C Spiritual care reduces spiritual distress                                     | Client-reported spiritual distress documented before and after spiritual care.               | “Are you experiencing spiritual pain right now?”                                                  |
| 3.D - Spiritual interventions increase clients sense of peace                     | Client-reported peace measure documented before and after spiritual care.                     | • Facit-SP-Peace Subscale
• “Are you at Peace?”                                                                       |
### Quality Indicator 

<table>
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<tr>
<th>Quality Indicator</th>
<th>Metric</th>
<th>Suggested Tools</th>
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| 3.E - Spiritual care facilitates meaning-making for clients and family members\(^{53,54}\) | Client-reported measure of meaning documented before and after spiritual care. | • Facit-SP: Meaning subscale  
• RCOPE\(^{55}\) |
| 3.F - Spiritual care increases spiritual well-being\(^{56}\) | Client-reported spiritual well-being documented before and after spiritual care. | Facit-SP |

### Appendix 3 — Glossary\(^*\)

**Spiritual history:** “…history-taking uses a broader set of questions to capture salient information about needs, hopes, and resources. The history questions are asked in the context of a comprehensive examination by the clinician who is responsible for providing direct care or referrals to specialists. The information from the history permits the clinician to understand how spiritual concerns could either complement or complicate the patient’s overall care. It also allows the clinician to incorporate spiritual care into the patient’s overall care plan. Unlike spiritual screening, which requires only brief training, those doing a spiritual history should have some education in and comfort with issues that may emerge and knowledge of how to engage patients comfortably in this discussion.”

**Spiritual screening:** “Spiritual screening or triage is a quick determination of whether a person is experiencing a serious spiritual crisis and therefore needs an immediate referral to a board-certified chaplain. Spiritual screening helps identify which patients may benefit from an in-depth spiritual assessment. Good models of spiritual screening use a few simple questions that can be asked in the course of an overall patient and family screening. Examples of such questions include, ‘Are spirituality or religion important in your life?’ and ‘How well are those resources working for you at this time?’”

**Spirituality:** Spirituality is recognized as a fundamental aspect of compassionate, patient and family-centered care. “Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.”

**Spiritual assessment:** “Formal spiritual assessment refers to a more extensive process of active listening to a patient’s story conducted by a board-certified chaplain that summarizes the needs and resources that emerge in that process. The chaplain’s summary should include a spiritual care plan with expected outcomes that is then communicated to the rest of the treatment team. Unlike history taking, the major models for spiritual assessment are not built on a set of questions that can be used in an interview. Rather, the models are interpretive frameworks that are based on listening to the patient’s story as it unfolds. Because of the complex nature of these assessments and the special clinical training necessary to engage in them, this assessment should be done only by a board-certified chaplain or an equivalently prepared spiritual care provider.”

**Professional chaplain:** The professional chaplain is master’s level prepared and has participated in clinical chaplaincy training. Board Certification in chaplaincy is preferred. Certified chaplains may also specialize in palliative care and have specialized certification. The chaplain is the spiritual care specialist on the interdisciplinary team and is trained to address spiritual and religious concerns of all patients and caregivers, regardless of their spiritual or religious beliefs and practices. The chaplain is also an emotional care generalist,
and interfaces closely with the social worker and other mental health providers to provide psychosocial-spiritual care as a unified domain.

**Palliative care:** Palliative care focuses on expert assessment and management of pain and other symptoms, assessment and support of caregiver needs, and coordination of care. Palliative care attends to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person- and family-centered approach to care, providing seriously ill people relief from the symptoms and stress of an illness. Through early integration into the care plan of seriously ill people, palliative care improves quality of life for both the patient and the family.

**Appendix 4**
**Family eMeeting**

As mentioned, one of the promising uses of telemedicine is for family meetings. Chaplains can play various roles. The most obvious is to conduct and document a thorough assessment of the patient and family's values and beliefs that might impact the decisions. Chaplains also help to introduce the idea to the family and help them decide who should attend. While the literature suggests that most family's want their religion and values included in this meeting, other factors including family preferences and chaplain availability need to be considered. The table below is from a study team at Emory University. It is used here with permission. The text in italics are suggested scripted phrases for the point just above each.

