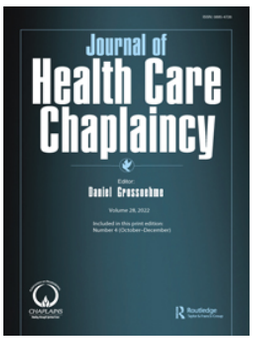

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Chaplains and telechaplaincy: best practices, strengths, weaknesses—a national study

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ABSTRACT

Telechaplaincy is the use of telecommunications and virtual technology to deliver religious/spiritual care. It has been used for decades, but chaplains' understanding of telehealth lags behind other disciplines. The purpose of this study was to describe the use of telechaplaincy in the United States and chaplains' perceptions of the practice. Researchers surveyed chaplains through chaplain-certifying-body email-listservs, then conducted in-depth interviews with 36 participants identified through maximum variation sampling. Quantitative analysis and qualitative, thematic analysis were conducted. Quantitative results show that in 2019, approximately half of surveyed chaplains performed telechaplaincy. Rural chaplains were more likely to have practiced. Chaplains who had not practiced were more willing to try if they believed it was effective at meeting religious/spiritual needs. Qualitative findings describe chaplains' perceptions of strengths, weaknesses, and best practices.

KEYWORDS

Best practice; chaplain; spiritual care; telechaplaincy; telehealth

Introduction

Telehealth chaplaincy, or *telechaplaincy*, is "the use of telecommunications and virtual technology (which can include but is not limited to, telephone, smartphone applications, live videoconferencing and internet interventions) to deliver spiritual and religious care by … chaplains or other religious/spiritual leaders" (Sprik et al., 2021, p. 2). It has been used for decades, with use increasing in recent years due to technological advances, healthcare shifting toward outpatient settings, and the COVID-19 pandemic (Atkinson, 2017; Pierce, Hoffer, Marcinknowski, Manfredi, & Pourmand, 2020; Sprik et al., 2021; Strano, 2014; U.S. Department of Veterans affairs, 2020; VA NW Health Network, 2013).

Telechaplaincy is feasible, acceptable, and effective in a variety of clinical settings (Betz et al., 2019; Maudlin, Keene, & Kobb, 2006; Steinhauser et al., 2016; Sprik, Walsh, Boselli, & Meadors, 2019, Sprik et al., 2021, Zwart, Palmer, Strawn, Milliron, & Brown,

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2000). During COVID-19, an emergency department ascertained it increased access to spiritual care and was effective for meeting spiritual needs (Pierce et al., 2020).

Telechaplaincy also has limitations, including cost of telehealth modalities, difficulty finding chaplains who are willing to practice telehealth, being perceived as less effective than in-person care, and fear of receiving a call due to associating the chaplain with death/bad news (Pierce et al., 2020; Sprik et al., 2021). Washington and colleagues showed lower acceptability of telehealth in hospice by chaplains than nurses and administrators (Washington, Demiris, Oliver, & Day, 2009).

Previous studies on telechaplaincy are limited to smaller-scale interventions, quality improvement initiatives, or single-institution descriptive studies. Chaplains do not have professional standards for telehealth. Currently, the discipline only has a few resources discussing authors' perceptions of best practices, in contrast to other professions, which have established professional standards (American Psychiatric Association & The American Telemedicine Association, 2018; Association of Professional Chaplains, 2020; National Association of Social Workers et al., 2017; Sprik, Ingram, Nelson, Grossoehme, & Simpson, 2020, Wade, 2020;). While standards from similar disciplines can provide groundwork for best practice, telechaplaincy has unique components to identify and address. This study sought to address this gap.

The purpose of this study was to describe (1) the use of telechaplaincy in the United States, (2) chaplains' perceptions of strengths and weaknesses and (3) best practices as described by a diverse sample of chaplains with telechaplaincy experience.

Methods

Participants

This mixed-method study was approved by the Atrium Health Institutional Review Board (IRB#01-19-36E). Participants were eligible if they were over the age of 18, able to read, write and speak English, and a chaplain.

Procedure

The research team consisted of two people doing qualitative analysis: (1) a board-certified chaplain with master-level education, and over five-years of telechaplaincy experience in an oncology setting and (2) a board-certified chaplain and clinical pastoral educator with master-level education, minimal experience using the telephone for telechaplaincy, and moderate experience using videoconferencing for chaplain education. The team also included (1) an advisor: a board-certified chaplain with doctoral-level education, extensive research experience, and experience researching telechaplaincy interventions and (2) a statistician.

From March to April 2019, email-listserv-managers from the Association of Professional Chaplains (APC), the National Association of Catholic Chaplains (NACC), and the National Association of Jewish Chaplains (NAJC) emailed their members (both certified and non-certified) surveys on behalf of the interview team. The email explained the purpose of the study, eligibility criteria, risks and benefits, identity protection processes, how responses would be used (including potential to be selected for an interview

and incentive for interview) and contact information for the primary investigator and IRB. The email contained a survey link and explained that completion implied consent. Each organization emailed surveys once; email recipients could forward the email to other people if they chose (this was not actively promoted). Surveys were closed to accrual in April 2019. Surveys were anonymous, unless participants answered positively to having practiced telechaplaincy, were willing to be interviewed, and provided contact information. Surveys were de-identified after interview participant selection and removal of duplicate surveys. Only the research team had access to responses.

The research team selected interview participants using maximum variation sampling, a strategy "aim[ed] at capturing and describing the central themes or principal outcomes that cut across a great deal of participant or program variation … by identifying diverse characteristics or criteria for constructing the sample" (Patton, 1990, p. 172). First, the research team identified characteristics of interest: gender, age, race, clinical setting, certifying body, geographical areas of practice, length of chaplaincy experience, length of telechaplaincy experience, and telehealth modalities used. Then, the first author selected potential interview participants from eligible survey respondents with the goal of accruing a diverse sample based on these characteristics. The first author approached all potential participants by email. Snowball sampling methods were used to accrue interviewees with characteristics that were not available to the extent needed among survey respondents. Participants received a $20 ClinCard upon completion of the interview. Subjects were accrued until saturation, defined here as that point when no new information was obtained after researchers paid special attention to gaining a cohesive and varied sample, and themes were supported with rich data (Morse, 1995).

