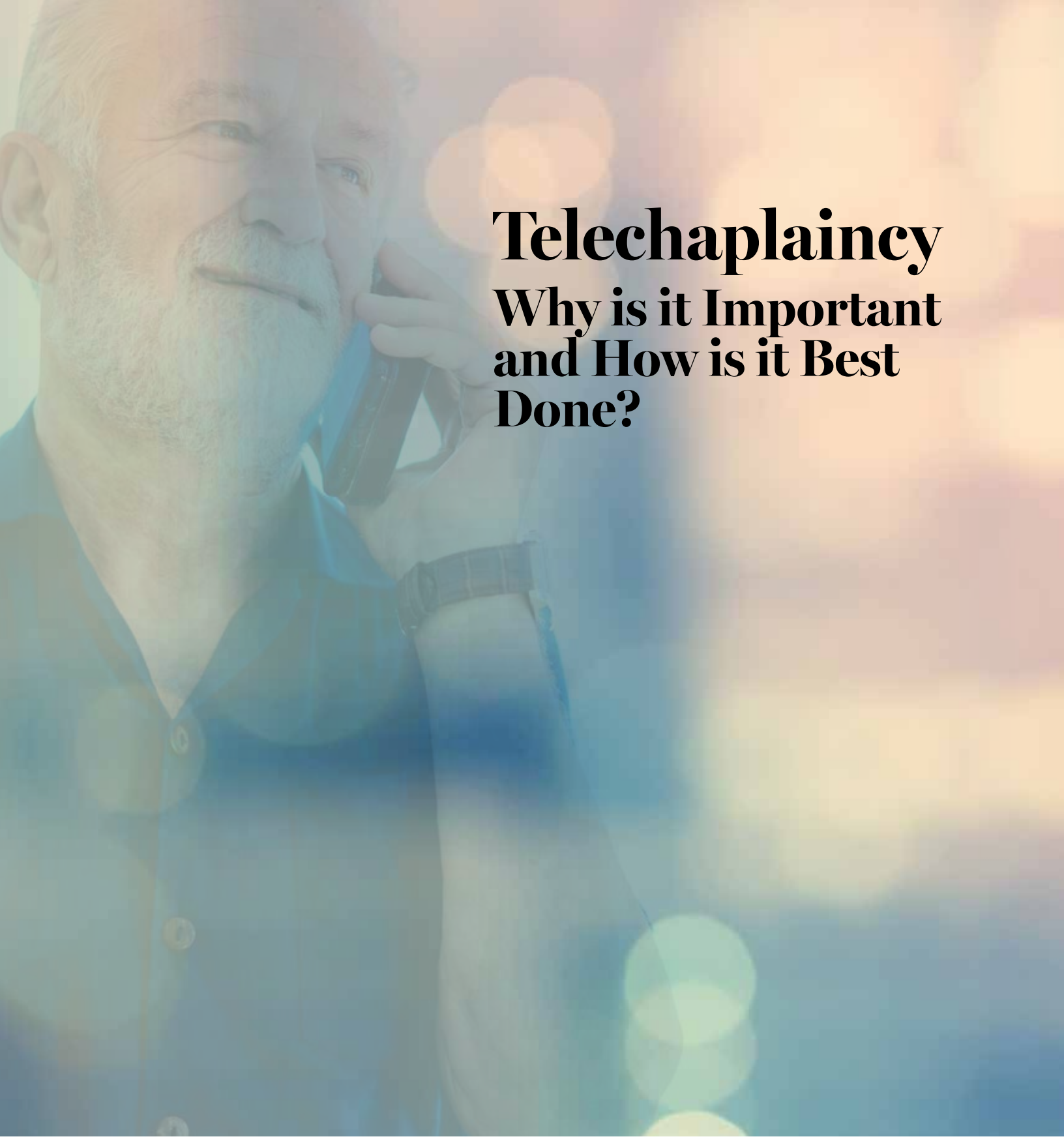

Telechaplaincy

Why is it Important and How is it Best Done?