| TABLE 1  |
| E-FAMILY MEETING PROCEDURE |

<table>
<thead>
<tr>
<th>Key Steps</th>
<th>Pearls and Helpful Phrases</th>
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<tbody>
<tr>
<td><strong>1. Identify a single point of contact for the family and schedule the meeting</strong>&lt;br/&gt;&lt;br/&gt;<strong>F0B7</strong> Coordinate with bedside nurse to set meeting time that aligns with anticipated nursing or respiratory patient care schedule. This also provides meaningful opportunities for other care team members to engage with patient's family.</td>
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<td><strong>F0B7</strong> Confirm planned meeting time allows for participation of necessary or interested care team members (e.g., ICU team, social worker, chaplain, other consultants)</td>
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<tr>
<td><strong>F0B7</strong> Identify and call single point of contact for the family and obtain their email address.</td>
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<tr>
<td><strong>F0B7</strong> If care decisions need to be made, confirm that the necessary legal surrogate/s will be available to participate at proposed meeting time.</td>
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<tr>
<td><strong>F0B7</strong> Schedule meeting and generate an email link.</td>
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<tr>
<td><strong>F0B7</strong> Share link with invited care team members.</td>
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</table>

| **2. Provide meeting link and instructions in email to family**<br/><br/>**F0B7** Email Zoom link with the family point of contact, instruct them share the link with anyone that they want to have join the meeting. |
| **F0B7** Email Zoom links for both audio only and audio/video participation to allow participation of individuals who lack Internet access. |
| **F0B7** Send email link from a protected and unmonitored email address with disclaimer that email address will not be used for further communication. |
“Please write down any questions you have about your loved one’s care before the meeting so we can be sure to address all your concerns.”

“Please join 10-15 minutes before the start of the meeting to ensure all technical difficulties may be addressed.”

“Please find a quiet environment for participation, during the meeting we ask that you stay on mute unless talking.”

3. Plan entry, “donning” and positioning of the tablet device

“Place the tablet in a plastic disposable sleeve cover (no-sterile paper sheet protectors) ensuring that the tablet speaker is at the open end of the plastic sleeve to optimize sound.”

“Place tablet in the stand on bedside tray table and position to ensure patient is in view.”

“If patient is not able to participate in meeting, mute audio on tablet to prevent meeting disruption due to alarms and monitor sounds in patient room.”

4. Start the E-Family Meeting

- Set an agenda sharing what you hope to cover and invite the family to add items to the agenda.
  - “We want to make sure that you have a meaningful visit and that this encounter meets your needs. From our perspective, we would like to provide a clinical update and answer any questions you may have and then allow a virtual visit. Are there any other items you would like to add to our agenda today? We have total of about X minutes.”

- Notify/warn the family before the patient appears on the screen what they will see.
  - “For some people it’s helpful to see their loved one by video when they are unable to see them in person; for others, it is not helpful. If you find the images disturbing, you can simply turn away from the screen or place your phone or tablet face down.”

- Provide guidance that the video content maybe upsetting to children or others.
  - “If there are children who may be present, we recommend that their parents or other adults view first and use their discretion if it is appropriate for children to view the video as well.”

- Discuss safety ground rules: no driving.
  - “Your safety is important to us. We will begin the meeting when you are able to bring your car to a stop and in a safe location.”

5. Conducting the e-family meeting

- Ensure proper introductions of the team and family can be larger than typical in-person meeting
- Allow for patient to speak
- Address as many people on video as possible Mute participants that are disruptive if necessary

6. Offer a virtual visit

- When able, allow time for family to have a visit with patient
  - “We are going to allow you a private virtual visit with X, we will mute our audio and video, and we will check in with you in about x minutes, please take this time to visit. We will let you know when we have about two minutes left.”

- For patients at end of life encourage participants to “please take this time to say whatever is in your heart.”
- For patients at end of life encourage participants to “please take this time to say whatever is in your heart.”
- Offer opportunity to allow for spiritual practices, prayer, or music; invite available spiritual health clinicians or chaplains to facilitate this portion of the meeting.
7. Ending the meeting
• Give a two-minute warning
• Use a timer verbal countdown to end e “this meeting will end in 10 seconds 10, 9, 8, 7 ” Then shut the
  video off.
• Recover, “doff,” and clean the tablet and stand
• Coordinate tablet removal preferably with available care team member who has patient care need for PPE
  and entry into room Doff the tablet from the protective sleeve and clean the device and stand with
  sanitizing wipe

_Suggested communication phrases are represented in italics._

Appendix 7
Creating a Supportive Telemedicine Visit
This tip sheet was developed by UCSF Clinicians Brook Calton MD, Sarah Bellows
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and Eve Cohen RN. Used with permission of the first author.