The first author conducted, recorded, and transcribed interviews, and the second author randomly selected half the interviews for verification of transcription accuracy. A second or third person were consulted for unintelligible passages.

Measurements

The research team developed survey questions and interview questions based on the study aims. An internal interdisciplinary research advisory group provided feedback on questions to ensure face validity.

The survey questions assessed demographics, current and previous chaplain experience, current and previous telechaplaincy practice, and respondents' opinions about telechaplaincy. Survey questions were multiple-choice, Likert-scale, and open response.

The semi-structured interview guide assessed various aspects of telechaplaincy including training, development of programs, motivation to practice, institutional requirements, interventional procedures, and views about strengths, weaknesses, and best practices. The protocol permitted iterative adaptation of the interview guide as themes emerged. Questions were added on what terminology chaplains preferred for telechaplaincy, length of the relationship with recipients, and length of average visit.

Analysis

Quantitative

Survey responses were summarized, described, and compared using Fisher's Exact and Wilcoxon rank-sum tests for categorical and continuous measures, respectively. Analyses were conducted using SAS 9.4 (SAS Institute, Cary, NC).

Qualitative

The first author and the second author performed emergent thematic coding of the in-depth interviews and open-ended survey questions using a constant comparative approach. The fourth author provided guidance about coding and feedback on the codebook. NVivo 12.0 was used (QSR International Pty Ltd, Version 12, 2020).

The first and second author coded the first nine interviews together, until a codebook was generated with less than two nodes added per interview. The first author and second author then coded ten interviews separately, until an interrater reliability analysis was a Cohen's kappa over 0.75 (which is considered excellent agreement) for five consecutive interviews (Jackson & Bazeley, 2019). The first and second author then coded eight interviews individually, co-coding two interviews to check for inter-rater reliability (Cohen's kappa values were 0.85 and 0.80). The first author then coded open-ended survey responses about strengths and weaknesses. The second author coded 117 entries (15% of survey responses) to assess inter-rater reliability (Cohen's kappa of 0.93).

Results

Sample

Survey

781 survey records were accrued. Records were removed if there were no responses ($N = 14$) or no response to the question indicating whether they have practiced telechaplaincy ($N = 62$). Duplicate responses (as identified by the respondent's name or email) ($N = 6$) were removed. This resulted in 699 unique survey records. Survey respondent characteristics were summarized (Table 1).

Interview

In total, 52 people were approached for interview, and 36 were interviewed by phone. Four people with pediatric ($n = 2$) and hotline experience ($n = 2$) were enrolled through snowball sampling rather than from survey responses. The first and second author agreed to remove one interview from analysis due to the participant describing evangelism rather than spiritual care. In turn, 35 interviews were analyzed, and interviewee characteristics summarized (Table 2).

Chaplains practicing

In 2019, when the survey was conducted, 47.4% of respondents had practiced telechaplaincy. Practice was not associated with age, gender, race, years of chaplain experience,

Table 1. Chaplain survey-respondent characteristics and survey responses.

Total respondents ($N = 699$) Variable	Telechaplaincy practitioners($N = 331$) Median [min,max]	Non-practitioners($N = 368$) Median [min,max]	Median [min,max]	*p*-Value
Age	57 [27,85]	56 [27,82]	57 [29,85]	.111
	N (%)	*N* (%)	*N* (%)	*p*-Value
Gender				.412
Female	350 (50.1)	169 (51.1)	181 (49.2)	
Male	311 (44.5)	141 (42.6)	170 (46.2)	
Transgender	1 (0.1)	1 (0.3)	0 (0.0)	
Prefer not to answer/unanswered	37 (5.3)	20 (6.0)	17 (4.6)	
Race/ethnic identity				>.999
Non-White	109 (15.6)	52 (15.7)	57 (15.5)	
White	535 (76.5)	253 (76.4)	282 (76.6)	
Prefer not to answer/unanswered	55 (7.9)	26 (7.9)	29 (7.9)	
Religion (multi-select)				
Agnostic	28 (4)	10 (3.0)	18 (4.9)	
Baha'i	1 (0.1)	0 (0.0)	1 (0.3)	
Buddhist	26 (3.7)	10 (3.0)	16 (4.3)	
Christian-Protestant	516 (73.8)	240 (72.5)	276 (75.0)	
Christian-Catholic	67 (9.6)	27 (8.2)	40 (10.9)	
Church of Jesus Christ of Latter-Day Saints	3 (0.4)	3 (0.9)	0 (0.0)	
Hindu	6 (0.9)	2 (0.6)	4 (1.1)	
Jewish	29 (4.1)	16 (4.8)	13 (3.5)	
Muslim	2 (0.3)	0 (0.0)	2 (0.5)	
None	3 (0.4)	0 (0.0)	3 (0.8)	
Spiritual but not religious	33 (4.7)	10 (3.0)	23 (6.3)	
Universalist	31 (4.4)	15 (4.5)	16 (4.3)	
Other	40 (5.7)	21 (6.3)	19 (5.2)	
Prefer not to answer/unanswered	32 (4.6)	16 (4.8)	16 (4.3)	
Years of chaplaincy practice				.716
0–5 years	156 (22.3)	68 (20.5)	88(23.9)	
6–10 years	187 (26.8)	90 (27.1)	97 (26.4)	
11–15 years	128 (18.3)	64 (19.3)	64 (17.3)	
16+ years	226 (32.3)	109 (32.9)	117 (31.8)	
Unanswered	2 (0.3)	0 (0.0)	2 (0.5)	
Professionally certified				.754
Yes	583 (83.4)	280 (84.6)	303 (82.3)	
No	109 (15.6)	50 (15.1)	59 (16.0)	
Unanswered	7 (1.0)	1 (0.3)	6 (1.6)	
Setting at assessment (multi-select)				
Healthcare setting				
Assisted living/ Nursing home	60 (8.6)	37 (11.2)	23 (6.3)	
Behavioral health	66 (9.4)	32 (9.7)	34 (9.2)	
Hospice	119 (17.0)	66 (19.9)	53 (14.4)	
Hospital	431 (61.7)	195 (58.9)	236 (64.1)	
Oncology	95 (13.6)	55 (16.6)	40 (10.9)	
Outpatient	55 (7.9)	41 (12.4)	14 (3.8)	
Palliative care	141 (20.2)	80 (24.2)	61 (16.6)	
Pediatrics	64 (9.2)	29 (8.8)	35 (9.5)	
Surgery	52 (7.4)	23 (6.9)	29 (7.9)	
Trauma	93 (13.3)	46 (13.9)	47 (12.8)	
Veteran affairs	13 (1.9)	10 (3.0)	3 (0.8)	
Non-healthcare setting				
Armed forces	51 (7.3)	29 (8.8)	22 (6.0)	
Corporate	7 (1.0)	3 (0.9)	4 (1.1)	

(*continued*)

Table 1. Continued.