HealthCare Chaplaincy Network™

SPIRITUAL CARE ASSOCIATION

Making Spiritual Care a Priority

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[iv]. 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 patents 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.[ii]

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 sreen" 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:
    - Call patient's mobile phone likely listed in medical record.
    - 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.
    - 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.
    - Contact RN, who can put you on speakerphone or hold phone to patient's ear.
    - 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.
    - 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

Reason: Inpatient, admitted with COVID-19.

- 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 participant 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 sooth 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

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

Quality Indicator	Metric	Suggested Tools
1. Structural Indicators		
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.[16,17,18,19]	Institutional policy recognizes chaplains as official members of the clinical team.	Policy Review
1.B Dedicated sacred space is available for mediation, reflection and ritual.[20,21]	Yes/No	
1.C Information is provided about the availability of spiritual care services.[22]	Percentage of patients who say they were informed that spiritual care was available	Client Satisfaction Survey
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.[23,24]	All clinical staff receive regular spiritual care training appropriate to their scope of practice and improve their practice.	Lists of programs, number of attendees and feedback forms.
1.E Spiritual care quality measures are reported regularly as part of the organization's overall quality program and are used to improve practice.[25,26]	List of spiritual care quality measures reported.	Audit of organizational quality data and improvement initiatives.
2. Process Indicators		
2.A Specialist spiritual care is made available within a time frame appropriate to the nature of the referral.6	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.	Survey of staff. Chaplaincy data reports
2.B All clients are offered the opportunity to have a discussion of religious/spiritual concerns.[27,28]	Percentage of clients who say they were offered a discussion of religious/ spiritual concerns	Client Survey

Quality Indicator	Metric	Suggested Tools
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.[4,6]	Percentage of clients assessed using established tools such as FICA,[29] Hope[30],7X7[31], PC-7[32] , AIM[33] or Outcome Oriented models with a spiritual care plan as part of the overall plan of care.	Chart Review
2.D Spiritual, religious, cultural practices are facilitated for clients, the people important to them and staff[4]	Referrals for spiritual practices	Referral Logs including disposition of referrals.
2.E Families are offered the opportunity to discuss spiritual issues during goals of care conferences	Percentage of meeting reports in which it is noted that families are given the opportunity to discuss spiritual issues	Chart Audit
2.F Spiritual care is provided in a culturally and linguistically appropriate manner.[4] Clients values and beliefs are integrated into plans of care. [37,38]	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.	Client Survey Chart audit
2.G. End of life and Bereavement Care is provided as appropriate to the population served.[39,4,40]	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.	Chart audit
3. Outcomes		
3.A Clients spiritual needs are met[41]	Client-reported spiritual needs documented before and after spiritual care.	• Spiritual Needs Assessment Inventory for Patients (SNAP)[42]. • Spiritual Needs Questionnaire (SpNQ)[43]
3.B Spiritual care increases client satisfaction[44,45]	Client-reported satisfaction documented before and after spiritual care..	• HCAHPS #21[46] • QSC[47]
3.C Spiritual care reduces spiritual distress[22,48]	Client-reported spiritual distress documented before and after spiritual care.	"Are you experiencing spiritual pain right now?" [49]
3.D - Spiritual interventions increase clients sense of peace[50]	Client-reported peace measure documented before and after spiritual care.	• Facit-SP-Peace Subscale[51] • "Are you at Peace?"[52]

Quality Indicator	Metric	Suggested Tools
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[ix]

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 provide."

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

Key Steps	Pearls and Helpful Phrases
1. Identify a single point of contact for the family and schedule the meeting	
F0B7 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.	
F0B7 Confirm planned meeting time allows for participation of necessary or interested care team members (e.g., ICU team, social worker, chaplain, other consultants)	
F0B7 Identify and call single point of contact for the family and obtain their email address.	
F0B7 If care decisions need to be made, confirm that the necessary legal surrogate/s will be available to participate at proposed meeting time.	
F0B7 Schedule meeting and generate an email link.	
F0B7 Share link with invited care team members.	
2. Provide meeting link and instructions in email to family	
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.	