Pre-Visit Preparation:
Many of the same best practices that apply to in-person visits also need to be taken
into consideration when providing care through telemedicine.
  • Quality of attention and respect for the patient can be communicated through factors like placing
    your camera level with your face which allows you to have a direct gaze. If using a laptop, place it on a
    stand or on books so the camera is at eye-level, rather than on your desk or lap.
  • Make sure that you are well-lit and clearly visible.
  • Consider your appearance. A professional appearance conveys respect and helps engender trust and
    confidence. Ensure you are wearing your hospital ID.
  • Be thoughtful about your surroundings and what they communicate to the patient. While some pro-
    viders may need to use Zoom virtual backgrounds due to constraints on available workspaces, be
    aware that they can interact with the image of the provider and interfere with the patient’s experience
    of the interaction as genuine and natural. Be aware of sound in your environment; consider closing
    windows/doors to minimize noise pollution and distractions.
    • Avoid using a handheld smartphone to conduct your visit as movement of your smartphone
      can be distracting or create nausea for your patient.
    • Test your audio, visual and WIFI connection before the visit.
    • Turn off applications that may create alerts and distractions during your visit.
    • For visits with multiple team members, decide if best for you to all be on one screen or sepa-
      rate screens. Consider if other family members/caregivers need to be part of the conversation
      and if so, ensure they can connect too.

At the Start of the Visit:
• Orient your patient to where you are sitting and let them know if anyone else is in the room with you. Assure
  them you are in a private space and the door is shut for confidentiality. Ask your patient if they are in a place
  where they are comfortable sharing information with you. Ask them to tell you who is in the room with them.
• Be a film director
  • Ask whether the patient can see and hear you clearly; adjust as needed
  • Troubleshoot if you can’t hear your patient well (ask them to move closer to their mic; if they are using
    a smartphone make sure their hand is not covering the mic; consider having them call in to Zoom).
  • Don’t be afraid to direct your patient. You can ask them to move to a different place in their home
if the lighting is not good (e.g. backlit or too dark). If a caregiver is participating in the meeting, ask them to reposition the camera so all meeting participants can be seen.

• For visits where there are more than two participants, utilize “gallery view” to see all participants at the same time. You can click on “hide self-view” in the upper right-hand corner of the box with your video as it can be distracting to see yourself.

• Make a plan with your patient at the start of the visit for if technology fails, e.g. “If Zoom freezes, try logging back in.

• Set a mutually-agreed upon agenda and remind your patient how much time you have allotted for the visit.

**During the Visit:**

Be aware that by telemedicine, the quality of your attention will be even more apparent to the patient than in person. Being present and focused are essential to an effective telemedicine visit.

• We strongly suggest minimizing or closing any other programs and enlarging the image of the patient to full-screen when possible. If this is not possible, consider making the image of your patient smaller and placing it at the top of the screen, below the camera; you can then have your electronic medical record open below it.

• It is apparent to patients when you are reading text on the screen, and when you are typing. While communication is best if charting is kept to a minimum during the visit, if needing to chart or look something up on your computer (e.g. UpToDate or the patient’s labs), tell the patient what, why and when you are doing this. During a particularly sensitive conversation, it’s even more important to keep charting to a minimum; if you need to take notes, consider using paper.³

• Wearing headphones with a built-in microphone can help reduce the distracting sounds from typing.

• Maintain a steady gaze and be aware of your facial expressions and what they communicate to the patient.

• If you are using non-verbal body communication (such as hand gestures) to show empathy, be aware of what the patient can see or not see based on the position of your camera.

• If you have difficulties understanding a patient, ask for clarification; this helps improve quality of care, and tells the patient that you care about what they have to say.

• Talk slower than in-person to create space for pauses in conversation so others can jump in and avoid talking over your patient.

• Before communicating about or engaging a particularly sensitive or difficult topic, ask for the patient’s permission to do so via telemedicine. Watch both their verbal response and their non-verbal body language that can help inform whether it is OK to proceed with the conversation.

• Name and respond to emotion expressed by the patient with respect and empathy.

• If you are working on a team (e.g. there are several members of your team participating in a patient visit either from one location or different locations), ensure your patient has officially left the zoom room before you debrief the visit.

**Between Visits:**

• Create a small habit or routine (e.g. stepping away from your computer for a moment, taking a few deep breaths or a quick stretch) that allows you to transition between interacting with the computer normally (charting, refilling medications, doing work that allows for or requires multitasking) and using the computer as a medium for telemedicine, which demands a different mindset and quality of attention.
References


3 Spiritual Health Association, (2020) Telehealth Guidelines for Spiritual Care, Spiritual Health Association (Accessed August 9, 2020).


50 Snowdon A., Telfer I, Kelly E, Bunniss S, Mowat H. (2013) “I was able to talk about what was on my mind.” The operationalisation of person centred care. The Scottish J of Health Care Chaplaincy. 16 (Special), 16-22.


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