Total respondents ($N = 699$) Variable	Telechaplaincy practitioners($N = 331$) Median [min,max]	Non-practitioners($N = 368$) Median [min,max]	Median [min,max]	*p*-Value
Law enforcement/Fire department/etc.	7 (1.0)	6 (1.8)	1 (0.3)	
Prison/Correctional facility	10 (1.4)	3 (0.9)	7 (1.9)	
School/College	8 (1.1)	4 (1.2)	4 (1.1)	
Other	56 (8.0)	38 (11.5)	18 (4.9)	
Unanswered	79 (11.3)	28 (8.5)	51 (13.9)	
Practice community setting (multi-select)				
Rural	120 (17.2)	79 (23.9)	41 (11.1)	*<.001
Suburban	175 (25.0)	91 (27.5)	84 (22.8)	.372
Small city or town	229 (32.8)	121 (36.6)	108 (29.3)	.157
Large city	327 (46.8)	166 (50.2)	161 (43.8)	.375
Unanswered	83 (11.9)	29 (8.8)	54 (14.7)	

*<.001

Note: [1] Analyses of religion and setting at assessment were not performed due to the volume and sparseness of factor levels. [2] Non-white includes: Hispanic or Latino, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or other Pacific Islander, and Other.

or professional certification (Table 1). For chaplains who had not performed telechaplaincy, there were non-significant relationships between their willingness to practice and age, gender, race, years of chaplain experience or professional certification (Table 3). Chaplains who had not practiced telechaplaincy were more willing to do so if they believed it was able to meet patients' spiritual and emotional needs (Table 4). Chaplains currently in rural settings reported the highest proportion of use among community types (Table 1). Telehealth mediums other than the telephone (i.e., text, email, video-conference, other) were used more commonly by those practicing in non-healthcare versus healthcare settings (Table 5).

Description of practice

Interviewees described various types of interventions similar to in-person. Conversation topics included but were not limited to spiritual care, grief support, rituals including prayer, rapport-building, connecting to resources, crisis-management, advanced care planning, funeral planning, family support, and staff support. Some reported they were not able to deliver certain interventions like advanced directives education via telehealth modalities; others reported they were able to do so.

Visit duration ranged from one minute to over an hour. Most often, introductory conversations were one to five minutes, while more in-depth visits lasted thirty-minutes to an hour. There were a variety of timespans for the relationship: one visit was common, though continuity of care extended over a year. Some programs had a prescribed number of contacts, while most chaplains determined the length of the relationship as it evolved.

Most interviewees personally developed their practice based largely on their own vision, because of no available benchmarks or trainings. By and large, telechaplaincy was not regulated by the institution, other than needing to be HIPAA complaint, conducted on a company phone, and charted. Several chaplains were unable to describe

Table 2. Chaplain interviewee characteristics ($n = 35$).

Variable	*N*
Age	
21–30	2
31–40	9
41–50	8
51–60	7
61–70	9
Gender	
Female	20
Male	15
Race/ethnic identity (multi-select)	
Asian	2
Black	5
White	26
Hispanic or Latino	2
Religion (multi-select)	
Agnostic	1
Buddhist	3
Christian-Protestant	24
Christian-Catholic	5
Indigenous	1
Jewish	4
Muslim	1
Universalist	4
Years of chaplaincy practice	
0–5 years	8
6–10 years	10
11–15 years	7
16+ years	10
Years of telechaplaincy practice	
Less than a year	6
1–3 years	6
3–5 years	7
5+ years	16
Chaplain certifying body (multi-select)	
Association of Professional Chaplains	26
Association of Clinical Pastoral Educators	2
National Association of Catholic Chaplains	4
National Association of Jewish Chaplains	2
National Association of Veteran Affairs Chaplains	1
Other	4
None	5
Practice setting for telechaplaincy (multi-select)	
Healthcare setting	
Assisted living/Nursing home	4
Behavioral health	7
Hospice	12
Hospital	14
Oncology	9
Outpatient	15
Palliative care	10
Pediatrics	6
Surgery	2
Trauma	2
Veteran affairs	4
Non-healthcare setting	
Armed forces	1
Corporate	2
Law enforcement/Fire department/etc.	3
Population (general)	3
Prison/Correctional facility	1
School/College	1
Modality used (multi-select)	
Telephone	33
Videoconferencing	13
Email	21
Texting	8
Other	2

Table 3. Characteristics of chaplains willing to practice telechaplaincy vs. undecided vs. not willing to practice.

Variable	Willing Median [min,max]	Undecided Median [min,max]	Not willing Median [min,max]	*p*-Value
Age	56 [29,85]	60 [30,80]	59 [30,82]	.126
	N (%)	*N* (%)	*N* (%)	
Gender ($N = 350$)				.411
Female	109 (50.9)	44 (57.1)	27 (45.8)	
Male	105 (49.1)	33 (42.9)	32 (54.2)	
Race ($N = 338$)				.541
White	168 (81.2)	61 (85.9)	52 (86.7)	
Non-White	39 (18.8)	10 (14.1)	8 (13.3)	
Professionally certified ($n = 361$)				.397
Yes	177 (81.9)	70 (88.6)	56 (84.9)	
No	39 (18.1)	9 (11.4)	10 (15.1)	
Years of chaplaincy ($N = 365$)				.158
0–5	58 (26.5)	19 (24.1)	11 (16.4)	
6–10	64 (29.2)	14 (17.7)	19 (28.4)	
11–15	37 (16.9)	15 (19.0)	11 (16.4)	
16+	60 (27.4)	31 (39.2)	26 (38.8)	

Table 4. Willingness to practice based on beliefs about effectiveness ($n = 360$), $p < .001$.