F0B7 "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."

F0B7 "Please join 10-15 minutes before the start of the meeting to ensure all technical difficulties may be addressed"

F0B7 "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

F0B7 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.

F0B7 Place tablet in the stand on bedside tray table and position to ensure patient is in view.

F0B7 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 Meister MDiv, Susannah Cornes MD, Jeffrey Gelfand MD, Marsha Blachman MSW, 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 providers 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 separate 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

- Webster P. Virtual health care in the era of COVID-19. Lancet Lond Engl. 2020;395(10231):1180- 1181. doi:10.1016/S0140-6736(20)30818-7
- Calton BA, Rabow MW, Branagan L, et al. Top Ten Tips Palliative Care Clinicians Should Know About Telepalliative Care. J Palliat Med. 2019;22(8):981-985. doi:10.1089/jpm.2019.0278
- Calton B, Abedini N, Fratkin M. Telemedicine in the Time of Coronavirus. J Pain Symptom Manage. Published online March 31, 2020. doi:10.1016/j.jpainsymman.2020.03.019
- Chua IS, Jackson V, Kamdar M. Webside Manner during the COVID-19 Pandemic: Maintaining Human Connection during Virtual Visits. J Palliat Med. Published online June 11, 2020. doi:10.1089/jpm.2020.0298
- Flint L, Kotwal A. The New Normal: Key Considerations for Effective Serious Illness Communication Over Video or Telephone During the Coronavirus Disease 2019 (COVID-19) Pandemic. Ann Intern Med. Published online May 14, 2020. doi:10.7326/M20-1982
- Cooley, Laura. Fostering Human Connection in the Covid-19 Virtual Health Care Realm. NEJM Catal. 2020. Available at https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0166. Published May 20, 2020. Accessed June 23, 2020.
- Ben-Arieh D, Charness N, Duckett K, et al. A Concise Guide for Telemedicine Practitioners: Human Factors Quick Guide Eye Contact. Available at https://cdn2.hubspot.net/hubfs/5096139/Eye-Contact-Quick-Guide.final.pdf. Published February 2016. Accessed June 30, 2020.
- The Academy of Communication in Healthcare. COVID 19 Telehealth: Relationship-Centered Communication Skills. Available at: https://www.achonline.org/Portals/36/COVID- 19%20Resources/Covid-19%20telehealth%20FINAL.pdf. Accessed June 20, 2020.
- Zulman DM, Haverfield MC, Shaw JG, et al. Practices to Foster Physician Presence and Connection With Patients in the Clinical Encounter. JAMA. 2020;323(1):70-81. doi:10.1001/jama.2019.19003

[1] Chaplaincy Innovation Lab. Chaplaincy Innovation Lab Resources for Chaplains Encountering Coronavirus. https://chaplaincyinnovation.org/2020/05/chaplaincy-coronavirus. Accessed September 1, 2020.

[2] Magruder, C. SoulWays Spiritual Accompaniment. https://www.civiclight.org/soulways. Accessed September 1, 2020.

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

[4] Chakrabarti S. Usefulness of telepsychiatry: A critical evaluation of videoconferencing-based approaches. World J Psychiatry. 2015;5(3):286-304. doi:10.5498/wjp.v5.i3.

[5] Cobb, J, Chang C. Spiritual Distress is Not Confined by Walls. (2018) Health Progress. May-June, 2018

[6] Association of Professional Chaplains, (2016) Standards of Practice for Professional Chaplains. (Accessed August 9, 2020 at https://www.professionalchaplains.org/content.asp?pl=200&sl=198&contentid=514

[7] Handzo, G, Wintz, S. (2020) A New Paradigm for Testing Clinical Competence in Chaplaincy Certification. Journal of Pastoral Care & Counseling. 74(1), 53-60. DOI: 10.1177/15423050209044

[8] The National Consensus Project for Quality Palliative Care Clinical Practice Guidelines for Quality Palliative Care 4th edition 2018. Available at https://www.nationalcoalitionhpc.org/ncp/.