		Do you think chaplains can meet people's r/s needs through telechaplaincy? *N* (%)			
		Yes	Sometimes	No	Total
Would you be willing to practice telechaplaincy?	Yes	84 (23.3)	130 (36.1)	3 (.8)	217 (60.2)
	Undecided	4 (1.1)	59 (16.4)	15 (4.2)	78 (21.7)
	No	1 (.3)	27 (7.5)	37 (10.3)	65 (18.1)
	Total	89 (24.7)	216 (60.0)	55 (15.3)	360

Table 5. Modalities used by practitioners in healthcare versus non-healthcare settings ($N = 331$) $p = .044$.

	Healthcare chaplains ($N = 300$)	Non-healthcare chaplain ($N = 28$)	Unknown practice setting ($N = 2$)
Telephone only ($N = 242$)	226 (68.3)	16 (4.8)	0 (0.0)
Other modalities ($N = 86$)	74 (22.4)	12 (3.6)	0 (0.0)
Unknown modalities ($N = 3$)	1 (0.3)	0 (0.0)	2 (0.6)

Note: Non-healthcare chaplains included those who indicated work in a non-healthcare setting only. *p*-Value reflects the Fisher's Exact test comparing known modalities and practice settings.

what HIPAA compliance meant via telehealth, even though they claimed it was an institutional requirement.

Terms for telechaplaincy

Chaplains used a variety of terms to describe telechaplaincy, including but not limited to e-chaplaincy, chaplaincy on-demand, virtual chaplaincy, mobile chaplaincy, and community-based chaplaincy. This study originally used the term virtual chaplaincy. The term telechaplaincy was later adopted because it was better received by interviewees. Some chaplains were confused by the term virtual chaplaincy or had perceptions that virtual implied not real.

Strengths and weaknesses

Within surveys and interviews, participants identified a variety of strengths and weaknesses of telechaplaincy. A few chaplains claimed it to be completely positive or negative, but most saw a more nuanced picture. Four main themes emerged for both strengths and weaknesses, with various sub-themes (Tables 6 and 7).

Best practices

Interviewees identified practices that helped them be more effective at telechaplaincy. While these did not eliminate weaknesses, they provided ways to ameliorate weaknesses and enhance strengths. Coders grouped described best practices into four themes based upon the timing and intent of the best practices. The four themes included (1) program implementation, (2) preparation for individual encounters, (3) delivery of encounters and (4) sustaining a program. Chaplains largely developed these practices on their own because trainings were not available. While these practices were not evidence-based, they were described as effective.

Program implementation

Chaplains described seven unique themes about best practices for starting a program. They are described below.

Get support from key stakeholders

Getting support from key stakeholders is a recommended first step. Chaplains described key stakeholders as upper-level and mid-level leadership, departmental leadership, interdisciplinary team members, information-technology support, chaplain colleagues, and potential program participants. Support could be financial, institutional buy-in, willingness to work collaboratively, strategic help, or enrollment as program participants. People gained this support through one-on-one or small group meetings with leadership and strategy teams, relationship building with interdisciplinary team members and program participants, and educational presentations about telechaplaincy and its goals. Larger programs appeared to rely more heavily on system buy-in than less formalized or single-person programs, but a variety of program types claimed to benefit from stakeholders' support.

> Get as much buy-in as you can early on. For us, it was much more helpful when the mid-levels and providers really were excited about it and wanted to talk it up in their visits … It just helped get the resources, the tools, the logistics in place much more quickly than it does if you're just kind of lone-rangering it. (Healthcare Chaplain)

Learn from precedents

Knowledge and experience gained from precedents limited the work and mistakes chaplains made in starting their own programs, subsequently limiting unnecessary cost. For some, learning from precedents meant consulting people from other disciplines who have practiced telehealth (similar professionals like psychologists or social workers were

Table 6. Strengths of telechaplaincy identified by chaplains.

Theme	Subthemes	Exemplary quotations
Theme 1: Extends access to experienced chaplain	A. Overcomes barriers that make being in-person harder, including distance, disability, transportation, etc.	"I was able to care for people who were probably a little more on the margins. Somebody who had TB and was quarantined … somebody who was a truck driver, who was constantly on the road" (Healthcare Chaplain)"[The soldier] may be back at the barracks or in a different location. … [So telechaplaincy allowed us to] hold the space no matter where we were." (Armed Forces Chaplain)
	B. Extends continuity of care	"The advantage to [telechaplaincy] though is that there's a real chance of long-term spiritual healing that may take several months. … there's a chance for them to actually work through a lot of the spiritual distress issues that they showed up with at the hospital." (Chaplain Manager)
	C. Timely response	"Some of the pressures of time of emergency response don't give you time to be face to face … And so a quick phone call is more important than face to face." (Healthcare/Prison/ Other Chaplain)
Theme 2: Delivers Effective, Appropriate Spiritual Care	A. High-quality care	"Some of my best work has been done over the phone …. I would say that it has the potential to be completely equally adequate as in-person spiritual care." (Healthcare Chaplain)
	B. Good for assessment, introducing services, and deep listening	"[In the] hospital realm, there's people coming and going, there's tubes shoved where tubes don't belong …, but there's less listening going on than there is activity. Whereas in a virtual encounter, it's all done by listening, by communicating. And, and when a patient feels heard, they're going to share things that they want someone to hear. (Healthcare Chaplain)
	C. Comfort	"I think that level of control and safety for a person in their home actually contributes to the visit." (Healthcare Chaplain)
	D. Limits bias	"Visuals that might contribute to a patient's perception of chaplain (age, gender, clothing, etc.) are less likely to contribute to projection and disrupt relationship." (Healthcare Chaplain)
	E. Resources and interdisciplinary work	"[I have] a whole bunch of [resources and contacts] in my phone, I can just text those off right away." (Armed Forces Chaplain)"I would say that the process has been fascinating for me to kind of see how technology can be used to facilitate patient care across disciplines." (Healthcare Chaplain)
Theme 3: Amenable	A. Preferred	"Some people … appreciated having phone calls, but they did not want visits." (Healthcare Chaplain)

(*continued*)

Table 6. Continued.

Theme	Subthemes	Exemplary quotations
	B. Theological or ideological agreement	"Most of my experience with virtual chaplaincy … is that the people that respond to it the most and that want it are people who are disconnected, who are isolated or who are afraid of talking to a faith representative in-person for lots of different reasons. So, for my theological language, it's probably about being present with the outcast. (Healthcare Chaplain)
	C. Promotes refined skills	"It's developing another skill because you really have to listen even more so, more deeply for what you're hearing, sensing, exploring." (Healthcare/School Chaplain)
	D. Flexible	"I actually loved that I could sit at home or sit in my car and provide this care. So, on some level for me, there was a way in which it was less taxing but still very rewarding." (Healthcare Chaplain)
Theme 4: Efficient use of chaplain, patient, and system resources	A. Cost	"I mean in terms of cost, it's cheaper for everybody." (Healthcare Chaplain)
	B. Time	"[Life] might make it hard for somebody to get someplace for an appointment, having to work all day, … not having the luxury of taking time off." (Healthcare Chaplain)
	C. Relevant	"They have developed [telehealth] to meet the real need that's out there. … We need to keep up if we're going to be relevant. And if we're going to really serve, we have to understand the way that (society and healthcare) is changing and incorporating that." (Population Health Chaplain)

commonly consulted), or chaplains who have established telechaplaincy programs. For others, it meant utilizing technologies and systems that were already in place at their institution, so they did not need to negotiate contracts with technology companies, establish new policies, or introduce technology to the system. Thirdly, it involved learning from research. Many desired more published research and evidence-based best practices.

Secure sustainable funding

Sustainable funding sources are needed to pay for technology, administrative fees, and chaplain time if the program operates as a separate line-item. Respondents used solicited donations, designated departmental funds, and reimbursement gained through company health insurance. Demonstrating evidence of the program's efficacy or return on investment helped secure or sustain funding.

Develop an easy referral and triage process

Having a clear and simple referral and triage process for consults led to better utilization of programs within larger institutions. Some programs used screening tools to

Table 7. Weaknesses of telechaplaincy identified by chaplains.

Theme	Subthemes	Exemplary quotations
Theme 1: Not as effective as in person	A. Not able to see person or environment	"On the phone, it's hard because you're not getting the visual cues. You don't know what else is going on in the room or for the person. And so, it's hard if they seem distracted or there's a long pause. Like, did you walk away from the phone?" (Healthcare chaplain)
	B. Limits interventions	"[To facilitate rituals,] we could talk about what they need, what it might look like, where they might get the materials they needed … but it was harder." (Healthcare chaplain)
	C. Feels removed	"People do have an immediate sort of disconnect … part of facing a screen. It's not really super obvious, but … they feel a little bit more removed. (Healthcare Chaplain)
	D. Changes energy	"There's no obvious precipitating event. … No energy that's already in the room that you're bearing witness to or adjusting or trying to match and pace. So, very much going into the situation very blind and being the source of energy there." (Chaplain Manager)
	E. Limits interdisciplinary work/resources	"Your resources are much more limited in a certain way than they are if you're inpatient. Inpatient you have just about everything in house." (Chaplain Manager)
	F. Shorter visits	"I tend to find those lingering moments of … silence and the longer pauses, they tend to be far less frequent on a phone call. And so, I also wonder … if people just tend to be a little bit more condensed in their sharing of information because they're on a phone call." (Healthcare Chaplain)
	G. Confidentiality difficult to ensure	"It's a potential risk of virtual chaplaincy. How do you protect the confidentiality of the conversation?" (Law Enforcement Chaplain)
Theme 2: Not appropriate or desired by all people, circumstances, and preferences	A. Technology inaccessible/more difficult due to disabilities, access, speech differences, etc.	"In hospice I often supported people in person who had dementia or some form of cognitive impairment. And … that needs to be a physical presence." (Healthcare Chaplain)"You notice I speak with some accent … Sometimes people think it is a robo-call, one of the people trying to call them to get them to sign up for something like a cell phone." (Healthcare Chaplain)
	B. Distractions	"Sometimes I don't have great timing and that's not something that I can control when I reach out to families. There was one family that said, 'I would love to meet with you, but I just came to the ER and I can't talk right now.'"(Healthcare Chaplain)

(*continued*)

Table 7. Continued.

Theme	Subthemes	Exemplary quotations
	C. Theological or ideological disagreement	"My foundational theology is that we are created to be in community … I have not yet worked all this out in my theological mind about how to be a community of connected humans virtually." (Healthcare Chaplain)
	D. Chaplain resistance	"Chaplains …. typically are very, very resistant to change. That's a reputation that we've unfortunately earned over the course of our developing as a discipline." (Healthcare Chaplain)
	E. Distrust, or frustration with contact or multiple contacts	"I was not the first person to call them that day and their baby wasn't doing so well. So, they were agitated that someone else was calling them from the hospital and voiced that." (Healthcare Chaplain)
	F. Boundary issues	"The only barrier I can see if people … continue to call and to lean on the chaplain for something more that the chaplain can't offer." (Healthcare Chaplain)
Theme 3: Costly	A. Technology	"The other big barrier is technology is expensive and it does require a lot of resources or the commitment from the organization and researchers to make it happen." (Healthcare Chaplain)
	B. Time	"We might call and there's no voicemail … There's no answer. How long do you keep trying to call these people?" (Healthcare Chaplain)
	C. Training/ Systems	"The other big barrier is … the discomfort and the lack of preparation and resources and training for chaplains be expected in that space. I think that as we learn more about it and develop these processes and tools that will get better. But, right now I don't think that we are there yet." (Healthcare Chaplain)
	D. Risk of being sued	"Who is in the same room as your client that you can't see when you Skype? … If your client commits suicide later on can those notes be used against you?" (Healthcare Chaplain)
Theme 4: Technological issues	A. Disruptions and errors	"When the technology is not working, it's just frustrating, and for me, it actually affects the relationship more. Like I get distracted by that and I can't be engaged." (Armed Forces Chaplain)
	B. Quickly irrelevant	B. "At the time we initiated this, … the technology was not what it is today. And today with people's smartphones, there is almost always a relative here who can use their smart phones to talk to the parent … And so, we really hardly use the technology at all now." (Healthcare Chaplain)

identify participants. To keep this system working, chaplains often had to educate and re-educate teammates on telechaplaincy services and referral processes.