[9] Calton B, Abedina N, & Fratkin M. (2020) Telemedicine in the Time of Coronavirus. Journal of Pain & Symptom Management. 60(1), e12-13.

[10] American Psychiatric Association, Security Issues In Telepsychiatry. Accessed October 5, 2020 at. https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/security-issues

[11] Betz, J, Szczesniak, R, Lewis, K, Pestian, T, Bennethum, AS, McBride J and Grossoehme DH (2019). "Feasibility and Acceptability of a Telephone Based Chaplaincy Intervention to Decrease Parental Spiritual Struggle," Journal of Religion and Health

[12] Selman L, Chao D, Sowden R, Marshall S, Chamberlain C, Koffman J. (2020) Bereavement Support on the Frontline of COVID-19: Recommendations for Hospital Clinicians. Journal of Pain and Symptom Management. 60(2), August, 2020 e81-e86.

[13] Frydman, J, Choi E. Lindberger E. (2020) Families of COVID-190 Patients Say Goodbye on Video: A Structured Approach to End of Life Conversations. Journal of Palliative Medicine.

[14] Wu A, Buckle P, Haut E, Bellandi T, Koizumi S, Mair A, Øvretveit J, Power C, Sax H, Thomas E., Newman-Toker D., Vincent, C. (2020) Supporting the Emotional Wel-Being of Health Care Workers During the Pandemic. Journal of Patient Safety and Risk Management.

[15] Wall Street Journal. Why Does Zoom Exhaust You- Science has Answer. lhttps://www.darley.com/documents/general_content/Why_Does_Zoom_Exhaust_You__Science_Has_an_Answer_-_WSJ.pdf

[16] Handzo, G. F. & Koenig, H. G. (2004). Spiritual Care: Whose Job is it Anyway? Southern Medical Journal, 97(12), 1242-1244.

[17] Wintz SK., Handzo GF. 2005. Pastoral Care Staffing & Productivity: More than Ratios. Chaplaincy Today. 21(1), 3-10.

[18] LaRocca-Pitts, M. (2019) The Board Certified Chaplain as a Member of the Transdisciplinary Team: An epistemological approach to spiritual care. Journal of the Study of Spirituality. 9(2), 99-109.

[19]Cunningham, C. J., Panda, M., Lambert, J., Daniel, G., & DeMars, K. (2017). Perceptions of chaplains' value and impact within hospital care teams. Journal of religion and health, 56(4), 1231-1247.

[20] The National Consensus Project for Quality Palliative Care Clinical Practice Guidelines for Quality Palliative Care 4th edition 2018.

[21] Baldacchino, D. (2017). Spirituality in the healthcare workplace. Religions, 8(12), 260.

[22] National Quality Forum. (2006) A National Framework and Preferred Practiced for Palliative and Hospice Care Quality. National Quality Forum, Washington, DC.

[23] Puchalski C, Ferrell B, Virani R, Otis-Green S, Baird P, Bull J, Chochinov H, Handzo G, Nelson-Becker H, Prince-Paul M, Pugliese K, Sulmasy D. (2009). Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference. Journal of Palliative Medicine. 12(10):885-904.

[24]Austin, P., Macleod, R., Siddall, P., McSherry, W., & Egan, R. (2017). Spiritual care training is needed for clinical and non-clinical staff to manage patients' spiritual needs. Journal for the Study of Spirituality, 7(1), 50-63.

[25]Arthur J. (2011) Lean Six Sigma- Simple Steps to Fast, Affordable, Flawless Healthcare. New York: McGraw Hill.