Chaplains advised creating policies for meeting referrals for non-English speaking recipients. Only two interviewees had a plan to address these needs, one used an over-the-phone interpreter, and another spoke multiple languages. Several people voiced uncertainty about how they would handle these needs if they arose.

Have a safety plan

Often when conducting telehealth, the recipient cannot be immediately admitted for psychological care if they voice suicidal or homicidal ideation, because they are not physically present with the practitioner. This barrier was thoughtfully addressed and referenced by some, and a major concern for others without a plan. Plans varied and included: identifying the recipient's location toward the beginning of the call, facilitating immediate connection to a suicide or safety hotline, and linking a social worker, psychologist, or suicide prevention case manager from one's workplace into the call. One chaplain underwent suicide-safety training to gain these skills himself. Importantly, when chaplains had skills to deal with suicidal ideation, telechaplaincy was a way to ensure safety for recipients. Three interviewees talked about visits saving people's lives due to addressing safety concerns.

Practice to develop confidence and understanding

Practicing helped people develop confidence and understanding of telehealth modalities and interventions. While many people had anxiety about performing telechaplaincy at first, most found that time and experience improved their practice and outcomes. Training was desired by nearly all participants who wanted to practice with their colleagues prior to delivering interventions, work with Information-Technology professionals to learn the technology, or discuss ongoing interactions with fellow practitioners for continual improvement. One educator suggested never letting learners make the first call alone, but letting them shadow a call, then make a supervised call.

Do not use telechaplaincy to replace in-person chaplains, or solely to save money

Interviews and surveys revealed significant distrust of systems using telechaplaincy to save money, reduce chaplain positions, or eliminate face-to-face visits. Repeatedly, chaplains expressed their desire for telehealth to be used thoughtfully to extend access, rather than replace current practice. Relatedly, only one of the thirty-five interviewees claimed to prefer telechaplaincy to in-person chaplaincy. Most required some in-person element to sustain their energy and interest in the profession. If systems are motivated primarily by efficiency, respondents predict they would face heavy push-back, and have difficulty recruiting long-term staff chaplains. Instead, they suggested that systems integrate telechaplaincy with in-person aspects of the role, and that all program aspects are thoughtfully created.

Preparation for individual encounters

Chaplains also described best practices for getting ready for telechaplaincy encounters.

Assess which modality to use

Chaplains identified that telechaplaincy is not ideal for all patients or circumstances. A way that chaplains circumnavigated this barrier was intentionally assessing which patients to meet via telehealth versus in-person, then assessing which modality to use. One chaplain described his process:

> You kind of go through this list of what needs to happen … to provide spiritual care. [And then you assess which modality to use] … the possibilities and you try to narrow those down, … where the person's at and what kind of reception they have and how confidential you can be. (Healthcare Chaplain)

Schedule interactions

The cost of provider time was partially addressed by scheduling visits to improve chances of reaching the recipient on the first contact. Scheduling also prepared the recipient to be contacted, so that they could limit distractions and would trust the interaction. The visit could be scheduled using email, a short introductory call, or while in-person.

Limit distractions

Chaplains suggested limiting distractions to ensure confidentiality, and to enhance their ability to listen and be present. This included blocking time to limit clinical responsibilities from interrupting, finding a quiet space, limiting distractions within the space (especially from the computer), and mentally/spiritually preparing for the interaction.

> I stumbled upon this quotation by Ram Dass …. "I am loving awareness." … what I'm learning is that when they do telephonic work that is so important. Part of it is creating space, like making sure that I'm sitting somewhere where I'm not going to be distracted by other things, which I think is a natural temptation when we're on the phone. (Healthcare Chaplain)

Establish relationship in-person if possible; enhance connection if not

Often chaplains found they had better interactions if they had previously met the recipient in-person, or if they were given a referral from a colleague who informed the recipient that the chaplain would reach-out. This helped establish a trusting relationship. One strong proponent of telechaplaincy programs said, "It is better if you have a warm handoff, because otherwise they have no idea who the heck is calling them" (Chaplain Manager).

In some cases, in-person contact was not possible as the first encounter. Chaplains had good experiences even when making cold calls. Knowing information about the recipient was helpful in these cases. One person conducted a thorough chart review to gain this information. He suggests knowing the person's diagnosis, treatment regimen, social information, communication barriers, former spiritual care interactions, and any

other information that would give a sense of who the person is. Additionally, having a good skillset to develop a relationship over the phone helped when making cold calls. These skills are further explained in the following section.

Delivery of interventions

Eleven unique themes emerged for describing best practices for improving the telehealth intervention as it was being delivered.

Use a flexible script

Many valued a flexible script. Scripts helped chaplains use HIPAA-compliant messaging, reduced anxiety if they were new to telechaplaincy practice, provided creative ways to deepen the conversation, and addressed common issues (i.e., people being fearful of the chaplain calling, people misunderstanding the reason of the call, and technical difficulties). Some chaplains had different scripts depending on the goals of the conversation.

Notably, three interviewees did not like using a script, each referencing it as being rote or prescriptive. In comparison, people who liked using a script deviated from the script as appropriate to maintain natural relationship-building conversation.

> For chaplaincy, I think there's a lot more give and take and flow to the conversation [than with other practices]. [A chaplaincy script] is not just an interview set of questions of how your pain meds are treating you … [Instead, it is] a place to start with some questions, but also being able to deviate from those and make it more conversational and having it be relational. (Healthcare Chaplain)

Define the purpose of the contact

For most of the interviewees, it was important to quickly and clearly define the purpose of the contact to ensure a better interaction. Often this had three parts: (1) introducing oneself, (2) explaining the reason for the contact, and (3) conveying any restrictions.

Practitioners explained the delicacy of introducing oneself via telehealth. Often, they found that recipients were fearful if they used the term "chaplain." Some chose different terms for first introductions to limit this fear, only later defining themselves as "chaplain" once trust was established. Terms used were spiritual care clinician, spiritual care coordinator, patient support member, spiritual care provider, and a member of the medical team. Others used the term "chaplain" at onset, but quickly explained the breadth of their services.

They also had succinct, sometimes scripted, ways to introduce the reason for the contact using language laypeople would understand. Explaining the purpose of the call meant first self-defining the reason prior to contact. Chaplains talked about the importance of having goals. While many held these goals loosely and were open to the flow of the conversation, an initial purpose helped. Purposes ranged from spiritual needs assessment, to spiritual care, to grief support, to a wide array of other reasons.

Lastly, some acknowledged any potential issues at the beginning of the conversation. They may talk about their time limitations, potential technical glitches, and

confidentiality-protecting processes. They may also tell the person about the physical environment they are in, any safety procedures, and any technical instructions. Examples included:

- "Thank you so much for sharing your child with me and this time with me… Do you have any concerns about doing this on Skype?" (Healthcare Chaplain)
- "It may look like my eyes are closed, but that's because the camera is at the top of my monitor and you're in the middle of my monitor, so I am paying attention to you." (Healthcare Chaplain)
- "When I had the computer in front of me with the camera, I'll show where I am in my setting." (Healthcare Chaplain)
- "[I address technical issues by using] my authority of recognizing that that emotional space had gotten disrupted and inviting us back to it." (Healthcare Chaplain)

Listen deeply

Practitioners enhanced their connection by listening even more deeply than they would in person. This included listening for background noise, slight voice modulations, and even silence.

> You rely on nonverbals way more than you thought you did. And so, you're going to have to be listening for the things that are in people's voices that kind of help you. (Law Enforcement Chaplain)

Be selective with word choice

Word choice was more important when providing telechaplaincy than when in-person. It was important for chaplains to develop ways to succinctly and appropriately state what they mean. They found ways to convey their reactions, to frame their understanding, mirror, convey presence, show empathy, and deliver spiritual and emotional care.

Pay attention to tone

Chaplains intentionally modulated vocal tone to convey appropriate emotions. For some, this is a natural ability, and for some it needed to be developed. Practitioners smiled or made the same facial expressions they would if they were in person. They found this could be heard by the recipient, even if it could not be seen. Others more intentionally modulated the pace to mirror the recipient.

Verbalize non-verbals

Interviewees limited the impact of not being able to see non-verbal communication by verbalizing their own non-verbals. Examples of these explanations are below.

- "My silence is just me holding you right now." (Healthcare Chaplain)
- 'I'm smiling' or 'I'm feeling touched.' (Healthcare Chaplain)

Chaplains sometimes asked recipients to explain their own non-verbal communication. Examples are below:

- "I needed to be intentional about asking the question of: 'what's about that silence?' 'Is there something there or was that just a pause?'" (Law Enforcement Chaplain)
- "There are times when someone is crying or, or upset in one way or another, where I would say 'because we are on the phone, I can't see your face, and I can't see how you're feeling. Can you tell me what you're feeling?'" (Healthcare Chaplain)

Use open-ended questions

Like in-person, open-ended questions helped some chaplains facilitate better empathetic connection because it conveyed interest and deepened the conversation. Some used more conversational, rapport-building questions at first to establish a connection and then moved to targeted, deeper questions for spiritual assessment and interventions. At the same time, reliance on only questions felt like an interrogation; chaplains had better results when they intermixed questions with statements.

Thoughtfully use silence

A common theme was figuring out a way to thoughtfully use silence in a way that felt comfortable to the recipient. In some cases, this meant using silence less frequently than in-person. In other cases, it meant acknowledging the silence, or intentionally incorporating it into the conversation. Part of using silence thoughtfully was overcoming one's own anxiety about using it. One participant advised, "You don't have to interject something every time there's a silence. Just wait and let people say what they need to say. Give them time to think and to speak" (Healthcare Chaplain).

Use creative rituals

Many chaplains frequently used prayer. Since this ritual relies heavily on voice, it was easier to deliver. A few successfully administered other rituals. This took creativity as rituals have physical components, and the provider and recipient are in different locations. Respondents described what worked for them. One person suggested having various supplies available in case a ritual was appropriate. Sometimes they had the recipient bring items like sage or communion items so that they could participate. Others used succinct language to walk the recipient through the process or provided clear instructions so that the recipient could do the ritual later. Others found ways to be physically present across technology. One chaplain put her hands on the screen to deliver a blessing. Another shared motivational or spiritual videos.

Give the recipient control

Some interviewees acknowledged that using technology can be dehumanizing. One way they addressed this is by giving the recipient control when possible, to provide a more

equal power dynamic and establish a greater sense of trust. This involved giving the recipient the choice of when to meet, when/if to end the conversation, which telehealth modality to use, conversation topic, and if they wanted to receive rituals.

Welcome the unexpected

Respondents mentioned encountering "strange," "unexpected" or "odd" things. Just as in-person, it was important for them to respond empathetically and non-reactively to deliver the best care. Several people found this easier to do via telephone as the recipient was not able to see their non-verbal reactions.

Sustaining a program

Finally, interviewees described best practices for supporting or growing an existing telechaplaincy program.

Engage in research and quality improvement projects

Since telechaplaincy is novel, people noted the need for research to improve and build programs. Many chaplains conducted pilot studies, did quality improvement, or kept statistics on benchmarks. Results from these projects were used to advocate for funding, build programs and develop evidence-based practice.

Work with an interdisciplinary team

Connecting to the interdisciplinary team led to a sense of not being alone in the work and improved the care that chaplains could deliver. Interdisciplinary teamwork took many different forms including getting technical support from Information-Technology professionals, referring to and receiving referrals from teammates, and gaining emotional support from other professionals doing telehealth work. Another key component was continually connecting with colleagues, so the spiritual care was not forgotten. Some contacted colleagues using email or phone. Others had in-person clinic days. This helped address the issue of being "out of sight out of mind."