[26] Cone, P. H., & Giske, T. (2018). Integrating spiritual care into nursing education and practice: Strategies utilizing Open Journey Theory. Nurse Educ Today, 71, 22-25. doi:10.1016/j.nedt.2018.08.015

[27] Williams JA, Meltzer D, Arora V, Chung G, & Curlin FA (2011). Attention to Inpatients' Religious and Spiritual Concerns: Predictors and Association with Patient Satisfaction. Journal of general internal medicine PMID: 21720904

[28] Lee, A. C., McGinness, C. E., Levine, S., O'Mahony, S., & Fitchett, G. (2018). Using Chaplains to Facilitate Advance Care Planning in Medical Practice. JAMA Intern Med, 178(5), 708-710. doi:10.1001/jamainternmed.2017.7961

[29] Puchalski, C., & Romer, A. L. (2000). Taking a spiritual history allows clinicians to understand patients more fully. Journal of palliative Medicine, 3(1), 129-137.

[30] Anandarajah, G., & Hight, E. (2001). Spirituality and medical practice. American family physician, 63(1), 81-88.

[31] Fitchett, G. (1993). Assessing spiritual needs: A guide for caregivers. Augsburg Fortress.

[32] Fitchett, G., Pierson, A. L. H., Hoffmeyer, C., Labuschagne, D., Lee, A., Levine, S., ... & Waite, N. (2019). Development of the PC-7, a Quantifiable Assessment of Spiritual Concerns of Patients Receiving Palliative Care Near the End of Life. Journal of palliative medicine.

[33] Kestenbaum, A., Shields, M., James, J., Hocker, W., Morgan, S., Karve, S., ... & Dunn, L. B. (2017). What impact do chaplains have? A pilot study of spiritual AIM for advanced cancer patients in outpatient palliative care. Journal of pain and symptom management, 54(5), 707-714.

[34] VandeCreek, L., Lucas, A. M. (2001). The Discipline for Pastoral Care Giving: Foundations for Outcome Oriented Chaplaincy. Haworth Press: New York.

[35] Ernecoff, N, Curlin, F., Buddadhumaruk,P, White, D. Health Care Professionals' Responses to Religious or Spiritual Statements by Surrogate Decision Makers During Goals-of-Care DiscussionsJAMA Intern Med. 2015;175(10):1662-1669. doi:10.1001/jamainternmed.2015.4124

[36] Maiko, S. M., Ivy, S., Watson, B. N., Montz, K., & Torke, A. M. (2018). Spiritual and Religious Coping of Medical Decision Makers for Hospitalized Older Adult Patients. J Palliat Med. doi:10.1089/jpm.2018.0406

[37] Joint Commission Resources. (2010) Advancing Effective Communication, Cultural Competence, and Patient-and Family-Centered Care: A Roadmap for Hospitals
http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

[38] Bashar, F. R., Vahedian-Azimi, A., Salesi, M., Hajiesmaeili, M., Shojaei, S., Farzanegan, B.,
Collaborative, M. (2018). Spiritual Health and Outcomes in Muslim ICU Patients: A Nationwide Cross Sectional Study. J Relig Health, 57(6), 2241-2257. doi:10.1007/s10943-017-0543-5

[39] Balboni, T. A., Paulk, M. E., Balboni, M. J., Phelps, A. C., Loggers, E. T., Wright, A. A., ... & Prigerson, H. G. (2010). Provision of spiritual care to patients with advanced cancer: associations with medical care and quality of life near death. Journal of Clinical Oncology, 28(3), 445-452.

[40] Donnelly, S., Prizeman, G., Coimín, D. Ó., Korn, B., & Hynes, G. (2018). Voices that matter: end-of-life care in two acute hospitals from the perspective of bereaved relatives. BMC palliative care, 17(1), 117.

[41] Balboni, et al. (2007). Religiousness and Spiritual Support Among Advanced Cancer Patients and Associations with End-of-Life Treatment Preferences and Quality of Life. Journal of Clinical Oncology, 25(5), 555-560

[42] Sharma, R. K., Astrow, A. B., Texeira, K. and Sulmasy, D. P.(2012) "The Spiritual Needs Assessment for Patients (SNAP): development and validation of a comprehensive instrument to assess unmet spiritual needs." Journal of Pain & Symptom Management 44, no. 1: 44-51.