Establish boundaries

Telechaplaincy can increase one's availability, making boundaries more important to maintain. People found it helpful to communicate one's availability, triage non-urgent referrals to work shifts, and end the relationship when needs are met. They repeatedly stated the importance of clearly communicating that one is not a friend, but a professional. Chaplains may state they are calling within their shift hours, refuse to meet patients at inappropriate times, and focus the conversation on spiritual and emotional needs rather than chit-chat. They also found it important to only use an institutional phone and not provide personal contact information. This was slightly different for chaplains in the armed forces, who are expected to be available 24-7. In these cases, triaging cases or making referrals to other professionals may be important.

Do self-care

For some, doing telechaplaincy work is more emotionally draining than in-person work because of feeling more disconnected. Self-care practices proved important. This involved taking breaks from telehealth mediums, debriefing with colleagues, performing resiliency-building practices, or engaging in other forms of meaningful work in-between calls. Additionally, developing theological language around one's reason for engaging in the practice was helpful for several people.

Discussion

The promise of telechaplaincy

This study supports the thoughtful integration of telechaplaincy and its promise for improving spiritual care in various settings. Respondents described a nuanced picture of inter-related strengths and weaknesses. Best practices hold promise of reducing the weaknesses and enhancing the strengths.

The utilization of telechaplaincy is extending well beyond what some chaplains predicted just a few years ago (Atkinson, 2017). This study was conducted prior to COVID-19 and demonstrated that approximately half of surveyed chaplains practiced telechaplaincy. Furthermore, this study supports that telechaplaincy is more often used in settings where there is opportunity to practice, like in rural areas. More chaplains have used telehealth modalities during COVID-19, with the majority claiming they will retain aspects of these ministries going forward (Flynn, Tan, & Vandenhoeck, 2021). With opportunity and practice increasing, more thorough understanding of telechaplaincy is necessary for quality care. This study is a step in that direction.

Addressing chaplain bias

While commonly practiced, a substantial number of people had negative perceptions of telechaplaincy or were not willing to practice. This is similar to findings from another study that showed chaplains to be less receptive to telehospice than nurses and administrators (Washington et al., 2009). Managers and departments could benefit from intentionally addressing this barrier. Based on suggested best practices, it is advisable to incorporate chaplains as key stakeholders in the planning process. Additionally, it may behoove programs to educate chaplains about the effectiveness of the practice. As is evidenced in this study, chaplains were more likely to practice if they believed that telechaplaincy was effective at meeting recipients' spiritual needs. Addressing theological reasons for this bias may also be important, as theology was a subtheme identified within strengths and weaknesses. Lastly, departments may be more successful if telechaplaincy is part, not all, of a chaplain's responsibilities. Chaplains repeatedly talked about the benefits of having in-person visits as a part of their responsibilities. Physical presence is important to chaplains and may be hard for chaplains to totally surrender. This aligns with other research that showed the importance of using telehospice as "an additional tool and not a substitute for actual visits" (Demiris, Oliver, Fleming, & Edison, 2004, p. 346).

Need for training

Chaplains were unaware of best practices outside of what they had created. Most interviewed chaplains claimed to have limited or no formalized training and wished they knew best practices and benchmarks. Consistent with Flynn et al., we suggest trainings on best practices be created and disseminated (2021). Training could focus on implementation, delivery, and sustainability. Additionally, we suggest that trainings highlight the nuances of telechaplaincy, while also highlighting that chaplains already possess professional competencies to help them succeed. For instance, the suggested best practice of 'defining the purpose of the contact' falls under the professional competency PPS1: "Establish, deepen and conclude professional spiritual care relationships with sensitivity, openness, and respect" (Board of Chaplaincy Certification Inc, 2016). Professionals should have an existing skillset of establishing the pastoral relationship, and trainings could highlight specific language or methods that could better help the chaplain succeed at doing this in the telechaplaincy context.

Case studies, role-playing and discussion could be effective educational strategies. National certifying chaplain bodies and state-level chaplaincy organizations are well-positioned for further dissemination of training material. These organizations have already begun to do this education during COVID-19 (Association of Professional Chaplains, 2020; Sprik, 2020, Sprik et al., 2021, Wade, 2020). Material from this study could supplement these materials, as suggested best practices draw from a diverse array of chaplain practitioners and offer new wisdom to the field.

This study is novel in that it is the first nation-wide study of telechaplaincy practice within the United States and draws from a large sample of people. Thirty-six interviews were conducted, drawing in-depth data from a diverse sample. Surveys were largely anonymous, limiting conformity bias. Research bias was addressed through triangulation.

A limitation was sampling bias; while the survey was sent out via three major certifying bodies, it was not sent to the National Association of Veterans Affairs Chaplains or the Pediatric Chaplaincy Network due to the timeline in which permission was necessary. It was not systematically disseminated to non-certified chaplains. Additionally, the primary investigator selected the cases (though variables of interest were discussed prior to selection). Additionally, best practices suggested by interviewees are not yet evidence based. Discussed best practices are based primarily on the experience of 35 chaplains with a variety of chaplain experiences. While robust, much more is needed for chaplains to reach similar experience and understanding of telehealth as other disciplines. Large interventional studies could provide more information about evidence-based best practices for providing rituals over telehealth modalities, scripting to enhance success of interventions, ideal timing of contact, and other important aspects of telechaplaincy. Lastly, this study was conducted prior to COVID-19, and cannot speak to the number of chaplains currently performing telechaplaincy. Nevertheless, meaningful conclusions may be drawn.

Telechaplaincy was a common practice prior to COVID-19, which has only grown since. There are strengths and weaknesses to telechaplaincy. Chaplains have found ways to enhance the strengths and limit the weaknesses of telechaplaincy through developed best practices. Suggested best practices can direct next steps in clinical practice, training, and research.

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Data availability statement

Due to the nature of this research, participants of this study did not agree for their data to be shared publicly, so supporting data is not available.

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