[43] Büssing A(1), Balzat HJ, Heusser P. (2010) Spiritual needs of patients with chronic pain diseases and cancer - validation of the spiritual needs questionnaire. Eur J Med Res. Jun 28;15(6):266-73

[44] Marin DB, Sharma V, Sosunov E, Egorova N, Goldstein R, Handzo G. 2015. The relationship between chaplain visits and patient satisfaction. Journal of Health Care Chaplaincy. 21 (1):14-24.

[45] Astrow, A. B., Kwok, G., Sharma, R. K., Fromer, N., & Sulmasy, D. P. (2018). Spiritual Needs and Perception of Quality of Care and Satisfaction With Care in Hematology/Medical Oncology Patients: A Multicultural Assessment. J Pain Symptom Manage, 55(1), 56-64 e51. doi:10.1016/j.jpainsymman.2017.08.009

[46] Giordano, L. A., Elliott, M. N., Goldstein, E., Lehrman, W. G., & Spencer, P. A. (2009). Development, implementation, and public reporting of the HCAHPS survey. Medical Care Research and Review.

[47] Exline JJ, Pargament KI, Grubbs JB, et al. The Religious and Spiritual Struggles Scale: development and initial validation. Psychol Relig Spiritual 2014;6:208–222

[48] Schultz, M., Meged-Book, T., Mashiach, T., & Bar-Sela, G. (2017). Distinguishing between spiritual distress, general distress, spiritual well-being, and spiritual pain among cancer patients during oncology treatment. Journal of pain and symptom management, 54(1), 66-73.

[49] Mako C, Galek M, Poppito SR. (2006) Spiritual pain among patients with advanced cancer in palliative care. J Palliat Med. 9(5):1106-1113.

[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.

[51] Peterman, A. H., Fitchett, G., Brady, M. J., Hernandez, L., & Cella, D. (2002). Measuring spiritual well-being in people with cancer: The Functional Assessment of Chronic Illness Therapy - Spiritual Well-Being Scale (FACIT-Sp). Annals of Behavioral Medicine, 24(1), 49-58.

[52] Steinhauser KE, Voils CI, Clipp EC, Bosworth HB, Christakis NA, Tulsky JA.(2006) "Are you at peace?": one item to probe spiritual concerns at the end of life. Archives of Internal Medicine. Jan 9;166(1):101-5.

[53] Flannelly, K. J., Handzo, G. F., Weaver, A. J., & Smith, W. J. (2005b). A national survey of health care administrators' views on the importance of various chaplain roles. Journal of Pastoral Care & Counseling, 59(1-2), 87 – 96.

[54] Robert, R., Stavinoha, P., Jones, B. L., Robinson, J., Larson, K., Hicklen, R., ... & Weaver, M. S. (2019). Spiritual assessment and spiritual care offerings as a standard of care in pediatric oncology: A recommendation informed by a systematic review of the literature. Pediatric blood & cancer, e27764.

[55] Pargament, K. I., Koenig, H. G., & Perez, L. M. (2000). The many methods of religious coping: Development and initial validation of the RCOPE. Journal of clinical psychology, 56(4), 519-543.

[56] Rabow M, Knish S. (2014) Spiritual well-being among outpatients with cancer receiving concurrent oncologic and palliative care. Support Care Cancer. DOI 10.1007/s00520-014-2428-4

[57] Ernecoff, N. C., Curlin, F. A., Buddadhumaruk, P., & White, D. B. (2015). Health care professionals' responses to religious or spiritual statements by surrogate decision makers during goals-of-care discussions. JAMA internal medicine, 175(10), 1662-1669.

[58] Kuntz J, Kavaailieratos K, Esper G, Ogbu N, Mitchell J, Ellis C, & Quest T. (2020) Feasibility and Acceptability of Inpatient Palliative Care E-Family Meetings During COVID-19 Pandemic. Journal of Pain and Symptom Management. 60(3), e28-e30)

[59] Calton B. Fast Facts and Concepts #406- Communication Strategies for Providing Palliative Care via Telemedicine, Palliative Care Network of Wisconsin. https://www.mypcnow.org/wp-content/uploads/2020/09/FF-406-Telemedicine-updated.pdf